

Meeting:	Kent Health and Wellbeing Board
Date of Meeting:	26th March 2014
Title of Report:	Swale CCG 2 Year Operating Plan
Reporting Officer:	Patricia Davies – CCG Accountable Officer

This paper is for <i>(Please annotate)</i>							
Assurance	x	Agreement	x	Discussion		Note for Information	

<p>Executive Summary:</p> <p><i>(Please annotate comments / recommendations of sub-committee, if appropriate)</i></p> <p>The following report aims to provide an outline of the key programmes within the CCGs Commissioning Plan for 2014/15 to 2015/16.</p> <p>From 1st April 2013 Swale Clinical Commissioning Group became a statutory body responsible for commissioning health services on behalf of the population of Swale. The establishment of the CCG has enabled our local GPs, who understand the health needs of our patients, to influence and monitor how our resources are spent on improving the health of our population. In addition we have agreed a strategic alliance between both Medway CCG and Dartford, Gravesham and Swanley CCG as a North Kent System, to support the transformational system wide change that is required to deliver improved quality and care for our patients within the ever challenging financial envelope. We have also developed a strong strategic partnership with Dartford, Gravesham and Swanley CCG that includes the sharing of both management and clinical resources.</p> <p>Swale CCG aims to clinically lead the commissioning of high quality, safe and effective health services for our local residents and we believe that using our local clinical experts in leading the planning and delivery of high quality healthcare, that we can make a real difference to people's lives.</p> <p>Our commissioning plan indicates what the key priorities are for the period of 2014/15 to 2015/16 and beyond. It incorporates the views of the public, our providers as well as Social Care and Local Authority stakeholders, and is in line with the Health and Wellbeing Strategy to which we have contributed with our key local authority partners. Based on the information we have received through the processes mentioned above, these priorities include making sure that all groups in the population have equal access to high quality services as close to home as possible, improving integrated working between our providers to deliver real patient centred care, continuously increasing the quality of healthcare services for optimum patient experience and ensuring best value for money.</p> <p>In line with the current health needs of our local population, outlined within the JSNA, and</p>

based on the expected increase in the local population, our plan includes a number of key actions:

- Implementing a programme to identify and provide focussed support for those groups of people most at risk of developing, or potentially with undiagnosed, long term conditions. Thereby reducing the health inequalities between the least and most deprived areas of our CCG
- A transfer of care from the acute setting to a community setting:
 - Moving to a prevention / self-management model of care for people with long term conditions,
 - Providing support for people via their GP and health and social care integrated teams, with swift access to expert intervention to support episodes of crisis
 - Ensuring patients are transferred to the most appropriate setting of care for their needs, reducing unnecessary stay in hospital
 - Including for patients with mental health issues who no longer need secondary care input, people with long term conditions including dementia, and children.
- For patients requiring planned care, ensuring we enable earlier diagnosis and swift treatment in the most appropriate setting for a patient's needs.

This is an exciting but challenging time for us all, but by working together we can make a difference and improve our local health services and health outcomes for our population.

Proposal and / or Recommendation

The Health and Wellbeing Board is asked to:

- Note the key elements of the Operating Plan.
- AGREE the proposed actions and levels of ambition against the
- Note the actions taken to:
 - ensure plans reflect the JSNA and Health and Wellbeing Strategy
 - engage with a variety of stakeholders including local Health and wellbeing Boards
 - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.

Development of the CCG Two Year Operating Plan

1. Background:

In line with national guidance for the development of NHS Strategic and Operational plans as described in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', Swale Clinical Commissioning Group has developed its two year Operational Plan, to:

- Deliver high quality care
- Meet the needs of the local population, as outlined within the Joint Strategic Needs Assessment, and agreed within the local Health and Wellbeing Board
- Reflect integrated commissioning plans across health and social care
- Deliver the aims of the Health and Wellbeing Strategy
- Address issues identified with, and feedback from, our patients, public, GPs, healthcare providers, Social Care and local authority partners, and the voluntary sector.
- Deliver the NHS England vision and ambitions, as summarised in the diagram below:

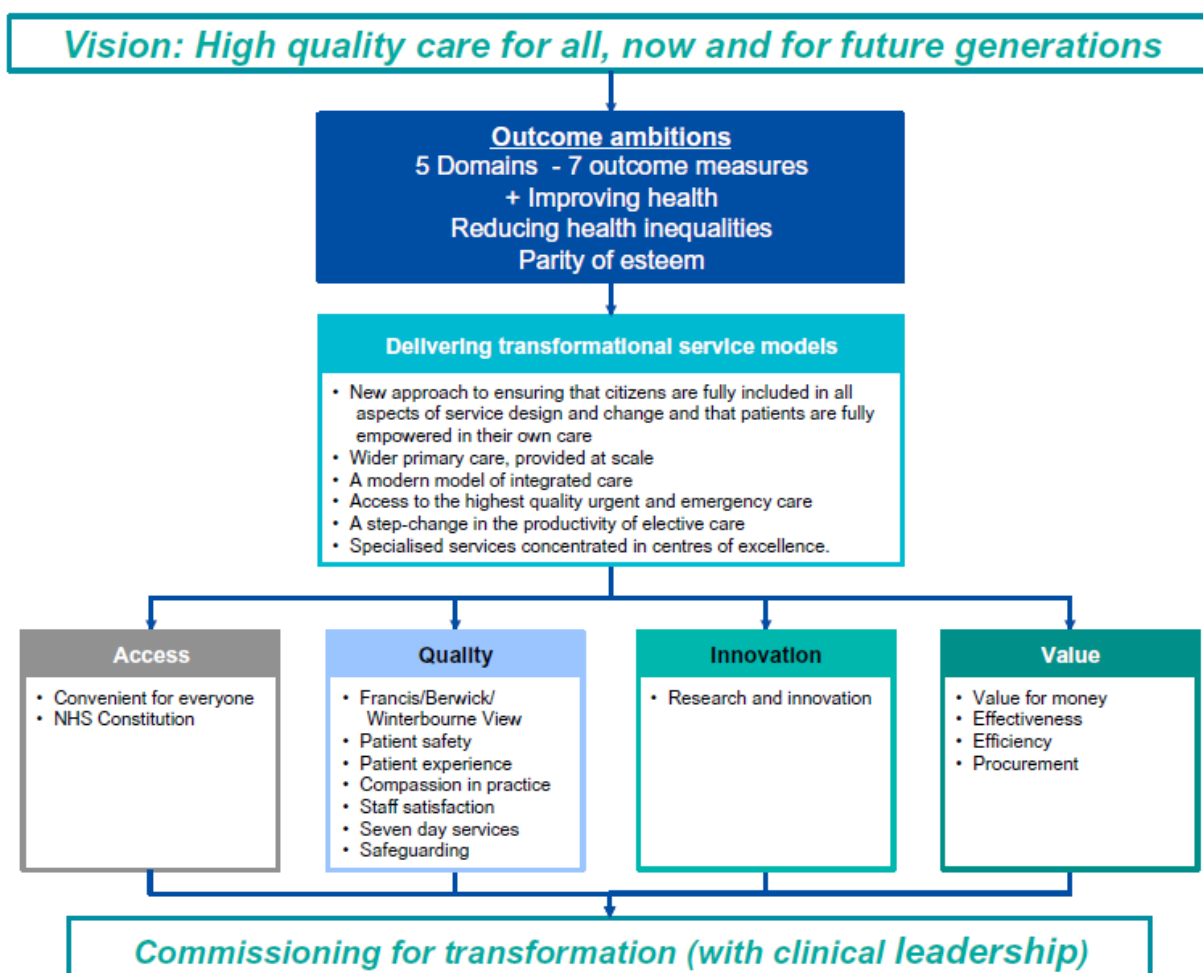
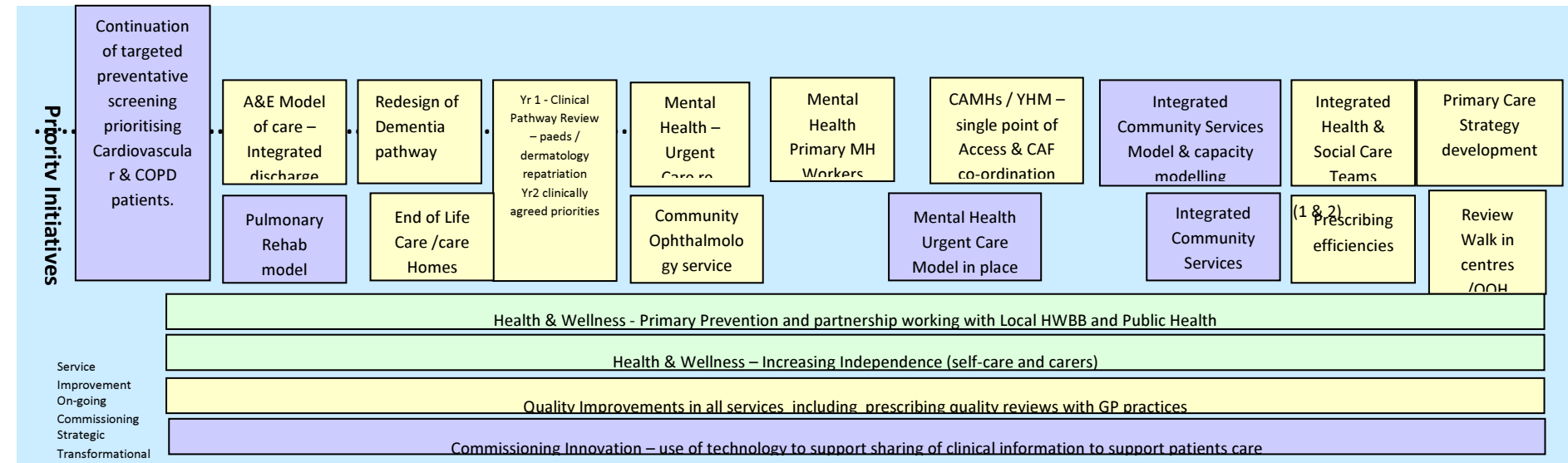


Figure 1: Extract from 'Everyone Counts: Planning for Patients 2014/15 to 2018/19

The following diagram outlines the CCGs key priorities for 2014-2016, linked to the Health and Wellbeing Strategy priorities

NHS Swale CCG 2014-2016 Summary

Strategy	HWB	Every Child has the best start in life	Effective prevention of ill health by people taking greater responsibility for their health and wellbeing	The quality of life for people with long term conditions is enhanced and they have good access to good quality care and support	People with mental health issues are supported to live well	People with dementia are assessed and treated earlier						
	Programme Strategy	<p align="center">Priority Programmes</p> <table border="1"> <tr> <td>Urgent Care</td> <td>Long term Conditions and Integrated commissioning</td> <td>Planned care</td> <td>Prescribing</td> <td>Children & Young People</td> <td>Improving mental Health and Wellbeing</td> </tr> </table> <p align="center">QIPP delivery is £2.3m (14/15) and £1.9m (15/16)</p>						Urgent Care	Long term Conditions and Integrated commissioning	Planned care	Prescribing	Children & Young People
Urgent Care	Long term Conditions and Integrated commissioning	Planned care	Prescribing	Children & Young People	Improving mental Health and Wellbeing							



Operating Plan	<p align="center">Op plan year 1 – QIPP DELIVERY £2.3M)</p> <ul style="list-style-type: none"> Implement community model / capitation contracting Full implementation integrated discharge Team Children's Community Nursing Model implementation Implement community Ophthalmology service Out of Hours / Walk in Centre re-design 	➔	<p align="center">Op plan year 2 – QIPP DELIVERY £1.9 M)</p> <ul style="list-style-type: none"> Primary Care Strategy implementation Full Implementation of community model / capitation contracting Review further clinical pathways and implement improved models of care- Implementation of new OOH service TBC
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2. Our Vision for 2016

Our vision is to commission health services that meet the needs of the Swale population, provide value for money, address health inequalities, and improve health outcomes, to enable the population of Swale to lead healthier and more independent lives.

To achieve this we will:

- Keep patients at the heart of everything we do
- Ensure all commissioning is clinically-led
- Aim to commission local services where viable
- Focus on partnership working with a range of health and social care partners
- Integrate services to avoid duplication
- Maximise resources at every opportunity

This vision cannot be delivered in isolation by the CCG, but requires a whole system approach to the delivery of care. The proposed commissioning intentions outlined within this plan, therefore, reflect the joint view and intentions from the Health Economy developed through partnership forums and clinically led workshops with providers.

This vision is set in the context of the CCGs longer term 5 year vision and Better Care Fund plans, to provide care and support to the people of North Kent (Swale and Dartford, Gravesham and Swanley) in their homes and in their communities. We want to achieve a health economy that is sustainable for the future. Our vision is of primary, community, mental health and acute care services working seamlessly together, with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities.

3. The Case for Change

An ageing population and increased prevalence of chronic diseases requires health services to move from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.

In addition there is the need to:

- Meet increasing clinical need and patient expectations
- Achieve strong performance from our providers tailored to the local population
- Increase efficiency of services and value for money
- Give people choice and control
- Ensure local services and interventions are effective
- Provide systematic and pro-active management of chronic disease within primary care to contribute to reducing health inequalities
- Commission more integrated models of care in order to improve the quality of care for patients and reduce waste.
- Consider prioritising the integration of mental and physical health care more closely as a key part of its strategy to improve quality and productivity in health care.

As mentioned above, the NHS is subject to increasing financial constraints, especially in the current economic climate. Therefore we will need to review how services are provided and how they link up with other services such as social care to develop the most optimum pathways designed around the needs of our patients. Only by reducing inefficiencies and duplication will we be able to provide the best possible services for the funding available to our population.

In order to deliver on the above, we need to work very closely with both patients and the public in Swale CCG, as well as the providers of services, and organisations in the voluntary (third) sector.

We will also need to have an on-going conversation with the population of Swale so that we create an increasing awareness and understanding of the things everyone can do to prevent illness. If we can enhance everyone's sense of responsibility for their own health and that of their families, we can not only tackle some of the most intractable health issues, but also prevent significant suffering, and deliver more and better quality services for our population.

The NHS Mandate is structured around five key areas where the Government expects the NHS Commissioning Board to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

3.1. Transformational Change

The need for transformational, system wide change is clearly recognised, and as such, is a key element of the CCG plans going forward. Following feedback from our member practices a review of community services was implemented during 2013. In order to fully identify the key issues, and develop sustainable, transformational change a review of acute and community services across North Kent was undertaken. This work has commenced with an audit by The Oaks Group, followed by stakeholder workshops facilitated by the Kings Fund, in November 2013 and February 2014.

For the Swale / Medway urgent care system, the review identified that:

- Up to 30% of adult admissions could have been avoided:
 - 70% were due lower levels of care not being considered
 - 47% of acute admissions could have been avoided by providing a variety of services at home.
 - 20% of acute admissions could have been provided for on sub-acute (e.g. community) wards.
 - Additionally, 10% of all admissions required supported living environments.
- 48% of the continuing stay days were avoidable
 - 17% of continuing stay days were due no available beds at alternate levels of care to Some delays due to discharge planning issues.
 - 46% of continuing stay days could have been avoided by providing a variety of services at home.
 - Additionally, 25% of continuing stay days required were for supported living environments.
- For paediatric patients 38% of admissions and 50% of continuing days of stay could have been avoided.

One of the key elements agreed following this review is the need, and potential, to reduce non-elective admissions by:

- 10% in 2014/15, equating to 928 admissions, or £1.662m
- With a further 5% reduction in 2015/16 equating to 418 admissions and £748,000
- i.e. a reduction of 1,346 admissions at a cost of £2.41m over two years.

The agreed areas of focus and plans – including KPIs, milestones, and system wide impact – have been used to underpin commissioning plans for 2014-16 and beyond. This level of change in admissions is only possible by true integration across health and social care providers, and therefore the North Kent proposals for the Better Care Fund underpin delivery of this operating plan.

3.2. Integrated Care:

The Joint Health and Well Being Strategy identifies integrated commissioning as a key priority and to support the delivery of this, Kent County Council and the CCG have developed a North Kent Strategic Commissioning Group to enable review and discussion of services that could be improved for patients and clients through integration. This aligns with the Integration Pioneer agenda for Kent, and will involve the CCGs GP Clinical leads (from Swale and Dartford, Gravesham and Swanley CCGs) and senior KCC and CCG managers to enable the development of a clear plan on how this will be developed to achieve improved outcomes for our patients/ clients and to monitor the impact of the current services that are being jointly funded.

The key integration projects outlined within the Better Care Fund for 2014/15 are:

- **Integrated Discharge Team model expansion** – to ensure that patients receive the treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living.
- **Integrated Primary Care teams** – GPs will be at the centre of organising and coordinating people's care. We will invest in primary care, through the reconfiguration of enhanced services and the secondary to primary care shift / shared-care and funding arrangements with other providers. We will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved. The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided.

- **Integrated Dementia service** within the community and rapid response teams to prevent unnecessary attendance to acute care and facilitate timely and appropriate discharge where an episode of acute care is required.
- **Access to records** – a shared IT infrastructure and record is seen as an enabler to achieve the above. This work has been commenced and a full timeline for implementation is being developed.

3.3. Key Programmes:

Our key programmes are based on addressing issues or areas of concern identified through:

- Health outcomes data
- The Joint Strategic Needs Assessment
- Patient feedback
- Service review – through the Kings Fund / Oak Group work.

The following table aims to summarise the issues identified for the Swale population and the key actions we have identified within our commissioning plans:

Issue	Key actions being taken
<ul style="list-style-type: none"> • Significant health inequalities with areas of high deprivation • Significant population increase by 2020, especially in the older age group • Higher potential years of life lost¹ • Prevalence of hypertension and COPD¹ • Fewer people feeling supported to manage their condition¹ • Poorer health related quality of life for people with long term conditions¹ • Higher rates of diabetes and obesity¹ • CVD • COPD • Readmission within 30 days of discharge from hospital 	<ol style="list-style-type: none"> 1. Continuation of health inequalities programme aiming to reduce the variation in health across the CCG, and provide focussed support to ensure the early identification of people at risk of developing, or with, long term conditions reducing incidence of complications. 2. Integrated primary care team, and dementia specialist team, to provide support to patients, particularly those with long term conditions, to more effectively manage their condition; this is linked to the Better Care Fund to support integration across health and social care. <p>In addition, we are working with Public Health and the Health and Wellbeing Board to review wider health issues for our local population, and identify key actions.</p>
<ul style="list-style-type: none"> • The need for improved communication between health and social care providers; and greater integration of care • Identified reduction in emergency admissions to acute care and length of stay in hospital 	<p>Feedback from patients identified the need to improve communications – both between health and social care teams; but also to enable people with long term conditions to manage their health more effectively. This feedback underpins the Better Care Fund projects summarised in section 3.2.</p>

<ul style="list-style-type: none"> Higher under 75 death rate from CHD and Cancer¹ 	<p>We are working with the Strategic Clinical Networks to review local service provision and identify key actions. Early identification remains a significant aspect of this work; our health inequalities programme aims to address some of the key risk factors for these diseases</p>
<ul style="list-style-type: none"> Healthcare associated infections 	<p>This remains an area of focus for our Quality and Safety Team who are working with all providers to minimise the incidence of MRSA and C difficile</p>
<ul style="list-style-type: none"> Patient experience of GP OOH services 	<p>Service model being developed during 2014/15 for a new service to commence in 2015/16 – the model will be developed based on insight from our patients and GPs</p>
<ul style="list-style-type: none"> Unplanned hospitalisation in under 19's for asthma, diabetes and epilepsy¹ 	<p>Development of a Community Childrens Nursing Service to ensure children and young people receive the right care in the right setting for their needs</p>

¹ denotes performance in comparison with England data.

4. Outcomes Indicators:

The national planning guidance - 'Everyone Counts: Planning for Patients 2014/15 to 2018/19 - outlined a number of key ambitions for the NHS in relation to the delivery of health improvements for local people and ensuring the delivery of:

- **An outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them

We have therefore reviewed the current level of performance and have outlined the improvements we expect to deliver during 2014/15 and 2015/16, which is also aligned to our expectations for the impact of plans over the next five years to 2018/19. The following diagrams summarise these expectations, and the projects identified to deliver these levels of ambition, which align with the aims of the Better Care Fund and integrated working across Health and Social Care.

1. r
educing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality

Projects

- review of health inequalities across the CCG, aiming to prevent incidence, or enable early detection and treatment of key conditions, including dementia
- enhancement of integrated neighbourhood teams
- further development of telehealth / telemedicine
- development of integrated childrens community nursing service

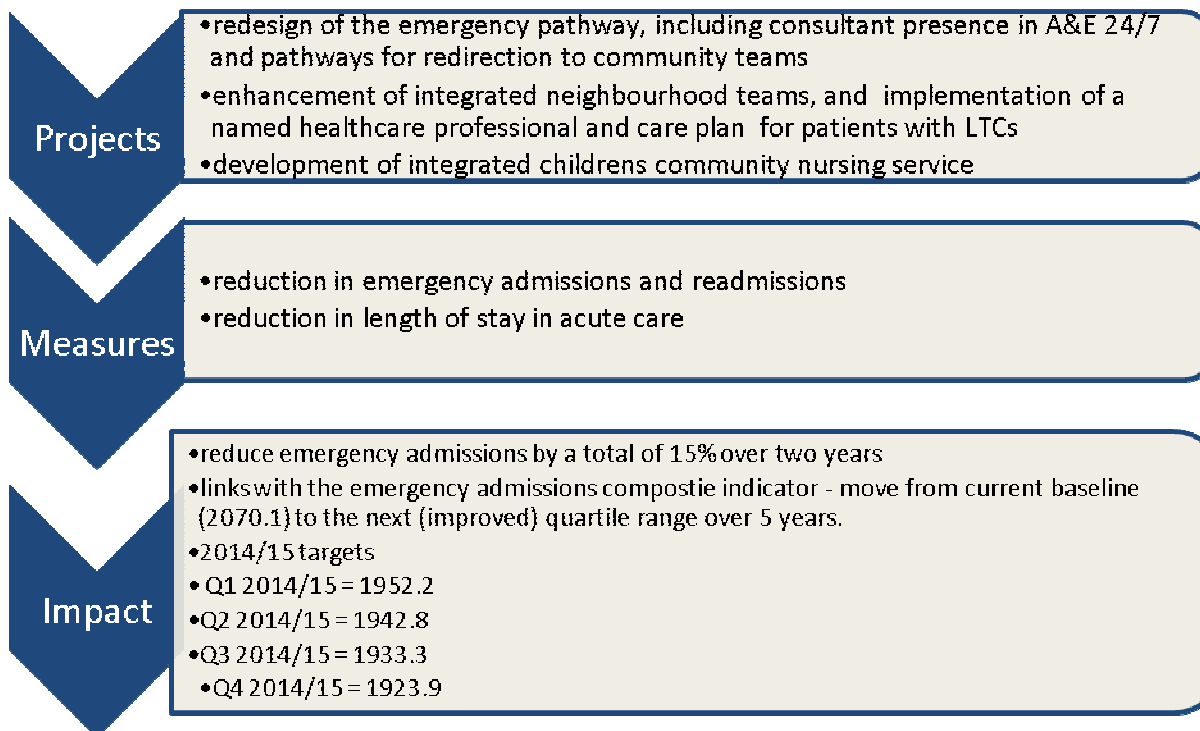
Measures

- reduce gap in life expectancy across the CCG
- prevalence of key conditions

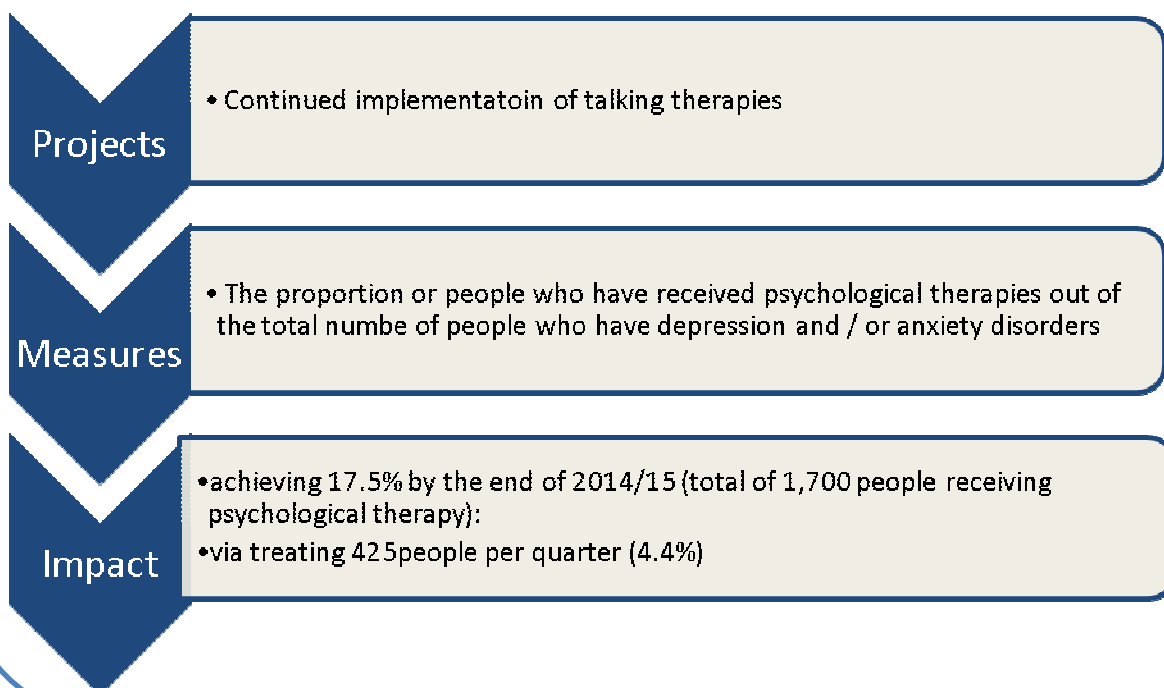
Impact

- Potential years of life lost rate per 100,000 to reduce by 4.6% (from a baseline of 1728.3 to 1648.8) *NB this reduction is currently based on national guidance - local data currently under review to confirm levels of ambition*

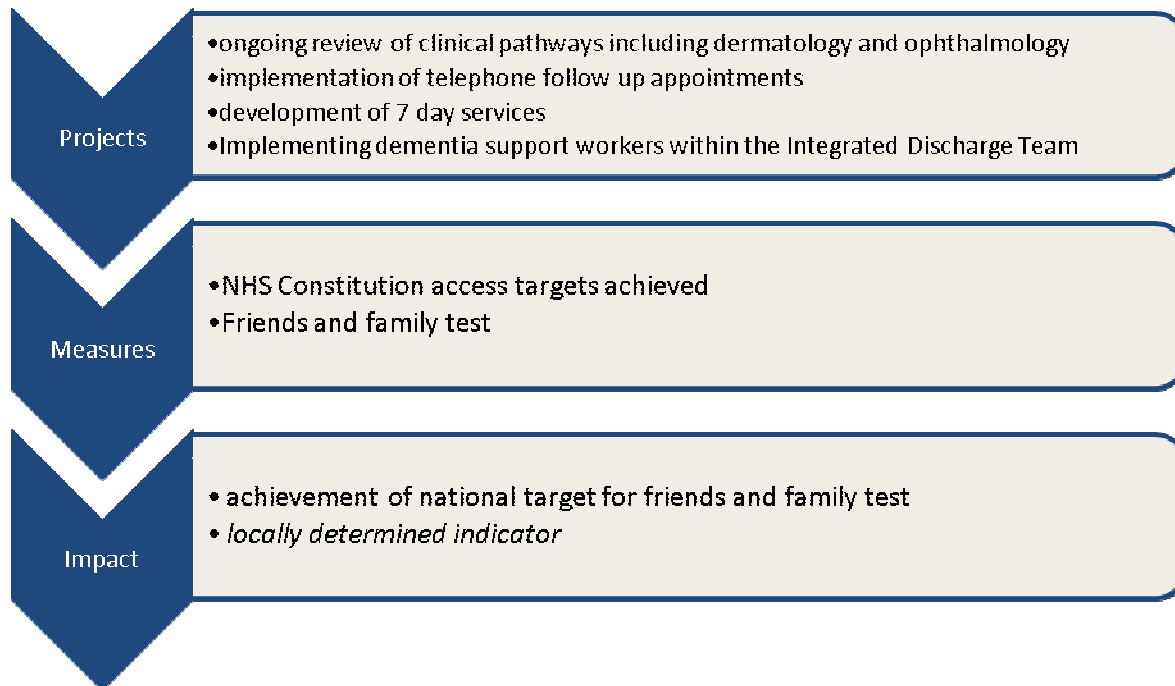
2. R
educing avoidable emergency admissions



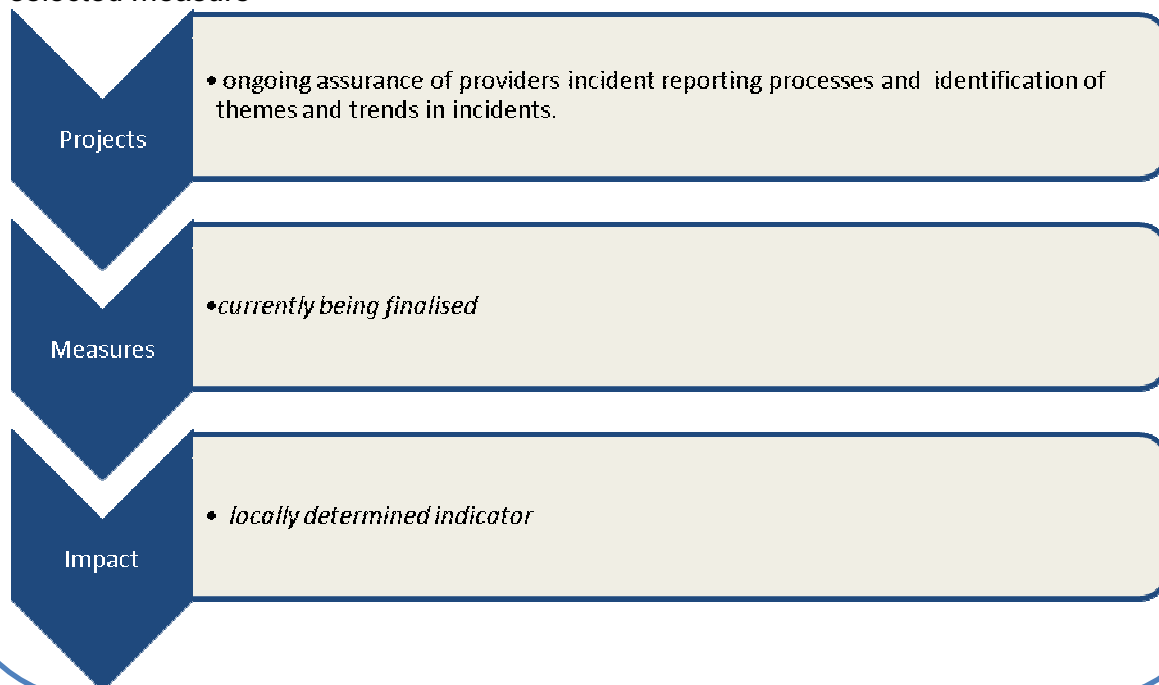
3. improving access to psychological therapies;



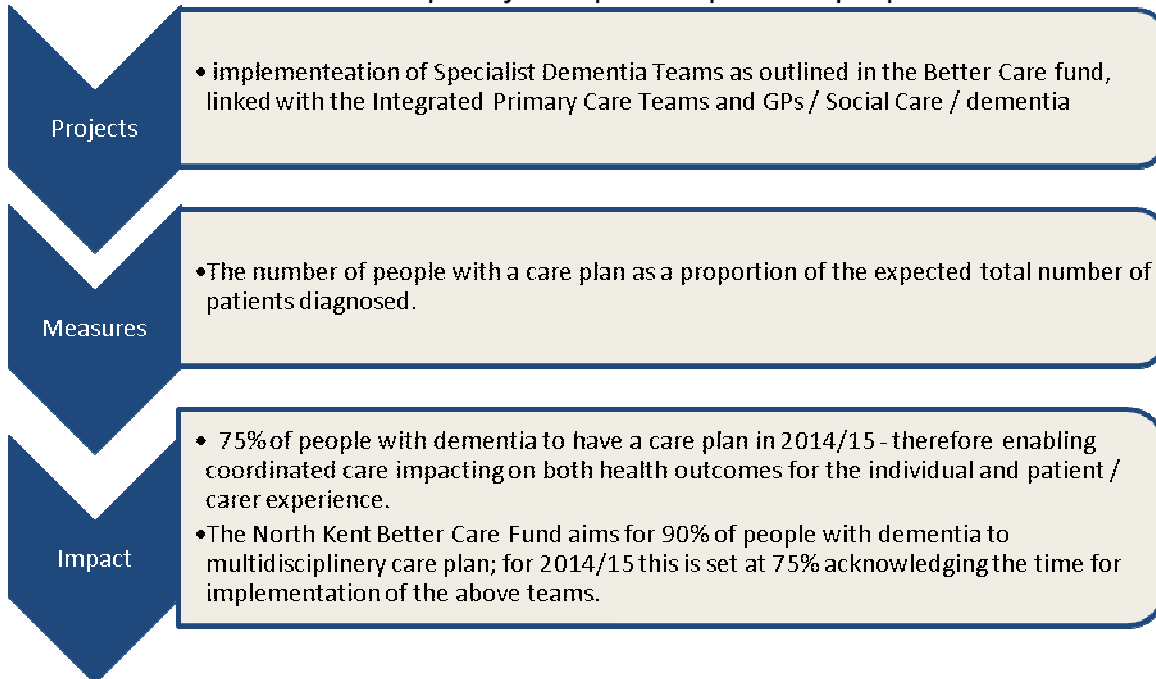
4. Demonstrating Improvement in patient experience: addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator



5. improving the reporting of medication-related safety incidents based on a locally selected measure



6. The number of multidisciplinary care plans in place for people with dementia



In order to ensure that these indicators addresses and aligns with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, the Kent Health and Wellbeing Strategy is asked to comment and approve on the above levels of ambition.

5. Development of Plans

The following table aims to provide assurance on the development of the Operating Plan against key criteria:

<p>Evidence of links to Pioneer and BCF</p>	<p>The Operating Plan recognises the key role integration between health – including primary, secondary and community care – and social care as key to delivering improved care pathways, reducing system inefficiency and, most importantly, improving health outcomes and patient / carer experience.</p> <p>The Better Care Fund – and therefore Pioneer plans – forms the core of our plans for the next two to five years.</p>
<p>Assurance that scrutiny by local HWBs has been carried out</p>	<p>Commissioning plans have been presented to the Swale Health and Wellbeing Board on an ongoing basis over recent months. In addition, plans have been shared at subgroups of the Board enabling input from a variety of stakeholders.</p>

<p>Evidence of compatibility with the HWBS and JSNA</p>	<p>The basis for the development of the Operating Plan is the JSNA and Health and Wellbeing Strategy. This is evidenced within the Operating Plan via:</p> <ol style="list-style-type: none"> 6. Plan on a Page for 2014/15 to 2015/16 (see page 4) 7. Summary of governance arrangements with the Health and Wellbeing Board outlining links with the Health and Wellbeing Strategy 8. Outline of the local health needs
<p>Evidence it has been discussed with a range of stakeholders</p>	<p>Stakeholder engagement forms an important aspect in the ongoing review and development of health services.</p> <p>In addition to public events – at which local authority, health care provider, social services and voluntary sector providers are also invited – we have undertaken a number of actions to ensure we share, and gather feedback on, plans – this remains an ongoing process and continues throughout the commissioning process. Discussions may focus on specific elements of plans e.g. integration or urgent care; or the plan in its entirety.</p> <p>Examples of forums for discussion with stakeholders include:</p> <p>Through existing governance frameworks:</p> <ul style="list-style-type: none"> • Executive Programme Boards – Social Care, health care providers and commissioner (including Bexley CCG) • Programme Delivery groups – social care, health care providers and commissioners • Protected Learning Time events with GPs and practice nurses • County and local Health and Wellbeing Boards and subgroups <p>Through events or dedicated sessions:</p> <ul style="list-style-type: none"> • Better Care Fund – workshops with GPs, healthcare providers and commissioners, Social Care • Kings Fund workshops - workshops with GPs, healthcare providers and commissioners, Social Care • Voluntary sector events – April 2013, October 2013 and planning for next event in Q1 2014/15 • Public Events held July 2013 and February 2014 – as well as working with local Patient Participation Groups and their Chairs to share information and seek feedback.

6. Recommendations

The Health and Wellbeing Board is asked to:

- AGREE the proposed actions and levels of ambition against the Outcomes Indicators outlined in section 4.

- Note the actions taken to:
 - ensure plans reflect the JSNA and Health and Wellbeing Strategy
 - engage with a variety of stakeholders including local Health and wellbeing Boards
 - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.