NHS
Southern Derbyshire
Clinical Commissioning Group

Priority Programme areas - Plans 2014/15 to 2018/19

Priority Area	1 year operational aim	2 year operational aim	5 yr strategic Aims
Older Person	• Fully implement Community Support Team model to undertake co-ordinated case management. • Develop role of OPMH specialists in CST's. • Review Intermediate Care & Reablement services to maximise efficiency and outcomes. • Review & Develop Single Points of Access (SPA) • Implement Memory Assessment Services across the CCG • Review Stroke Care pathway • Tender Community Services for integrated service to commence 15/16	Commission integrated Community Services based around GP practice population, including OPMH services Further develop community/home based reablement services to support 7 day discharge and admission prevention. Commission integrated pathway for Stroke services (tbc)	Older people are supported to remain independent and in control of their lives Co-ordinated support is available in the community when needed. Unplanned hospital admissions for older people are reduced When people do go to hospital they are supported to get home as soon as possible. Admission to long term care is reduced

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Long Term Conditions	• Fully implement Community Support Team model to undertake co-ordinated case management. • Review Intermediate Care & Reablement services to maximise efficiency and outcomes. • Review & Develop Single Points of Access (SPA) Condition specific pathways:- • Procure Integrated Diabetes Pathway Service • Review services for Neurological conditions • Review Respiratory services • Implement Community Pulmonary Rehab service ? Tender Community Services for integrated service to commence 15/16	Commission integrated Community Services based around GP practice population. Further develop community/home based reablement services to support 7 day discharge and admission prevention. Condition specific pathways:- (tbc) • Implement outcome of Neurological conditions review	People living with long term conditions feel supported to manage their condition. Co-ordinated support is available in the community when needed. Unplanned hospital admissions for people with LTC are reduced When people do go to hospital they are supported to get home as soon as possible

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Mental Health	• Work with local authorities to look at the implementation of Personal Health & Social Care Budgets (PHB) • Review CMHT links to CST's • Review the Liaison Services at RDH (RAID) • Work with DHcFT to develop the Crisis services locally, moving to community based / intermediate care facilities where possible. • Improve usage of IAPT services – in particular for people with LTC & Older people. • Review progress against the Autism act. • Work with Primary Care to review physical health needs of people with a mental illness. • Review current services against Closing the Gap: Priorities for essential change in mental health, and develop a plan.	Implement "Closing the Gap" Plan	People with Mental Health needs are supported to remain independent and in control of their lives Mental Health services will be an integral part of other Health and care services. Crisis support will be available in the local community with easy access to this for patients and clinicians. People with a Mental Illness will be expected to have the same health outcomes as the general population (i.e. not worse!!)

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Urgent Care	Evaluation of the four work streams Improve non conveyance protocol for EMAS. Procure walk-in services. Implement 7 day working in Emergency Department. RAID to be evaluated and recommendations to be implemented. Review diagnostic access and re-procure the service. Support the development of self-care management tools.	Profile reduction to be developed. Improve integration working with Integrated Services. Review community discharge to ensure that delivered improvements are sustained. Implement flow principles to surgical pathway.	To reduce the emergency activity by 15%. Support patients to make appropriate choices when seeking healthcare service and advice. 7 day working across the health and social care spectrum to be available. All year results system resilience with flexible bed base and staffing levels.

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Primary Care	• Active promotion of practices working together and targeted support to practices most willing to innovate or most in need. • Support for practices in advance of requirements re >75year olds. CST model implemented. • Identify workforce risks and develop plan with Area Team. Strengthen education programmes; include leadership and commissioning • Identify areas where quality or performance could be enhanced. • Use consistent framework for practice visits, feedback and action planning and use governance structures to support and develop practices • Practices supported (through the Challenge Fund if successful) to implement range of technology solutions to increase on-line services for patients. • Implement new enhanced commissioning framework with consistent specifications and opportunities to work across practice boundaries. • Ensure primary care included in innovation initiatives. Use flexibility of new enhanced commissioning framework to incentivise and reward practices.	Implement number of new arrangements Implement actions from workforce plan. Targeted improvement using suitable benchmark information and patient experience data. Consider and implement technology such as health apps, skype (if evaluate positively nationally). Increase the range of services available Increase opportunities for practices to share and learn from each other.	Practices working collaboratively to offer wide range of services at scale. Multi-disciplinary teams based in primary care with GPs at heart of co-ordinated, proactive and personalised care for those in greatest need. Motivated primary medical care staff with high recruitment and retention in the CCG area. Patients confident of access to high quality primary care service across Southern Derbyshire. Patients able to choose to use technology to interface with their practice and to seek advice and support where appropriate. Patient able to access wider range of services from their practice or nearby rather than attending hospital. Practices motivated to innovate and develop

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Children	• **Review children's use of urgent care services to determine need /opportunities for prevention and greater support to self-care for parents.** • **Begin addressing Commission new integrated pathway of care for children and young people with a mental health / behavioural need including single entry point** • **Review the current process of transition of young person to adult services across key pathways and begin work on highest priority.** • **Implement changes to assessment and commissioning arrangements in line with requirements of the Children and Families Bill, including offering Personal Health Budgets.** • **Determine commissioning options for services to maximise health outcomes and efficiencies ahead of new contracts required from April 2015.**	**Continue programme to maximise use of least intensive / most cost-effective resources to support children and families** **New pathway in place, assess impact** **Complete work on first area and identify next priority.** **New arrangements in place, increasing take-up of Personal Health Budgets** **New contracts in place, continue service developments across service areas not impacted upon by behaviour and disability workstreams.**	• **To reduce inequalities and narrow the gaps in health and well-being and Children's outcomes.** • **Prevention, help and early intervention to support families and reduce demand for services.** • **New delivery models in universal and targeted provision/ care based around an integrated approach.** • **Children, young people and families of children with a disability feel greater clarity, control and flexibility in managing services to achieve what matters to them.** • **More streamlined, simple range of provision that's easy to access from primary care. Appropriate use of high quality specialist / acute provision that's 'drawn down' into local services where possible.**

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Planned	• Explore use of CCG and practice websites to encourage self-care and informed decision making around when to seek clinical advice. • Further develop range of clinical guidelines and ensure readily accessible for GPs. • Targeted uptake from newly qualified GPs and locums. • Rapidly assess potential models for referral management service, then trial and evaluate. • Redesign and procure new MSK pathway with a focus on out of hospital care. • Determine if viable case (clinically and financially) to develop much greater provision of diagnostics, triage, minor interventions and post hospital follow up treatment in range of non-acute locations across the CCG area.	• Evaluate impact using patient groups and health panel • Continue development of guidelines. • Maximise opportunities of NHS e-referral system to improve primary and secondary care interface. • Continue to see reduced variation in referral rates and quality plus utilise referral management service information to support peer review, education and service changes. • Evaluate and commission increased range of services in diagnostic and treatment 'hubs' if positive evaluation.	• General public and health care professionals have access to a broad range of resources that assist patients taking greater care of themselves. • Patients are actively involved and feel informed and in control of the decision making at all stages of their care. • Patients receive the best possible care, as primary care clinicians have all available resources to make the most appropriate intervention. • Patients are able to access a greater range of diagnostic and minor treatment services closer to where they live providing an improved patient experience, with these services provided in a cost efficient manner.