South Kent Coast
Clinical Commissioning Group

NHS South Kent Coast CCG Strategy 2014-19

“Ensuring the best health and care for our community”

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Welcome

This strategy sets out the NHS South Kent Coast Clinical Commissioning Group (CCG) high level ambitions and plans for the next 5 years. It explains our vision for developing high quality out of hospital services, as close to a patient's home as possible, whilst ensuring that hospital services offer first class specialist treatment.

In our first full year as a CCG we have spent time listening to the views of local people and have reflected these views in our strategy, particularly to understand what good patient experience and heath outcomes will look like in 5 years time.

Dr Darren Cocker
Clinical Chair

Hazel Carpenter
Accountable Officer

Introduction

NHS South Kent Coast CCG is a clinically led membership organisation, responsible for 70% of the local healthcare budget. Our members are local GPs who are committed to ensuring the best possible health care for people in the South Kent Coast area.

This strategy sets out our high level ambitions and plans over the next 5 years and illustrates our commitment to ensuring real improvement in the way patients experience healthcare and their health outcomes.

It explains our plans for developing high quality and safe out-of-hospital and hospital services and the financial context in which we will do this.

We realise that we can't make these changes alone and we are committed to working collaboratively with local healthcare providers and our local authority partners, Dover District Council, Shepway District Council and Kent County Council.

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Our Vision

Our mission and vision has been developed through wide consultation and engagement with our membership, patients and the public and our partners across South Kent Coast.

Mission

'To ensure the best health and care for our community

Vision

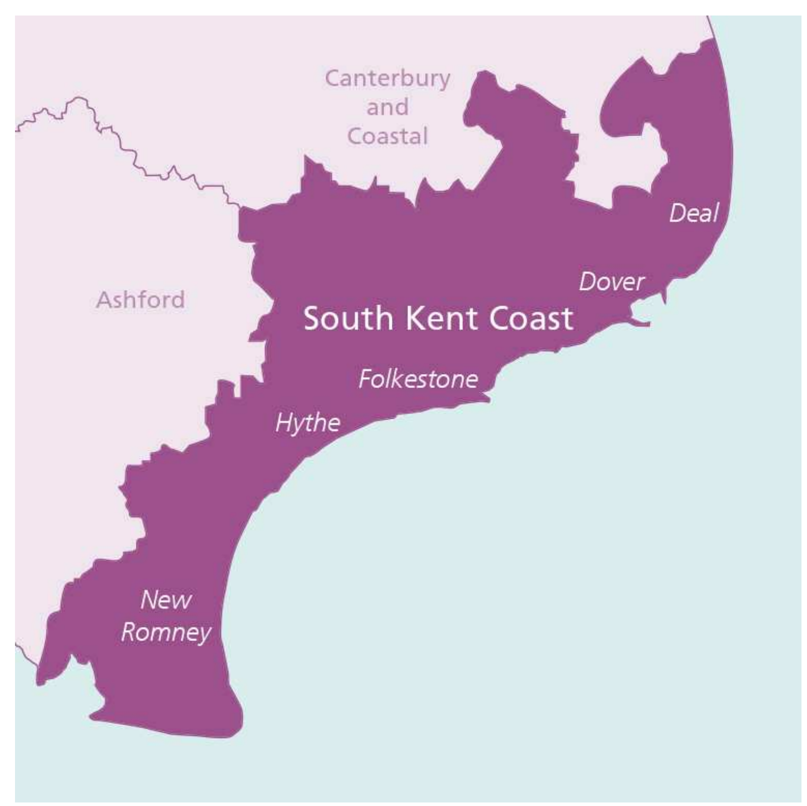
Hospital Care	Out-of-Hospital Care
• Acute care requiring specialist facilities, whether for physical or mental health needs, will be highly expert to ensure high quality. • Hospitals will act as a hub for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.	• For services to integrate, wrapping around the most vulnerable to enable them to remain in their own home for as long as possible. • Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions.

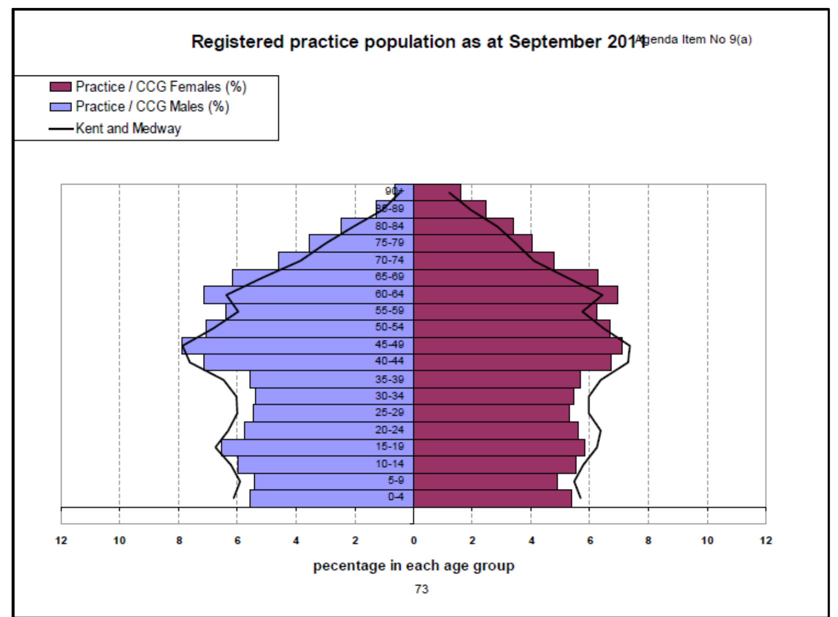
Our Profile

South Kent Coast CCG serves a population of approximately 200,000 living in sparsely populated rural areas and within the urban coastal towns of Folkestone and Dover. We consist of 31 member GP practices which are grouped into two geographical localities, Dover/Deal and Shepway (including the Romney Marsh area).

Overall the population of South Kent Coast enjoys relatively good health and is in line with the average life expectancy in England. However there is significant variation in life expectancy between those in the most affluent and deprived areas, with a gap of up to 13 years.

South Kent Coast has the highest proportion of over 65+ year olds in Kent and Medway at 21%. This is set to increase by 15% by 2016. The high number of older people in South Kent Coast poses a significant challenge for the local health and social care system.





Our Strategy: Engagement

The views of the local population matter to us and we'll do all we can to make sure that they continue to be heard. We're committed to a decision-making process that's honest and transparent, and one that gives the patient an opportunity to have a say.

Our Governing Body Lay Member for Patient Engagement – Brian Wash – has created a practical engagement structure which has allowed our patients to help shape our strategy and plans. This includes;

Patient Participation Groups

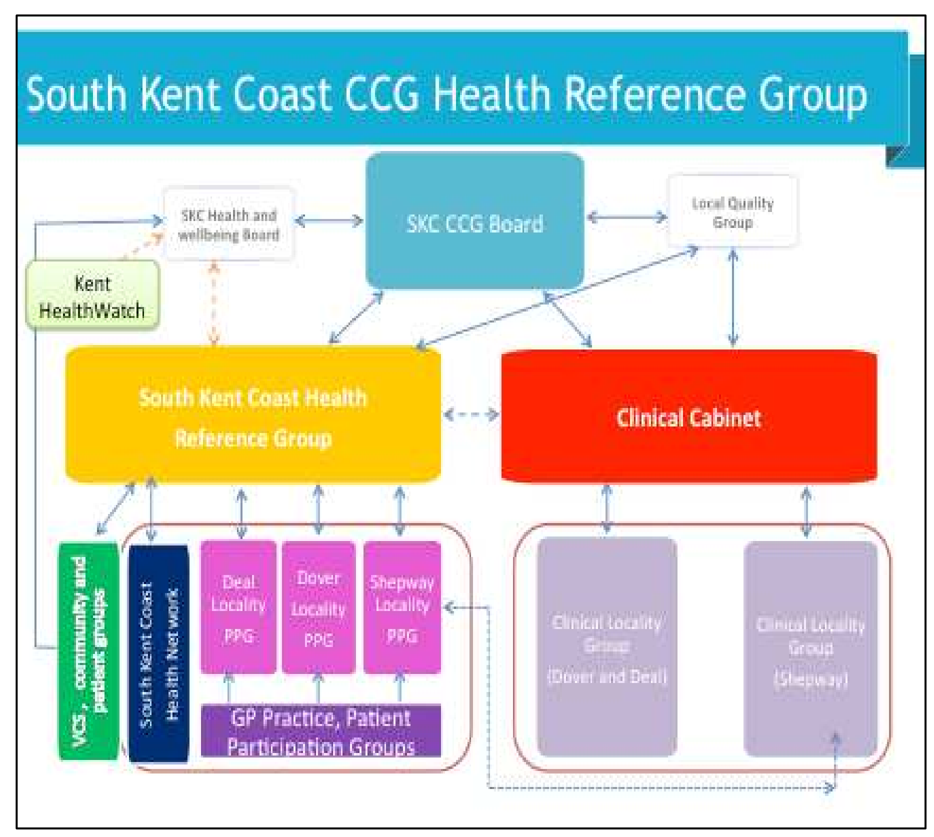
We have patient participation groups in Shepway, Dover and Deal. The have worked with the CCG to help plan and evaluate the local changes to health services described in our strategy.

Health Reference Group

This group ensures that patient participation group members and representatives from the community and voluntary sector have a key part in the work of the CCG. They have provided a patient perspective on specific healthcare issues, supporting our GP leaders in shaping services which fit with local needs.

Public meetings

We have held meetings with our community to explore people's views on some of the larger areas undergoing transformational change, such as urgent care, mental health and out-of-hospital services.. These views have again supported us in ensuring our future ambitions are built around service users.



The National Context

We must deliver change locally within a national context of ensuring an equitable national health service. The Department of Health has issued a mandate to the NHS in England which sets out our national objectives and highlights the areas of health and care where the government expects to see improvement

Through the mandate, the NHS will be measured, for the first time, by how well it achieves the things that really matter to people. Nationally, commissioning organisations like NHS South Kent Coast CCG have been tasked with supporting delivery of five key outcome domains.

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

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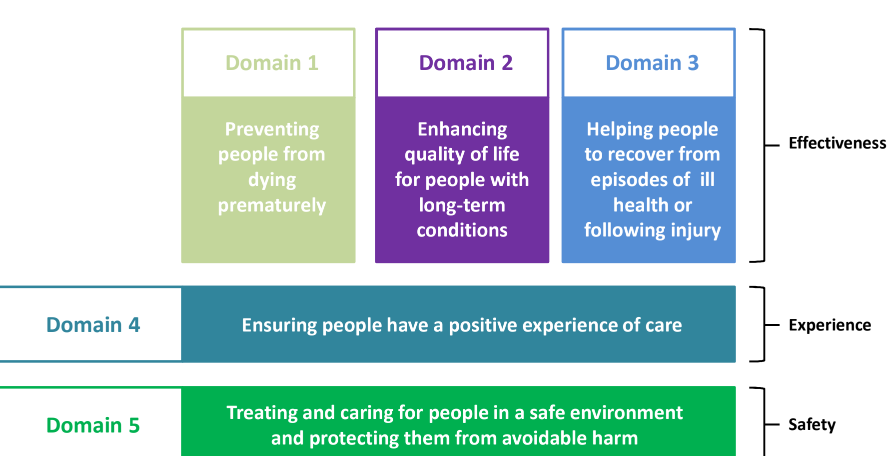


Figure 1

The National Context

These 5 national domains are underpinned by 7 outcome measures that the CCG will be measured against:

1.Securing additional years of life for the people of England with treatable mental and physical heath conditions.

2.Improving the health related quality of life of the 15+ million plus people with one or more long term condition (including mental health conditions).
3.Reducing the amount the amount of time people spend avoidably in hospital through better and more integrated care out of hospital.
4.Increasing the proportion of older people living independently at home following discharge from hospital.
5.Increasing the number of people with mental health and physical health conditions having a positive experience of hospital care
6.Increasing the number of people with mental health and physical health conditions having a positive experience of out of hospital care
7.Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care.

These national outcome measures fit well with the local priorities we have identified based on understanding the needs of our local population.

Understanding Local Health Needs

The CCG has to place the national context against our local health needs when defining our long term ambitions. Joint Strategic Needs Assessments (JSNAs) for the area are available on South Kent Coast CCG website (www.southkentcoastccg.nhs.uk). These assessments are used to inform us and our local authority partners about the potential health needs of the population.

SUMMARY – SKC POPULATION HEALTH CHALLENGES	
Population	• The proportion of SKC population aged 65+ is 21%, this is the highest proportion of over 65+ within Kent and Medway. 3% of the local population are over 85+. • Life expectancy from birth in the SKC area is estimated to be 80.5 years, marginally better than the East Kent average of 80 years. • However, the range between ward with the highest life expectancy – River (86) – and the lowest – Folkestone Harvey Central (73) – is 13 years.
Inequalities	• 53% of people in Dover, and 60% of people in Shepway are in the bottom 2 deprivation quintiles • SKC has statistically significant correlations between life expectancy and deprivation • Folkestone Harvey, Folkestone Harbour and Castle have over 25% unemployment • The biggest issue for the gap in life expectancy is Heart Disease
Causes of Death	• Circulatory Disease is now the main cause of death, followed by Respiratory Disease and Cancer.
Lifestyles	• Smoking rate - Shepway 21.1% Dover 27.4% • Obesity - Shepway 25.9% Dover 26.8% • SKC is high in Chlamydia prevalence and both has increasing teenage conception rates (particularly Shepway)
Long Term Conditions	• SKC: Higher than Kent average for premature deaths (<75) from CHD • Only 7 out of 31 GP practices come within 75% of the expected prevalence for patients registered with CHD • 15 of the 31 GP practices reach over 60% of the expected prevalence of COPD • 8% of GP practices reach 60% of expected prevalence for hypertension, only 1 reaches 70%
Dementia	• Estimates suggest 3250 people in SKC have Dementia. This is set against confirmed diagnosis of 1545. • The numbers of people with Dementia is set to increase by 837 by 2026

Understanding Local Health Needs: The Big Issues

By assessing and understanding these local health needs the CCG has identified 6 key issues which our strategy and plans will set out to address:

Understanding Local Health Needs: *Closing the gap between mental and physical health*

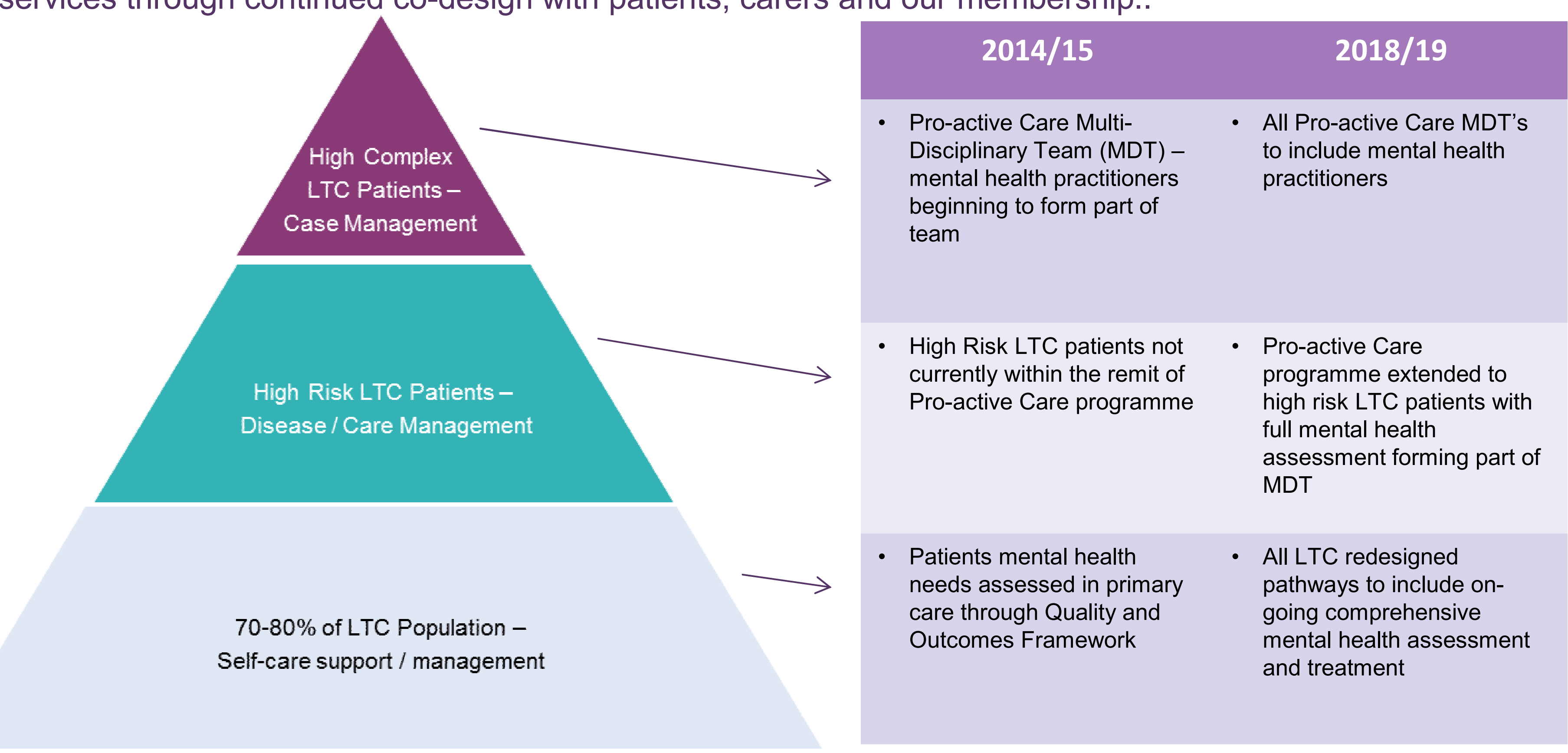
As an illustration of our approach about one of the 6 big issues, and as a key CCG priority, we briefly outline some of the ways we will ensure that physical health and mental health conditions are treated equally. Failing to do so reinforces stigma and adds to the disjointed care patients often experience. What we know already….

Mental health is widespread and common	Mental health is a significant burden	Mental health impacts on life expectancy
1 in 4 adults experience at least one mental disorder	Mental ill health is the single largest case of disability in the UK	Average life expectancy in England and Wales for people with mental health problems is 60 years behind the national average

People with mental health problems have worse physical outcomes	There are often long waits for mental health services	There is a wider economic impact of mental health
People with mental illness are at increased risk of the top 5 five health killers	1 in 10 people wait over a year for access to talking therapies	The full costs of mental illness in England have been estimated to be £105.2 billion a year

Understanding Local Health Needs: *Closing the gap between mental and physical health*

The CCG has worked throughout 2013/14 to build capacity in local community mental health services. This is improving access to patients who have a mental health need, but there is more work to do. Our goal in the next 5 years is to significantly reduce the barriers that exist between physical and mental health services through continued co-design with patients, carers and our membership..



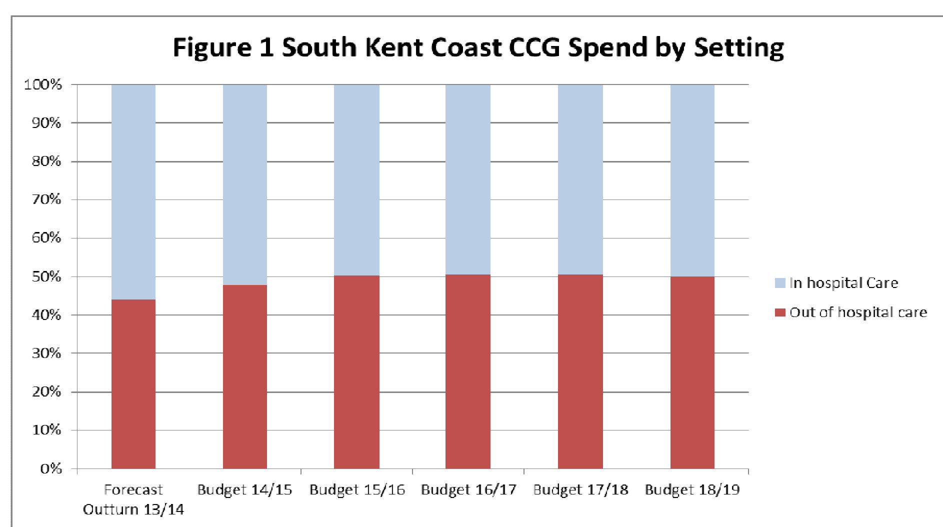
2014/15	2018/19
• Pro-active Care Multi-Disciplinary Team (MDT) – mental health practitioners beginning to form part of team	• All Pro-active Care MDT's to include mental health practitioners
• High Risk LTC patients not currently within the remit of Pro-active Care programme	• Pro-active Care programme extended to high risk LTC patients with full mental health assessment forming part of MDT
• Patients mental health needs assessed in primary care through Quality and Outcomes Framework	• All LTC redesigned pathways to include on-going comprehensive mental health assessment and treatment

Understanding the Financial Challenge

Like all of the public sector the NHS faces a substantial efficiency challenge. This amounts to £30 billion for the NHS in England over the next five years. The health economy in South Kent Coast has a share of this efficiency challenge amounting to £120m over the same period.

NHS financial allocations are not expected to rise in real terms over the next five years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without intervention, growth would continue at this rate because of the ageing population, new medical technologies and rising expectations.

South Kent Coast CCG's approach is based on delivering high quality streamlined healthcare closer to patients homes. This ensures that patients are treated correctly first time avoiding unnecessary appointments and hospital admissions. The hospital contract for 2014/15 is designed to drive these changes in patient care while releasing wasted resources. Our spend on hospital services will decrease and our spend on out-of hospital services will increase (See Figure 1) as hospital based services become community based.



To ensure the CCG meets its financial requirements, we must achieve £9.2m worth of efficiencies in year 1 and £7.5 in year 2.

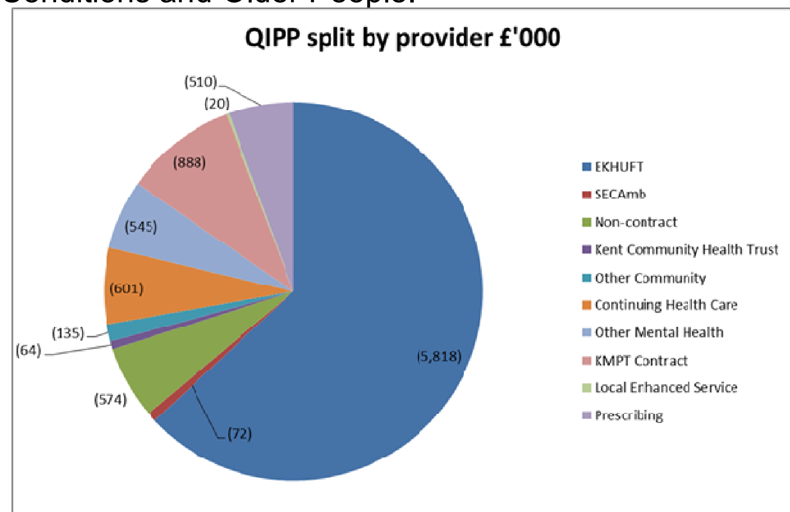
This approach will be facilitated by the delivery of our out-of-hospital plans which are explained in Appendix 1 and 2.

Understanding the Financial Challenge

In SKC we have focussed on six areas;

•Planned Care
•Urgent Care
•Long Term Conditions
•Mental Health
•Children's and Young People (includes Maternity)
•Older People

As an example, our GP practices are supported by district nursing teams and social services staff to provide comprehensive support to elderly and frail patients. In future we are expecting consultants from the hospital, together with specialist nurses, to join these teams limiting the need for costly and unnecessary hospital stays. This work supports Urgent Care, Long Term Conditions and Older People.



Other areas of efficiency gain are GP prescribing, out of area mental health beds and better management of patient placements and AQP contracts. In all of these areas there are opportunities to driver better patient care at lower unit prices.

Understanding the Quality Challenge

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

Understanding the Quality Challenge

South Kent Coast Quality Approach

2014	2019
Patient experience and patient voice is not sufficiently embedded in the commissioning process to drive quality improvement.	Patient experience and patient voice influences and informs service design and monitoring to drive improvements in quality.
Clinical leaders across the health system and not routinely influencing the design of improved services.	Clinical leaders are at the forefront of service improvement driving improvements in quality and improved health outcomes.
The quality of service in our local providers is variable and performance measurement is not sufficiently focused on improved health outcomes.	Our local providers offer high quality, safe, services with a real focus on improved health outcomes
Care Planning is fragmented and does not support the holistic treatment and care of patients with effective forward planning	Anticipatory, personalised care planning is common practice and supports good patient experience and fewer visits to hospital.

Our Strategy: Out-of-Hospital Care

OUT-OF-HOSPITAL - 2014		OUT-OF-HOSPITAL - 2019	
Variable access to primary care	Patients struggle to access GP practices for appointments. Defaulting to walk in facilities or A&E	**Easy Access to high quality, responsive primary care**	High quality primary health care services available 8-8pm, 7 days a week.
Professionals confused as to the local services and pathways available to them	Local pathways for diagnostics and access to specialist opinion poorly defined, resulting in unnecessary hospital referrals and high number of Out Patients appointments	**Clearly understood planned care pathways**	Patients treated in the most appropriate setting
Patients spend more time in hospital than necessary due to variable access to community services 7 days a week	Discharge into community often confused, lacking proper planning and robust information leading to delays in discharge from hospital	**Patients will spend the propriate amount of time in hospital when admitted**	Neighbourhood nursing and care teams provide well organised and appropriate early supported discharge back into community
Primary and community health services lack the capacity to respond to urgent health needs	Patients default to ambulance services or hospital emergency services	**Rapid response to urgent needs**	Fewer patients will access hospital emergency care. Where appropriate patients with an urgent need will receive a rapid community response.
Communication between health and social care professionals is poor and leads to disjointed care.	Patients left confused by system with care fragmented	**Neighbourhood teams of health and social care professionals, working together**	Patients receive well organised, integrated and high quality care across organisational boundaries.
Variable support for patients and carers to manage their own conditions	Patients left feeling ill informed and unable to cope	**Information, advice and support vailable to enable patients and carers to manage their conditions**	Patients and carers feel better able to cope and avoid unnecessary urgent visits to hospital

Our Strategy: Hospital Care

HOSPITAL - 2014		HOSPITAL - 2019	
Fragmented outpatient services	Patients make multiple hospital attendances for specialist input and diagnostics	**One-stop outpatient services**	Patients will make one single trip to receive assessment, diagnosis and treatment plan
Confusing urgent and emergency care system	Resulting in patients waiting longer than necessary in A&E, admitted with ambulatory conditions, delays in treatment with poor outcomes	**Integrated Urgent Care Services**	Patients have access to senior input early within A&E. Rapid integrated discharge teams enable early supported discharge to prevent unnecessary admissions.
Too many visits to hospital for follow up consultations	Resulting in poor patient experience and inefficient hospital activity	**Greater use of technology to enable follow up consultations closer to home**	Patients have access to specialist follow up without unnecessary travel and hospital manage elective activity more efficiently
Partial implementation of ambulatory care pathways	Unnecessary admissions for patients with conditions that could be more appropriately managed in the community	**Full implementation of ambulatory care pathways**	No unnecessary admissions for patients with ambulatory sensitive conditions.
Delayed transfers of care from inpatient hospital beds due to poor working across agencies.	Patients spending too long in hospital when they could be more appropriately treated in the community	**No delayed discharges caused by poor multi-agency working**	Patients are discharged from hospital appropriately with the necessary support available in the community

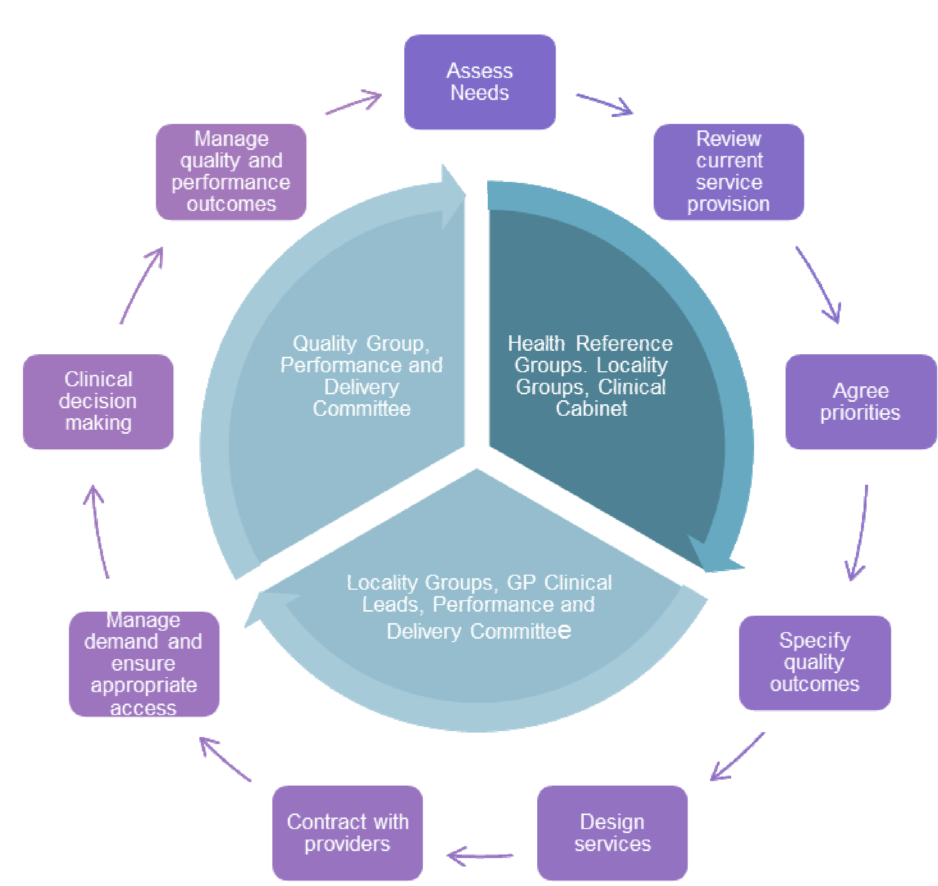
Our Strategy: Organising for Delivery

We organise the way we will deliver the strategy into clinical commissioning programmes of work. These programmes are led by our GP clinical leads, with support from other GP members who bring together their knowledge and expertise to prioritise areas for redesign and service improvement.

- Our GP clinical leads work alongside the CCG staff team to drive forward the ambitions for improvement developed collaboratively with our members, patients and provider stakeholders.

- Strong clinical leadership within each of the programmes ensures our focus is always on improving quality and outcomes.

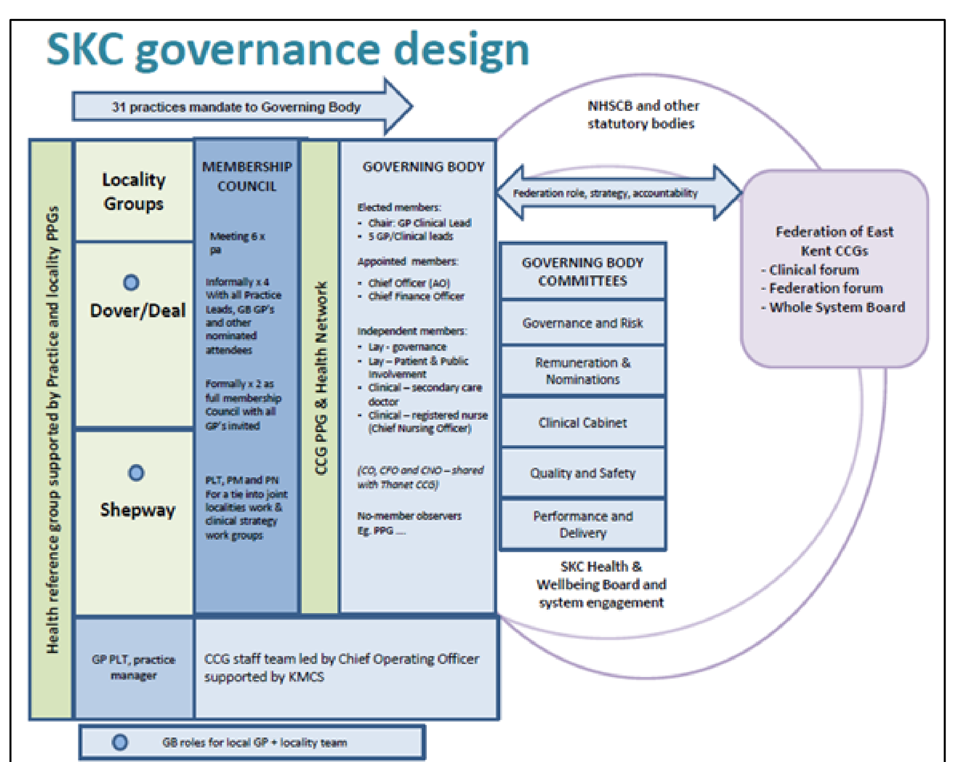
- The need to improve quality as a result of our actions as commissioners is fundamental to our organisational purpose. From ensuring no harm, to achieving the best outcomes in patient experience and clinical outcomes; consistently quality will be core to all the work we do.



Our Strategy: Organising for Delivery

A key element to the development of more joined up patient care will be effective communication between clinicians in different areas of the health system. The local governance arrangements have allowed our strategy and plans to be shaped through continued membership engagement and support.

We recognise the benefits of working collaboratively with our neighbouring CCG's in Ashford, Canterbury and Thanet. Structures are in place to support working and planning services across a wider footprint where it makes sense to do so;



- Clinical Forum – Enables clinical discussion to explore areas where the four CCGs can work together in the development of strategy.
- 4 Integrated Care Board's (ICB's) – Planned Care / Urgent Care and LTC's, Mental Health, Maternity and Child Health. Provide a detailed planning and delivery mechanism for those work programmes which the CCG's have agreed to collaborate on.
- Federation Forum and Whole System Board – Provides strategic oversight of the collaborative work across East Kent.

Shaping Local Health & Social Care Supply

The CCG currently spends £35m on Out-of Hospital services with a range of providers. Once Social Care and GP spend is included this rises to £115m.

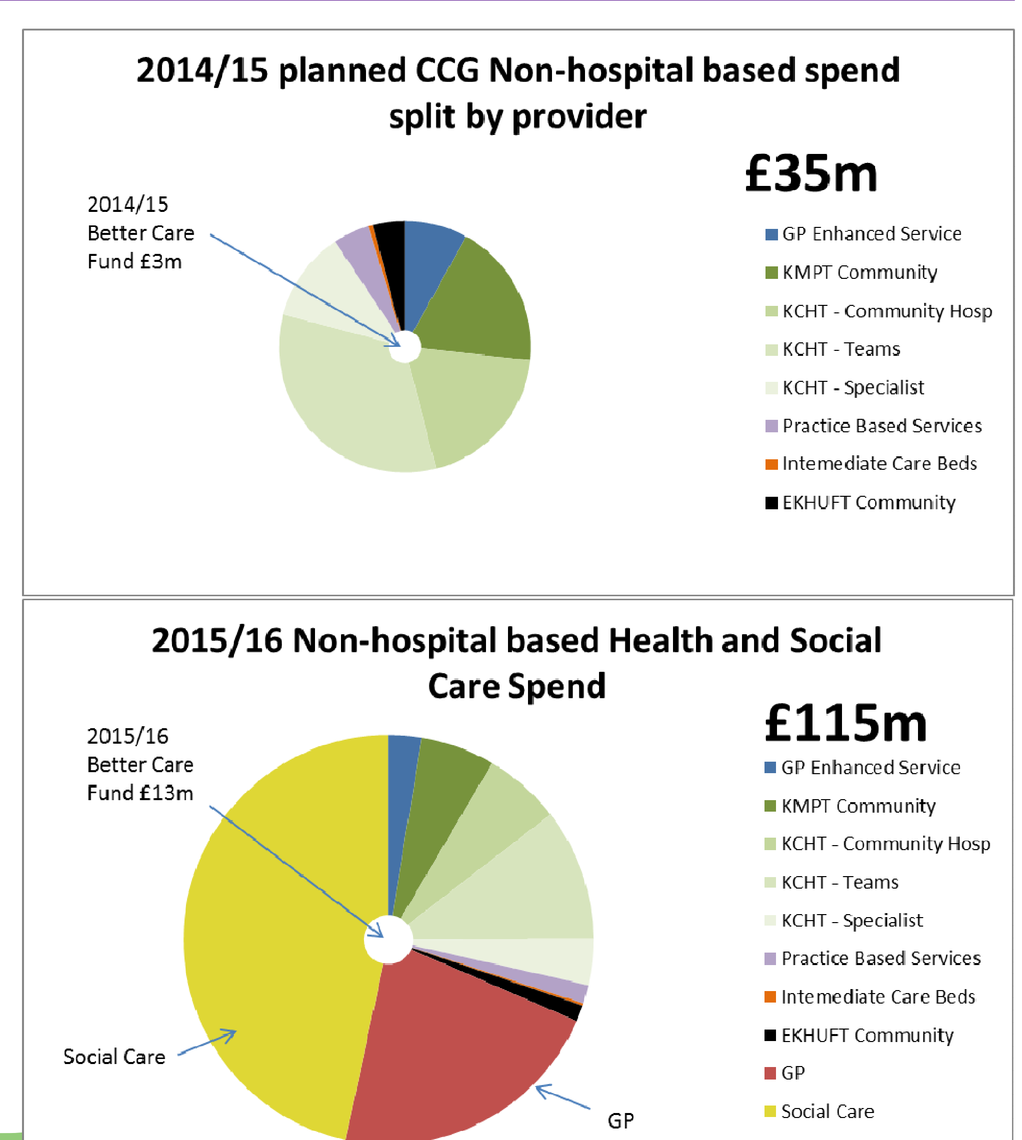
•Over the next 5 years our ambition is to use the Better Care Fund to facilitate the level of integration with KCC we know is needed to improve health outcomes for our population

•In 2014/15 £3m of our total Out of Hospital spend will be used to increase capacity and levels of integration. This will increase to £13m in 2015/16

•Each year over our 5 year strategic period we aim to increase the scope of the Better Care Fund to further support alignment of services. This will enable historic organisational barriers to be broken down, allowing patients to be cared for holistically between health and social care.

•Workforce alignment is a key component of integration which will ultimately improve patient experience and quality of care

•The CCG is working closely with KCC through the Health and Wellbeing Board to deliver this vision.



Conclusion: Our Strategy on one page

NHS South Kent Coast CCG Mission:
'To ensure the best health and care for our community'

NHS South Kent Coast CCG Vision:
Out of Hospital Care – *Services will be integrated, wrapping around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions.*

Hospital Care – *Acute care requiring specialist facilities whether for physical or mental health needs will be highly expert to ensure high quality. Hospitals will act as hub for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.*

All interventions are delivered following engagement activities with membership via Locality Groups / Membership Council and local patients via SKC Health Reference Groups and Locality Patient Groups

CCG Objective One
Reducing the number of years of life lost by the people of South Kent Coast from treatable conditions by X

→ **Delivered through;** Implementation of Health Inequalities Plan – Bi-annual Equity Audits, Targeted practice visits, Annual Reward Scheme, Education specific to health inequalities

CCG Objective Two
Improving the health related quality of life of people with one or more long term conditions by X

CCG Objective Three
Reduction in under 75 mortality rates from respiratory disease by X

→ **Delivered through;** Further roll-out of Pro-active Care Project, Improved Intermediate Care Service, Re-designed Pulmonary Rehabilitation Service, Re-designed Integrated Diabetes Care Pathway, Roll out of CCG Diabetes training programme, Increased community consultant geriatrician support to care homes, Re-designed Anti-coagulation Monitoring Service, Further roll-out of Personal Health Budgets

CCG Objective Four
Develop and deliver planned care which improves quality of life, reducing reliance on hospital services and improves the quality of primary care for physical and mental health

→ **Delivered through;** Community Pre-operative Assessments, Redesigned Musculoskeletal Pathways, Primary Care Gastroenterology Diagnostics, Redesigned Ophthalmology Pathways, Introduction of one-stop outpatient services, Redesigned Deal Hospital services

CCG Objective Five
Reduce the proportion of people reporting a very poor experience of care:
- Inpatient
- Outpatient
- Primary Care

→ **Delivered through contractual levers;** friends and family test, CSU acute contract management / performance meetings, collaboration with NHS England re primary care strategy, Quality Alerts / Surveillance

CCG Objective Six
Reducing the amount of time people spend avoidably in hospital through better and more integrated care out of hospital, covering both physical and mental health by X

→ **Delivered through;** Introduction of Integrated Urgent Care Centre (IUCC) within A&E departments, Redesigned MIU provision, Redesigned Out-of-Hours GP services, Increased Community Rapid Response Nursing Service, Continued roll out of ambulatory care pathways, Redesign of community mental health crisis services, Implementation of CCG End of Life Strategy, Redesigned community DVT service, Introduction of Community Falls Car Service

Overseen through the following governance arrangements
- Governing Body
- Performance and Delivery Committee
- SKC Health and Wellbeing Board
- SKC Integrated Commissioning Group
- SKC Locality Groups
- Health Reference Groups
- Whole System Board
- EK Clinical Forum
- Programme Boards for Urgent Care/LTC and Planned Care
- EK Diabetes Clinical Forum
- EK Mental Health Clinical Forum
- EK Childrens Strategy Gorup

Measured using the following success criteria
- Measured against NHS Domains 1,2,3 & 4
- Specific KPIs established for each contract (access, quality, clinical outcomes and patient experience)
- Financial balance & sustainability achieved

High level risks
- Maintaining and improving service quality and safety through significant service change
- Financial sustainability
- Ability of providers to respond to changes

Appendix 1 – Operational Delivery Plan 2014-16

Commissioning and Contracting Approach 2014-16

The financial position for NHS South Kent Coast CCG in 2014/15 is very challenging, with savings plans estimated currently at £9.4m in order to deliver the required surplus and contingencies.

- The commissioning approach to 2014/15 will be two-fold. Commissioning Intentions are worked up to build on 2013/14 schemes. These focus on specific pathway changes in areas such as DVT, Anti-Coagulation and one-stop outpatient clinics. The main efficiency drive, however, is centred around a major transformation of the way in which care will be delivered in the future.

- 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.

- The neighbourhood team approach has been delivering reduced A&E attendances and admission to hospital - by tailoring care around individual patient needs. It is planned for 2014/15 that secondary care consultants and their teams will join the neighbourhood teams to up-skill the GP and nursing teams and offer out-of-hospital advice and guidance to patients and neighbourhood teams.

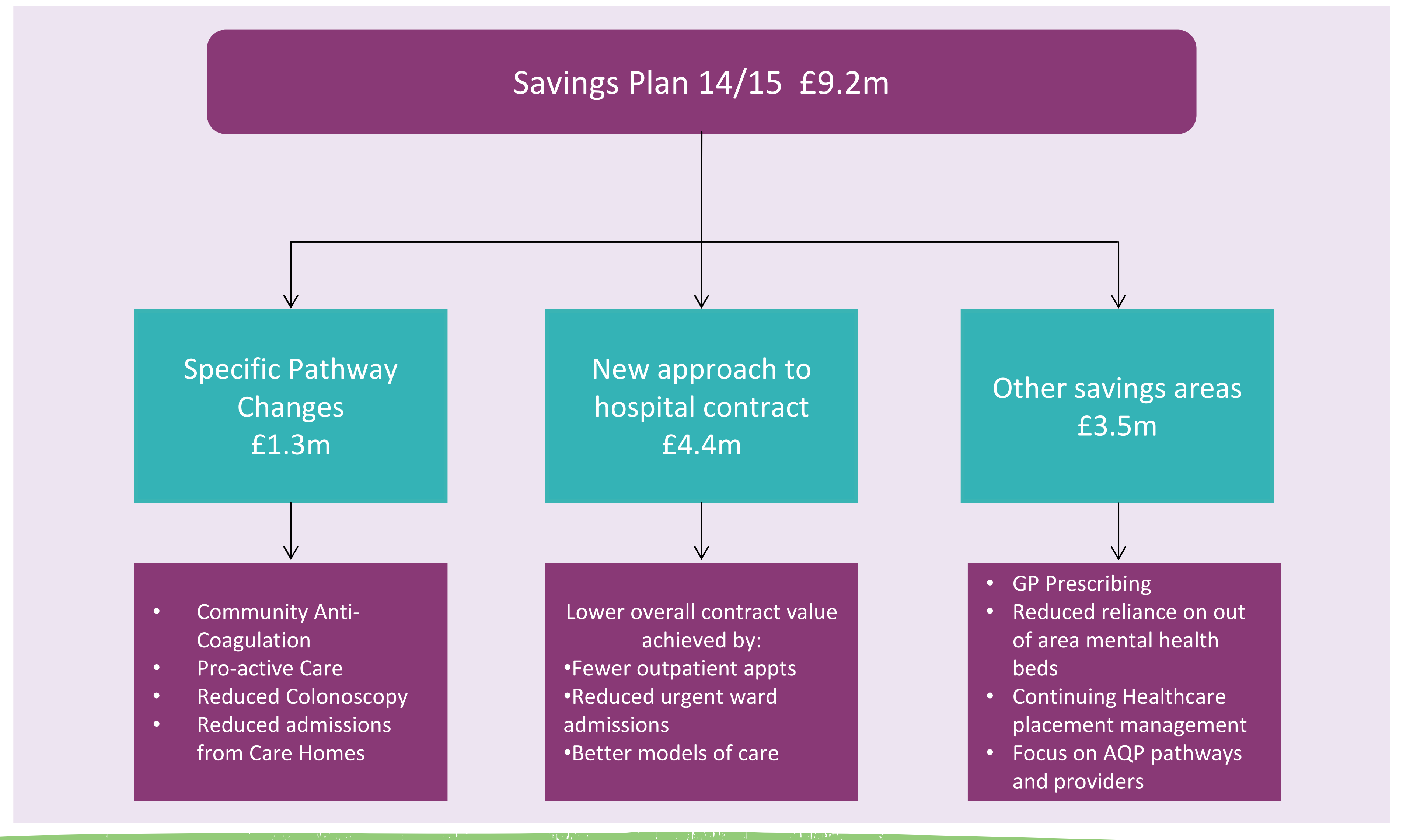
- The 2014-16 contract with EKHUFT is designed to offer financial security to both the Trust and the CCG, by limiting the reliance upon activity counting and unit prices. This will reduce bureaucracy and allow focus on improving patient services and delivering value for money.

- Neighbourhood teams will form the central pillar of patient care. They will manage long term conditions and for urgent assessment, guidance and stabilisation of exacerbations - to ensure that patients are kept out of hospital as much as is possible.

- CQUINs will also incentivise a special focus around patients aged over 75, to compliment the named GP policy incentivised as part of change to GP contracts from April 2014.

- This commissioning approach will mark a step change to enable clinically led transformation of services prior to the introduction of new contracting models such as Year of Care Tariff.

Contracting and Commissioning Approach 2014-16 - Finance



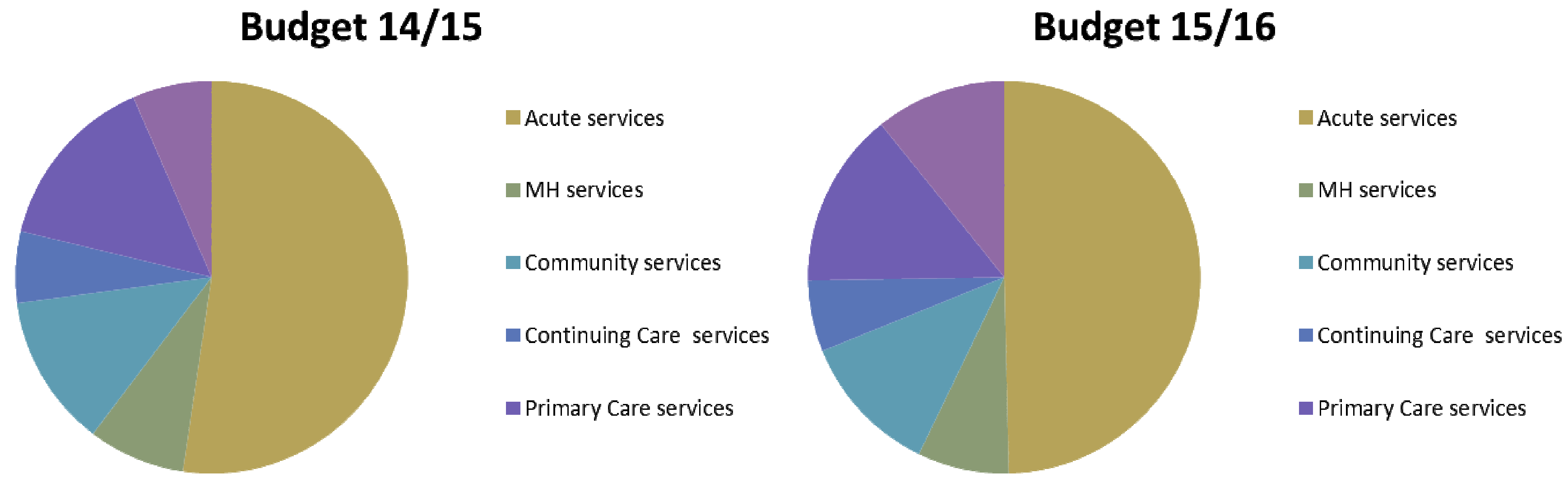
Contracting and Commissioning Approach 2014-16 - Finance

South Kent Coast CCG has a baseline budget of £261.7m for 2014/15; this delivers a 1% surplus of £2.63m.

The budget for 2014/15 is based on the budgets set for 2013/14. We have adjusted this budget for non-recurrent spend, growth, full year effects of QIPP schemes not delivered in 2013/14, cost pressures and required savings.

We have a predicted population increase of 0.87% as per Office of National Statistics figures. Further to this ambulance and continuing health care services have a demand uplift of 5% due to historic trends and prescribing has an uplift of 4% as per NICE guidance.

As with 2013/14, the CCG approach is based on delivering higher quality care with better value for money.



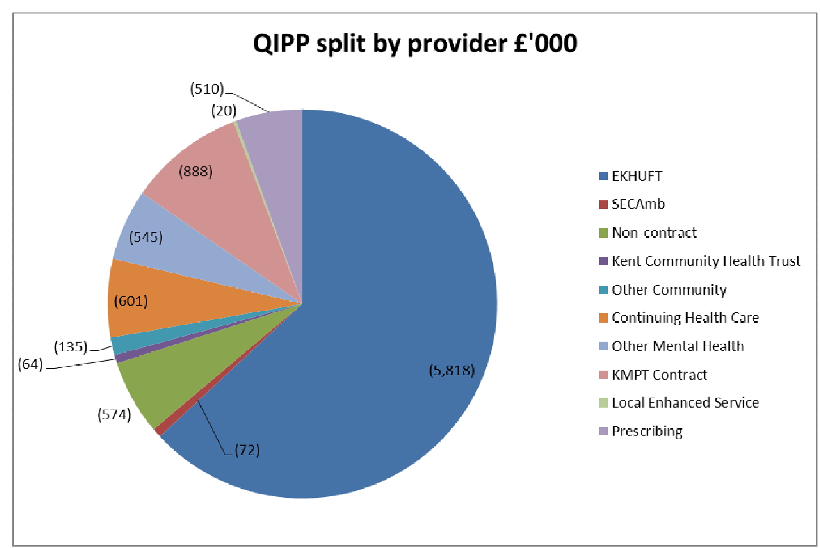
Contracting and Commissioning Approach 2014-16 – Finance QIPP

We are aiming to deliver a total saving of £5.8m on our main hospital contract – EKHUFT, to invest in out of hospital services that better reflect patient need. This is made up of already identified schemes (£1.3m) and 'capping' the contract (£4.4m). As part of this we are looking to deploy £3.9m in year 1 of non-recurrent transformational funding to drive the patient centred quality approach set out in the strategy. This investment is linked to a risk management arrangement with EKHUFT that sets the total contract sum as a maximum cost to the health economy, limiting the need for large contingencies.

In 'capping' the contract we recognise that it is below the 2013/14 outturn and as such EKHUFT will need to work with community and primary care providers to redesign pathways and services. CQUINs have been designed to help drive this process.

Our activity plan is cautious in year 1. In year 2 the areas where activity would be expected to fall as part of the contracting approach with EKHUFT have been clearly indicated. In practice we would expect these savings to made starting in Q2 in year 1 as the hospital identifies areas for stream-lined working within a secure income base.

We have already committed £1m against the top slice due to the inclusion of retrospective CHC claims within our allocation.



The other areas for QIPP include GP prescribing where the CCG has a strong record of delivery, out of area mental health beds where a comprehensive plan has been agreed with KMPT and improving continuing health care patient management and contracting arrangements. Local agreements to charge contracts specific to local CCG populations have also delivered small savings to the CCG in some areas. A small amount of QIPP will be delivered by robust management of AQP providers and reduction of duplication.

With all these actions SKC CCG is confident in delivering £9.2m of QIPP in year 1. This puts the CCG on a sound basis for delivery of financial targets in future years.

Contracting and Commissioning Approach 2014-16 - Quality

Central to our 5 year strategic approach is our ambition is drive up the quality of care our patients receive. In the first 2 years we have chosen over and above nationally defined quality incentives to have 4 local incentives shared jointly between our two main hospital and out of hospital service providers. 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

COPD	Over 75 years with LTC	Diabetes	Heart Failure
2014/15	2014/15	2014/15	2014/15
Work collaboratively to analyse the current COPD pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.	In relation to Share my Care (SMC), working with all contributors to the pathway, agree standard documentation to upload to SMC and responsibilities within this process. Agree a standard set of information to be uploaded and maintained on SMC.	Working with acute colleagues to analyse current pathways, in comparison to the new pathway identified by the CCG's. Identify areas which need change and undertake that change to deliver the new model within agreed contract.	Work collaboratively to analyse the current Heart Failure pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.
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

Contracting and Commissioning Approach 2014-16 - Quality

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).

2014/15	2014/15	2014/15
Work collaboratively to ensure safe and effective transition from Child and Adolescent mental health services to Adult mental heath services. Develop a multi agency transition pathway with implementation from Q4	Work collaboratively across providers to develop an integrated care pathway for people with dementia. Pathway will deliver early diagnosis and intervention and personalised care planning covering multiple co-morbidities.	Work collaborative across providers and agencies to improve urgent access to mental health crisis support. Develop comprehensive multi-agency crisis plans for patients in key acute cluster pathways to improve early intervention and prevent future crises.
2015/16	2015/16	2015/16
Full implementation of transition pathway with improvement across all key quality and performance indicators.	Full implementation of integrated pathway with improvement across all key quality and performance indicators.	Full implementation of agreed % of Crisis plans across key acute cluster pathways. Reduced crisis episodes and unplanned admissions.

Out of Hospital Programme: Vision / Future Operating Model

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.' 'I do not know who the main person in charge of my care is.' 'When I was discharged from hospital to my home, I was not clear on what would happen next.' 'I panic when my condition deteriorates. I do not know who to contact.' 'The care and support I receive has made me dependent on others. I feel no longer able to live my life independently.'	**SYSTEM CHANGES** • **Integrated Teams and Reablement** - Revised Intermediate Care Pathway, Enhanced Community Rapid Response Teams, Revised rehabilitation and non-weight bearing pathway • **Enhanced Neighbourhood Care Team (NCT)** - Further roll our of Pro-active Care Programme, Hospital specialists integrated into NCT's • **Enhanced Primary Care** – Integration of GP practices within NCT, Greater support from hospital teams within primary care using technology, Improved primary prevention and signposting, Promotion of Personal Health Budgets, Pre-operative Assessments in primary care • **Enhanced Support to Care Homes** – An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes • **Local Integrated Urgent Care** – Revised MIU service, Integrated MIU / Out of Hours primary care model re-procurement, Increased access to primary care • **Mental Health –** Primary Care MH Specialist pilot, Community link workers in primary care, Targeted community development work • **Winterbourne –** Implementation of joint plan with KCC, discharge of patients currently within in-patient facilities to community placements with providers able to support people with complex needs	'The professionals involved with me talked to each other. I could see that they worked as a team' '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 moved between services or settings, there was a plan in place for what happened next.' 'I had systems in place so that I could get help at an early stage to avoid a crisis' Taken together, my care and support helped me live the life I want to the best of my ability'

Out of Hospital Programme: Vision / Future Operating Model

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

- **Community DVT Service –** town based model integrated with existing MIU facilities
- **End of Life –** Improved co-ordination and timeliness of care, Palliative care education programme, Increased specialist bereavement counselling service, Procurement of system wide electronic palliative care system
- **COPD –** Increased provision of Pulmonary Rehabilitation Services across SKC
- **Diabetes -** Type 2 Diabetes primary care training programme, Integrated Diabetes care pathway implementation
- **Anti-coagulation Services -** Re-procured model ensuring both initiation and on-going monitoring within the community
- **Gastroenterology –** Introduction of faecal calprotectin testing in primary care
- **Dermatology** – Review of community pathway with a view to re-procuring service
- **ADHD –** Re-procurement of community specialist ADHA service for adults and children
- **Dementia –** New out-of-hours service for older people with MH problems and Dementia
- **Falls Prevention –** Implementation of falls response vehicle
- **Children with Challenging Behaviour –** New multi-agency intensive support team model
- **Looked After Children –** Re-procurement of LAC service

Hospital Programme: Vision / Future Operating Model

From:	By doing what:	To:
'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.'	**SYSTEM CHANGES** • **One-stop outpatient services –** Urology, Breast, Colorectal one-stop services across East Kent • **Integrated Urgent Care Service –** Multi-disciplinary service within hospital consisting of GP, Hospital Specialists, Mental Health and Health and Social Care Teams. Improving the co-ordination and flow of patients through the urgent care system, with 24/7 care co-ordination centre and enhanced ambulatory care services. **PATHWAY SPECIFIC CHANGES** • **Ophthalmology –** Review of hospital eye services with a view to re-procurement of specific pathways suitable for management in the community. Macular Oedema – A central acute site to deliver treatment and drug administration, with hub and spoke community model to provide monitoring • **MSK –** Lead provider model for MSK across primary to secondary care • **Early Pregnancy –** Improve awareness of pathway and services to reduce the level of EPAU in A&E • **Dementia –** A sustainable dementia buddy scheme within acute hospital	'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.'

Out of Hospital Programme: Performance and Delivery Summary

PERFORMANCE INDICATOR	Baseline	2014/15 Target	2015/16 Target
Patient Experience - GP / Out of Hours Primary Care	5.80	5.72	5.64
Proportion of people feeling supported to manage their condition	64.8%	70.0%	n/a
Long Term Conditions - Quality of Life Scores (EQ-5D)	72.40	72.25	71.63
Under 75 Respiratory Mortality	65	64	62
Years of Life Lost (Treatable Conditions)	2073.2	2055.2	2037.1
Permanent admissions of older people to residential and nursing care homes	156.2	154	n/a
Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88.10%	90.0%	n/a
Delayed Transfers of Care	38.5	36.4	n/a
Emergency Admissions (Activity)	1774.9	1759.7	1699.1
Dementia Diagnosis (% of expected diagnosed)	38%	47%	55%
Access to Psychological Therapies	17.1%	17.1%	17.1%

RISKS	RATING	MITIGATING ACTIONS
Workforce - Reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the out-of-hospital work programmes and 24/7 availability of NCT's.	HIGH	Each provider has been required to develop a detailed workforce plan to support the delivery of each scheme within this programme.
Communication – Patients and providers may not know how to access services within an integrated system to ensure services are used appropriately	HIGH	Communication plan to be developed to support delivery of each scheme.
IT – Systems across services not integrated and therefore do not enable shared care plans between organisations to support integrated outcome measurement and monitoring.	HIGH	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Finance – Non-delivery of the projects within this programme will have significant effect on the CCG's ability to meet its statutory obligations.	HIGH	Current QIPP monitoring processes will continue to ensure delivery and early identification of slippage / risk.
Population Health – Failure to delivery key projects aimed at reducing health inequalities will result in the continued health gap between the poorest and the most affluent wards in SKC.	HIGH	Primary Care Group in place to drive forward schemes across the member practices.

Appendix 2 – Better Care Fund Plan

Vision

The South Kent Coast vision for integrated health and social care is for patients to always be at the heart of their care and support, receiving coordinated services without organisational barriers that are easy to access 24/7, of high quality and that maximises their ability to live independently and safely in their community and in their own homes wherever possible. We will ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.

We will achieve this by building integrated health and social care teams around every patient. These teams, linked to every GP practice, will undertake integrated health and social care assessments and coordinated care planning to pro-actively manage patient's conditions and needs in the community helping people to stay out of hospital or to recover more quickly after a hospital stay.

Our plans for the Better Care Fund will be achieved by a number of schemes aimed at services working together to provide better support for people with long term conditions, older people and people with disabilities at home to maintain independence and earlier treatment in the community to prevent people needing emergency care in hospital or care homes and education and empowering people to make decisions about their own health and well-being. We will deliver this by:

- Building on and enhancing some of the local projects already implemented or planned and;
- Introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

Changes to service configuration

As set out in the CCGs five year strategy the overall vision to ensure the best health and care for our community will result in changes to current service configuration. Achieving the CCGs vision will require building sufficient capacity in the community, including the workforce, whilst reducing capacity in acute hospitals in order to deliver the following:

- Out of hospital services to be integrated and wrapped around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions;
- Acute hospital services will be specialist facilities whether for physical or mental health needs and will be highly expert to ensure high quality. Hospitals will act as hubs for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.

Patient and service user outcomes

By working in new and innovative ways we aim to achieve the following:

- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient's needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care.

Aims and objectives of an integrated system

With a high elderly population in South Kent Coast and increasing numbers of people who have one or more long-term condition we aim to focus the Better Care Fund on prevention, reducing the demand and making the most efficient and effective use of health and social care resources.

Our plans for the Better Care Fund support the delivery of the CCGs five year strategy which has a strong focus on the management of long term conditions and the subsequent impact long term conditions has on the local health systems. The plan will also support the delivery of the five year East Kent Strategic Plan (2014-2019).

Given the extent of integration set out in our plans, there are considerable changes to the current ways of working and the existing workforce across multiple organisations. This will require us to undertake work to re-shape the supply of the market to enable delivery of our plans over time; this may take the form of an Integrated Care Organisation.

South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the local authority and both Dover and Shepway District Councils. This Strategy identified four shared aims which are working together toward:

- To improve the health and wellbeing of people in Dover and Shepway living with long term conditions, enabling as many people as possible to manage their own condition better;
- People with disabilities and older people will be supported to actively participate in the lives of their local communities, enabled by environments that are inclusive, accessible and safe for all;
- To support families and carers in their caring roles and enable them to actively contribute to their local communities and;
- To ensure that the best possible care is provided at the end of people's lives.

Measuring improved outcomes

By delivering the above aims to will achieve the following outcomes:

Reduced hospital admissions;	Reduction in duplication;	Carers will have access to good quality information and advice;	Improved end of life care for people with dementia and long term conditions.
Reduced length of stay in hospital;	People will have access to local quality housing that meets their needs;	Carers will be supported to access services to support them in that role;	Ensure services respond rapidly and more effectively;
Timely access to local health and social care services;	People will be able to get around and access facilities in their local communities;	Carers will be supported to stay mentally and physically well and treated with dignity;	Support carers and empower individuals to do more for themselves;
Improved access to information which allows people to make decision about their own lives;	People will have more choice and control over the health and social care services they use;	Improve end of life care for people living in residential, nursing and extra care housing;	Improve the patient experience of the delivery of care
Thriving and self-reliant communities;	After people are discharged from hospital they will return home to a safe and accessible environment as quickly as possible;	More people die in the place of their choice having received the care appropriate to their needs;	

The above measures will be monitored using an integrated performance dashboard for the Better Care Fund, this will be developed and piloted during 2014/15.

Integrated Teams and Reablement

Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.

SCHEME REQUIREMENTS:

Integrated Intermediate Care Pathway & flexible use of community based beds

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points;
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite;
- Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
- The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

Enhance Neighbourhood Care Teams and Care Coordination

This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

SCHEME REQUIREMENTS:

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

•Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day, seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
•The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
•The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to assess a patients home environment;
•Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted to secondary care;
•Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
•The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
•The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

Enhance Primary Care

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

SCHEME REQUIREMENTS:

Develop primary care based services with improved access and integrated with other community and specialist services

•GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services, working with at risk patients to avoid crisis and better use of carer support services. This could also include a virtual ward round of at risk patients following hospital discharge;
•GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
•Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
•Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital.
•GP practices to link with the support to care homes pathways to provide more intensive support

Primary care service will support and empower patients and carers to self manage their conditions

•Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
•Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
•The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
•Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of care records with the patient and between health and social care professionals;
•Improved signposting and education and access to signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services;
•Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.

Enhance support to Care Homes

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory can plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

SCHEME REQUIREMENTS:

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes;

•The integrated team can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
•The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes;
•Access to specialist services such as Dementia Crisis will be available to support care homes

Integrated Health and Social Housing approaches

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment.

SCHEME REQUIREMENTS:

An integrated approach to local housing and accommodation provision supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate place for their needs

•Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
•Responsive timely adaptations to housing;
•Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
•Flexible housing schemes locally;
•Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
•Different types of supported accommodation for those with learning disabilities and mental health needs

Falls prevention

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service

•This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

•Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
•Develop an Integrated Ambulance Falls Response Service;
•Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Success factors and timeframes for delivery

Each of the above schemes has a range of outcome measures to demonstrate success. The key measurements of success are as follows:

•Reduced A&E attendances;
•Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia;
•Reduced length of stay;
•Improved transfers of care;
•Reduced long term placements in residential and nursing home beds;
•Reduced need for long term supported care packages;
•Increase patients returning to previous level of functionality in usual environment;
•Increase levels of patient self management of long term conditions;
•Reduction in falls and secondary falls;
•Reduction in hip fractures;
•Improve patient satisfaction and well-being;
•Increase levels of patients with personal health budgets and integrated budgets;
•Improve health outcomes by better use of prevention services;
•Reduce unnecessary prescribing.

To ensure the delivery of the above schemes in 2015/16 a programme plan setting out details of the key milestones is in development and will be refined during 2014/15 to ensure clarity of when the changes come into effect and the implications of these changes as well as the expected outcomes. The programme plan will also include contingencies if the plans are not delivered.

Alignment with local JSNA and local commissioning plans

The schemes outlined in this plan which have been developed in partnership with social care commissioners. The schemes, along with the CCGs overall commissioning plans, will support addressing the pressing needs identified through the local Joint Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them. These health priorities are as follows:

•Being ready to respond to the impact of our aging population;
•Tackling increasing inequalities;
•Improving access to primary care services;
•Managing patients mental health (including Dementia);
•Increasing access to care closer to home;
•Tackle patients’ long term conditions;
•Tackle unnecessary and unfair variations in care;
•Improve management and identification of diabetes;
•Pro-active general practice (smoking, weight, alcohol, health checks etc.);
•Work closely with partners to tackle patients and carer wellbeing.

Implications on the acute sector

The plans align with the delivery of the CCGs strategy, as outlined in section 2a above. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should enable the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement / rehabilitation services.

Governance

The local Better Care plans will be implemented and monitored using a commissioning project management framework. The delivery of the schemes will be supported by the local Integrated Commissioning Group which will report progress to the local Health and Well Being Board. Delivery of the plans will ultimately be the responsibility of the CCGs Governing Board.

All defined milestones and outcomes of the plan will be monitored at a CCG's Governing Body committee level via the Performance and Delivery Committee and reported for assurance purposes to the Governing Body. The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Performance and Delivery Committee.

The committee feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee. Whilst many of the metrics are nationally defined and officially reported annually, proxy measures will be used to monitor them in year, including the Levels of Ambition Tool, Atlas of Variation and SUS data.

Protecting Social Services

The Better Care Fund plans set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact the care on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

By managing to reable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services.

Development of a Self Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

7 day services to support discharge

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

•Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
•Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

All schemes within the local CCG plan require accessible 7 day a week service to support patients being discharged from hospital and prevent unnecessary admissions at weekends.

In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

Data Sharing

The prime identifier across health and social care in Kent is the NHS number.

NHS

At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations.

The NHS standard contract states:
"Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user."

Social Care

A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT. Monthly batches of client records are sent to the NHS matching service (MACS) and if they can match to a single record on their system they return the NHS number which is uploaded into SWIFT.

The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.

KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource. The MACS service is due to close at some point (no date given yet) so KCC are in the process of transferring to the Personal Demographics Service (PDS).

South Kent Coast CCG, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Joint assessment and accountable lead professional

In South Kent Coast the accountable lead professional for people at high risk of hospital admissions is their GP. Risk stratification is undertaken by practices and shared with community nursing teams to identify those patients most at risk. These patients are recommended for Proactive Care to ensure coordination of all their health and social care needs to prevent hospital admissions. If the patients are under the care of the community nursing or intermediate care teams they are informed on how to contact a member of these teams 24/7 if they need to. All patients at high risk of hospital admission and put forward for Proactive Care have a joint care plan in place.

Risk Profiling (Pro-Active Care)

South Kent Coast CCG has been running a programme called Pro-Active Care which almost all practices are participating in. Pro-Active Care is a 12 week intervention by a multi-disciplinary health and social care team for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification Pro-Active Care targets the patients at highest risk of hospital admission and then works its way through the lower risk patients. This is something that, over a year on, the first practices to run pro-active care are now starting to achieve after having seen all of their highest risk long term condition patients. In turn this means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

Pro-Active Care is delivered by a multi-disciplinary health and social care teams undertaking joint assessments, clinically led by a GP, and jointly agreeing anticipatory care plans for every patients going through the programme. A pharmacist offers a review of their medicines, a health trainer supports them to develop a healthier lifestyle and signposts the patient to other services in the community. Physiotherapists and Occupational Therapists review the patient's needs. Social Services and Mental Health services also visit to offer advice and services if required. The GP remains the accountable professional for their patients.

Risks

Risk	Risk Rating	Mitigating Action
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.

Risks

Risk	Risk Rating	Mitigating Action
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	High	To be discussed with NHS England.
Cultural change – significant shift in how systems need to work in the future requirement large culture change	High	Ensure whole health and social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
Regulatory and legislative environment – current arrangements not always looking at how the overall system works	High	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.