NHS
Dorset
Clinical Commissioning Group

NHS Dorset CCG Business Intelligence

Annual Delivery Plan Monitoring Report – November 2013

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Data Source: CCP Leads
Date Published 02/12/13

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: November 2013
1.1	Improving Dementia Diagnosis		There continues to be no formal update on the dementia diagnosis rates, which are recorded on GP systems, as the data is currently being migrated across national systems and the CCG do not own the data. • GP figures are expected to be reported end December and these will assist the team in targeting further activity. The last formally reported percentage was 45% against a target of 50% for this financial year. • New diagnosis figures reported by the Memory Assessment Service indicate a diagnosis rate of 49.4% as at end September. The following work streams continue to be 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 will be presented to the Dorset Dementia Partnership in January 2014

			• Two primary care dementia facilitators have been commissioned by the CCG, employed by Dorset HealthCare, to continue visit practices to carry forward the work started by the GP Fellowes, raise awareness of services available to clients and carers and undertake data validation of GP registers against the memory assessment service data to ensure accurate coding. To date the service has updated 95 GP registers, 5 surgeries have chosen to complete this work themselves. They have visited 59 practices this calendar year and another 5 are booked sessions. Some surgeries have cancelled and are been rebooked, with 2 surgeries declining input from either the GP Fellowes or the primary care dementia facilitators to date. The facilitators are taking on the Fellowes role of delivering education were agreed by staff in primary care. **Memory Gateway and Electronic Screening Pilot** A three month pilot for electronic screening (CANTAB) has been launched 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 is to facilitate the early screening of clients who are referred to the service (open referral). In August 20 people who were concerned about their memory were screened by the memory support and advisory services using CANTAB, 18 required further assessment by the memory assessment service in September this number reduced to 2. 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 completed after six months. This has led to staff from both services working as a team. The pilot has rolled out to the Christchurch locality end on the 28 October and 4 November. Weymouth & Portland and the Purbeck localities would like to join. Discussions are underway with Weymouth & Portland with the memory gateway model is planned to start on the 9 December, with CANTAB commencing in January 14. Discussions will commence with Purbeck locality later this month. For the Bournemouth & Poole localities, discussions have commenced with Dorset HealthCare who provider both memory support and advisory and the memory assessment services. Commencement of a pilot in the North Poole locality will commence on the 2 December. A meeting has been booked with Poole Central to discuss the memory gateway pilot on the 19 December. **Deep Dive into Care Homes** The aim of the project 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 (PCDF's) are working with GPs, primary care practitioners/nurses and community staff in their work with Care Homes in the detection and diagnosis of people with dementia**.** The PCDF's have crossed checked all Learning Disability records with clients on caseload to the learning disabilities teams pan Dorset who have also a diagnosis of dementia, with the memory assessment service in Dorset HealthCare and the GP dementia registers. Work has commenced pan Dorset on cross checking a sample

			of the Section 117 record with Dorset HealthCare and the GP records for those patients with diagnosed dementia. It was hoped the CCG could cross check the Continuing Health Care (CHC) database for those clients with dementia, due to information governance constraints, this project could not be taken any further, due the patients not consenting to their personal information been shared. **In Dorset County Council area:** A pilot commenced in Weymouth and Portland Locality as a community matron in the locality had gathered information of residents in care homes that have dementia. This list is been cross checked across Dorset HealthCare information systems and with all the practices in the Weymouth & Portland locality by the PCDF. It will be completed and reported by the end of December 13. To date a fulltime joint post of Dementia Care Home Facilitator with Dorset County Council (DCC) localities has not been able to been appointed to, in the quality directorate, although advertised and interviewed 3 times. This post 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 will be scoped with communications team to actively support the gaps in knowledge and understanding in our population. It is likely that this would be implemented in 2014/15 to assist in the push to increase awareness of dementia, local services and the diagnosis process.
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.		A new Adult Dorset Respiratory Integrated Service model has been developed, with patients and clinicians which is now at the stage of agreeing a detailed service specification for sign off by the General Medical and Surgical Clinical Commissioning Programme in December. It is anticipated that this will be ready for implementation through the contract round for 2014/15. Workshops have commenced to continue to engage with patients during the implementation and delivery phase over a 2 year period. It is anticipated that Patient Reported Experience Measures will commence during January 2014 to benchmark the current service across Dorset.
1.4	Encourage the universal adoption of PROM scoring in patients referred for elective hip and knee		Oxford Hip and Knee scoring embedded in referral process for vast majority of practices . Improved version of referral form to be sent out to practices shortly. DCH is benchmarked as highest national achievement in use of PROMS for knees. The trend so far in 2013/14 is for improved health gain for knees. Against contracted position, hip and knee procedure resources allocated are underspending across the whole CCG

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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: November 2013**
2.1	Enhance access to palliative and end of life care for children and young people		Contract waiver complete and service being delivered at an interim position whilst a full service review is undertaken as agreed with providers
2.2	Review and implement pan Dorset pathways of care for maternity services		Draft Maternity Strategy completed and pathway audit process agreed with audit to commence. Further individual pan Dorset Pathways under development
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: budget for equipment and consumables now with Poole Hospital and pathway in place short stay assessment tariff for paediatrics: a pilot of Advice & Guidance pathway within the Bridport area Commenced in November Therapy services: service now in place Looked after Children: updated service in place Ophthalmology: service in place

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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: November 2013**
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 and support commissioned jointly between CCG and RBH has concluded Phase 1 of its work (Diagnostics) and has submitted its report. Phase 2 – Action Planning (to be completed by end-February) is being defined and agreed with Kings Fund and will focus on:- • System Leadership (linking with the Better Together work strand) • Development of our urgent care strategy (including a piece of work dedicated to developing our frailty model) • Capacity modelling (building on the findings of the bed-utilisation audit conducted as part of the review The 2013-2014 In-Year projects are being progressed and the performance metrics which have been put in place will enable measurement of the degree of success of each

			initiative. Appropriate engagement to take place when proposals are known.
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 COPD pathway has been implemented across Dorset and linked to the Map of Medicine. The Map of Medicine roll out was not identified in the funding priorities for 2013/14. Project superseded by the development and implementation of the New Respiratory Integrated Model. Patient representatives consulted on COPD pathway development during 2012/13

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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: November 2013**
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 referrals doubled by end of Qtr 2. Service implemented in 11 of localities, targeted discussions where slow uptake • Community heart failure specialist nurses provider appointed and currently recruiting staff • Community rehabilitation procurement commenced • Weymouth and Portland pilot linked to flu clinic for opportunistic identification of AF At least 5 people with AF identified, full evaluation to be written up for learning and spread in 2014/15 • SALT new specification and temporary staff in place whilst permanent appointments made • 6 month post stroke service contract to commence in December • Familial hypercholesterolaemia services commenced mid November.

			Patients are part of the CCP, whether directly involved in the Service Delivery Groups, one-off meetings to develop specifications or the CVD Patient Engagement Forum
4.2	Enhance primary and community diabetes services and implement improvements in foot care		• Dietetics service within intermediate care provider appointed and in process of recruitment • Foot care clinics in place for West Dorset, early indications of reduction in more major amputation rates Patients are part of the Service Delivery Group and have informed development of the model of care
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 CCG awaiting outcome as to whether Kings Fund will be able to deliver.

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Ref	**Musculoskeletal and Trauma** Lead GP: TBC Lead Director: Jane Pike Lead Deputy Director: Margaret Allen Lead Manager: Cindy Shaw-Fletcher	**Progress Against Commissioning Cycle**	**Position As At: November2013**
5.1	Implementation of community persistent pain management service		Persistent Pain services are now provided by "Dorset Community pain services" run by DHUFT. The service rolled out in the West in June 2013 and in the east from October 2013. Two further patient/public events were held in the East of the county on 25 October at the RNLI and on 12 November at the Miramar Hotel. Both events were well attended and well received. Legacy patients are being 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 . DHUFT have launched an interactive website with personal log in areas for patients on www.soaring abovepain.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 Hip and Knee scoring embedded in referral process for vast majority of practices . Improved version of referral form to be sent out to practices shortly. DCH is benchmarked as highest national achievement in use of PROMS for knees. The trend so far in 2013/14 is for improved health gain for knees. Against contracted position, hip and knee procedure resources allocated are underspending across the whole CCG

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Ref	**Mental Health and Learning Disabilities** Lead GP: Dr Ros Maycock Lead Director: Jane Pike Lead Deputy Director: Sally Sandcraft Lead Manager: Kath Florey-Saunders	**Progress Against Commissioning Cycle**	**Position As At: November 2013**
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 and reported back in August 2014.
	Review and re-commission dementia advisory services across Dorset.		The specification is in the final stages of development and the Dementia Partnership has commented on the specification at the last meeting. The advert will be placed on Supply to Health and the CCG's website in mid-December with the objective of awarding preferred provider by end of this financial year.
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. Further actions will be implemented by April 2014, these are required to be delivered jointly with our partners. Actions are on track to achieve joint contracts with the LAs for patients in care homes and receiving domiciliary care, with a new nursing specification, by end March 2014. 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 and board, which included clinicians and partner organisations have been working hard to launch the pilot, but it has not been possible to recruit to the key role of primary care mental health worker in all of the localities. As a result of this project board convened to review and discuss options for the project. At that meeting a unanimous decision was made to pause the project for 6 months and develop options for further development of mental health in primary care after further benchmarking. It was agreed that the aspects of the

			project mandate that are not reliant upon recruitment will still be progressed in this 6 month period. A decision on how to best progress the development of services will be taken in May 2014. Although this is disappointing, the project board believe that this decision offers the most pragmatic solution to the current issues directly associated with workforce recruitment and the challenges that this is causing across the mental health system.
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.		• Additional funding was agreed and the CCP approved the development of a mobilisation plan to roll out the best practice service currently in the east of the county across the west of the county. • The specification has been agreed and the CV is in the process of being agreed between the CCG and DHC • Mobilisation is expected to start in late 2013 with the service fully operational by the end of the financial year, subject to successful recruitment.

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Ref	**Cancer and End of Life** Lead GP: Dr Lionel Cartwright Lead Director: Jane Pike Lead Deputy Director: Margaret Allen Lead Manager: Denise Adcock	**Progress Against Commissioning Cycle**	**Position As At: November 2013**
7.1	Implement the National Awareness and Early Diagnosis Initiative		NAEDI programmes of work continue linked to Strategic Clinical Network and local priorities. Delivery group established. Work in progress on reviewing referral criteria against NICE guidance. Diagnostic review and research completed on 3 clinical areas and commenced on a further 3. 2 Macmillan GPs appointed to support improvement.
7.2	Implement the findings of the East Dorset Specialist Palliative Care Review		End of life care review commenced following appointment of project management support. On schedule to deliver work plan. Stakeholder involvement planned throughout with key event to consider agreed future model.
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.

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Ref	Pan Programme Priorities	Progress Against Commissioning Cycle	Position As At: November 2013
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		The methodology of deploying the investment has been agreed and mobilisation plans and expected outcomes are now being agreed with the provider. Additional staff expected to begin (following recruitment) to be available from the end of Q4. Integrated teams/expansion of district nursing 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.
8.3	Technologies – implementation of telehealth and		Implementation of Telehealth is on course for COPD

	roll out to diabetes, oncology, mental health, intermediate care and end of life care		and CHF. 315 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. Diabetes and end of life developments are in progress
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 will mobilise for the remaining areas by the beginning of February. Leg ulcer services engagement activities: Stakeholders have been engaged and participated on the Task and Finish group to develop the business case for a Leg Ulcer service Pan Dorset. This work stream links/engages with a service development for Foot Care services and the patient representative of that work stream is aware of this service review In formalising commissioning arrangements with General Practice for the GP providers will now be required undertake patient experience surveys and report this to the CCG to inform future service improvements.
8.5	Carers – with social care partners we will continue to develop and implement support programmes for carers	Commissioned to commence December 2013	Partnership discussions with LAs have set the framework within which the review can proceed. The review, informed by relevant carers needs assessment, has been resourced and will be undertaken on a joint appointment basis between

			Health and 3 x LAs. Integration provides an opportunity to develop cohesive services across Dorset and to achieve a single carers strategy across Dorset. DCCG will be working towards funding being managed on a joint integration fund basis from 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.