NHS Dorset CCG Business Intelligence

Annual Delivery Plan Monitoring Report – March 2014

Produced by: Sarah White

Data Source: CCP Leads

Date Published: 10th April 2014

Supporting people in Dorset to lead healthier lives

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Clinical Commissioning Programmes – Top Priorities

Ref	**3 Local Priorities for 2013/14** Lead Director: Jane Pike	**Progress Against Commissioning Cycle**	**Position As At: March2014**
1.1	Improving Dementia Diagnosis		There continues to be no formal update on the dementia diagnosis rates on GP registers. The number of diagnoses made by the memory assessment service between 1 April 2013 and end January 2014 was 1048. These figures indicate a diagnosis rate of 52.8% based on a prevalence figure of 13705 and 6184 diagnoses as at end 2012/2013. The following work streams were undertaken with the specific aim of continuing to improve diagnosis rates. **Improving awareness in general practice and data validation** • Four GP Fellowes were commissioned to provide education to practices on dementia. The final report has been completed and it was presented to the Dorset Dementia Partnership in January 2014. • Two primary care dementia facilitators (PDCF) were commissioned by the CCG, employed by Dorset HealthCare, to continue visiting practices to carry forward the work started by the GP Fellowes, offering education sessions, raising awareness of services available to clients

			and carers and undertaking data validation of GP registers against the memory assessment service data to ensure accurate coding. **Memory Gateway and Electronic Screening Pilot** A three month pilot for electronic screening (CANTAB) was launched in August at Bridport Medical Centre working with Age UK, the memory advisory service provider in Dorset County Council area and the memory assessment service working as one to test out the memory gateway model. The aim of this was to facilitate the early screening of clients who are referred to the service (open referral). In the first 3 months 32 people who were concerned about their memory were screened by the memory support and advisory services using CANTAB and 25 required further assessment by the memory assessment service. Bridport Medical Centre has purchased CANTAB for a year so the pilot can be reviewed over a longer period of time. An interim report will be presented to the Dorset Dementia Partnership in May 2014. • The pilot was started in the Christchurch locality at end October, using CANTAB for the first 3 months. Age UK with Dorset HealthCare will review this pilot in April 2014. • The Weymouth & Portland pilot started in December and used CANTAB for 3 months. • Purbeck locality is working with Age UK to complete initial screening from April 2014. • The North Poole locality started a pilot on 2 December. In the first 3 months 44 people were referred. • Poole Central locality will start a pilot in April 2014.

			At present Dorset HealthCare are unable to participate in any further pilots as a review of the service specification memory assessment service is scheduled and the commissioner needs to ensure that there services is commissioned appropriately for the demand. **Improving Processes for the Diagnosis of Dementia** The aim of the work stream is to support general practice to increase diagnosis of dementia in primary care and develop up to date registers to support service development and individual care needs in care homes. The primary care dementia facilitators (PCDFs) are working with GPs, primary care practitioners/nurses and community staff in their work with Care Homes in the identification and diagnosis of people with dementia**.** • The PCDFs have crossed checked dementia registers with clients on the learning disabilities community teams' caseload. • Work has started to cross check a sample of Section 117 records with Dorset HealthCare and the GP records for those patients diagnosed with dementia. • It was hoped the CCG could cross check the Continuing Health Care (CHC) database for those clients with dementia, but due to information governance requirements, this project could not be progressed. • In Weymouth & Portland locality a community matron employed by Dorset HealthCare had gathered information of residents in care homes that have dementia. This list has been cross checked across Dorset HealthCare information systems and with practices in the Weymouth & Portland locality by the PCDF. Initial

			findings are: 63 clients were identified with no diagnosis of Dementia and require GP follow up; 23 clients were cross referenced with the RiO system in Dorset HealthCare and added to GP dementia registers. Another 32 cases with mild cognitive impairment were identified and require annual reviews. • A full time joint post of Dementia Care Home Facilitator with Dorset County Council (DCC) has been appointed to, in the quality directorate. The post holder started in March 2014, and the role is essential to take forward this work in the other localities in this area. **Campaign** A campaign to promote benefits of early diagnosis and services is being scoped with communications team to actively support the gaps in knowledge and understanding in our population. It is likely that this will be implemented in 2014/15 to assist in the push to increase awareness of dementia, local services and the diagnosis process. The communications team are planning events during Dementia Awareness week in May 2014.
1.1	Improving Dementia Services		See Narrative as per 6.1
1.2	Reducing avoidable emergency admissions		See Narrative as per 3.1 and 3.2
1.3	Reducing Preventable deaths of COPD for people under 75 years of Age.		See Narrative as per 3.3
1.4	Encourage the universal adoption of PROM scoring in patients referred for elective hip and knee		See Narrative 5.3

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	**Maternity, Reproduction and Family Health** Lead GP: Dr Karen Kirkham Lead Director: Jane Pike Lead Deputy Director: Frances Stevens Lead Manager: Deborah Hirons	**Progress Against Commissioning Cycle**	**Position As At: March 2014**
2.1	Enhance access to palliative and end of life care for children and young people		Updated service commissioned and in place
2.2	Review and implement pan Dorset pathways of care for maternity services		Maternity strategy completed and associated pathways in place
2.3	Review community paediatric services and pathways of care for chronic diseases in children (asthma, epilepsy and diabetes) including: • Insulin pumps (phased increase in provision, subject to funding) • Short stay assessment tariff for paediatric emergency admissions and advice and guidance service • Increase therapy services for children (subject to funding) • Looked After Children designated doctor in West Dorset and paediatric cover for the SARC (all subject to funding) • Implement Ophthalmic Service in West Dorset.		Insulin pumps commissioned and service in place Advice & Guidance pilot continues LAC service in place Updated therapy provision commissioned and in place

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	General Medical and Surgical Lead GP: Dr Chris McCall Lead Director: Jane Pike Lead Deputy Director: Frances Stevens Lead Manager: Hazel Thorp	Progress Against Commissioning Cycle	Position As At: March 2014
3.1	Review and redesign of urgent and emergency care services progressing the work commenced in 2012/13 and the action agreed at the pan-Dorset event on 28.2.13		The Pan-Dorset Kings Fund review has concluded Phase 1 of its work (Diagnostics) and has submitted its report. Phase 2 – The Kings Fund have conducted a further piece of work in relation to the Elderly Care Pathway. Recommendations are being reported to the CCG Board May 2014 to agree a way forward. The 2013-2014 In-Year projects have been assessed. The four urgent care hubs have be asked to recommend two key projects each for consideration of further funding by the Urgent Care Board in April. Performance metrics have been used to measure the degree of success of each initiative. An Urgent Care Strategy is now in the process of being developed and agreed.
3.2	Embedding of new NHS 111 service into the Dorset health and social care community to ensure effective integration into urgent care pathways		Implementation phase complete. Service being monitored through contract review; remedial action (where necessary) being taken on issues arising. Current performance meets or exceeds the majority of national standards.

3.3	Fully implement the primary care COPD pathway		The new Dorset Adult Integrated Respiratory Service now has been specified and is currently being commissioned. Three preferred suppliers have been identified, two of which have now supplied detailed implementation plans and a Contract Variation has been issued. The remaining provider is currently agreeing the implementation plan and is expected to be able to issue a Contract Variation by the end of May 2014. The key aims of the service are: • to ensure an effective high quality service • integrated working between primary care localities and the specialist respiratory teams in the local acute providers • reduce emergency admissions for respiratory conditions • admission avoidance, where appropriate • provide care closer to home and provide a service that is more responsive to the patients' needs • deliver a sustainable healthcare model A hub and spoke model has been developed with the 3 acute hospitals in Dorset currently being commissioned to extend their current respiratory service into the community and to interface, formally, with the services currently being delivered via primary care. These teams

			will align with the Dorset CCG GP clusters and will work collaboratively. Each Cluster Team will include Respiratory Nurse Specialists, Chest Physiotherapy and support workers and will have access to Psychology / Counselling. The new service will link with GP Practices, Community Nursing and therapy teams, Pulmonary rehab providers, 3rd sector providers and carers and Smokestop services. Briefings across the health community about the service introduction and the interfaces between the different tiers of care are being progressed. A leadership group has been formed to ensure the equality of the service throughout the County while offering County wide support during the initial phases of the service launch. The other key elements that are currently being designed or delivered are: • A common respiratory education programme for Dorset Primary and Community Care staff • A common Spirometry training and accreditation package, ensuring a improvement in testing and a consistency of approach improving diagnosis, in line with new national guidelines. • A Patient Reported Experience Measure survey (PREM) is being developed by the respiratory nurses and our patient reference group. This will offer a key indicator of the effectiveness of the

			service delivering improved patient care. The 'out of hours' service is being developed jointly with the SWAST 111 & SPoA service and integrating with the 'Virtual Ward' pilot in the East of the County to support patients at times when specialist cover is not immediately available.

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	**Cardiovascular Disease, Stroke, Renal and Diabetes** Lead GP: Dr Craig Wakeham Lead Director: Jane Pike Lead Deputy Director: Sally Sandcraft Lead Manager: Fiona Richardson	**Progress Against Commissioning Cycle**	**Position As At: March 2014**
4.1	Develop cardiovascular disease services to enhance co-ordination and integration: • Agree and progress implementation of a heart failure pathway to support identification, early management, rehabilitation, prevent admissions, step down and end of life care • To work collaboratively with locality management of people with atrial fibrillation • To improve the identification of high risk families and reduce their risk factors		• BNP - pathways implemented across all localities and targeted work with specific practices • Community heart failure specialist nurses provider in post • Community rehabilitation procurement in place in Poole, proposals from DCH and RBCH under discussion to align costs more closely with current providers • Weymouth and Portland pilot linked to flu clinic for opportunistic identification of people with AF. 22 people with AF provided and 6 with cardiac disease. For every £1 invested £225 return on investment. Service specification under development for County rollout. • SALT new specification and staff recruited. Waiting times for stroke patients reduced from an average of

			over 12 weeks to 4 weeks. • 6 month post stroke reviews commenced in December • DVT service review and new model developed so support care closer to home • Familial hypercholesterolaemia services commenced mid November. Programme for patient engagement for the coming year agreed with patients.
4.2	Enhance primary and community diabetes services and implement improvements in foot care		• Dietetics service within intermediate care provider appointed staff recruitment • Foot care clinics in place for West Dorset, early indications of reduction in more major amputation rates Patient workshops in May to review medicines formulary for glucose meters.
4.3	Develop effective relationships with Wessex LAT to ensure that specialist commissioning decisions meet the needs of our population • Implement the strategy national service specification for vascular services to improve clinical outcomes • Evaluate the outcome and implications of the King's Fund cardiology review		• Slow progress on vascular service commissioning intentions with Wessex LAT. A patient engagement event was held pre- April by the Cardiac Network. Kings Fund review not commenced, scope of review under discussion. Remit redefined and agreed with all parties. SEKIT have commended their element of the review.

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	Musculoskeletal and Trauma Lead GP: Dr Christian Verrinder Lead Director: Jane Pike Lead Deputy Director: Margaret Allen Lead Manager: Cindy Shaw-Fletcher	Progress Against Commissioning Cycle	Position As At: March 2014
5.1	Implementation of community persistent pain management service		The new Dorset Community Pain Service is now available in both the east and west of the County the service is provided by Dorset HealthCare University NHS Foundation Trust. The service rolled out in the West in June 2013 and in the east from October 2013. Patient/public events were held in the East and of the county. Both events were well attended and well received. Legacy patients have been integrated into the new service and provided with interventional procedures where they were booked previously, prior to being fully integrated into the holistic persistent pain service. Patient feedback is becoming positive. The referral process has been significantly simplified .The service have launched an interactive website with personal log in areas for patients on www.soaringabovepain.com

5.2	Specify primary care adult (16+) MSK physiotherapy provision in all primary care and out patient services contracts including physiotherapy self referral model		The new Primary Care Direct Access service specification has been agreed with all providers of these services and now forms part of all of their contracts and will be closely monitored with regular contract review meetings. The contractual position with independent sector physiotherapy providers has been formalised. Physiotherapy is key to supporting services and as such a major review of physiotherapy services will be a key priority for the MSK CCP.
5.3	Encourage the universal adoption of PROM scoring in patients referred for elective hip and knee		Oxford Score templates have been provided to GPs to help them assess whether people with hip and knee problems should be referred to a specialist. Patients are asked to 'score' their pain and mobility difficulties in several activities, for example washing or kneeling. This enables the GP to reach an overall assessment of their problems and to decide the best course of action for them. Use of the scoring system has led to improved referrals, a reduction in waiting times and improved outcomes for patients.

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	Mental Health and Learning Disabilities Lead GP: Dr Paul French Lead Director: Jane Pike Lead Deputy Director: Sally Sandcraft Lead Manager: Kath Florey-Saunders	Progress Against Commissioning Cycle	Position As At: March 2014
6.1	Implement and evaluate the older peoples mental health service reform programme (East of Dorset).		The transfer of patients from Kings Park to the renovated Alderney site at has been completed. An evaluation of the new services will be undertaken on the first 6 months of operation (October 2013-end April 2014) and reported in Q2 2014/15 as part of the older people's pathway review and design.
	Review and re-commission dementia advisory services across Dorset.		The tendering process is in progress and shortlisting has been completed. Bidder presentations are scheduled for 16 April 2014. The new service is aiming to be operational on 1 September 2014.
6.2	Ensure the recommendations from the Winterborne View report are implemented within all local health providers and our organisation.		The Winterbourne View action plan has been developed Pan Dorset between the three Local Authorities and the CCG. The two Adult Safeguarding Boards are overseeing the implementation of the plan, and it is reviewed at each quarterly meeting. A report on progress of the CCG actions is received regularly by the Audit and Quality Committee meeting. The key milestones which were

			required to be completed by June 2013 have been achieved, including a register of people in learning disability inpatients beds being maintained within the Clinical Commissioning Group. There are still 5 patients in inpatient beds, which are clinically appropriate placements, and plans are in place for discharge to community settings. Further actions are being delivered jointly with our partners. Joint contracts with the LAs for patients in care homes and receiving domiciliary care, with a new nursing specification, are now in place. Patients and the public are represented at both the Adult Safeguarding Boards and the Audit and Quality Committee and the joint Learning Disability Commissioning Partnerships include patients and the public.
6.3	Implement a pilot programme to improve Primary Care Mental Health Services		The project team were not able to recruit to the clinical position, which is an increasing issue in the mental health market, and therefore the project was not able to be delivered. Options for improving services in primary care are being developed and a decision will be taken in May 2014 on how to progress this piece of work. The CCP is also working with the Strategic Clinical Network on the development of a mental health passport for people with Serious Mental Illness linking with primary care.

6.4	Autism & Autistic Spectrum Disorder Service. Joint Commissioning with the Local Authorities of an expanded and extended diagnostic and assessment service based on existing CAAS model.		The service has been commissioned and is now in the mobilisation phase. It will be fully operational in early 2014/15

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	**Cancer and End of Life** Lead GP: Dr Lionel Cartwright Lead Director: Jane Pike Lead Deputy Director: Margaret Allen Lead Manager: Cindy Shaw-Fletcher	**Progress Against Commissioning Cycle**	**Position As At: March 2014**
7.1	Implement the National Awareness and Early Diagnosis Initiative		Throughout the year there have been three BCOC campaigns. Jul – Aug, Lung Cancer Campaign; Oct – Dec Bladder and Kidney campaign and Jan – Mar Breast for over 70 campaign. All campaigns were delivered nationally and locally through the media. Uptake was positive and data is currently being reviewed to analyse the outcomes from the projects. Joint posts for Macmillan GPs has meant they are now supporting the local agenda for early diagnosis with cancer and are working closely with the CCG and primary care to run education and information events. All 2 week wait referrals forms have been revised and are out for consultation. Evaluation of current pathways for diagnostics in relation to Brain, Pancreas and Ovarian have been reviewed and the outcome of the recommendations will be shared via the Macmillan GPs with Primary Care as an educational resource.

7.2	Implement the findings of the East Dorset Specialist Palliative Care Review		The East Dorset Palliative Care Review has been implemented, providing integration and learning and setting the basis for which the Pan Dorset Palliative Care Review has proceeded. The Project Management Support have written up their findings and the EOL Board are reviewing next steps. MacMillan GPs in post, work programme under way. GSF Cross Boundary Care progressing with additional GSF participation across sectors. Dementia and EOL education project progressed with the National Council for Palliative Care (NCPC).
7.3	Reduce follow up attendances for patients with specific cancers (for example colorectal, prostate and breast)		Meetings commenced between GP and specialist consultants to discuss the changes in follow up to the three key specialist areas. These include Breast, Colorectal and PSA. Task and Finish Group has been set up for a pan Dorset approach to risk stratified follow up care. A task and finish group is to be set up to reduce follow up duration for specific cohort of colorectal patients from 5-2 years A revised PSA LES has been rolled out to all of primary care in the 14/15 NHS Standard Contract. This pathway will be reviewed during the next twelve months in line with NICE guidance and recommendations.

NHS DORSET CLINICAL COMMISSIONING GROUP

ANNUAL DELIVERY PLAN 2013/14 – MONITORING REPORT

Ref	Pan Programme Priorities	Progress Against Commissioning Cycle	Position As At: March 2014
8.1	Community IV Therapy Services		The IV therapy pilots for ambulatory patients are running in Weymouth, Portland, Blandford and Bournemouth and Poole. The pilots are being evaluated which will then inform the roll out across the CCG. IV therapy engagement activities: As part of the engagement for transforming community services through workshops with patient groups a key supported theme is care closer to home and this service is a key part of this through delivering IV therapies to ambulatory patients in local settings rather than always in secondary care hospitals.
8.2	Implementation of integrated teams, expansion of district nursing, intensive case managers		Work to agree the service delivery improvement plan in light of the investment with Dorset Healthcare is being finalised and is expected to be agreed within the next 2 weeks. This has been informed by the feedback from GP's including feedback through a survey monkey. A draft workforce mobilisation plan has been shared from DHC and is being finalised, which will then be shared with Locality lead GP's.
8.3	Technologies – implementation of telehealth and roll out to diabetes, oncology, mental health, intermediate care and end of life care		Implementation of Telehealth is on course for COPD and CHF. 300 of the 500 pods have been distributed. Outcomes are good with significant

			examples of reduced acute admissions and reduced health professionals contacts. Oncology and mental health developments are ongoing with first pods being given to oncology patients and lifestyle monitoring patients Diabetes and end of life developments have been slow to progress and are to be put on hold for the foreseeable.
8.4	Improving the provision of leg ulcer services (subject to investment)		The commissioning arrangements have been agreed and the GP practices mobilised to new specification. The community provider has had a phased mobilisation which is complete by the end of March 14.
8.5	Carers – with social care partners we will continue to develop and implement support programmes for carers		Agreement has been reached on statement of intent to work within existing LA and CCG Carer's Strategies for 2014-15. Project Initiation Document drafted for full review and initial stocktake of current position across Dorset has been undertaken in partnership with Bournemouth University. Project is now into service review and design phase working towards one Carers Strategy to implemented alongside joint integrated fund in 2015/16.
8.6	Personal Health Budgets – continued roll out of Personal Health Budgets • Continuing Health Care – all domiciliary CHC • Mental Health – acute and community and Section 117 • Carers • Reablement		All newly eligible CHC funded patients are being offered PHB, and communication is commencing offering this to existing CHC funded patients. PHBs are being delivered for domiciliary CHC in Dorset and about to commence for B&P now that a resource has been identified to assist process. Carers PHBs are being granted. Reablement funding has been withdrawn from 1/4/13 with existing PHBs

			being maintained with recurring funding. 2 Section 117 PHBs have been granted with a proposal to develop further and work with providers on PHBs in Mental health and LTC is in progress.