NHS
Dorset
Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Clinical Delivery Group Priorities Report - September 2016

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Clinical Delivery Group Priorities Overview

CDG	PROJECT REFERENCE	CDG PRIORITY	RAG	STATUS SINCE LAST REPORT	PROJECT PLAN Y/N
Maternity and Family Health	MAT001	Maternity and Paediatric acute hospital network development		↔	Y
	MAT002	Define and develop local integrated community children's health service		↔	Y
Integrated Community Services	ICS001	Integrated Teams and End of Life Care: Risk stratification and implementation of end of life care strategy		↔	Y
	ICS002	Intermediate Care: intensive rehabilitation and re-ablement, links with early supported discharge and rapid response		↔	Y
	ICS003	Longer term project: Out of Hospital Respiratory Services		↔	Y
Planned and Specialist Care	PS001	Rheumatology		↔	Y
	PS002	Radiology and Diagnostics		↔	Y
	PS003	Dermatology		↔	Y
	PS004	Cancer		↔	Y
Urgent and Emergency Care	UE001	Integrated urgent care hub (Out of Hospital/111)		↔	Y
	UE002	Weymouth urgent care centre mobilisation to be completed including an assessment of transferability of service across system		**Completed**	Y
	UE003	Trauma model of care developed to support the proposed acute model configuration		**Completed**	Y
	UE004	Implementation of discharge to assess county wide (linked to the work of the systems resilience group).			Priority moved to SRG
	UE005	Provision of specialist advice and guidance within one clinical pathway that assists admission avoidance.		↔	Y
Mental Health	MH001	Co-produced model for acute mental health services resulting in enhanced access and service user experience (Acute Care Pathway Project)		↔	Y
	MH002	Improved rates of dementia diagnosis (67% by March 2016 – stretch target 70%) and improving post diagnostic support		↔	Y
	MH003	Development of effective provision to support the delivery of the 4 stage crisis model for learning disabilities (LD Crisis Assessment and Support)		↔	Y
	MH004	Deliver the national MH waiting times for IAPT and EIP		↔	n/a
	MH005	Work with the Maternity and Families CDG to develop an All Age Psychiatric Liaison Service by 2020.		↔	Y
	MH006	Co-produce model for rehabilitation and recovery services incorporating related employment services and supportive housing		↔	Due to commence Sept/Oct 16
	MH007	Co-produce model for organic specialist pathway (in-patient and community provision)		↔	Y

MATERNITY AND FAMILY HEALTH MONITORING REPORT AS AT: 31 August 2016

CLINICAL CLEAD: KAREN KIRKHAM HEAD OF SERVICE: JANE BRENNAN

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Project Timescale	RAG	Status Since Last Report
MAT001	Maternity and Paediatric acute hospital network development	Jun-16	Work is being progressed through the Acute Vanguard against milestones and timescales. Two Frameworks for Future Commissioning, one for Women's Healthcare - Maternity and one for Paediatrics/Child Health have been developed and shared with both these workstreams.	Attending Paediatric Vanguard on a monthly. Womens Haelthcare Vanguard hasn't met since March 16. Linking with the PMO leads in Onenhsdorset since in post - July-August 16.	Drafts shared with	Timescale to be agreed jointly with Acute Vanguards and CDG		↔
MAT002	Define and develop local integrated community children's health service	Nov-15	Feedback from stakeholder workshop (Feb)gathered. Vision to be further defined and agreed following consultation of the Framework for Future Commissioning for Paediatrics/Child Health. A project group is yet to be established. Created a template for collating childrens services from Local Authorities. Received update from DCC. Chasing Bournemouth and Poole for feedback. Developing terms of reference for project group, inviting stakeholders and setting up first meeting.	A draft PID has been developed, outlining the whole system redesign programme, this needs to be updated (Sept 16).	Draft PID to be updated following Vision workshop in July on Paediatric/Child Health.	30-Dec-16		↔

MATERNITY AND FAMILY HEALTH MONITORING REPORT AS AT: 31 August 2016

CLINICAL CLEAD: KAREN KIRKHAM HEAD OF SERVICE: JANE BRENNAN

Reference	Priorities/Projects	Commencement date of project	Progress Updates/Comments	Current Milestone	Milestone Timescale	Project Timescale	RAG	Status Since Last Report
MAT005	As part of pan Dorset Maternity Strategy review and implement revised perinatal mental health pathway	Apr-15	The perinatal mental health pathway has been agreed, implemented of revised pathway of pan Dorset wide specialist perinatal community team is planned of April 16. Staff in place August 16. Full implementation of new pathway Sept/Oct 16	Recruitment delay, hence this pathway will be in place Autumn 16				↔
MAT006	Implementation of the Special Educational Needs (SEN) Act 2014 statutory requirements	01/04/2014	SEND is progressing. SEND is now being reported through the Joint Operational Commissioning Group (JCOG) to pan Dorset CYP Joint Commissioning Partnership Board. All local offers have been published. Ofsted inspection by each LA (x3) is awaited. This will include the CCG 3 over putting time pressure on the M&FH team	Currently preparation is underway for a new joint inspection. SEND lead in M&FH is moving to a new post in CCG (Sept 16)		Not know at present		↔
MAT007	Review and redesign of children's audiology service	01/08/2015	Agreement with both providers has been reached to work together to redesign a new model of service delivery across Dorset for Children. This is moving forward with delays.	Agree with both providers	Apr-16	Jan-17		↔
MAT008	Children's Palliative Care	Aug-16	Review of Children's Palliative and EOL Care in DCH and PGH pathway inclusive of a revised service specification, working with Children's CHC team.	Childrens CHC lead contacts confirmed	31-Jul-17	01-Apr		↔
MAT009	Assisted Conception (review of Policy from 2015)	Sep-16	Review of Policy adopted in April 15, will commence this month, as new revised policy following learning and updates needs to by in place April 2017	Minor changes made to current policy in Dec 15	31-Mar	01-Apr		start date agre

INTEGRATED COMMUNITY SERVICES PROGRAMME HIGHLIGHT REPORT

CLINICAL LEAD: KAREN KIRKHAM PROGRAMME MANAGER: SALLY SANDCRAFT As at 31 August 2016

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Timescale	RAG	Status Since Last Report
ICS001	Integrated Teams and End of Life Care including:	Nov-15						
	a) Risk Stratification		Service specification for integrated teams and outcome measures. Frailty reference group established and agreed output, task and finish group will be established. Outcomes agreed for work programme. Mapping of frailty services commenced. 1) Agree frailty risk screening and assessment tools, including the comprehensive Geriatric assessment to recommend pan Dorset. 2) Agree Dorset care plan template pan Dorset interfacing with information systems. 3) Recommend approaches for supporting people in care homes more proactively.	Frailty and End of Life Care Reference Group to provide guidance on risk stratification to build on work of Better Together locality developments. Workshop has taken place and this will inform framework and guidance developed. This will be subsumed within the ICS programme and inform the pyramid of need and recommended models of care.	Jul-16			↔
	B) Implementation of End of Life Care Strategy		Gap analysis of Dorset EOL services against national strategy EOL. Outcomes: 1) Primary care - integrated with frailty work 2) Understand how to support DHUFT EOL strategic vision and integrated community teams 3) Acute care - ensure Trusts have plan to meet national NICE guidance and understand commissioning implications. ICS will subsume the DHUFT service development and interface with integrated teams and palliative care team.	To define with trusts reporting that is standardised to help inform future planning. Proposals for more integrated care at end of life in East still awaited. This will transfer to the contract management team in the Directorate. The national Audit will form the basis of future reporting. Awaiting DHUFT report this delay impacts on Do plans				↔

INTEGRATED COMMUNITY SERVICES PROGRAMME HIGHLIGHT REPORT

CLINICAL LEAD: KAREN KIRKHAM PROGRAMME MANAGER: SALLY SANDCRAFT As at 31 August 2016

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Timescale	RAG	Status Since Last Report
ICS002	Intermediate Care including:	Dec-15	CDG considered output from stroke workshop and have recommended the service model: 1) Is not disease specific, 2) Is based on a 'pull out' of hospital model 3) Ensures specialism/specialists are included within community teams providing rapid response, intensive rehabilitation and reablements, early supported discharge and 4) Services are integrated and minimise the handovers between teams.					
	a) Intensive rehabilitation and re-ablement (including stroke)		Better Together programme review of intermediate care and reablement. Initial meeting taken place. Mapping of service due to complete in February. Links to the frailty work above. DHUFT meeting to review their service action plan in March.	JCOG agreed work programme. IPC concluding research to inform key features and functions	Jun-16			↔
	b) Links with Early Supported Discharge - Stroke		Community Hospital bed modelling for future needs. Modelling completed for stroke care and tested with clinicians. Community bed requirements identified but Acute Vanguard interface unclear. A task and finish group will be established to develop proposals for early supported discharge/ ESD light touch services that are not disease specific	Recommended model based on the principles above for ESD and ESD light touch - Task and finish group meeting in May. Interface with Stroke Vanguard agreed	May-16			↑
	c) Rapid Response		Stroke rehabilitation model of care for Dorset. Workshop on right time right place stroke rehabilitation completed. Project on target. Acute Vanguard have included within their outputs and direction of travel not including commissioners	Frailty workshop included all clinicians still considerable issues from specialists on more integrated models of care				↑
	Longer term projects including:							
ICS003	a) Out of Hospital Respiratory Services	Dec-15	Dairs non-recurrent funding for 2016/17 to be considered at CCC. Completed and outcomes shared with Trusts. Model of care to be developed for Dorset. Detailed work has not commenced. ICS team to conclude work for CCC in august for implementation by both contracting and primary care function within Directorate	CCIP includes emphasis on COPD. Pulmonary rehab lead provider agreed as DCH. New service spec & performance metrics agreed. Mobilisation plan to be agreed. Proposals for DAIRS resource redistribution to support enhanced primary care will be commenced in June	Apr-16			↔

PLANNED AND SPECIALIST MONITORING REPORT AS AT: 31 August 2016

CLINCIAL LEAD: CHRISTIAN VERRINDER HEAD OF SERVICE: CINDY SHAW-FLETCHER

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Project Timescale	RAG	Status Since Last Report
PS001	Rheumatology including:							
	a) Development of Rheumatology Clinical Network pan Dorset	Nov-15	The Rheumatology Task and Finish Group and the existing Rheumatology Clinical Network will meet on May 18th as the new Clinical Network. Development of the model of services commenced.	Clinical Network established. Stage 2 of the project is complete.	Apr-16	6months		Complete
	b) Move appropriate rheumatology outpatients into the community. Focus on inflammatory disease service provision	Nov-15	The Task and Finish Group in September will further develop the model. A patient reference group will be held on Tuesday 6 September to gain input for the model with patients . Patient representative has agreed to chair the reference group and several GPs have identified patients to attend the reference group. There will also be a Clinical Lead present. MSK Masterclass (GP education) will be held on 13 October.	Task and finish Group to be held in September.	Apr-17	18months		↔
	c) Secure new service to ensure any reorganisation agreed to complement and further enable the Dorset MSK strategy and the implementation of the Spinal Pain specification	Nov-15	Stage 5 of the project will commence in October 17.	This priority will commence in stage 5 of the project plan.	Jan-19	4 years		↔
PS002	Radiology and Diagnostics including:							
	a) Develop a pan Dorset unified radiology platform for reporting and accessing images	Nov-15	The project team are involved in the Acute Vanguard work in order to analyse and agree the best approach for delivering the integration of the pathology objective at present. A service brief has been completed and shared with the COO's. The Framework for Future Commissioning has been drafted and will be distributed for comments. This will act as a guide for the Acute Vanguard Radiology agenda in line with the CSR and CCG agreed outcomes.	Project Plan has been established.	01-Apr-20	5 years		↔
	b) Use findings to design and agree the integrated radiology and pathology IT services to include commissioners (quality, procurement, finance, information)	Nov-15	The plans to link the instances of ICE across Dorset continue and work has slowed as the Acute trusts face challenges in agreeing this as a priority in their current workstream. The issue has been escalated to again agreement for it to go ahead. The Acute Vanguard Radiology group has met and they have limited funding available for their work programme.	On target.	Apr-17	18months		↔
	c) Development of a Dorset radiology clinical network	Nov-15	The Acute Vanguard Radiology group continue to be the vehicle for delivering the Clinical Network for Pan-Dorset diagnostics and will be reviewed regularly to ensure this is effective. The CCG Clinical lead for diagnostics has met with the COO from DCH to agree how the acute vanguard for diagnostics and transformational work will deliver ICE across Dorset.	The Radiology Clinical Network is currently facilitated through the Acute Vanguard	Apr-16	6months		↔

PLANNED AND SPECIALIST MONITORING REPORT AS AT: 31 August 2016

CLINCIAL LEAD: CHRISTIAN VERRINDER HEAD OF SERVICE: CINDY SHAW-FLETCHER

	Dermatology including:							
	Development of a Dorset Dermatology clinical network	Nov-15	Dermatology Clinical Network members have provided their views on aspects of the proposed service model. Findings are being themed and will be passed onto the working teams for the service development.	Clinical Network Established	30/04/2016			Complete
PS003	Agree integrating dermatology model (acute, community, primary care)	Nov-15	High level service model draft complete. Advice & Guidance/teledermatology pilot based on the RD&E model is commencing September 2016 with RBH to inform service requirements. This will be followed by DCH and then PGH. The Dermatology Task & Finish Group met on 22nd July 2016 and confirmed the project scope. Work teams were also agreed to develop key parts of the service. These are Paediatrics, Prevention & Self-Care, Advice & Guidance/Teledermatology, primary care education. The high level service model proposals align with the Integrated Community Services design with more work around dermatology to be undertaken on clinic requirements. Concurrently, work has commenced to establish viability of developing 5-8 key areas for GP dermatology E-Learning videos.	Stage 2 completing, Stage 3 commencing	31-Dec-16	12 months		↔
	Move appropriate dermatology outpatients into the community	Nov-15	The final stages of the project are scheduled for 18 months from 1st January 2017.	This priority will commence in the final stage of the project plan.	01-Jan-18	18 months		↔
PS004	Cancer							
	Adapt cancer pathways to meet agreed performance targets	Nov-15	PHFT maintaining Cancer standards performance and RAP closed. The RBCHFT RAP for 31 day and 62 day has met the second milestone. DCHFT met the 2WW standards from May and 62day from June and therefore the RAP process was reduced at the contract meeting into an agreed monitoring process rather than a formal RAP The Wessex Cancer wait times group meeting is on 13 September 2016 and Dorset/Wessex/England will be benchmarked.	Remedial action plans agreed with RBCH/PHFT.	Dec-16 Jul-16			↔

PLANNED AND SPECIALIST MONITORING REPORT AS AT: 31 August 2016

CLINCIAL LEAD: CHRISTIAN VERRINDER HEAD OF SERVICE: CINDY SHAW-FLETCHER

PS004	Continue to develop a Dorset Cancer clinical network	Nov-15	It has been agreed that the Dorset Cancer Alliance will be known as the Dorset Cancer Partnership. The outputs from the event on the 21st June have been summarised and will be acted upon in the development of cancer services. One of the key issues to be addressed is patient experience and this will be at the heart of all cancer work. The newly formed Dorset Cancer Alliance will meet on 16 September 2016. The membership and ToR will be agreed. One Dorset Cancer priorities for 2016/17/18 have been agreed and will be confirmed on 16 September.	Agreement of Dorset Cancer Priorities	Oct-16			↔
	Continue to develop a single Dorset cancer service	Nov-15	Patient triggered follow ups for colorectal patients has been designed and the Dorset Cancer Partnership will agree this workstream. A Pan Dorset meets to agree the criteria for IT to support this and moving to one system has been set up. It has been agreed that a Pan-Dorset review of effectiveness and efficiency of all Endoscopy services will be undertaken by the university of Southampton, commissioned by Wessex Cancer SCN. This will report in the Autumn of 2016. Dorset has been asked to develop the lung pathway on behalf of Wessex and present at the September Strategic Cancer Network. The draft pathway will be designed at the Wessex Cancer WT meeting on 13th September 2016. It has been agreed that Dorset become a demonstrator site, with RBCHFT leading, to pilot test 28 day referral to diagnostics including patients being informed about whether or not they have cancer. Lung, Prostate and Colorectal pathways will be included.	Project plan has been developed				↔
	NICE NG12 Rerral Implementation	Nov-15	NICE NG12 referrals for suspected cancer will go live from January 2017. GP training and communication and provision of additional capacity in diagnostics and fast track appointments, will support this. A plan for education covering Dorset is being devloped and will be carried out between October and December 2016l. A meeting has been arranged for 27 September 2016 with radiologists from each of the Trusts to agree direct access to radiology as per the referral forms. Meetings have been held with the Trusts throughout late September to discuss and agree financial implications of the roll out.	GP Education	31-Dec-16			↔

URGENT AND EMERGENCY CARE MONITORING REPORT AS AT: 13 August 2016

CLINICAL LEAD: SIMON WATKINS HEAD OF SERVICE: HAZEL THORP

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Timescale	RAG	Status Since Last Report
UE001	Integrated urgent care hub (Out of Hospital/111)	NEW	Delays evident due to impact on resources within hub associated with elements of recent CQC report and activity linked to a neighbouring CCG (Devon). Contract monitoring meetings continue to track progress. Current focus is upon agreeing target dates/milestones for remaining standards. Awaiting feedback from more recent CQC visit as a follow up to original inspection. Discussions around procurement for service from 01 April 2018 have commenced.	Implement remaining 7 integrated hub standards	01/03/2018	01/03/2018		↔
UE002	Weymouth urgent care centre mobilisation to be completed including an assessment of transferability of service across system	NEW	Completed					↔
UE003	Trauma model of care developed to support the proposed acute model configuration	NEW	Completed					↔
UE004	Implementation of discharge to assess county wide (linked to the work of the systems resilience group).	NEW	Forms part of wider work on Delayed transfers of care (DTOC) that is co-ordinated via SRG due to cross cutting nature. Dorset wide agreed plan developed and linked to Better Care Fund. Updates will be provided via SRG.	**MOVED TO SRG**				
UE005	Provision of specialist advice and guidance within one clinical pathway that assists admission avoidance.	NEW	Pan Dorset Joint Health & Social Care Falls Strategy 2016 - 2019 has been reviewed and updated. Implementation aspect needs further consideration with specific emphasis and link to prevention agenda in the context of increasing trends of incidence of falls and fractures presenting to acute hospitals. Strategy to be put forward for inclusion in CCC with recommendation for multi-agency input around prevention highlighting links to STP and ICS work stream. Strategy also to be presented to both Health & Wellbeing board for consideration. Awaiting further data from SWAST regarding non conveyed fallers pathway before discussing follow up actions needed.	Refresh SWAST non-conveyed fallers pathway	31/08/2016	tbc		↔

MENTAL HEALTH AND LEARNING DIFFICULTIES MONITORING REPORT AS AT: 31 AUGUST 2016

CLINICAL LEAD: PAUL FRENCH HEAD OF SERVICE: KATH FLOREY SAUNDERS

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Timescale	RAG	Status Since Last Report
MH001	Co-produced model for acute mental health services resulting in enhanced access and service user experience (Acute Care Pathway Project)		Further additional co-production group convened for September 2016 to shortlist options in relation to mental health beds in the Linden Unit, Weymouth. In light of interdependancy with CSR ICS site specific proposals. Consultation provsionally planned to commence 05 December 2016 to run alongside CSR consultation.	Stage 3 modelling & business case	Aug-16			↔
MH002	Improved rates of dementia diagnosis (67% by March 2016 – stretch target 70%) and improving post diagnostic support		Recent meeting with NHSE (Wessex). NHSE recognised good progress and work that has been completed to date. Now acknowledging that target may be poorly derived. Appear to be moving towards a position that maintenance of existing rates will be acceptable.	Increased accuracy of Dorset dementia prevalence estimates Identification, care and support of people with dementia within Care homes	Mar-17			↔
MH003	Development of effective provision to support the delivery of the 4 stage crisis model for learning disabilities (LD Crisis Assessment and Support) - Transforming Care Plan		TCP plan approved by NHSE. Transformation fund (£180k) confirmed for step down element. Contract signed with Partnerships in Care and Shottsford House now opened with first service user stepped down from secure setting. TCP programme plan developed and workstreams progressing as planned. The team have also been successful in securing £145k capital funding for a LA step down unit (subject to approval of the PID)	Specified number of service users stepped down from hospital to local service provision	31-Mar-17	31-Mar-19		↔
MH004	Deliver the national MH waiting times for IAPT and EIP by 1st April 2016		Delivery by 1st April achieved. Service is compliant with new standards and continues to be monitored and managed under business as usual. work commenced to understand resource requirements to improve penetration rates to 25% by 2020 New Access standards for IAPT to continue to be met monthly - continued pressure upon referral rates. EIP - Interim data collection via UNIFY put in place nationally pending improved reliability of data collected via HSCIC. Work continuing to enable reporting capability within RiO IT system. National reports indicate service is complaint with new standard.	Continued achievement of new national Mental health access standards for Early Intervention in Psychosis and IAPT	Apr-16	01-Apr-16		↔

MENTAL HEALTH AND LEARNING DIFFICULTIES MONITORING REPORT AS AT: 31 AUGUST 2016

CLINICAL LEAD: PAUL FRENCH HEAD OF SERVICE: KATH FLOREY SAUNDERS

Reference	Priorities/Projects	Commencement Date of Project	Progress Updates / Comments	Current Milestone	Milestone Timescale	Timescale	RAG	Status Since Last Report
MH005	Improve emotional wellbeing and mental health outcomes by developing and implementing the Emotional Wellbeing and MH Strategy (CAMHS)		Responsibility for CAMHS transferring to MH/LD CDG on 1 September whereby any existing plans and work to date will continue to be built upon			01-Apr-20	Priority owned by M&FH	
MH006	Co-produce model for rehabilitation and recovery services incorporating related employment services and supportive housing		Project scheduled to commence late 2016: may be delayed to 2017 due to resources being focussed on ACP/ PL and EIP					
MH007	Co-produce model for organic specialist pathway (in-patient and community provision) - Dementia Services Review		Project structure in place. PID being refined in line with proposed wider scope to encompass social care components. Milestones in the process of being reviewed in light of changed scope.	PID/PIA/EIA Risk & Issues log / Engagement & Comms Plan produced and agreed	Jul-16	Dec-17		↔

Key	
	On schedule to meet target
	Potential to miss target
	Likely to miss/missed target
↑	Improvement
↓	Decline
↔	no change