NHS South Kent Coast Clinical Commissioning Group
Operational Delivery Plan 2015/16

Our Commissioning plans for 2015/16

The predominant commissioning approach in 2015/16 will be to further develop out of hospital care as part of a Multi-specialty Community Provider (MCP) Model (including an application to the *New Models of Care Programme*), underpinned by strong GP clinical leadership and supported by medical specialists. In addition, we will drive schemes which will impact on 'in hospital" pathways in order to meet constitutional targets and improve patient outcomes through seven day working.

Specific areas of focus for the CCG's MCP Model and "in hospital" schemes, reflecting local intelligence, performance and the *NHS Right Care* programme, will be:

Out of Hospital:

- Cardiovascular Disease (including Stroke);
- Respiratory Disease (including Asthma and Chronic Obstructive Airways Disease (COPD)
- Diabetes Care & Treatment improvement;
- Prevention, Self-Care and Self-Management;
- Implementing the 5 point Inequalities Strategy
- End of Life Care;
- All-age Neuro-development (including Attention Deficit and Hyperactivity Disorder (ADHD) and / Autistic Spectrum Disorder (ASD))
- Children with Challenging Behaviour;
- Looked After Children;
- Community Mental Health (including Dementia);
- Better Care Fund Scheme Delivery; (Integrated teams and Re-ablement, Falls Prevention, Enhance Primary Care, Enhance Care Home Support, Enhance Practice Level Teams, Integrated health & Social Housing)
- 111/Out of hours re-procurement
- Frailty Pathway

In Hospital:

- Cancer Diagnosis, Treatment & Recovery;
- Dermatology;
- Orthopaedics;
- Cardiovascular Vascular Disease – acute management of stroke and vascular services review
- Psychiatric Liaison
- A& E
- Diagnostics central point of referral

Out of Hospital Programme

From:	By doing what:	To:
'The professionals involved in my care do not appear to communicate with one another. I have to repeat my story every time.'	**SYSTEM CHANGES**	**'The professionals involved with me talked to each other. I could see that they worked as a team'**

'I do not know who the main person in charge of my care is.'	• The development of four Multi-specialty Community Provider 'hubs' (underpinned by an application to the *New Models of Care Programme*) offering specialist advice and support, including urgent and planned care responses, in:
	  • Deal
	  • Dover
	  • Folkestone
	  • Romney Marsh (including Hythe) (see model page 18)
		'I had one first point of contact. They understood both me and my condition(s). I could go to them with questions at any time.'

'When I was discharged from hospital to my home, I was not clear on what would happen next.'	• The development of multi-disciplinary integrated working at General Practice level - including social care and mental health - to improve management of patients longer terms needs in a proactive way. This will include promoting prevention, self-care and self-management and extend to enhanced support for patients in care homes;	**'When I moved between services or settings, there was a plan in place for what happened next.'**
'I panic when my condition deteriorates. I do not know who to contact.'	• Further mobilisation of the Medical Interoperability Gateway (M.I.G) to ensure access to patients' GP records across multiple providers (with patient consent) to avoid duplication and improving care for patients by enabling them to tell providers 'once';	**'I had systems in place so that I could get help at an early stage to avoid a crisis'**
'The care and support I receive has made me dependent on others. I feel no longer able to live my life independently.'	• Mobilisation of community assets to ensure reaching as much of the population possible via District councils, domiciliary care agencies and voluntary organisations;	**Taken together, my care and support helped me live the life I want to the best of my ability'**

Out of Hospital Programme

From:	By doing what:	To:
‘I do not know what to do and where to go in an emergency.’		‘I could plan ahead and stay in control in emergencies’
‘I was not provided with good information about my condition following diagnosis. I no longer feel able to manage without support.’		‘I had the information and support I needed in order to remain as independent as possible’
‘I was not given the opportunity to input into future care arrangements should my condition worsen.’		‘Information about me, including my views and preferences and any agree care plan, was passed on in advance’
‘I only have a quick review of my care and treatment once a year. ‘		‘I has regular reviews of my care and treatment, and of my care plan’
‘I struggled to keep on top of my medicines regime. Are they all still working?’		‘I had regular, comprehensive reviews of my medicines’

PATHWAY SPECIFIC CHANGE

- **Cardiovascular disease* -** focussing on improved prevention and management of stroke, anti-coagulation and community DVT services;
- **Children with Challenging Behaviour -** development of a new multi-agency intensive support team model;
- **Community Nursing -** implementation of a practice level model to ensure that care is coordinated for vulnerable patients groups together with GPs Specialist Nursing – broaden the skills of specialist nurses to be able to manage a greater elements of the pathways for patients with long term conditions;
- **Diabetes* -** implementation of a Type 2 Diabetes primary care training programme and an Integrated Diabetes Care Pathway;
- **End of Life -** improved co-ordination and timeliness of care via a palliative care education programme, increased specialist bereavement counselling and procurement of system wide electronic palliative care system;
- **Falls*** - improved prevention via a refreshed falls pathway between health, social care and public health;
- **Intermediate Care -** to integrate health and social care elements of intermediate care services to reduce duplication and increase the skill of those delivering intermediate care to build capacity and resilience;
- **Looked After Children -** re-procurement of LAC service;
- **Respiratory Disease* (including Asthma and (COPD) -** implementing integrated pathways / services.

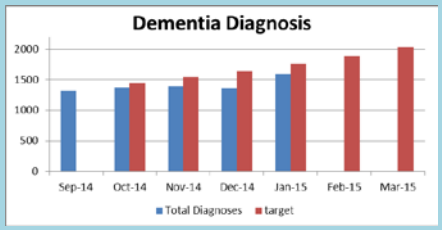
***NHS Right Care: Commissioning for Value Schemes**

- Mental Health Programme

From:	By doing what:	To:
'I had to wait too long for an assessment '.	**SYSTEM CHANGES**	**'I was seen quickly by the psychiatrist and given a clear treatment plan'**
'All of my health needs have never been considered in one place'	• **Community Mental health Team Redesign –** Alignment with older people mental health and crisis team to reduce silo working, improve transfer of care between mental health services to improve patient outcomes and experience whilst increased efficiency and extended hours • **Mental health Personal Health Budgets** – Providing flexibility to meet gaps in services to meet peoples needs to promote choice in provision in mental health services • **IAPT Re-procurement *–** to improve access for hard to reach groups, to be closer aligned to both primary care and acute services for a more integrated mental health service	**My mental health team understood my physical health problems and helped me get the support I needed'**
'I went to A&E and had to wait hours for psychiatric help'	**PATHWAY SPECIFIC CHANGES** • **Community Mental Health and Wellbeing (including dementia)* -** integration of a series of community-based providers to provide a consistent model of community early mental health intervention, increasing diagnosis, support and preventing the need for secondary care. • **All-age Neuro-development Pathway (including ADHD and ASC)** - procurement of an integrated community specialist service for adults and children; • **All-age Eating Disorder Pathway –** procurement of an integrated community eating disorder service • **Acute Liaison Psychiatry *** - Embed a more sustainable service to reduce 136 sections and ensure improved patient experience and outcomes in an acute hospital setting. • **Personality Disorder** – improve the current provision in Folkestone for the benefit of more patients with a personality disorder	**'My condition was stabilised and I was discharged back home and visited by a CPN on the same day.'**
'I was placed in a bed miles away from my home and family.'		**'I was admitted to a bed in the nearest mental health unit'**
'I was not told about the side effects of my medication. I became unwell again and went back to A&E.'		**'My care plan gave me good information about my medication and how to manage the possible side effects'**

***Achieving Better Access to Mental health Services 2020/Commissioning for Value**

Mental Health Performance

	Target	Performance in 2014/15	Challenges and Improvement Plan
Mental Health			
Dementia			
% diagnosis rate	66.7%		The CCG aims to improve the identification and care for patients with Dementia. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis. Practices in SKC have made significant improvement in their rate of diagnosis, with further work planned for 2015/16.
In-patient follow-up			
Follow-up within 7 days after discharge from in-patient care	95%		Exception reports for non-compliance are reviewed through contract meetings.
Improved Access to Psychological Therapy (IAPT)			
IAPT access proportion	15%		South Kent Coast CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15. The CCG continues to monitor access and outcomes for psychological therapy on a monthly basis.
IAPT recovery rate	50%		
Treated within 6 weeks of referral	75%	As of January 2015 – average 93% compliance	To be monitored monthly as a new national target in 2015/16
Treated within 18 weeks of referral	95%	As of January 2015 – average 100% compliance	To be monitored monthly as a new national target in 2015/16
Early Intervention in Psychosis			
Treated within 2 weeks of referral	50%	By April 2016	To be monitored monthly as a new national target in 2015/16

	Target	Q1	Q2	Q3
% recovery rate	50%	54%	49%	52%
% of need entered treatment	15%	22%	23%	20%

Hospital Programme

From:

'I had to make 3 or 4 trips to hospital to receive consultations and tests before I was diagnosed.'

'I was admitted to hospital over night when my condition worsened. I had to wait longer than expected for my discharge arrangements to be made.

'I was not asked my view on my treatment post-discharge. I was placed in a bed miles away from my home and family.'

'I was not told about the side effects of my medication. I became unwell again and went back to A&E.'

By doing what:

SYSTEM CHANGES

- **Accident & Emergency 4 Hour Access Target-** Have in place clear parameters for success and performance monitoring. Testing full 7 Day working across the whole system. Developing an 'Early Warning System' to ensure patients are discharged or transferred between providers in a safe and effective way. Ensuring effective and appropriate escalation processes are embedded across the health and social care economy. Being clear about the messages we share with the Public regarding alternate pathways for accessing healthcare admission avoidance schemes as relevant. Learning from the two 'Perfect Week' programmes
- **EKHUFT Outpatient Strategy** - the CCG will continue to engage with the Trust as it progresses towards consolidation of its outpatient services on six sites, in particular ensuring equitable access to outpatient services for Deal and Shepway patients;
- **Outpatient Follow-Ups** - the CCG will work with EKHUFT and other secondary care providers on new models to follow-up patients secondary care, such as open access / patient initiated and telephone follow-ups.

PATHWAY SPECIFIC CHANGES

- **Cancer*** - focussing on improved diagnosis, sustained Cancer Waiting Times (CWTs) compliance, treatment and recovery / survivorship;
- **Cardiovascular disease*** - focussing on improved acute management of stroke;
- **Dermatology** - full pathway review to develop an integrated pathway that supports appropriate patients in the community rather than default referral to EKHUFT and impact upon their RTT compliance;
- **Orthopaedics*** - continuation of the Collaborative Orthopaedic Referral Point (CORP) Pilot, including review, to continue to ensure inappropriate orthopaedic referrals do not default to EKHUFT and impact upon their RTT compliance.

***NHS Right Care: Commissioning for Value Schemes**

To:

'There were no big gaps between seeing the doctor, going for a test, getting the results and a treatment plan.'

'My condition was stabilised and I was discharged back home and visited by my community nurse on the same day.'

'I was involved in the discussions and decisions about my out of hospital care and treatment before I was discharged.'

'On discharge I was given information about any medicines I was taking with me – their purpose, how to take them, potential side effects.'

Our approach to contracting in 2015/16

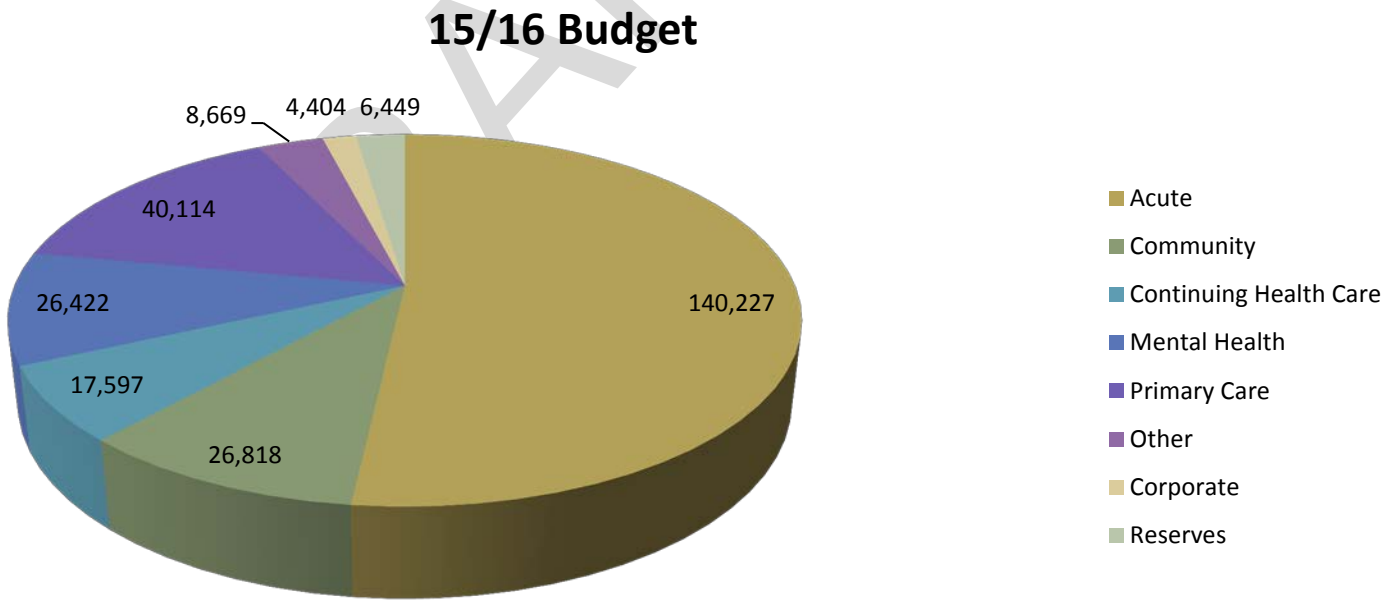
- The CCG will work to further integrate Health and Social Care services through delivery of the Better Care Fund (BCF). This programme will be the vehicle by which the local system, through early identification of deterioration, will achieve reductions in A&E attendance and subsequent admission and premature admissions to long term care.
- The CCG will negotiate a 2015/16 contract with East Kent Hospitals University Foundation Trust (EKHUFT) that provides financial security to both the Trust and the CCG, by limiting the reliance upon activity counting and unit prices. This will reduce bureaucracy and allow focus on improving patient services and delivering value for money.
- The CCG will ensure that parity of esteem for mental health patients is captured within all contracts for 2015/16.
- The CCG will continue to develop the Local Health Economy (LHE) Workforce, including a Health and Social Care Apprenticeship Programme, to ensure 'right care' by the 'right person' at the 'right time', to provide clinical leadership and support recruitment and retention. All with the intention of supporting delivery of our transformative plans for new models of care.
- The CCG will develop system integration via the Medical Interoperability Gateway (M.I.G) where access to the patient GP record (with patient consent) will be visible across multiple providers to avoid duplication and improving care for patients by enabling them to tell 'us once'.
- Commissioning for Quality and Innovation (CQUIN) measures will be targeted towards incentivising a continued focus on patients aged over 75, to compliment the named GP policy incentivised as part of change to GP contracts from April 2015. CQUINs of all major providers will be tailored towards adding capacity and capability to South Kent Coast's already successful neighbourhood teams, which currently bring together GPs, Social Services and Community Services to deliver improved outcomes for all residents.

Our financial approach in 2015/16

South Kent Coast CCG has a baseline budget of £270.7m for 2015/16; this delivers a 1% surplus of £2.7m.

The budget for 2015/16 is based on the outturn of 2014/15. The budget was adjusted for non-recurrent spend, growth, full year effects of QIPP schemes not delivered in 2014/15, cost pressures and required savings.

Demographic change based on the forecast population increase has been calculated at 0.9%, based on Office of National Statistics figures combined with the shifting age profile of the population. In addition to this, ambulance and prescribing have a demand uplift of 5%, following historic trends and NICE guidance. Placements growth is estimated at 8% as per current trends.



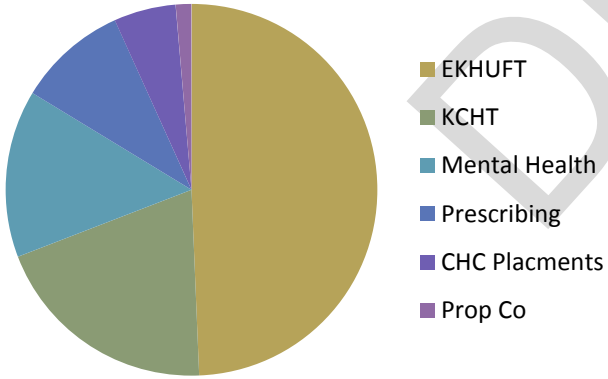
Our financial approach in 2015/16

The CCG is aiming to deliver £6.3m of net QIPP savings in 2015/16. £3.1m of this is attributable to the contract with EKHUFT. This will include targeted reductions in outpatients, anticipating a fall in referrals and reduction in low value follow-ups. There is also anticipated a reduction in activity relating to new pathways developed in COPD, Heart Failure and improved over 75s management. This figure also includes 1% reduction in non-elective activity due to the improvement of integrated health and social care services through the better care fund. There will be cap and collar arrangements in the contract with EKHUFT as in 14/15. To help support EKHUFT to make the changes needed to their services to release long term savings the CCG has allocated its top slice of £2.6m non-recurrently to this contract.

The CCG is planning £1.2m of savings to be delivered from the KCHT contract. This will be delivered through service redesign, beginning with community nursing.

During 13/14 and 14/15 the CCG invested in local mental health services to reduce expensive out of area placements. The impact has been delayed, leading to a large overspend on mental health services. For 2015/16 further investment is pledged locally, and contracting arrangements changed to incentivise local treatment. As a result the CCG is planning a decrease in out of area costs, with a higher quality and more efficient service from local mental health providers.

QIPP 15/16



Other QIPP areas:

Placements - improved management of existing placements and placing of new individuals is expected to lead to a saving on placements. There should be also be savings made from the improvement in community beds usage, leading to a reduction in placement referrals.

Prescribing - savings are anticipated from focussing on value for money prescribing, reducing variation in practice in primary care including a continued focus on antibiotic prescribing.

Prop Co - savings are planned from better use of NHS property in the CCG and reduction in void spaces.

Our approach to improving quality in 2015/16

Patients and the quality of the care they receive is the focus of everything we do. Our job is to commission clinical services for the local population which must provide good experience, be of high quality and have the best possible outcomes for patients. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

As well as promoting on-going quality improvement, commissioners need to assure themselves that existing services meet acceptable standards. Whilst regulators play a key role in this arena, commissioners must still actively monitor the quality of services delivered by our providers.

Our approach to quality has been informed by 3 key national quality reports following incidents at Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital;

Francis Report

- Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013
- The report considers and makes recommendations on a range of issues;

1. How to embed the patient voice throughout the system
2. How to engage health care staff generally in the leadership of their organisations
3. The standards set for safety and quality of care
4. The collection, use and sharing of information and data

Berwick Report

- Following the Francis Report, Don Berwick led a national advisory group around Patient Safety. The report details the specific changes required in the NHS as a result of the Francis and Keogh inquiries;
- Four guiding principles fall out of this report;

1. Place the quality and safety of patient care above all other aims for the NHS
2. Engage, empower, and hear patients and carers throughout the entire system, and at all time
3. Foster wholeheartedly the growth and development of all staff
4. Insist upon, and model in your own work, thorough transparency

Winterbourne Report

- Report following the uncovering of years of physical and psychological abuse of patients with learning disabilities (LD) and challenging behaviour, at Winterbourne View Hospital
- Highlighted the need to stop hospitals becoming homes for LD patients
- CCG responsible for jointly reviewing with local authority partners all patients in NHS funded in-patient LD facilities
- CCG responsible for finding supported community placements with appropriate personal care planning in place for these patients

Our approach to improving quality (CQUINs) in 2015/16

Central to our strategic approach is our ambition to deliver quality related improvement whilst reducing spend. There is commitment across the local health and social care system to develop and deliver integrated care via a new model of care that ensures alignment of commissioner and provider plans. The areas of attention will be:

- Focus on specific health needs and areas of pressure identified in our strategy
- Support the level of integration we expect between our hospital and out of hospital service providers
- Support the system change we require to make the local health system fit for the future

Respiratory	Over 75 years with LTC	Diabetes	CVD
2015/16	2015/16	2015/16	2015/16
Work collaboratively to embed and measure performance of new integrated care pathway for COPD patients, with ultimate aims being to; • Reduce non-elective admission / re-admission By; • Delivering care close to home • Improving transfer of care • Improving self-management	Embed and measure performance, with ultimate aims being to; • Develop a collaborative shared care plan approach • Improve transfer of care between providers • Improve the safety and quality of patient care	Embed and measure performance, with ultimate aims being to; • Reduce non-elective admission / re-admission By; • Delivering care close to home • Improving transfer of care • Improving self-management	Work collaboratively to embed and measure performance of new integrated care pathway for Heart Failure patients, with ultimate aims being to; • Reduce non-elective admission / re-admission By; • Delivering care close to home • Improving transfer of care • Improving self-management

Our approach to improving quality (CQUINs) in 2015-16

To further support our strategic ambition to close the gap between mental and physical health, we have devised 3 local quality incentives with our main mental health service provider – Kent and Medway Partnership Trust (KMPT). The quality incentives will;

- Focus on specific health needs and areas of pressure identified in our strategy
- Support the level of integration we expect between our hospital and out of hospital service providers
- Support the system change we require to make the local health system fit for the future

Transition from adolescent to Adult Mental Health care	Dementia	Crisis Plans
2015/16	2015/16	2015/16
Full implementation of safe effective transition pathway for adolescence from CAMHS to adult mental health services	Full implementation of ratified multi-agency integrated pathway for patients with Dementia	Full implementation of agreed % crisis plans across key acute cluster pathways. Reduced crisis episodes and unplanned admissions

Quality Premium

QUALITY PREMIUMS 15-16	target	% of QP	value
NATIONAL			
Reducing potential years of life lost through causes considered amenable to healthcare	1.2% reduction	10%	£100,183.00
Reduction in antibiotics prescribed in primary care	1% reduction	5%	£50,091.50
Reduction in proportion of broad spectrum antibiotics prescribed in primary care	10% reduction or below 11.3%	3%	£30,054.90
Secondary care validation of antibiotic prescribing	provider validation completed	2%	£20,036.60
URGENT CARE			
Reducing composite avoidable emergency admissions	reduction or 0% change	12%	£120,219.60
Including acute conditions that should not usually require hospital admission, chronic ambulatory care sensitive conditions, and children with lower respiratory tract infections, asthma, diabetes and epilepsy			
Reducing delayed transfers of care which are nhs responsibility	lower than previous year	12%	£120,219.60
Increased number of non-elective admissions discharged on weekend or bank holiday	.5% higher than previous year, or above 30%	6%	£60,109.80
MENTAL HEALTH			
Reduction in smoking SMI	lower than previous year	15%	£150,274.50
Increase in MH patients in paid employment	increase from previous year	15%	£150,274.50
LOCAL			
Increased diagnosis rate for people with dementia	67%	10%	£100,183.00
Increased admission to an acute stroke unit within 4 hours of arrival to hospital	70% (10% increase on nat. average of 59.9%)	10%	£100,183.00
subtotal			£1,001,830.00