NHS England Plan 2013-14

Merseyside Area Team

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England

Merseyside Area Plan 2013-14

NHS England – Merseyside Area Team

First published: 22nd March 2013

Updated: 3rd May 2013

Prepared by: Philip Dunn

Contents

Section 1.

Executive Foreword

Clare Duggan

Director / Accountable Officer –

NHS England (Merseyside5)

Regatta Place - Liverpool

I am very pleased to present to you, the first ever annual operating plan for NHS England – (Merseyside).

Delivering our plan during such difficult times will rightly challenge us; and through constructive self-criticism and robust engagement with our patients and internal and external partners, we have recognised those areas where we need to learn, increase our capacity or commission expertise from other sources in order to ensure success.

The most common agreed health issues facing Merseyside remain:

- Cardiovascular Disease,
- COPD,
- Cancer,

These are also reflected in local CCG plans and local Health & Wellbeing Strategies

NHS England (Merseyside) is committed to the core values of the NHS Constitution which will be at the core of everything we do.
Ultimately it will be the people of Merseyside who will judge whether or not we made the improvements in health and health and wellbeing services promised both within this report and discussed, and agreed, during CCG engagement.

We commend this plan to all our partners in this venture and look forward to implementing it together to improve health outcomes whilst reducing inequalities for our population.

Best wishes

Section 2.

Executive Summary

In our vision of a modern, patient centered NHS on Merseyside, improvements will be driven by the new clinically-led, local commissioning system.

Health and Wellbeing Boards are a dynamic environment where the local health and wider needs of the population can be considered in partnership. The Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy determine locally what needs to be done to support better outcomes and a better service to the public irrespective of organisational boundaries.

We are taking the approach to secure better outcomes as defined by the five domains of the NHS Outcomes Framework and upholding the rights and pledges within the NHS Constitution within available resources.

The purpose of this plan is to outline a clear picture for staff, partners and the public in Merseyside of what NHS England (Merseyside) will do throughout the 2013-14 financial period.

This is a very difficult task given the changing face of the NHS, nationally, and the new challenges and dynamics that come with the new landscape.

Quite simply, a primary purpose of the coming year will be to maintain the existing high quality health care currently delivered across Merseyside whilst, simultaneously, attempting to try and establish, and nurture, new working practices and relationships between the designated commissioners and providers.

This plan has been developed in line with the limited guidance whilst ensuring that the fundamental values of the NHS Outcomes Framework and 'Everybody Counts' document remain at the heart of what is delivered to the people of Merseyside.

Key Challenges:

The continuing economic downturn challenges all public sector organisations in deciding on how to deploy resources to maximise health outcome benefits whilst also reducing the impact of health inequalities. Some key issues facing NHS England, both Nationally and at a local Merseyside level, include:

- Developing new working practices with and across newly established NHS organisations to ensure health outcomes improve;
- Ensuring new organisations are aware of their respective roles within the commissioning arena;
- Ensuring effective public engagement and involvement in planning, procuring and monitoring of service development;

- Effectively supporting the Merseyside CCGs to ensure commissioning is targeted, evidence based, value for money and of a consistently high quality standard across the region;
- Ensure direct commissioning functions are effective in being proactive and preventative to reduce the impact of reactive health care whilst reducing hospitalisations, and;
- Ensuring clinicians across Merseyside are of a sufficiently high quality standard and suitably validated.

NHS England - Direct Roles and Responsibilities:

NHS England has a clear remit of roles and responsibilities within the commissioning arena with direct commissioning responsibility for Primary Care and Public Health services. The Merseyside area team will subsequently commission and manage:

Primary Care Commissioning	Public Health (inc Public Health England)
GP Medical Services	Child Health Information Service (CHIS)
Dental Services (Primary & Secondary)	Immunisation Programmes
Optometry contract monitoring	Family Nurse Programme Service
Pharmacy Services	Health Visitor Programme
Local Professional Network Development	Offender Health Services (within secure settings)
	Screening Programmes (Cancer, Newborn and Diabetic Retinopathy)
	Health Child Programme (0-5yrs)

NHS England (Merseyside) will also work collaboratively with partner area teams, within the region, to commission specific and specialised services whilst ensuring they are integrated within the local health system. NHS England (Cheshire, Warrington and Wirral Area Team) will commissioning specialised services, NHS England (Lancashire Area Team) will commission elements of Offender/Prison Health services whilst North Yorkshire and Humber will commission Military & Veteran health services on behalf of the Merseyside Area Team. Relationships with these neighboring area teams are key to ensure effective health system development across the Merseyside region.

In addition to the above direct commissioning functions, there are key supportive functions offered by the respective Medical, Assurance & Delivery and Nursing & Quality directorates.

Combined, these functions will ensure that the Merseyside Area Team of NHS England verifies that:

- All clinicians are trained and fully qualified and pass the respective appraisal process;
- Clinicians are revalidated in line with national requirements;
- CCGs commission high quality services for the population and perform to a high standard;
- That patient experience is captured and retained to allow for whole system utilisation when commissioning and re-designing services;
- Ensuring that the findings of the respective Winterbourne and Mid-Staffordshire review are fully implemented across Merseyside providers and;
- Ensuring HCAI's are controlled whilst future operating processes and responsibilities are confirmed.

Improving the quality of care that patients receive and the outcomes we achieve for the people of Merseyside is what unites NHS Commissioners in a common purpose.

Key information sheets outlining the full detail of these work areas are available within Appendix 6 of this document

Equality and Diversity:

Equality and diversity is an integral part of NHS England's core business values and is actively encouraged and promoted equality throughout all activity.

We will continue to work tirelessly to improve equality and diversity by removing the barriers that exclude individuals from accessing healthcare, reducing health inequalities.

This plan has been Equality Impact Assessed by the equality lead representative and we are positive it doesn't negatively impact on the pillars of equality and diversity.

Section 3.

Introduction & Context

Key Issues & Deliverables

- Merseyside has a combined population of over 1.25 million
- Complex health economy with commissioning spread over 5 Local Authorities, 6 CCGs and 1 NHS England Area team
- Main causes of ill health across region remain cancer, CVD and COPD
- Provider landscape remains complex yet comprehensive
- Merseyside has established history of Clinical involvement and leadership
- Collaboration across the commissioning landscape essential to improve health outcomes

Merseyside is a complex health economy with a population of over 1.25 million spanning across five separate local authorities (Halton, Knowsley, Liverpool, Sefton and St Helen's). The health system, as a whole, has a population that has high levels of deprivation and poor physical and mental health. The three major causes of ill health and death remain as: cardiovascular disease, cancer and respiratory disease. The prevalence of these diseases are above both national and regional averages with pockets of greater local inequality. The Merseyside health system has a shared drive and passion to improve these entrenched health and wellbeing needs through long term transformational change, targeted commissioning and rigorously structured implementation of evidence based interventions.

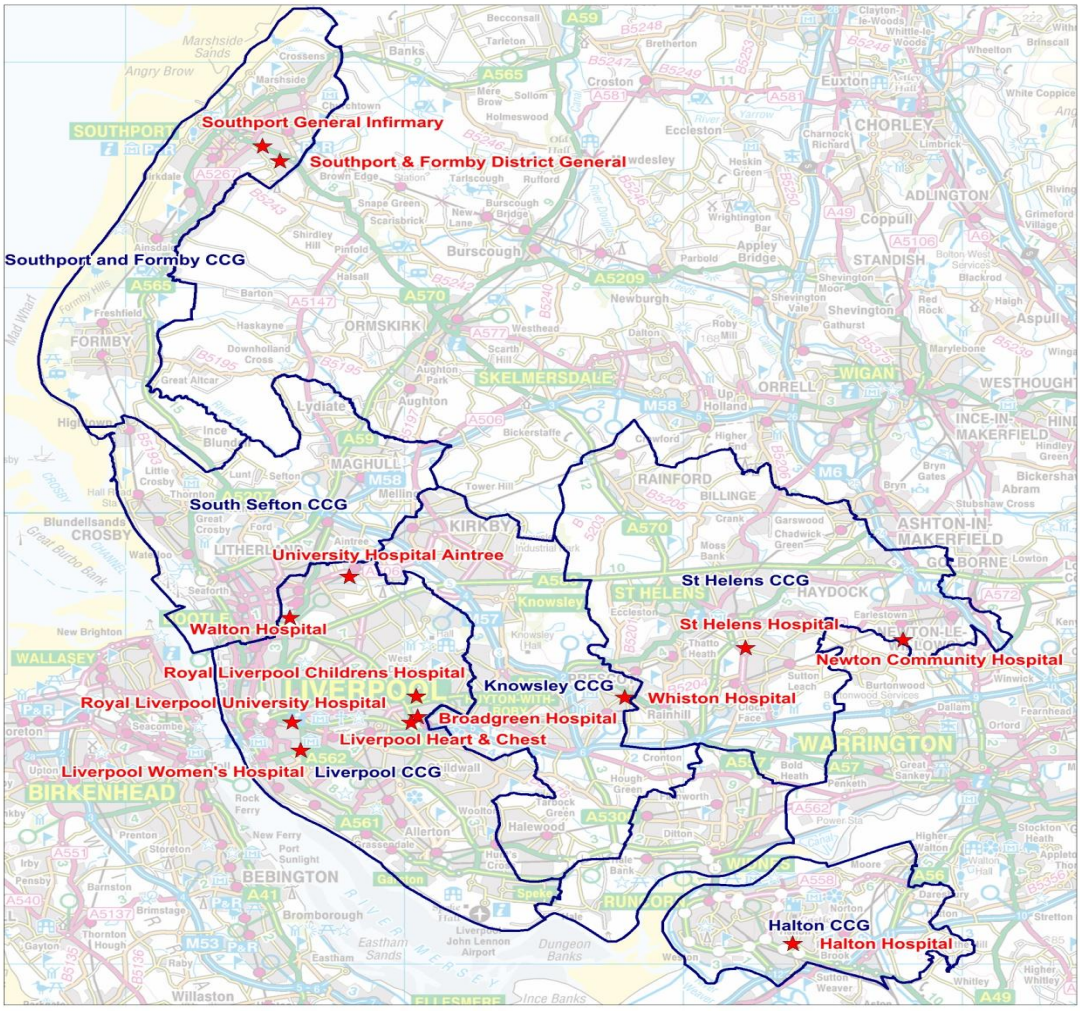
In conjunction with this period of unprecedented change and transformation, the existing provider landscape within Merseyside remains extensive, comprehensive and increasingly complex. The range of health care providers includes:

- 4 acute hospital providers (4 having A&E provision)
- 2 mental health trusts
- 2 Vertically integrated Community Trusts (Southport and Knowsley Integrated Provider Service)
- 2 community health trusts (Bridgewater and Liverpool Community Health)
- 1 specialist children's hospital (Alder Hey Children's Hospital)

- 3 specialist hospitals (Walton Neurological Centre, Clatterbridge Centre for Oncology and the Liverpool Heart & Chest Hospital)
- 8 walk-in centres
- 1 children's minor injury unit
- 1 primary care treatment centre
- 240 GP Practices
- 156 Dental Practices
- 312 Pharmacies
- 139 Optician sites
- 118 Nursing Homes

The following map visually illustrates some of the main acute and specialised hospitals across the Merseyside footprint. Through examining this current status it is clear to see that the network is extensive and complex with institutions transcending geographical boundaries, local authorities and CCG borders.

Figure 1 – Hospital sites located across the Merseyside CCG/LA boundaries



Merseyside has experienced sustained economic challenges over the past decade, but has managed to achieve some positive results and accomplishments during an unprecedented period of growth for demand. Merseyside, as a whole, has effectively met the QIPP challenge, with high levels of pre-existing clinical engagement. A strong focus on maintaining financial balance has ensured that the Merseyside Area Team and CCGs have effective and strong foundations to both implement the required reforms whilst also ensuring the population of Merseyside see an improvement in their health and wellbeing in line with the NHS Health Outcomes Framework.

Strong, committed leadership, both within the Area Team and CCGs, will ensure the delivery of transformational change and service delivery documented within this plan. The changes will lead to better quality care, increased choice, patient voice centred reform and delivery, better health outcomes whilst ensuring financial stability and viability.

Locally there is a strong and proud history of clinicians being involved in and leading changes across the health care system. However, the Area Team recognises, in line with CCGs, Local Authorities and partners, the pressures that these systems will face in the coming years. Working in a collaborative and efficient way is the only way improved outcomes will be achieved. Locally, the CCGs, Local Authorities and the Area Team are embracing this challenge and seeking to deliver real and effective change to secure the efficient, high quality services and professionalism required to make a difference to our patients and wider population.

3.1 Demographic Profile of Merseyside

Key Issues & Deliverables

- Merseyside experiences some of the poorest health in the country
- Improving health outcomes and reducing inequalities is main challenge
- New NHS organisations must work together collaboratively
- Public Health Departments transferred to respective Local Authorities
- CCGs will receive Public Health guidance via Local Authorities
- Health Promotion programmes must be prioritised to shift away from reactive healthcare

Health needs in Merseyside

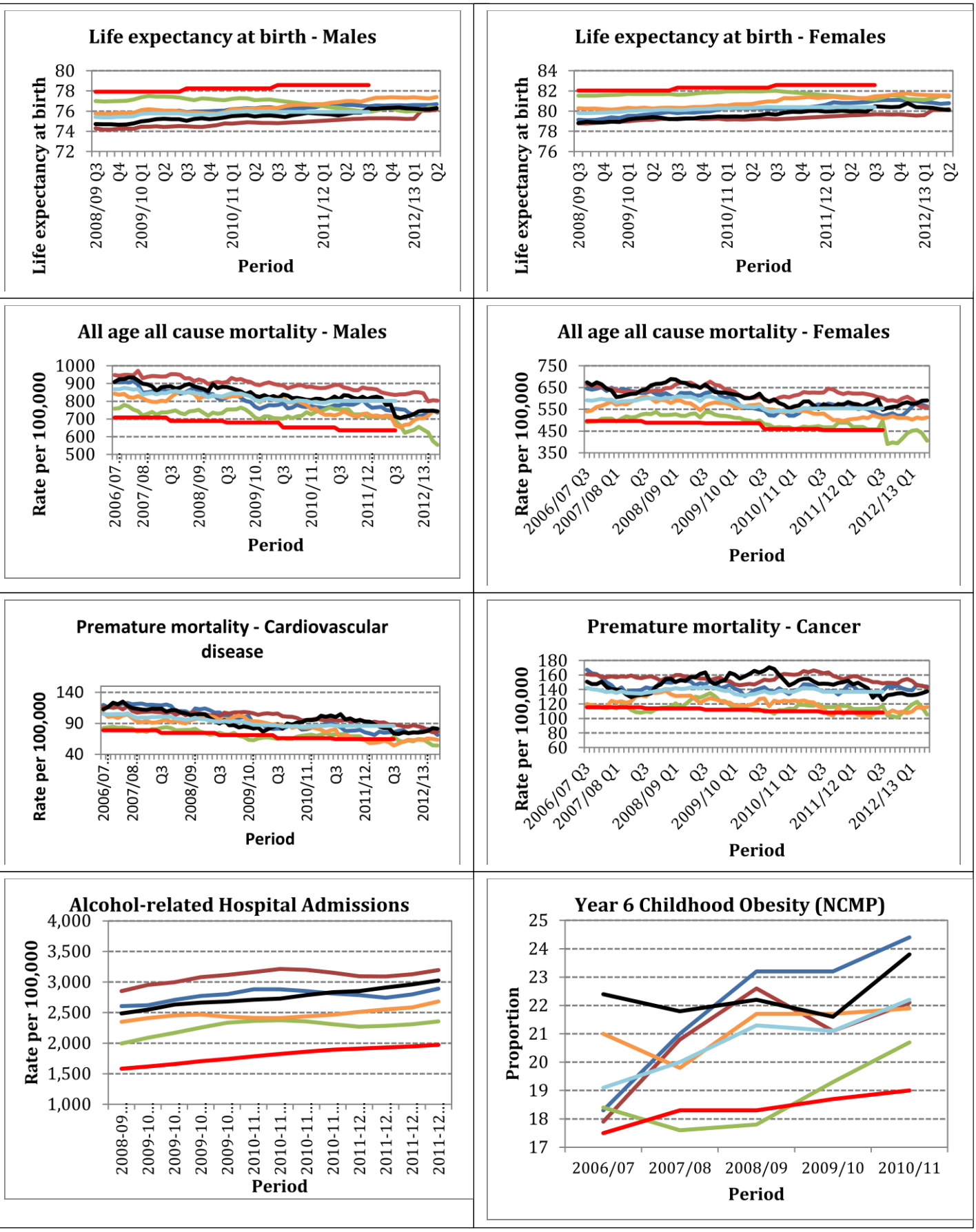
The health needs of Merseyside are well documented and improving health outcomes and reducing health inequalities remain a major challenge. Merseyside experiences some of the poorest health in the country but there have been some successes in recent years, as outlined below, and it is vital that the new commissioning organisations work together to maintain and build on these successes.

A Merseyside Public Health Performance report was presented at the final Merseyside PCT Cluster Board meeting in March 2013 which details some of the major achievements and also some of the areas for concern within the health economy. These points can be summarised as:

- Life expectancy across both males and females has continued to steadily rise for both males and females;
- All age all-cause mortality has generally decreased for both male and females;
- Premature mortality for cardiovascular disease remains a high level cause of mortality but is slowly decreasing across the region;
- Premature mortality for cancer remains as a high level cause of mortality with minimal levels of depreciation;
- Both alcohol related admissions to hospitals and childhood obesity continue to increase causing real concerns for the long term health prospects of our population.

The tables, overleaf, illustrate the above key points whilst the full explanatory narrative can be found in appendix 7 (Merseyside Cluster - Public Health Performance Narrative):

Figure 2 – Public Health Performance Figures (Merseyside)



Public Health departments have now moved to their respective Local Authorities following transfer from their originating PCTs. However, they continue with their priority workload, including their re-fresh of the local Joint Strategic Needs Assessments (JSNAs) in consultation with local people, usually on an annual or bi-annual basis, with these comprehensive assessments providing a description of the future health and wellbeing needs of local people; and the strategic direction of service delivery to meet these needs. Whilst Local Authorities and Public Health teams will be providing healthcare public health expertise to CCGs in order to ensure clinical commissioning decisions are based on need, these assessments also remain of critical importance to NHS England in ensuring that, the Primary Care and Public Health services it is responsible for commissioning, not only meet national service specifications and standards but are also responsive to local need. As described later within this document, the need for collaboration between all commissioners including: NHS England, Local Authorities and CCGs cannot be underestimated and the JSNA provides the opportunity for the system, as a whole, to be better informed and prepared to meet the needs of a changing population now and in the future. This partnership and collaboration across the system is the only way we can reduce health inequalities and improve health outcomes whilst ensuring the provision of safe, high quality services, which also provide value for money, are delivered across Merseyside.

The full suite of JSNA's for each Merseyside area can be found via designated hyperlinks located within the appendices section of this report (Appendix 8).

In developing the Area Team plan, considerations have not only been made to local need, as per the JSNAs, but to the Health and Wellbeing Strategies that have been developed and ratified by local Health and Wellbeing Boards. These Boards bring together those who identify, plan and commission and procure services for local people across the NHS, Adult Health and Social care including local Public Health teams and Children's Services. Health and Wellbeing Boards ensure that the views of local people and of elected members are considered and acted upon in the development of these strategies to ensure that the services commissioned are responsive to local need and reflective of local voice.

Whilst NHS England is responsible for commissioning a prescribed suite of services, against nationally developed single operating models, in both the Primary Care and Public Health departments of Direct Commissioning; it is vital that links are established and maintained with the wider commissioning family to ensure coherence across the system. The new architecture provides the opportunity for reconsideration of how services have been commissioned and delivered in the past and makes changes where appropriate to secure improvements for the future.

In developing their own plans, CCGs have clearly considered evidence of local need ensuring that each CCG can be truly responsive to their respective populations. The Area Team takes a Merseyside wide approach and there are some key themes and priority areas for action which appear in many local CCGs plans, Health and Wellbeing Strategies and in the Area Team plan. Whilst not exhaustive they include a focus on:

- Mental Health including the emotional and development needs of Children and Young People and Dementia
- Alcohol and a reduction in alcohol related harm and hospital admissions
- Better care for those with Long Term Conditions (including COPD and diabetes)
- CVD and Cancers which remain major causes of both morbidity and mortality within the heath economy
- Reductions in unplanned hospital admissions

A focus on prevention and, moreover, a need to continue to invest in evidence based interventions is also a recurrent theme within local plans. This demonstrates the recognition within the system that, whilst it is important to ensure that treatment services are available and responsive to those who are already ill, health promotion and prevention programmes must also be prioritised. The commissioning of services which enable prevention and early detection of diseases amenable to health care is clearly a key priority for NHS England and the embedded Public Health England (PHE) 'Screening and Immunisation Team'. Together these organisations will play a major role in ensuring the provision of safe, high quality services for some of the most vulnerable populations throughout Merseyside.

3.2 Aim, Vision & Values – '*the national thread*'

Key Issues & Deliverables

- NHS England launched on 1st April 2013
- Single operating model for NHS England and National vision
- NHS England (Merseyside)team in place and now operational
- There are 6 CCGs across the Merseyside region
- All CCGs and the Area Team have specific visions for health care across regions within Merseyside

The vision for NHS England, Merseyside is:-

"Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving"

NHS England (Merseyside) was officially launched on 1st April 2013 and it has subsequently recruited a talented and ambitious team to work in partnership with the people of Merseyside, Clinical Commissioning Groups and Partner Agencies to achieve the best outcomes for the population.

Throughout the past 10 years, Merseyside has successfully met the economic and demand for care challenge. Positive results have been achieved, during a period of unprecedented growth in demand for service whilst facing an increasingly complex and challenging health economy and associated endeavors including:-

- *High levels of deprivation and poor physical and mental health*
- *Life expectancy is poor*
- *High hospital utilisation*
- *Lack of 24/7 access to some critical services*
- *Impact of Local Authority budget cuts*
- *Various provider Trusts facing financial difficulties*

NHS Merseyside and the associated six Merseyside CCGs have the vision to make a difference and deal with these challenges by providing high quality care for all, now and for future generations.

Below is the complete set of vision statements for all Merseyside CCGs:

Halton CCG Vision

"To involve everybody in improving the health and wellbeing of the people of Halton"

Knowsley CCG Vision

"An ambition for a healthier, happier population with a better quality of life, a reduction in health inequalities and improved access to healthcare when required, as close as possible to the patient".

Liverpool CCG Vision

"By 2020, health outcomes for people within Liverpool will have improved relative to the rest of England, and health inequalities within Liverpool will be narrowed. This will be measured by life expectancy for Liverpool people and numbers of Disability Adjusted Life Years lost"

South Sefton CCG Vision

"We want to work with the local community, and other partners, to improve the health and healthcare of everyone living in South Sefton, spending money wisely and supporting clinicians to do the best job they can."

Southport and Formby Vision

"A sustainable, healthy community."

St Helens CCG Vision

"Make a Difference – Commissioning the right care, at the right place, at the right time for the population we serve"

3.3. NHS England – Meet the Merseyside Team

Key Issues & Deliverables

- NHS England (Merseyside) Area Director is Clare Duggan
- Executive Team is now in place and operational
- In line with National operating model there are 5 distinct directorates within NHS England (Merseyside)
- Directorates within NHS England are: Assurance & Delivery, Direct Commissioning, Finance, Medical and Nursing & Quality
- NHS England Teams remain patient focused and clinically led

The NHS England, Merseyside Area Team Director, Clare Duggan, became Acting Accountable Officer with effect from the 1st October 2012 and assumed the full responsibilities of the substantive Chief Executive/Accountable Officer.

The development of the NHS England Merseyside Area Team was led by Clare Duggan from, October 2012, with oversight from the National and Regional Centres of the National Commissioning Board.

Operating in line with the single operating model, NHS England, has five distinctive Directorates with defining roles and responsibilities to ensure the Area Team plays a defining role within the health economy for Merseyside.

The five Directorates of the team consist of:

- Assurance & Delivery;
- Direct Commissioning
    - Primary Care Commissioning
    - Public Health Commissioning
- Finance
- Medical Oversight;
- Nursing & Quality;

The team is committed to being a patient focused and clinically led organisation that has the culture and efficient leadership to foster co-operation across the health network whilst playing a key part in truly improving health outcomes for the people and patients of Merseyside. To this end, there are some key generic core roles and responsibilities of the team which are outlined as:

1. To ensure everything we do has the voice of those we do it for at the centre.

2. To ensure staff are engaged in our vision, values and behaviours to improve their own and the public's experience of healthcare.

3. To allocate resources to the 6 Clinical Commissioning Groups operating across Merseyside (Halton CCG, Knowsley CCG, Liverpool CCG, Southport & Formby CCG, South Sefton CCG, and St Helen's CCG)

4. To support CCGs to commission the health services on behalf of their patients (in line with evidence base and quality standards/guidance)

5. To have direct responsibility for commissioning services relating to:

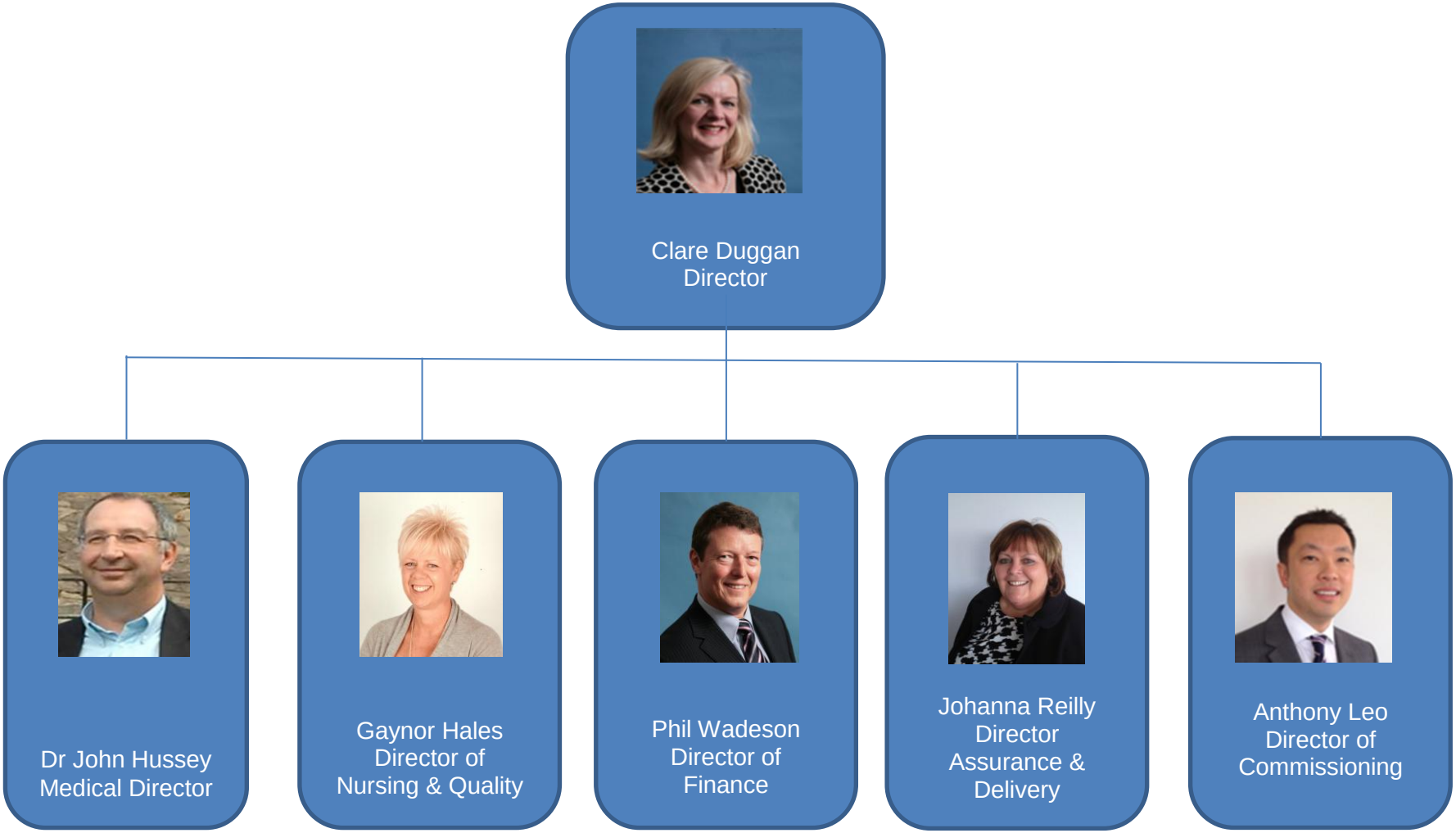
    - Primary Care (Medical, Dental, Pharmacy and Optometry services)

    - Public Health (including 0-5 Healthy Child Programme, Screening and Immunisation Programmes & Prison Public Health)

6. Military and Offender health – *(led by NHS England's - North Yorkshire and Lancashire Area Teams respectively)*

7. Specialised Commissioning – *(led by NHS England – Cheshire, Warrington and Wirral Area Team)*

Figure 3 – NHS England (Merseyside) – Executive Team Structure



3.4 Directorate Outline – Roles, Responsibilities & Remit

3.5 Medical Directorate

1. Preventing people from dying prematurely (Domain 1).

2. Enhancing quality of life for people with long-term conditions (Domain 2)

3. Helping people to recover from episodes of ill health or following injury (Domain 3)

4. Oversight of Direct Commissioning and CCGs.

5. Responsible Officer and Re-validation process & delivery.

6. QIPP

7. Clinical Leadership:
   I. Clinical senates and clinical networks;
   II. Providing and quality assuring clinical advice;
   III. Professional performance issues;
   a. Service failure,
   b. Poor performance in Primary Care

3.6 Nursing & Quality Directorate

1. Oversight of Domain 4 of the NHS Outcomes Framework: ensuring people have a positive experience of care (friends and family Test, Patient Experience, Staff Experience, Safeguarding, Nurse Education and Professional Leadership).
2. Oversight of Domain 5 of the NHS Outcomes Framework: Treating and caring for people in a safe environment and protecting them from avoidable harm (Quality Surveillance Groups, Healthcare Acquired infection, maternal 7 Child Health, LETBs and Workforce planning, SUI reporting and learning).
3. Providing professional leadership for nursing and midwifery professionals within the health & social care system and implementation of National Nursing strategy.
4. Support the implementation of Direct Commissioning teams and general CCG oversight.
5. Ensure the development and implementation of patient and public involvement processes are implemented across Merseyside Healthwatch, Service user and Carer Forums).
6. To contribute to the development and delivery of the QIPP agenda.

3.7. Commissioning Directorate

Direct Commissioning for Merseyside, including identifying needs, contracting, and development of services, assurance and interventions of numerous services including:

1. Primary Care (861 contracts)
   a. Medical (GPs)
   b. Dentists
   c. Optometrists
   d. Pharmacies

   The above services will be underpinned by core functions:

   Planning – right services at right time
   Securing – Excellent services by contracting and performance management
   Monitoring – on-going reviews to ensure high quality care

2. Public Health services (0-5 Healthy Child Programme, Screening & Immunisation Programmes and Prison Public Health)

3. Specialist Services – NHS England – Cheshire, Warrington & Wirral Area Team

4. Military Health Services – NHS England - North Yorkshire Area Team

5. Offender Health Services – NHS England - Lancashire Area Team

3.8. Finance Directorate

1. Design and implement a clear financial strategy for Merseyside consistent with the NHS England's Clinical Strategy, investment priorities and resource assumptions.

2. Assuring the supporting and effective financial performance of CCGs and the CSU.

3. Overseeing and assuring the financial planning and re-design of services, such as large scale, complex service reconfigurations, partnership working with CCGs, HWBs, NHSCB local area teams, NTDA and other stakeholders.

4. Co-ordination of the delivery of the planning guidance and credible financial plans

5. Responsibility for 2013-14 Contracting Round

6. Tripartite Financial Agreements

7. Trust Financial status and CIPs

8. *PCT closedown (relevant until June 2013 – for financial accounts closure)

3.9. Assurance & Delivery Directorate

1. Strategically lead, support and hold to account, Merseyside CCGs in their commissioning of high quality, safe, patient and client-centred services within the framework of the NHS CB's single operating model.

2. Setting and implementing the planning framework for CCGs, ensuring agreed mandate priorities are both planned for and delivered.

3. Implementing the leading of effective emergency planning and resilience system for the NHS across the Merseyside region.

4. Leading and managing national predictable events (e.g. Winter pressures) and other less predictable events such as industrial action.

5. Co-ordinating single, coherent relationships with all our key external stakeholders.

3.10. Merseyside's Direct Commissioning Functions

Key Issues & Deliverables

- Primary care and public health must work together to reshape health care provision to improve health outcomes
- Key challenge is to direct resources to those who need it the most and have the greatest need
- Area Team will undertake a baseline assessment of all primary care contrcats
- Area Team will work with CCGs, and other partners, to develop and realise a primary care strategy for Merseyside
- Area Team will work with CCGs and partners to utilise brief interventions such as exercise and alcohol direct enhanced services
- Area Team must develop relationships with key groups such as the Local Medical Committees, Local Dental Committees and Local Pharmaceutical Committees to ensure participation in system reform
- Area team will work with CCGs and Local Authorities to re-address the focus of treatment to prevention and community based medical care
- Area Team will work with CCGs to ensure quality standards are agreed and adhered to. A system of utilising patient experience information and contractual performance will be developed to aid the process of quality assurance
- Area Team will ensure all medical practitioners are full appraised in line with government targets whilst ensuring high quality medical performance
- Area Team Public health functions include representation from Public Health England
- Key targets for Public Health commissioning include screening and immunisation programmes
- Key relationships with partner Area Teams are established to Commission Specialist Services, Military & veteran Health Services and elements of Offender Health on Merseyside's behalf,

3.11. Primary Care Commissioning:

Where applicable, primary care services should be universally accessible, whilst ensuring that patients receive care in a coordinated and cohesive manner. Primary care has an essential role to play in improving health outcomes and linking to the associated commissioning undertaken by CCGs. Seen as part of a collective system,

the transformation of primary care can be achieved alongside the redesign required by CCGs within secondary and tertiary care to develop one unified system.

A Vision for Primary Care:

Our ambition and vision for the new primary care commissioning arrangements within Merseyside entail:

- A common, core offer for patients of high quality patient-centred

  Primary care services;

- Continuous improvements in health outcomes and a reduction in

  inequalities;

- Patient engagement and empowerment and clinical leadership with

  engagement visibly driving the commissioning agenda;

- The right balance between standardisation/consistency and local

  Empowerment, flexibility and innovation.

Delivering the Vision:

Driven by a single operating model, (Securing Excellence in Primary Care) the Merseyside Area Team will seek to commission a primary care system with the following key attributes:

- Delivers an increased range of services from a primary care setting and reduce the need to refer patients to hospital,
- Improves access and choice for patients,
- Ensures that providers are supported through a period of change,
- Delivers services from fit-for-purpose premises or access points,
- Addresses health inequalities,
- Delivers high quality services through a range of providers,
- Prevents ill health,
- Effectively uses NHS resources,
- Seeks to continually improve patient experience and service development.

Primary care is at the heart of the transformational agenda for health care services. It is important to ensure that primary care services are resourced and configured effectively to meet these future needs and continue to reduce morbidity and mortality rates

The ageing population coupled with the increased prevalence of chronic diseases, requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is coordinated and integrated.

The Merseyside primary care workforce will play a critical role in supporting the development of the new primary care system. To achieve this, the workforce must be supported across the whole system ensuring consistency of standards whilst ensuring that the system encompasses:

- A more systematic and proactive approach towards the management of chronic disease to improve health outcomes, and reduce inappropriate use of hospitals; whilst:

- Fostering the empowerment of patients. The active engagement of patients is a common thread to all commissioning on Merseyside

The Merseyside Area Team must take a population-based approach to commissioning and a key challenge is to direct resources to the patients with greatest need and redress the 'inverse care law' by which those who need the most care often receive the least. This means shifting the focus from patients that present most frequently within their practice to the wider population that they serve:

Effective primary prevention helps patients to avoid health problems before they occur; whilst prevention in childhood provides the greatest long term benefits.

Improved systematic primary prevention in general practice has the potential to improve health outcomes and save costs in many areas of primary care. The Merseyside team will seek to develop, with CCGs and other partners, greater use of brief interventions such as exercise and alcohol direct enhanced services.

Additionally, an increase in the development of integrated models of care needs to be fostered across Merseyside. This may take a variety of forms from 'virtual' integration through shared protocols, to integrated teams and in some cases shared budgets and direct organisational integration.

Throughout the financial year, the Primary Care Team will work closely with CCGs, the relevant professional bodies, and recognises that the LMCs, LDC's LPC's have a key role in shaping the future of primary care and delivering the vision for Merseyside.

Delivering Quality Improvement in Primary Care

NHS England and Merseyside CCGs have collaboratively and actively discussed the need to continue to develop standards of care across primary care and community health services. One of the strategic aims of the local health economy's clinical strategy is to develop primary, community and intermediate services in order to affect a significant shift in the focus of health services from treatment to prevention

and management. One of the work streams to effect this change is: ‘Quality in Primary Care’.

The Merseyside CCGs have collectively developed an infrastructure to provide their respective Boards with the necessary assurance and oversight; with regards to the quality of services their constituent practices provide. All Merseyside CCGs have either introduced, or are planning to introduce, primary care quality standards locally that secure minimum thresholds beyond those nationally contracted.

NHS England (Merseyside) and the local CCGs have committed to work together during the forthcoming financial year to:

- agree standardised Merseyside wide minimum standards for primary care (which may then be further enhanced by individual CCGs);
- develop mechanisms to ensure any trends identified through complaints and appraisals are fed into CCG primary development forums.

In addition to this, the Merseyside Area Team’s activities will be focused, during 2013/14 on:

- Ensuring 100% of eligible practitioners receive appraisal and that any actions arising from appraisal are followed through (from sharing of good practice, remediation plans, referral to performers committee, identification of group learning needs from trend analysis etc)

- Quality assurance activities, with CCGs where appropriate, to secure the continuous improvement of quality in primary medical care;

- Collaborating with CCGs to establish any cause for concern and act accordingly, including quality reviews;

- Implement decision making systems and processes across all contracts;

- Assess practice performance data and identity priorities;

- Drafting the annual performance report;

- Oversee any contractual requirements post quality reviews;

- Supporting each CCG in the development of a primary care medical ‘Quality Strategy’ involving all practices;

- Supporting practices and performers in the achievement of their ‘Quality Improvement Plan’;

- Triangulation of all data regarding performance into primary care provider profiles.

The previously outlined single operating model will provide a framework that supports the development of locally commissioned primary care services. This will ensure that there is a standardised approach to issues access, as well as ensuring that services in primary care are made more universally available in the long term. In addition there will be basic standards that all practices will be expected to meet as part of CQC registration which will be monitored and reviewed on a regular basis to ensure legality of practice and quality assurance.

- The Primary Care team will be focused on maintaining the effective relationships with contractors built up over many years - vital for effective Primary Care Commissioning. However, the nature of these relationships will change, with a new focus on outcomes across all types of contracts within Primary Care.
- The Primary Care Team will be responsible for securing high quality local dental services and many of the pharmaceutical and optical services. Strong clinical leadership and engagement should be integral to the local area teams and the Local Professional Network (LPN) concept is one way of achieving this. This will enable effective service planning and make it possible to translate strategy into implementation.
- The Primary Care team will commission some enhanced services using nationally agreed service specifications. These enhanced services will replace the current arrangements that place Primary Care Trusts under a duty, through legal directions, to commission prescribed enhanced services to meet the needs of the population (services currently known and commissioned as 'Directed Enhanced Services').
- The Primary Care Team will also have the flexibility to commission enhanced services, locally, to meet the differing primary care needs across Merseyside.
- Provision of Primary Care Services should consider, where possible, outreach services by practitioners which offer a more flexible approach to ensure all groups in the population have good access to services.

All of the above functions within Primary Care will be underpinned by some core operations delivered via the Primary Care Support Services (PCS) (alternatively known as Family Health Services, (FHS)) which provide administrative support to primary care contracts (GPs, dentists, opticians and pharmacies) including making payments for contracts, administering the National Performers Lists, registering patients with practices, providing screening call and recall programmes and distributing contractor supplies. These professional services are vital to the efficient and effective administration of all primary care services and add a quality aspect by ensuring that contractors are well supported to deliver health services to patients. In August 2012, it was confirmed that the PCS function would lift and shift to NHS England.

3.12. Public Health Commissioning:

NHS England (Merseyside) has a critical part to play in securing good population health. The Public Health Directorate has a particular focus on population approaches. In November 2012, NHS England and the Department of Health published their detailed agreement showing how NHS England will drive improvements in the health of England's population through its commissioning of specified public health services.

The document detailing which services are to be commissioned can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127215/s7A-master-131114-final.pdf.pdf

The key deliverables relating to these services are focused on achieving positive health outcomes for the population (in line with the NHS and Public Health outcomes framework) and reducing inequalities in health.

The agreement sets out the outcomes to be achieved in exercising these public health functions and provides ring fenced funding for NHS England (Merseyside) to commission public health services. The services commissioned, as part of this agreement, are those where there is, for example, alignment with national clinical pathways and added value of central commissioning.

NHS England (Merseyside) is committed to ensuring that all of these key deliverables are achieved and in order to safeguard that work can be undertaken in a systematic way; has examined the full spectrum of what needs to be delivered, aligned these together (where appropriate) into clear, targeted programmes of work with an identified lead officer for each of these.

Narrative templates outlining each programme area can be located within Appendix 6 and are as follows:

- Child Health Information System (CHIS)
- Family Nurse Partnership (FNP)
- Healthy Child Programme 0-5
- Health Visiting (HV)
- Public Health Services for people in prison or other places of detention, including those held in the Young people's Secure Estate
- Screening Programmes and Vaccination and Immunisations
- Antenatal and Newborn Screening Programme
- Cancer Screening Programmes
- NHS Diabetic Eye Screening Programme

- Relationship Management of Screening and Immunisations and New Programmes
- Seasonal Immunisation Programmes

The Public Health directorate, including the embedded Public Health England (PHE) 'Screening and Immunisations' team, do not underestimate the cumulative size of the challenge ahead. Not just in terms of improving health outcomes for our populations but also in terms of the system challenges that the health economy faces as a whole. There is a clear need to ensure close working with other commissioners such as our CCGs and Local Authorities and, in particular, Directors of Public Health and their teams. This practice is essential to ensure that already established care pathways are not fragmented and de-stabilised. This is particularly challenging where different statutory bodies are responsible for commissioning different elements of a pathway. The 'Healthy Child Programme' is an excellent example of this issue. NHS England (Merseyside) is responsible for commissioning 0 – 5 elements, Local Authorities responsible for 5 – 19 and some elements of the pathway are delivered via Maternity services commissioned via CCGs and paid for under existing tariff arrangements. This example, alone, outlines the complexity of the commissioning landscape and the challenges ahead for delivering effective integrated care.

As part of the planning process, NHS England (Merseyside) has met with the local CCGs to discuss the importance of partnership working to deliver some of these services. Whilst the logistics of how this will work in practice has yet to be finalised, an agreement has been reached, in principle, across the system, that some services will need to be co-commissioned and performance managed in order to ensure fragmentation is reduced whilst ensuring optimum use of resources whilst driving up quality and improving health and wellbeing outcomes.

Furthermore, the Merseyside Area Team Nursing and Public Health directorates hosted a Public Health Quality Transition Assembly with both sender and receiver organisations in attendance. The session was well attended by both local Public Health teams and CCG nursing representatives.

Whilst the key purpose of the session was to highlight key risks within the system, the session also provided a useful opportunity to secure a commitment across the system to work together moving forward, ensuring that where current performance is good, this is maintained, whilst where improvements need to be made, a concerted and strenuous effort is made to address and resolve this urgently. Throughout the session there was an acknowledgement that, whilst NHS England is the accountable body for delivery of the services, the system has a collective responsibility for improving health and wellbeing of the population. The Public Health team is committed to ensuring that these partnerships are further developed and strengthened to ensure we are able to deliver the best that we can for local people.

Collaboration with other NHS England Area Teams

NHS England (Merseyside) will work closely, as part of the single operating model, with other Area Teams across England, particularly those in the North of England to ensure a consistent approach to quality standards and direct commissioning responsibilities.

Engagement with the National and Regional Patient Experience Leads has already commenced to ensure patients, the public, carers and families are at the heart of everything we do.

Work has already been undertaken within the team to ensure that regionally led plans, in relation to specialised services, military & veteran health and offender health, are integrated, as much as possible, into the Merseyside plan. The Merseyside Area Team has, additionally, identified a designated team member to lead on working with the regional commissioning leads to ensure any developed plans are as inclusive of Merseyside's needs as possible; whilst also ensuring local implementation is planned and instigated in a rigorous manner.

It is a clear objective of the Merseyside team to ensure that all sections of the population have their health needs addressed, regardless of their background or personal circumstances.

The available plans (Plans on a Page) in relation to these specialised areas of commissioning are located within this plan, for reference purposes (Appendices 1 to 5).

3.13. The Current Financial Landscape, Overview & Planning

Key Issues & Deliverables

- Total cost base for the Mersey Cluster in 2012-13 was £2.525 billion
- Indicative allocations for 2013-14 have been issued by NHS England
- Potential for allocation levels to change prior to final approval in May 2013
- National planning assumptions for 2013-14 require a minimum 0.5% contingency reserve to mitigate emerging risks
- All Merseyside CCGs and the Area Team have exceeded the minimum contingency requirement
- Current Merseyside Area Team planning indicates a £4 million deficit
- Merseyside Area Team has a duty to, and will, oversee the CCG Commissioning and Financial plans

2013-2014 brings significant change to the commissioning landscape with the establishment of Clinical Commissioning Groups and NHS England with responsibility for commissioning healthcare for their populations. Responsibility for commissioning public health functions has been distributed across Public health England, Local authority and NHS England Area team commissioners. These planned changes have driven an associated resource re-allocation process.

The cost base for the former Mersey Cluster in 2012-13 was £2.525 billion and includes Liverpool, Halton and St Helens, Sefton, and Knowsley PCT's. These costs have been mapped to successor commissioner bodies broadly as follows:

Successor Body	£m	%
CCG's	1,875	74.3%
NHS England	556	22.0%
Local Authority Public Health	88	3.5%
Public health England	5	0.2%
Other	1	0.0%
Total	2,525	100%

3.14. 2013-2014 Financial plans

Indicative allocations have been issued by the NHS England including Primary Care Medical, Dental, Public Health and CCG's. However there is potential for these to change until the approval of commissioning and expenditure plans by the NHS England in May.

National planning assumptions for 2013-2014 require a minimum 0.5% contingency reserve to support the mitigation of emerging risks. All CCG's and the Area Team have met or exceeded this minimum requirement. Additionally there is a requirement for 2% non-recurrent headroom whereby only approved expenditure schemes can be committed on a non-recurrent basis. The financial plans are inclusive of the associated costs.

2013-14 Net growth uplifts for planning purposes are:-

Primary care 1%

Primary care IT 0%

Public health 2.6%

NHS Property services commissioned service costs 1%

PbR net deflator -1.1%

Non PbR net deflator – 1.3%

Each CCG within Mersey has planned to achieve a 1% cumulative surplus and all have exceeded the requirement for a 2% recurrent surplus by the end of 2013/14. With regard to the Area Team current plans show a planned 1% surplus, with utilisation of 2% non-recurrent headroom..

The CCG's have planned for the continuation of the 30% tariff for non-elective admissions, including the administration of the 70% balance by the Area Team.

A key focus of the NHS reorganisation has been to continue the reduction in management and running costs, maximising resource available to support direct patient care. Each organisation must deliver costs within its running cost target. Mersey CCG's plans comply with the £25 / head maximum allowance.

The NHS England (Merseyside area team) is required to plan for the direct commissioning responsibilities it holds locally and to work with other area teams who have responsibility for the commissioning of NHS England services on a broader footprint, to ensure equitable provision of health services for the Mersey population. For example Cheshire Warrington and Wirral Area Team commission specialised services, Lancashire Area Team commission offender health. In addition the area team has a responsibility to review and oversee Mersey CCG commissioning and financial plans

Current 2013-2014 planned expenditure, reflective of those services for which the Merseyside Area Team has direct commissioning responsibility along with the expenditure plans of the 6 Mersey CCG's is summarised below.

	Mersey		
	CCG's £000's	Area team £000's	Total £000's
Secondary & community	1,418,092	22,362	1,440,454
Primary care	264,521	283,454	547,975
Public Health		39,692	39,692
other	97,734	391	98,125
totals	1,780,347	345,899	2,126,246

Expenditure plans include provision for demographic and non-demographic growth in line with local intelligence. For the Area Team, for example, this includes anticipated growth in 0-5's in line with ONS projections in addition to planned investment in line with Health Visiting Call to Action growth trajectories.

CCG's have identified local risk pooling arrangements for key risk areas, for example continuing health care. Risks are identified, quantified and risk mitigation plans identified.

Section 4.
Improving Outcomes, Reducing Inequalities

Key Issues & Deliverables

- Merseyside Area team will ensure communities are targeted and treated equitably
- Commissioning system needs to be focused on reducing inequalities and advancing quality outcomes
- All commissioning work must address and focus around the 5 Domains within the NHS Health Outcomes framework
- NHS England (Merseyside Area Team) Medical Directorate to lead on delivery of Domains 1, 2 and 3; whilst the Nursing Directorate will lead on Domains 4 and 5
- The Merseyside Area Team will continue to work with CCGs and providers to ensure effective service reconfiguration to reduce premature mortality
- Primary Care services will work towards proactive treatment rather than being reactive
- Care will be commissioned and configured to be community focused and practice based
- Public Health programmes to be closely linked to Primary Care to ensure preventative action is taken to reduce mortality
- Merseyside Area Team will ensure Primary Care capacity can meet demand for service delivery
- Merseyside Area Team will measure and compare performance (contract, patient experience and performers list triangulation) across Primary Care Providers to ensure consistency in quality standards.
- Merseyside Area Team will ensure a strong primary care focus will tackle ACS conditions to address the long term conditions and hospitalisation rates agendas
- Merseyside Area Team will ensure patient experience is focal to all commissioned services whilst working with providers and CCGs to ensure consistency of approach
- Merseyside Area Team will ensure effective systems are developed/procured to capture patient feedback that can be utilised system wide for quality management and service development
- Merseyside Area Team will work with CCGs and providers to ensure approach and responsibilities to HCAI's are clear and transparent

The Merseyside Area Team must guarantee that no community is left behind or disadvantaged – the commissioning system needs to be focused on reducing health inequalities and advancing quality in its drive to improve outcomes for patients. The services it is responsible for commissioning must have improving outcomes and reducing health inequalities as their primary aim.

4.1. **Domain 1** - Preventing people from dying prematurely

The Merseyside Area Team Medical Directorate has assumed leadership for this outcome domain, working closely with direct commissioning & nursing leads and our respective CCGs. As co-commissioners, through working closely together, the health economy can ensure well developed plans are in place to drive up mortality across Merseyside.

Merseyside CCGs generally plan to address, through prioritising initiatives and service developments:

- Under 75 years mortality rate from cancer;
- People diagnosed within primary care with lung cancer;
- Uptake of bowel, breast and cervical screening programmes;
- Hospital admissions for patients with COPD;
- Hospital admissions related to alcohol;
- Maternal smoking;

Secondary and tertiary care services have already begun to reconfigure service provision which has been informed by best practice models for Major Trauma, Vascular, Cardiac and Cancer care. All of which are now being delivered through collaborative service models and are beginning to impact on mortality.

The principal aim for NHS England (Merseyside) is to continue to support these new service models through an initial period of consolidation during 2013; learning from peer review and patient outcomes, to determine the key next steps to further service improvement that will impact upon mortality.

90% of all healthcare contracts in England and 300 million consultations annually occur within primary care. When considering these national figures it is obvious that primary care commissioners need to focus on improving both outcomes and quality.

For example Primary Care Medical services will ensure that patients with long term conditions will be managed by the relevant Practice. It is envisaged that such management will include, for example, CVD checks and Medication reviews. Patient management will be based on clear evidence which shows, in such circumstances, that patients with COPD who are admitted following an acute exacerbation are susceptible to modifiable behaviours.

The development of locally enhanced services in Primary care Medical will support the CCGs in the delivery of a new Direct Enhanced Services (DES) aimed at Risk Profiling and Care Management; this will encourage GP Practices to co-ordinate and manage the care of the frail and elderly. In addition to this are opportunities in Pharmacies and Dental practices to deliver preventative messages linked to long term conditions such as 'Stop Smoking' and 'dietary advice'.

Primary care contractors have multiple opportunities to deliver agreed public health messages to patients known to be suffering from certain diseases and these link to those priorities already identified by CCGs in the previous section.

Close working between Public Health and Primary care teams will be critical in addressing the need to improve outcomes and reduce inequalities. It is now well reported that those communities affected by high levels of deprivation see increased mortality rates across a wide range of diseases and this is a challenge that Primary care.

Further to this evidence and work, NHS England's 'Screening and Immunisations' programmes make a significant contribution to the prevention of people dying prematurely. The key general purpose of these programmes is both the prevention of, and early detection, of diseases and illnesses and the subsequent reduction of mortality from causes amenable to health care.

The 'Healthy Child 0 – 5 programme' directly contributes to this domain in terms of both universal and targeted work with children but also in terms of the support that both Health Visitors and Family Nurse Partnership practitioners provide to identified families in relation to the wider determinants of health. If these factors are not addressed they can generally lead to poorer health outcomes.

In addition to this above example, it is well documented that those within the criminal justice system are more likely to suffer poorer health than the rest of the population. The Merseyside Area Team will work extremely closely with Local Authorities to target this population as a percentage of the budget required for this work has transferred to them as part of Health Improvement services contracts. In partnership with Local Authorities and the Lancashire Area Team the Merseyside Area Team will co-commission these key Public Health programmes and develop robust performance management arrangements to ensure delivery in accordance with the common single operating model set out in "Securing Excellence in Commissioning – Offender Health".

4.2. **Domain 2** - Enhancing the quality of life for people with long-term conditions

People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days. Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England

NHS England's (Merseyside) Medical Directorate has also assumed effective leadership for addressing long term conditions across the Merseyside region. Improved management of long-term conditions is a key theme within, the developing, Merseyside wide clinical strategy. It is recognised by all partners that it is only through a reduced dependency on acute intervention within secondary care and the development of integrated service models within a community setting for, in particular, diabetes, CVD and COPD that the health system across Merseyside will be fit for purpose as we move towards the end of the decade. A key outcome of this service shift will be a managed patient pathway with reduced acute emergency episodes and enhanced quality of life for people with these long term conditions

Merseyside CCGs and Local Authority plans to address this shift in focus include:

- To improve the detection and management of LTC by promoting self-care;
- To identify those at risk of CVD via the 40 – 75 Health checks programme;
- Identification and management of patients, who are most at risk of hospital admission and re-admission;
- Develop the use of personalised care plans for targeted LTCs across primary, specialised community and secondary care teams;
- Increased screening for dementia, COPD, diabetes & CKD;
- Explore the use of telemedicine to deliver 24/48 hour ambulatory blood pressure and ECG monitoring.

Both Primary Care and Public Health commissioners will work in close collaboration to ensure the appropriate and timely delivery of screening and Immunisation Programmes across Merseyside. The Primary Care Team will ensure that this is addressed via contract and performance monitoring whilst also working with General Practices, through CCGs, to ensure that capacity can meet demand. Other work will include ensuring that General Practices are supported by CCGs in terms of accessing all relevant training and development opportunities. In addition to supporting the development and training needs of those working within primary care, a thorough application of the Primary Medical Care Assurance Framework will also be administered.

These actions will enable the Merseyside Area Team to assess performance across the health economy and moreover assess performance between General Practices and identify any anomalies. An outlining example of this could be to highlight any practices that are outliers with regard to emergency COPD admissions.

The assurance framework will include QOF performance as well as achievement against the NHS Outcomes Framework and relevant indicators/improvement areas

for Primary Care. The Area Team will ensure a timely and appropriate response to underperformance practices, in partnership with CCGs.

The Primary Care Medical Team will focus on the full suite of existing Quality Outcomes Framework (QOF) indicators and new ones that have been developed for 13/14:

- Diabetes Mellitus
- COPD
- Hypertension
- Heart failure
- Rheumatoid Arthritis

It will be essential that information collated from QOF achievement is shared with CCGs and linked with other sources of performance information. Additionally the introduction of a new Public health domain within QOF will increase collaborative commissioning between primary care and public health teams.

Ambulatory care sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions Care Sensitive. We know that those older patients are admitted predominantly with conditions such as COPD, CCF and Diabetes complications.

Early identification of patients is therefore crucial if their management is to be successful such as in cases of influenza and pneumonia. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices.

The management of ACS should be seen as a key enabler in the local out of hospital/clinical strategies and will contribute to the successful delivery of cost improvement plans. Recognising that those patients living in deprived areas are twice as likely to suffer from ACS conditions will be essential in linking primary care to secondary care and the overall potential for reductions in admissions.

Some progress can be made through relatively simple measures such as expanding vaccination, where available, to prevent the onset of a condition older people and other high risk patients.

Developing relationships with CCGs will be critical for Primary Care Medical Services as the GP has an essential role to play in terms of a coordinated multidisciplinary team approach. A key requirement for the health system within Merseyside for 13/ 14 will be to develop and foster relationships with co-commissioners and providers to ensure effective working practices are established are maintained. Without these relationships the delivery of health benefits will not be realised.

In addition to those services commissioned by the primary care team there are key public health programmes which contribute to the management of LTC, such as the diabetic eye screening programme Diabetic retinopathy is the most common cause

of blindness in the UK's under 65 age group. If diabetic retinopathy is diagnosed and treated at an early stage, the outlook for the condition is good. Research has found that treatment can prevent severe vision loss in 90% of cases of diabetic retinopathy. Retinal screening is proven as an effective way to reduce or prevent diabetic retinopathy and thus enhance the quality of life for those with Diabetes. A 2012 Quality Assurance review of the three diabetic retinopathy programmes within Merseyside reported that they are safe and run well.

Throughout 2013-14, the Merseyside Area Team will work closely with all CCG colleagues who are responsible for other elements of the 'diabetes care pathway' to ensure both comprehensive and seamless service delivery for relevant local people. A selection of Merseyside CCGs have specifically highlighted Diabetes as a priority area; with Liverpool CCG including the delivery of all 9 care process for diabetics in line with NICE guidance as one of their 3 Quality Premium indicators.

In addition to this work, the seasonal 'Immunisations Programme' focuses on vaccinations of a number of "at risk" groups. Vaccination uptake rates show that a major challenge for Merseyside is to increase uptake for patients under 65s with a long term condition. This will form a major part of the work stream for this programme.

4.3. **Domain 3** - Helping people to recover from episodes of ill health or following injury

NHS England (Merseyside) Medical Directorate has assumed leadership for this outcome domain. Merseyside commissioners benefit from a strong PCT legacy of bringing patients requiring long-term rehabilitation back into Merseyside, this has delivered a significant reduction in the number of 'out of area' placements with the benefits to patients and careers of reduced travel time and costs, increased contact time with family and loved ones, and more co-ordinated care due to the proximity of their respective network of support services. This practice has also contributed to the delivery of significant savings for commissioners.

During 2012 Merseyside has seen the development of a Rehabilitation network which to be fully operational from May, designed to provide a comprehensive pathway of care for people suffering a sudden and devastating loss of function. NCB Merseyside will continue to support this provider network during the transition to a potential local Operational Delivery Network.

Reablement services are to be further developed within CCG plans and Local Authorities received a report regarding readmissions across Merseyside and are keen to work closely with co-commissioners through H&W boards in reducing readmissions.

Linked to the actions identified through dealing with people suffering with long term conditions, a particular focus a particular focus of CCGs is the support available to people who have suffered an acute exacerbation of a long-term condition, to ensure optimised recovery and reduce the likelihood of further acute exacerbations through

interventions such as:

- Introduction of a care pathway for patients who have had a glycaemic episode requiring hospital attention
- Joint management of complex care through alignment of health and social care resources and systems
- Development of enhanced integrated discharge

Application of the Primary Medical Care Assurance Framework in partnership with CCGs will ensure a timely response to underperformance, in relation to conditions with a high local incidence. For example, practices that are outliers with regard to A&E attendances will be assessed.

Additionally, QOF 13/14 will retain, for a further year, the Quality and Productivity (QP) indicators on reducing unnecessary emergency admissions, referrals and A&E Attendances.

Performance will be assured within the context of the NHS Outcomes Framework and this will link to those indicators relevant to CCGs, but just as importantly should link to the commissioning of community services by the local authorities. There is an opportunity for Primary Care medical commissioning to be a core part of the developing integrated commissioning framework. This developmental opportunity will be addressed and developed over the coming financial year.

4.4. **Domain 4** - Ensuring people have a positive experience of care

The Merseyside Area Team Nursing Directorate has assumed leadership for this outcome domain. The NHS England Merseyside Team will provide system clinical leadership to ensure that patients, the public, carers and families, experience a high standard of medical care; and positive experience. This expertise and leadership will be via system assurance, working in collaboration with CCGs and providing oversight of Directly Commissioned services Primary Care and Public Health. It is recognised that there are a number of opportunities for commissioners to build the need for positive patient experience into the vision, strategy, systems and structures for all services commissioned and provided.
During recent years, several documents and initiatives have highlighted the importance of the patient's experience and the need to, where possible, focus on improving these experiences. Lord Darzi's report *'High quality care for all' (2008)* highlighted the importance of the entire patient experience within the NHS, ensuring people are treated with compassion, dignity and respect within a clean, safe and well-managed environment.

Following on from this, the development of the *NHS Constitution (2009–2010)* was one of several recommendations from Lord Darzi's report. The Constitution describes the purpose, principles and values of the NHS and illustrates what staff, patients and the public can expect from the service. Since the 'Health and Social Care Act' came into force in 2012, service providers and commissioners of NHS care

have had a legal obligation to take the Constitution into account in all their decisions and actions.

The *Equality Act 2010* replaces all previous anti-discrimination legislation, and includes a public sector equality duty requiring public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework which should improve the experience of all patients using NHS services.

The '*Health and Social Care Bill' (2012)* advocates for a greater patient voice. The Government aims for there to be "no decision about me, without me" for patients and their own care. The same goes for the design of health and social care services at both a local and a national level. A key part of patient empowerment is to offer increased choice about their care

Despite these clear policy initiatives, there is evidence to suggest that further work is needed to deliver the best possible experience for users of NHS services. The Government signaled in its White Paper '*Equity and Excellence: liberating the NHS' (2010)* that more emphasis needs to be placed on improving patients' experience of NHS care.

The Kings Fund, NHS Institute for Innovation and the Department of Health (2012) suggest that NHS organisations collect feedback from patients without first asking the fundamental question, 'What problem are we trying to solve?' and 'When we have the data, what will we do with it?' They found very few NHS organisations with an overall strategy for improving patient experience, a defined budget, personnel with relevant expertise to collect data, analyse and present it, and an education and training plan with a budget for improving patient experience.

In this respect, patient experience differs from other dimensions of quality (clinical quality and patient safety) where the debate is rightly less about measures and measurement, and more about what needs to be done to respond to the evidence and what works in terms of change management. A national definition is a move in the right direction and as part of one operating model we strive to achieve NHS cultural change by using Patients views and opinions to shape services nationally.

The Public Health Area Team recongises the importance of ensuring that all commissioned services are responsive to the needs of local people and that experience of both children's and screening and immunisations services are positive e.g. improving women and their families experiences of maternity services is a key priority area.

Public Health will work closely with the Primary Care direct commissioning team who will have responsibility for ensuring people have a positive experience of primary care in relation to those screening and immunisation services delivered in general practice. The Primary Care Medical team will also work closely with CCGs who have systems and process in place to receive patient experience as part of their quality improvement strategies

The Family and Friends Test CQUIN will be applied to all Merseyside Area Team Public Health services commissioned from acute trusts and the Area Team is mindful of the need to put implementation plans in place for rolling out the Family and Friends Tests to other areas during 2013/ 14 particularly as the first rollout in October 2013 will be for maternity services.

Outcome Measures:

In February 2012 the NHS National Quality Board (NQB) published the NHS Patient Experience Framework. This framework has been developed based on patient and carer views of what matters to them and it outlines those elements which are critical to the patients' experience of NHS Services and will the Framework used and implemented by the NHS England Merseyside Nursing Directorate.

The NHS National Quality Board (NQB) agreed on a working definition of patient experience to guide the measurement of patient experience across the NHS. The framework is based on a modified version of the Picker Institute Principles of Patient-Centered Care, an evidence based definition of a good patient experience. When using the framework the NHS is required under the Equality Act 2010 to take account of its Public Sector Equality Duty including eliminating discrimination, harassment and victimisation, promoting equality and fostering good relations between people.

NHS patient experience framework:

1. **Respect of patient-centred values, preferences, and expressed needs**, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making;

2. **Coordination and integration of care** across health and social care system;

3. **Information, communication, and education** on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion;

4. **Physical comfort** including pain management, help with activities of daily living, and clean and comfortable surroundings;

5. **Emotional support** and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances;

6. **Welcoming the involvement of family and friends**, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers;

7. **Transition and continuity** as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions;

8. **Access to care** with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

NHS England (Merseyside), through dedicated Nursing leads, will act in a clinical leadership role to ensure delivery across the system. Patient Experience should be a 'Golden Thread' that runs through the commissioning cycle and patients and carers seen as partners in the process. For this purpose the Area Team will support both CCG's and Direct Commissioners to embed the cultural change required to deliver **"no decision about me without me".** The work programme will be determined by the commissioning intentions and priorities of commissioners. In the first instance, assurance will be required that governance, process and systems are in place.

Key Deliverables for 2013-14:

NHS England (Merseyside) during 2013-14 will:

- Implement Patient Experience NICE Quality Standards in all directly commissioned services.
- Develop an electronic data collection system to actively seek out, respond positively to and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real time' data techniques
- Include the patient, carer, public voice in designing, redesigning, re-commissioning, decommissioning and tendering of any services to ensure patient-centred care, where "there is no decision about me without me"
- Demonstrate compliance with Section 242 Duty to Consult and Equality Act 2010.
- Work with Health Education England, Provider Trusts and academic providers to implement the Chief Nursing Officers Nursing Strategy, Developing the culture of compassionate care: Creating a new vision and strategy for nurses, midwives and care-givers. Recruiting for values and behaviours.
- Implementation of the recommendations from Winterbourne View Hospital Review
- Implementation of the recommendations from Mid-Staffordshire Hospitals Review.
- Implement Assurance and Accountability Governance for Safeguarding Children and Adults

- Develop assurance systems to ensure implementation of the Friends and Family Test.

Key Performance Indicators:

- Patient experience of primary care:
  - GP services 4a i
  - NHS dental services 4a iii
- Patient experience of GP out-of-hours
- Patient experience of hospital care
- Friends and Family test
- Improving people's experience of outpatient care
- Improving hospitals' responsiveness to personal needs
- Improving people's experience of accident & emergency services
- Improving patients' access to primary care services
- Improving women's and their families' experience of maternity services
- Improving the experience of care for people at the end of their lives
- Improving the experience of care for adults with mental illness
- Improving children and young people's experience of healthcare
- Improving people's experience of integrated care

4.5. Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

As indicated within the NHS Constitution, patients should be able to expect to be treated in a safe and clean environment and to be protected from avoidable harm. In line with this goal, the Department of Health has set healthcare providers the challenge of demonstrating zero tolerance of MRSA BSI through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance. For their part CCGs are to collaborate closely with the organisations involved in providing patient care, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA bloodstream infection. To facilitate this process the Health Protection Agency and Public Health England will be introducing a new Data Capture System (DCS) for recording surveillance data relating to healthcare associated infections (HCAI).

Furthermore, despite large national reductions in the number of *C.difficile* infections, there remains significant variation in performance across the NHS generally. The *Clostridium.difficile (C.diff)* Objective for 2013-14 uses a "sliding scale" methodology that requires organisations with the highest rates to make the greatest proportional improvements, whilst requiring almost all organisations to make at least some positive reduction in rates. Assurance of delivery of the HCAI objectives will be via contracts, local monitoring dashboards; Health Protection Agency (HPA) data capture system and the National Quality Dashboard. Reducing the incidence of

MRSA and *Clostridium difficile* infections will be one of the national measures used to calculate the Quality Premium for our partner Merseyside CCGs.

Further to this, during the recent Merseyside Public Health Quality Transition Assembly, there was a robust discussion about the future management of HCAI across the system. The designated Quality and Assurance Manager (North of England) presented an update in relation to appeals (re: MRSA and C.diff) and reaffirmed that the current process would remain the same. It was confirmed that there was a requirement for a communication to be circulated from the national and Regional management to articulate the appeals process post March 2013.

As per national directive, some aspects of responsibility for infection control transfers to Local Authority Public health teams but it clear that elements of the money related to this area of work has not been transferred to Local Authority budgets during transition but remains entwined within current CCG budgets. It was agreed by the attendees of the Quality Assembly that further discussion were urgently required to agree the key principles of 'who' has responsibility for 'what' within the new health system (re: HCAI as there was still a lack of clarity on roles and responsibilities of the different organisations in the new system).

An agreement was reached that a Merseyside group, with representatives from Local Authority Public Health teams, CCG nursing leads, primary care commissioners and the Nursing Directorate of the Merseyside Area team would be convened to agree how we resolve this, as a health economy, in a co-ordinated and cohesive manner whilst ensuring shared ownership of the entire infection control agenda. The Nursing directorate within the Merseyside Area Team agreed to lead on the implementation of this agenda locally. This approach will ensure both partner 'buy in' and consistency across the health system.

Outcome Measures

To embed a culture of patient safety in the NHS and

- Ensure that the essential standards of quality and safety are maintained and
- Drive continuous improvement in quality and outcomes.

Key Deliverables 2013/14

NHS England (Merseyside) during 2013-14 will:

Establish a Quality Surveillance Group

Implement the recommendations from Winterbourne View Hospital Review

Implement the recommendations from Mid-Staffordshire Hospitals Review.

Gain system assurance for zero tolerance of MRSA

Obtain system assurance that CCG commissioners are receiving a level of quality over and above that stipulated in NHS Standard Contracts from all services commissioned.

System assurance with regard to improvements against the NHS Safety Thermometer.

Implement Primary Care Quality Assurance for all four contractor services.

Performance will be monitored using key performance indicators

Overarching indicators

- Patient safety incidents reported
- Safety incidents involving severe harm or death

Reducing the incidence of avoidable harm

- Incidence of hospital-related venous thromboembolism (VTE)
- Incidence of healthcare associated infection (HCAI)
  - **i** MRSA
  - **ii** C. difficile

- Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
- Incidence of medication errors causing serious harm

Improving the safety of maternity services

- Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings

- Incidence of harm to children due to ‘failure to monitor’

Primary Care Quality Dashboard

Section 5.

The Basics of Care

Key Issues & Deliverables

- NHS England (Merseyside) will oversee the delivery of NHS services upon Merseyside, including continuous improvement of the quality and experience and treatment of care via direct and non-direct commissioners
- NHS England (Merseyside) and the CCGs will oversee, in full collaboration, the strengthening of provider quality accounts
- NHS England (Merseyside) and partner CCGs will quality assure provider CIP plans
- Both NHS England (Merseyside) and CCGs will examine all provider intelligence to ensure accurate CIP plan baselines can be established

Improving patient safety and experience involves numerous elements: treating patients with dignity and respect; high quality clinical care; creating systems and processes that prevent both error and harm; whilst creating a culture of learning from patient safety incidents and patient experience to prevent them from materialising again.

NHS England (Merseyside) will oversee the delivery of NHS services upon Merseyside, including continuous improvement of the quality and experience of both treatment and care, through our partner CCGs and NHS England direct commissioners making decisions about services based on the needs of their communities. To support this process, NHS England (Merseyside), in full collaboration with the Merseyside CCGs, are overseeing the strengthening of quality accounts, which all providers are legally required to publish to illustrate and account for the quality of their services.

'Everybody Counts: Planning for Patients 2013/14' requires both the constituent CCGs and direct commissioners to quality assure provider Cost Improvement Plans (CIPs). Upon sharing the first draft of plans, CCGs, with their Area Team Directors, are required to include high-level 'self-certification' of this assurance asking key questions such as: "*Have you assured provider CIPs are deliverable without impacting on the quality and safety of patient care"?*
Both Monitor, and previous NHS Operating Frameworks, have required both Foundation Trusts (FTs) and NHS Trusts to ensure that Cost Improvement Plans (CIPs) are agreed by Medical and Nurse Directors and include intrinsic assurance of patient safety and quality. The 'Quality Impact Assessment' of CIPs is the primary responsibility of provider boards.

To help commissioners quality assure CIPs, the National Quality Board (NQB) has produced a guidance paper '*Quality Impact Assess Provider Cost Improvement Plans'* providing helpful scenarios and tested methodologies. Both CCG and NHS England Commissioners should examine all known data about providers, including material on quality, patient safety/experience, activity, finance, workforce and performance metrics, to create a baseline against which the CIP can be appraised. Consideration of integrated performance and specific quality dashboards in the context of soft intelligence is crucial if a balanced and fair judgement process is to be concluded by experienced and senior staff. A specific review of the relevant 'Care Quality Commission's Quality Risk Profiles (QRP)' must be included at this stage. It is also advisable to reflect on the NICE quality standards as a source of measures and indicators to help ensure that quality is not compromised as a result of CIP delivery. This robust process of consideration can be given to data such as serious incident reporting rates/trends, never events, safety thermometer patient harms, key performance indicators on quality and infection rate profiles.

NHS England's Merseyside Team recognises that this process will require continuous oversight, particularly as CIPs may fluctuate and impact throughout the course of the year.

Section 6.

Patient Centred, Customer Focussed

Key Issues & Deliverables

- Commissioners have collectively agreed there is a need to strengthen primary and community care/services to allow shift of focus from acute care towards prevention and management
- NHS England (Merseyside) will work with CCGs to ensure agreed standards for access are met and to identify examples of best practice within primary care
- NHS England (Merseyside) will work with partner CCGs to develop and strengthen Quality Accounts
- NHS England (Merseyside) will work with partner CCGs to quality assure provider CIP Plans
- NHS England will assist partner CCGs in monitoring the impact of the provider CIP plans to ensure quality and safety levels are maintained

6.1. NHS services - 7 days a week

24/7 working has been a best practice standard considered within all strategic health service developments across Merseyside in recent years. Good progress is being made, particularly within the acute sector, with regard to emergency and urgent care services and the key amenities that support these (e.g. 24 hour access to imaging – including: CT; interventional radiology; consultant ward rounds at weekend, therapies services) seven days a week to maintain active rehabilitation and recovery programmes as well as assessments within emergency departments.

Across primary care and community services, out of hours arrangements are robust and CCGs are focused on expanding the range of community services available seven days per week as commissioners, collectively, are in agreement with regard to the need to strengthen primary and community services. This is required in order to shift the health service focus, locally, from acute treatment towards prevention and management.

During 2013/14 direct commissioners will, in partnership with the public and CCGs work to ensure national minimum standards with regard to access are fully met and to identify areas of best practice across primary care. The agreement of locally defined minimum standards for primary care (over and above the national contracted requirements) with CCGs, GPs and pharmacists, is intended to enhance access as one of the key benefits to patients.

6.2. Listening to Patients and Increasing Their Participation

Engagement with Healthwatch across the Merseyside Area is on-going and working principles have been agreed to commence this journey together.

Initially, strong governance structures are required to allow a cohesive health system to work together for the common gain of improving all patient experience regardless of area of need or specialty. NHS England (Merseyside) will work with all stakeholders to ensure enhancements can be made to current methodologies to ensure all experience data is captured, recorded, centralised, coordinated and, most importantly, utilised to improve experience and outcomes in line with NHS England single operating model.

Currently, across the Merseyside area, Patient Reported Outcome Measures (PROMs) are utilised with varying degrees of consistency, depending upon the nature of the service being delivered. Ultimately, this means there is no natural "one size fits all" approach. Each PROM is tailored to ensure the service user has a meaningful and relevant PROM to feedback on. Surveys are often used to obtain feedback. Real Time measures are used such as voting type systems used during consultation events; focus groups; and 1:1 structured feedback sessions. Real time feedback is crucial and will be used by Clinical Commissioning Groups (CCG's) and the Merseyside Area Team for directly commissioned services; whilst working collaboratively with the providers to ensure swift responses are made, whilst comments are recorded and logged to demonstrate where this has impacted upon service delivery.

Standardisation of approach is key to enable clear, transparent and honest choices to be made by patients, carers, families, providers and commissioners. This work has begun with the implementation of the 'The Friends and Family Test' (FFT) which represents data collection on a national scale in a systematic way to enable comparative data to be analysed. From 1st April 2013, all hospitals in England will be expected to give every discharged adult inpatient or A&E attendee the opportunity to complete the Friends and Family Test.

Given a target response rate of 15-20%, this is close to four million responses per year (nationally). The key requirement is for one question: *'How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?'*

Responses to this question will be collated nationally and acute trusts will be paid under CQUIN arrangements for conducting the test and increasing their response rate within the year. Payments will also be made based on trusts' results for a similar question in the NHS Staff Survey.

The FFT will be rolled out to Maternity, Children's, Mental Health, Community Services and NHS Funded services in Care Homes in a phased approach. The results will be used to enable real time discussions with Providers regarding Quality of services and changes required as a result of trends and themes emerging from FFT feedback. Each Merseyside CCG, subsequently, has in place a Quality and

Performance Group which discusses patient feedback on a monthly basis. Direct Commissioning will establish a similar process throughout the reporting period of 2013-14.

Further to this, from a direct commissioning perspective, the GP NHS Choices site will inform support required to GP practices to improve patient choice and experience. This system should work in with respective practice patient groups which are active in every GP Practice across the Merseyside area. Practice meetings also ensure wider surgery level issues can be shared and mutually resolved with regard to patient experience.

There is an identified need to procure an electronic system for Direct Commissioning such as, for example, the 'REACT' database. This system allows for commissioners to access key information when redesigning and reviewing patient feedback on services that are directly commissioned. Such a web based system would enable real time recording of engagement activity and effective monitoring of consultations carried out. One of the major drivers behind the development of systems such as 'REACT' has been an identified need from Commissioners and Provider services for real time data, to encourage greater collaborative working, preventing duplication of work and to support identification of gaps in engagement and feedback.

Furthermore, an annual commissioning conference could be organised collaboratively across Merseyside between the CCG's and NHS England's Merseyside team to share where services have aligned themselves according to local need and local feedback. This methodology has been proven, previously, within Merseyside to be highly beneficial to sharing experience and best practice whilst also being an inclusive practice for the whole commissioning body.

Further to this, members of the public should be allowed to join tender panels whilst being involved throughout the procurement process. This process demonstrates transparency in the decision making process, whilst also ensuring experience from all members of the community is captured. Again, this has proven to be a positive working practice within Merseyside which will hopefully be developed over the coming year.

In terms of quality assurance and rigorous adherence to the Patient Experience, proven models of practice should be utilised, such as, for example, the SENSE model. This methodology was rated as 'World Class' during the Department of Health's World Class Commissioning performance management periods. Proven practices should be utilised across the Merseyside area through collaborative commissioning ventures (primary, secondary and tertiary). The strategic SENSE model is a robust and transferable model and supports performance management requirements in regard to Patient Experience, Duty to consult, and the wider responsibility of endorsing Quality Accounts with provider services. Additionally, it is the collective duty of all commissioners to identify any gaps in consortia intelligence via regular engagement with CCG leads and other providers of care; to ensure a smooth transition takes place and a quality assurance system is developed and adopted across the region.

Working with clinical colleagues, stakeholders and partners; the Nursing Directorate will implement the 6 C's outlined within the Nursing Strategy 'Developing the culture of compassionate care: Creating a new vision and strategy for nurses, midwives and care-givers' (2013). Modeling a collaborative leadership style and working closely with patients, carers and relatives and between nurses, doctors, therapists, managers and support staff who look after them to improve patient experience.

Work will be undertaken with academic providers to ensure they are recruiting for values and behaviours to achieve the culture change in workforce required to improve patient outcomes and experience.

6.3. Keeping Patients Informed

Direct Commissioners and CCGs are both established members of the Health and Wellbeing Partnership Boards (HWBPB) across the entire Merseyside region.

Annually a Joint Strategic Needs Assessment (JSNA) will be undertaken and developed, with full public engagement and involvement, to determine local health priorities and requirements. The JSNA will reflect public, patient, carer and family experience, alongside current evidence, population need, socio-economic & demographic factors determining good health and wellbeing outcomes. JSNA plans and subsequent priorities are currently reflected in all respective Merseyside CCG and Direct commissioning plans for 2013-14.

HWBPB will develop outcome metrics, throughout 2013-14, that can demonstrate benefits realisation on return on investment in its widest terms. Healthwatch will be a key stakeholder in determining wider public engagement and that hard to reach groups views are heard.

Section 7.

Higher Standards and Safer Care

Key Issues & Deliverables

- NHS England (Merseyside) have initiated and administered the Winterbourne implementation process with partners across Merseyside (CCGs, LA's and Providers)
- NHS England (Merseyside) will work with CCGs, Local Authorities and Mental Health providers to implement all 64 recommendations from Winterbourne report
- All agencies to ensure 'out of area' assessments are completed to secure local community placements (re-settlements)
- Acute trust are assisting local commissioners to ensure care plans are individualised
- Merseyside Area Team to seek assurance from CCGs on Winterbourne implementation (via Self-Assessment Framework)
- Merseyside Area Team have worked with CCG partners to prioritise and implement key areas of the Mid-Staffordshire review/report during financial year
- The Merseyside Area Team will comply with requirements to participate and contribute to all local safeguarding boards and issues (Adult and Children)
- Merseyside Area Team will oversee the overall quality of safeguarding within Merseyside (commissioning and provision)

In February 2013 NHS England (Merseyside) initiated and administered a Winterbourne Transition Handover meeting with CCG, Local Authority (LA) and Mental Health Provider Trust colleagues. This was to ensure a smooth changeover of information, governance, programmes of work and organisational memory transitioned to the new system in a safe and effective manner. Risks and issues were also identified moving forward to ensure these are dealt with accordingly.

From May 2013 the Merseyside Learning Disability Network will have its inaugural meeting with representation from NHS England (Merseyside), CCGs, LA and Mental Health Trusts to ensure the 64 recommendations from the Winterbourne View Hospital report are effectively implemented whilst demonstrating improvements in care for people with Learning Disability, Autism and general mental Health can be demonstrated in real time patient and carer feedback.

All Merseyside CCG's, have in place, registers of all people with a learning disability, autism and mental health issues and from 1st April 2013 a review of all 'out of area'

placements will be undertaken to ensure that those who are in hospital are helped to move to a community setting. Work is underway with Acute Hospital Trusts to ensure that care plans are in place for people with challenging behaviour and that care plans reflect the needs of the individual and their carer/families.

NHS England (Merseyside) will gain direct assurance from the CCG's, through the 2013 Self-Assessment Framework submissions, with regard to any areas of concern or risks to implementation of the Winterbourne recommendations. This aspect will be taken forward via the 'Learning Disability Network'.

In addition to the Winterbourne Report, the report of the Mid Staffordshire NHS Foundation Trust, identified that numerous warning signs, which cumulatively, or in some cases singly, could and should have alerted the health system to the problems developing within the Trust, these were not present. The report concluded with 290 recommendations for the health and social care system to take into account whilst commissioning and providing services to the public. Furthermore, the report strongly advocates for the public to be 'listened to' and 'their experience' to be taken into account when designing, reviewing, re-commissioning or providing services.

The recommendations within the report have been thoroughly reviewed by the Merseyside team culminating in both Direct and CCG commissioners highlighting and prioritising specific areas for focus on throughout the 2013-14 financial year. These priorities relate to:

7.1. *Implementing the recommendations*: - commissioning organisations in healthcare should consider the findings and recommendations. They should announce the extent to which they accept the recommendations and how they will implement them (reporting on a regular basis).

7.2 *A common culture made real throughout the system – an integrated hierarchy of standards of service*:

- *Fundamental standards of minimum quality and safety*, where non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations.
- *Enhanced quality standards* – such standards are higher than fundamental standards. The NHS England together with CCGs should devise enhanced quality standards designed to drive improvement. Failure to comply should require performance management by commissioners rather than the regulator.
- *Developmental standards* which set out longer term goals for providers – these would focus on improvements in effectiveness, these are implemented by commissioners and progressive providers.

7.3 *Responsibility for, and effectiveness of, healthcare standards*: A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in real time.

7.4 *Effective complaints handling*: Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible.

7.5 *Commissioning for standards*:

- GPs must have continuing partnership with their patients. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality.
- Consider whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.
- Commissioners should, wherever possible, apply a safety and quality standard in respect of each item of service it is commissioning and agree a method of measuring compliance and redress for non-compliance, including powers of intervention where substandard or unsafe services are being provided.
- Commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards.
- NHS England and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive.
- Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise.
- Commissioners need to have close engagement with patients (via membership forums, patient representatives etc) to ensure that fundamental safety and quality standards are maintained.
- Commissioners – not providers – should decide what they want to be provided, in consultation with clinicians both from potential providers and elsewhere.
- Commissioners wherever possible need to identify and make available alternative sources of provision.
- Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract

- Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily
- NHSCB and local commissioners must ensure proper scrutiny of commissioned provider services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.

7.6 *Performance management and strategic oversight*: The NHS England (through regional offices) should support the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers.

7.7 *Openness, Transparency and Candour*: There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner. The Care Quality Commission' duties should be supported by monitoring undertaken by local commissioners.

7.8 *Nursing*: All commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.

Information: Department of Health/the NHS England/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations. These accounts should be lodged with and contain the observations of commissioners.

Both CCGs and the NHS England, nationally, are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This includes specific responsibilities for looked after children and for supporting the Child Death Overview process, to include sudden unexpected death in childhood. Local authorities have the same responsibilities in relation to the public health services that they commission.

Both CCGs and NHS England have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs) and are expected to be fully engaged with local Safeguarding Adults Boards (SABs), working in partnership with local authorities to fulfil their safeguarding responsibilities.

CCGs and the NHS England (Merseyside) will ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed were abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs), which are commissioned by LSCBs/SABs, whilst also, where appropriate, conducting individual management reviews. CCG's and

direct commissioning will work in partnership and cooperate with LSCB or SAB for information which is relevant to a Serious Case Review.

Additionally, to the distinct responsibilities that NHS England has as a direct commissioner, it is also responsible for ensuring that the health commissioning system, as a whole, is working effectively to safeguard and improve the outcomes for children and adults at risk and their families.

The Merseyside Area team will work closely, both internally across Directorates, and with the Merseyside CCGs, as well as with Local Authorities, LSCBs and SABs, to ensure there are effective NHS safeguarding arrangements across each local health community. Simultaneously, the area team will ensure there is absolute clarity about the underlying statutory responsibilities that each commissioner has for the services that they commission. There is a clear leadership and oversight role for NHS England (Merseyside) throughout this process, which will be upheld rigorously.

7.9 Compassion in Practice Standards – *applying the 6 C's across Merseyside.*

Key Issues & Deliverables

- NHS England (Merseyside) will continue to work vigorously with Health Education North West to ensure ethos of 6 C's are integrated within all training programmes
- Merseyside Area Team will continue to work with academic providers to map all pre and post registration nurse training courses against the 6 C's
- Merseyside Area Team will continue to support the '6 C's Live' initiative to ensure best practice evidence is available across the country for all care staff

NHS England (Merseyside) Direct Commissioners have worked in partnership with Health Education Northwest to discuss the planning and delivery of training for Directly Commissioned services across, primary, dental, optometry and pharmacy services. There is a clear strategy present here to see the ethos of Care, Compassion, Courage, Communication, Competence and Commitment embedded into all training programmes to ensure a full cultural change.

NHS England (Merseyside) and the respective CCG's have recruited all members of staff using a value and behaviours model to ensure the right workforce is in place to commission for the future.

Work is also underway with academic providers to map all pre and post registration nurse training courses against the 6 C's whilst all the Universities are applying the

same ethos for recruitment and feedback on practical placements. An event was held on 1st March 2013 in the North of England to discuss the 'Compassion in Practice Strategy' with academic providers, commissioners and healthcare providers to maximise the engagement of Higher Education in delivery of the action areas and embedding the 6 Cs within nursing and midwifery education.

A joint planning event, with all NHS providers, commissioners and Higher Education Institutes, is currently being devised and structured to determine a local, 'Merseyside' approach whilst also identifying current exemplars of the 6Cs in practice to allow replication across the wider landscape.

Further to this, the 'Merseyside Care Homes Nursing Network' has been established locally and is facilitated by NHS England (Merseyside) Nursing Directorate. This network has recently organised and administered an event to discuss, the Francis and Winterbourne reports, its impact on the health economy and the local Nursing Strategy.

Health Education Northwest is working with all Trust Provider Directors of Nursing to establish the workforce requirements of the future and the ethos of the 6C's is fundamental to planning.

Finally, NHS England (Merseyside) Nursing Directorate are supporting the '6 C's Live' which builds on the strong foundation of 'Energise for Excellence'. This initiative takes the values, philosophy, learning and momentum into the culture of compassionate care nursing strategy as 6Cs Live. This supports nurses, midwives and care staff by helping them deliver the six areas of action by signposting to evidence based tools and techniques as well as examples of how colleagues from across the country have delivered improvement in these areas.

Section 8.

Quality, Assurance and Appraisal

Key Issues & Deliverables

- The Merseyside Area Team will assess performance of delivery across both direct and in-direct commissioning functions
- NHS England (Merseyside) will continue to develop and foster network and inter agency partnerships to ensure effective collaborative commissioning
- The Area Team will ensure all general practitioners under take the annual appraisal process
- A single process for appraisals and revalidation across Merseyside has been developed
- New governance process have been implemented to ensure effective and appropriate oversight and management of the 'performers list'. NHS England (Merseyside) will continue to comply with this process

Health System Assurance & Delivery

The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires NHS England (Merseyside) to publish its approach to CCG assurance.

Significant progress has been made since the publication of the Health and Social Care Act 2012, in preparation for the formal establishment of the new NHS commissioning system from April 2013. The NHS England local area teams, including Merseyside, have been working effortlessly to develop strong relationships with CCGs that embed the principles of the Act into the reality of delivery. It is a fundamental cultural shift and a mindset change for many working within the Healthcare system. To successfully commission high quality care, we will need to rely more than ever on engagement, transparency and high quality relationships between all involved in the delivery of health and care services in order to realise our collective vision of a health system shaped by patient and stakeholder participation and designed with improved outcomes and patient experience at its heart.

A vital element of the on-going relationships between NHS England (Merseyside) and CCGs will be a local process for CCG and direct commissioning assurance – an important way in which NHS England can demonstrate the results delivered from the significant expenditure by both CCGs and NHS England itself (from a direct commissioning perspective).

New organisations call for a conscious new approach with emphasis on a mature and equal conversation between CCGs and area teams informed by rich sources of evidence. Reciprocally, NHS England (Merseyside) will commit itself to the same level of scrutiny of its own direct commissioning responsibilities.

Additionally, our local assurance and delivery approach is the process by which risk can be identified within the system and supportive action taken to improve patient care. It can also contribute to how the CCG demonstrates to its local population and the local Health and Wellbeing Board's the progress it is making to improve health outcomes.

Appraisal, Revalidation & Quality

The Medical Directorate will ensure that NHS England within Merseyside fully meets its responsibilities with regard to ensuring that all general practitioners participate in annual appraisal process, as part of one of the strands contributing to on-going improvement in patient safety and quality of clinical care.

GP appraisal is an essential component of the revalidation process, which requires licensed doctors to demonstrate on a regular basis (usually every 5 years) that their clinical practice is "up to date" and the individual clinician is fit to practice.
The annual appraisal process promotes continuous professional development and learning from incidents and patient complaints.

In line with the new Medical Profession (Responsible Officers) Regulations 2010, all appraisers across Merseyside have attained 'top up' training to carry out strengthened appraisals for contractors and NHS England (Merseyside) aims to maintain and further develop this local expertise into 2013/14.
In preparation for NHS England (Merseyside) responsibilities from April 2013 a single process to support appraisal and revalidation across Merseyside has been developed.

New governance processes have also been introduced locally to ensure appropriate oversight of the Performers List and compliance with NHS (Performers List) Regulations which includes the establishment of a Performance Steering Group (PSG) and Performers List Decision Panel (PLDP) which will be responsible for primary care contractors.

Section 9.

Healthier Together – Public Service Reform

Key Issues & Deliverables

- NHS England (Merseyside) recognises the current opportunity to develop new commissioning practices with partner agencies
- New APMS Contract will be implemented across Liverpool and Sefton localities saving £1.5M whilst improving service quality
- Further localised QIPP savings to be identified and developed within the current financial year
- Qualitative descriptions of QIPP, within direct commissioning functions, are fully outlined within Appendix 6 of this document
- NHS England (Merseyside) will baseline service quality within the current financial year to ensure performance can be measured
- Risks relating to direct commissioning functions have been recorded within a localised risk register and outlined within this current section

9.1 QIPP Development 2013/14

NHS England (Merseyside) recognises that commissioning on a Merseyside footprint, but as part of a national organisation with a single operating model, provides a real opportunity to develop an integrated commissioning template, where both the Public Health and Primary Care commissioning agendas form part of an overarching approach to improving the health and wellbeing of the Merseyside population.

2013/14 will see the benefits of the implementation of a new APMS contract procurement across Liverpool and Sefton localities. In addition to service quality benefits, this will generate recurrent financial savings of £1.5m. The Operating Framework and associated financial planning guidance requires the delivery of a 4% efficiency saving on acute and community provider contracts. In 2013/14 application of this efficiency equates to £1.9m. During 2013-14 further QIPP intentions will be worked up in to robust plans delivering further quality and efficiency benefits in future years.

In addition to this, the Merseyside Area Team recognises the real opportunity to identify and tackle performance issues with providers and address unwanted variation in a consistent and robust way. The new commissioning landscape provides an opportunity to consider recommissioning some services on a bigger footprint where this makes sense to do so (e.g. Child Health Information Systems (CHIS)) and

whilst in their early stages, some initial discussions have already begun in relation to this.

As stated earlier, the Public Health commissioning landscape is complex with a range of commissioners and providers involved. The new architecture provides the opportunity to look at different models of delivery e.g. some vaccination programmes in Merseyside are provided almost exclusively in primary care, some are provided by community provider's services and some use a combination of the two. Commissioning across a larger footprint provides the opportunity to examine performance within and between areas using different delivery models. Whilst ensuring that maintaining delivery of high quality and high performing programmes must remain paramount, this does provide an opportunity with other commissioners and key stakeholders to look at rationalising and redesigning services which could lead to real efficiency savings.

For further detail on how the Area Teams work contributes to the QIPP agenda please refer to Appendix 6 for the descriptive templates per directorate.

9.2 Financial Planning

Please refer back to Section 3 to review financial landscape and overview for further detail on financial assumptions, tariffs and risk.

9.3 Operational Risks and Mitigation

NHS England (Merseyside) has undergone a process of scoping and identifying what its responsibilities are with regards to delivery across the health economy within 2013-14 and beyond. In line with this, several key risks have been identified as being prominent within the process of delivery. The below table (table 1) outlines some of the key risks identified by the organisation (by Directorate) , how they are rated with regards to likelihood of occurrence, impact and how these could possibly be mitigated across the board. It must be remembered that this register remains a live and evolving document that will subsequently change throughout the process.

Table 1 – Risk Register for Primary Care Operational Delivery – 2013-14

Merseyside PRIMARY CARE RISKS							
Region	**Risk Area**	**Risk Description**	**Likelihood 1-5**	**Impact 1-5**	**Risk Score**	**Recommended Mitigation**	**Responsibility**
Merseyside	Assurance	Lack of clarity with regards destinations of various contracts	3	3	9	Legal advice sought during process.	Head of Primary Care Commissioning
Merseyside	Quality	Failure to develop robust and mutually respectful relationships with CCGs and / or H&WBB	2	4	8	Formal dialogue with all CCG Leaders re primary care strategy has commenced and working arrangements being developed.	Head of Primary Care Commissioning
Merseyside	Quality	Direct commissioning plans not aligned with CCG/other partner intentions	2	4	8	Clear processes and plans for close working and cooperation with all CCGs, LA, PHE, and other stakeholders to develop cohesive plans for the whole health economy.	Head of Primary Care Commissioning
Merseyside	Quality	Failure to secure sufficient funding for clinical advice for the Area Team for dental, pharmacy, optometry	2	4	8	Review financial allocations and buy sessional time for clinical advice in line with available budget.	Head of Primary Care Commissioning
Merseyside	Single Operating Model	Financial allocations and savings assumptions insufficient to meet contractual obligations	4	5	20	Financial allocations being reviewed and compared to expected expenditure built up from baseline.	Head of Primary Care Commissioning

Merseyside	Single Operating Model	Delay and lack of testing of Single Operating Model, Assurance Framework, single performers List, polices, procedures etc.	3	3	9	Primary Care Team Medical and Nursing Directors Team will continue to use, adapt, standardise current policies and systems to create interim Area Team policies and procedures.	Head of Primary Care Commissioning
Merseyside	Single Operating Model	Lack of capacity, skills or experience within PC team to deliver SOM	3	3	9	Matrix working within AT, support from agency and CSU, OD and training for PC team (including SOM training), discussions begun with neighbouring AT about mutual aid, cooperation and system wide projects.	Head of Primary Care Commissioning
Merseyside	Single Operating Model	Failure to ensure clinical leadership or engagement required to deliver LPN	2	4	8	LPNs piloted across all three independent contractor groups, progressing well. Work programmes being developed.	Head of Primary Care Commissioning
Merseyside	Single Operating Model	Break down in relationships with providers / LMC as CCG / PC work to define "core service"	3	4	12	A sympathetic, supportive and cooperative approach will be adopted.	Head of Primary Care Commissioning
Merseyside	Single Operating Model	Lack of clarity regarding support arrangements for primary care eg. Procurement and business intelligence, communications, legal advice, complaints, estates, IT infrastructure	3	3	9	Area Team to continue to use current systems and adapt where necessary on an interim basis until clarity is achieved.	Head of Primary Care Commissioning
Merseyside	Single Operating Model	APMS re-procurements across Area not undertaken.	2	5	10	Area Team to quickly identify all contracts which expire within year and commence, public engagement and procurement process immediately.	Head of Primary Care Commissioning
Merseyside	Securing Excellence Dentistry	Failure to complete contractual negotiations for 2ndry care activity by nationally set timescales.	3	4	12	Robust work program to deliver contractual sign off within the set timescales which includes clinical leadership, management expertise and CSU specialist skills with commissioning and data analyses. Potential to seek support from Specialised Commissioning whilst they negotiate contracts.	Head of Primary Care Commissioning

Merseyside	Securing Excellence Dentistry	Failure to complete dental service review would risk implementation of national dental care pathways.	2	2	4	Established dental team with skills and experience in this area.	Head of Primary Care Commissioning
Merseyside	Securing Excellence Dentistry	Failure to maximise re-procurement opportunities presented by AT commissioning dental services missing opportunity to release funds	2	4	8	Robust program to review services and procure redesigned services which will meet national care pathways delivering service and financial efficiencies.	Head of Primary Care Commissioning
Merseyside	Securing Excellence Dentistry	Failure to undertake re-procurement of community dental services	2	5	10	Area Team to develop specifications and commence procurement process in accordance with agreed timetable.	Head of Primary Care Commissioning
Merseyside	Experience	Failure to engage Patients and Public in Direct Commissioning	4	5	20	This will require robust planning to ensure patient and public engagement is a golden thread through all design, redeisng, commissioning, decommissioning and tendering of services.	Deputy Director of Nursing - Patient Expereince
Merseyside	Quality & Safety	Failure to develop Primary Care Quality Dashboard	3	3	9	Primary Care, Nursing and Medical Directorate working closely to develop dataset as interim solution prior to NHS England Dashboard.	Head of Primary Care Commissioning

Table 2 – Risk Register for Public Health Operational Delivery – 2013-14

Merseyside PUBLIC HEALTH RISKS							
Region	**Risk Area**	**Risk Description**	**Likelihood 1-5**	**Impact 1-5**	**Risk Score**	**Recommended Mitigation**	**Responsibility**
Merseyside	Transition	Programme delivery may be compromised during transition	3	4	12	Establish robust working arrangements between NHSCB Public health team and the embedded PHE team and with CCGs, DsPH and their team and Health and Wellbeing Boards	Head of Public Health Commissioning
Merseyside	Transition	Contracts may not be signed and in place for 13/14	2	4	8	As above	Head of Public Health Commissioning
Merseyside	Transition	Lack of clarity on where AT will secure PH intelligence, BI, comms and Inisght both between now and the end of March and from 1.4.13	4	4	16	Assurance to be given by the Centre on where these corporate functions are to be secured	National team
Merseyside	Transition	Agreement may not be reached on how DsPH will ensure that adequate screening and imms programme plans are in place to protect the population	2	4	8	DsPH, PHE area team and AT agree process moving forward	Head of Public Health Commissioning
Merseyside	Commissioning	Direct Commissoning Arrangements are at an early stage	3	3	9	Further assessment required	Head of Public Health Commissioning
Merseyside	Health Visiting	Allocations not sufficient to fund the required workforce expansion and workforce development to meet the requirements of the new model	4	3	12	Further assessment required	Head of Public Health Commissioning

Merseyside	Health Visiting	Providers not committing to future training requirements	3	3	9	Further assessment required	Head of Public Health Commissioning
Merseyside	Finance	QIPP Plans for PH programmes not sufficiently developed	2	4	8	These will be developed as part of direct commisisoning planning round for 13/14.	Head of Public Health Commissioning
Merseyside	Commissioning	Uptake rates for V&I not met	3	3	9	Robust plans developed and close monitoring and remedial actions	Head of Public Health Commissioning
Merseyside	Commissioning	Immunisation and screening delivery framework operating model not yet implemented	2	3	6	Single operating model implemented	
Merseyside	FNP	Funding allocations not secured going forward	4	3	12	Further assessment required	Head of Public Health Commissioning
Merseyside	CHIS	One local programme with insufficient funding allocation and in transition to the new system with the current system having high likelihood of failure.	4	3	12	Further assessment required	Head of Public Health Commissioning

Section 10.

Declaration of Executive Approval

The Executive Team of NHS England (Merseyside) have been fully engaged and participative throughout the development of this plan and herby authorise it's submission to the Regional and National leads of NHS England.

It has been submitted on the 5th April 2013, in line with the nationally directed submission requirements.

Appendices:

1) Primary Care Plan on a page (Merseyside Area Team)

2) Public Health Plan on a page (Merseyside Area Team)

3) Specialised Commissioning Plan on a page (Cheshire Area Team – Regional Lead)

4) Offender Health Plan on a page (Lancashire Area Team – Regional Lead)

5) Military & Veterans Health Plan on a page (North Yorkshire – Regional Lead)

6) Merseyside Area Team Template Packs

7) Public Health Performance Narrative (Merseyside Cluster Level)

Appendix 1: Primary Care Plan on a Page

Area Team Merseyside Primary Care Programme

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda		Balance between standardisation and local empowerment
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13	Strategic Context and Challenges	QIPP Improvements	Organisational Development
• Deliver Primary Care Strategy in line with out of Hospital Strategy • Support and enable AT, CCGs and LA deliver priorities . • Establish strong relationships and partnership working with providers, Area Team functions, CCGs and H&WBB. • Commission services in a transparent and collaborative way. • Identification and mitigation of transition risks •Support mobilisation of Liverpool and Sefton APMS contract preferred bidder	• Establish relationships with HWBs • Ongoing development effective and supportive relationships with CCGs • Implement guidance on key areas for Primary Care including Performance Assurance Frameworks • Understand AT requirements in relation to Primary Care Data / Intelligence and Business Intel support from CSU • Primary Care Medical workforce and long term planning	• Primary Care Medical APMS realising net saving of £1,5806 •Dental- Community and Acute, application of 4% national efficiency savings totalling £875k •Complete work on PMS/GMS Practices as part of GP Contract 13/14 changes •Premises (developments, reimbursements), estates capacity planning •Patient pathway improvements including quality improvements, improving access initiatives/specific projects. LPNs will support these developments	•Continuous development of relationships with Primary Care (professional bodies included), CCGs and H&WBB. • Independent Provider Group based training. • Cascade training received on the Single Operating Model for relevant AT staff. • Embed systems and procedures across AT and develop lean working practices •Maximise use of AT resources and matrix working •Implement Team work plans and identify PDPs for all staff

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Assurance	• Safe and effective transition of contracts from Merseyside PCTs to NHS CB and mitigation of all risks • Use national and local data and intelligence to drive up outcomes in Primary Care • Consistent Contract and Performance Management of Independent Contractors • Implement single performers list and delivery of GP Revalidation and appraisal	• Improved contract compliance by using assurance frameworks • Clear and concise process for clinicians to join lists; 100% GPs appraised & 33% GPs Revalidated • Process developed between Primary Care / Medical / Nursing in terms of triangulation of complaints/individual performer issues/contract compliance • Develop greater focus on patient outcomes and clinical engagement • Implementation of Francis Report recommendations for Primary Care • Robust governance for safeguarding adults and children in relation to Primary care services	• Implementation of Performance Assurance Frameworks and improved contract compliance • Reduction in variation of the quality and performance of all Merseyside providers and performers against agreed standards • Robust, safe and effective primary care services within Merseyside that are patient focussed • Public engagement in designing, redesigning and reviewing commissioning / de-commissioning of services
Quality	• Continuously improve quality and outcomes of primary care services. • Work with and support CCGs define "core offer" of high quality patient centred primary medical services. • Clinically lead commissioning • Improve access to medical and dental services, including improved availability of primary care services	• Complete stocktake of Primary Care Medical identifying key themes and trends as part of development of quality profiles for practices working with CCGs • Support CCGs in the development of local Quality Improvement Strategies • Develop mechanisms to ensure any trends identified through complaints and appraisals are fed into CCG primary care development forums • Contribute to the Quality Surveillance Group work programme for all PC services	• Improved quality of services, patient experience and focus on outcomes. • Quality built in as overriding principle to commissioning • Robust clinical leadership and engagement delivering greatest outcomes • Improved patient satisfaction with GP & dental access; Increased no of GPs open 7 days per week, increased number of dentists open in the evenings and at weekends, increased of pharmacies open 100 hours. • LPNs that support the commissioning of primary care services
Single Operating Model	• Co-produce a Primary Care Strategy for AT with patients groups CCGs, LAs, providers and local professional committees. • Embed Single Operating Model across AT • Commissioning the 4 new DES's to meet national priorities. • Develop existing LPNs across Dental, Optometry and Pharmacy	• Locally PLAN/SECURE/MONITOR Primary Care services • Offer 4 new DES across Primary Care Medical by June 2013 as part of GP Contract • Implement 13/14 QOF changes in line with GP Contract. • Implement Single operating Model / Single Performers list • Support CCGs in the implementation of GP IT systems and develop assurance processes • Develop LPNS in line with guidance	• A common core offer to patients that is high quality and patient centred • Continuous improvements in health outcomes • Patient engagement / empowerment and clinical leadership visibly driving commissioning • Right balance between standardisation /consistency and local empowerment/flexibility • Commissioning built around PLAN/SECURE/MONITOR
Securing Excellence-Dentistry	• Pilot new NHS Dental contract. • Review and re-procure community, primary care oral surgery and community orthodontic services across AT. • Implement national dental care pathways. • • Effective commissioning of 2ndry care services.	• Continue support for pilot practices. • Transformed service provision • Improved services to patients delivered through standardised care pathways all AT patients working with other ATs where appropriate • Maximised commissioning opportunities. • All Dental contracts reviewed by AT (31.3.14) • Implement new performance framework	• Nationally agreed contract commissioned locally. • Commissioned services to meet needs of patient and practitioners. • Patient satisfaction with access to NHS primary care dentistry shows improvement • Redesigned services which follow established care pathways across AT led by clinicians • Released funding reinvested in dental services via QIPP work in 14/15
FHS	• Safe lift and shift of function to NHS CB • Work with CWW Area Team to review and streamline FHS Services	• Safe transfer of staff • Smaller, efficient service and increased use of technological solutions	• Efficient service provision with no adverse impact on primary care • £1pp financial enve-lope achieved with no adverse impact on services

Appendix 2: Public Health Plan on a Page

Area Team : Merseyside

Public Health Programme

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13

Safe transfer of all services in Section 7A & ensuring continuity of service provision and delivery of nationally agreed targets including:
-Effective commissioning of 0-5 HCP incl. incr no's of Health Visitors (HVs) & Family Nurse Partnership (FNPs)
-Commitment to improving the quality of the CHIS
-Roll out AAA screening
- Improve prison public health services
- Risks to delivery identified & mitigation plans developed
-Benchmark screening and immunisation provision to achieve high level of service across Area Team

Strategic Context and Challenges

Reduce Health Inequalities in all programmes of work and the development of measurable KPIs
-Agree a pace of change with providers during 13/14 to ensure current contracts fit with Section 7A specs
-Ensure robust monitoring & reporting systems, supported by appropriate informatics with access to data at GP and small area level
-Interface with EPPR, particularly in relation to surge capacity
-Develop robust working arrangements with all key partners.
--Avoid duplication & fragmentation of services
-Explore opportunities for joint commissioning arrangements

QIPP Improvements

- Total QIPP savings of £1m applied to PH contracts with acute & community providers as per 4% efficiency saving requirement
Establish quality & financial benchmarking to reduce variation in efficiency & quality of programmes
- Capture all screening activity during 13/14 to support a 14/15 baseline reassessment, trajectories & delivery plans
- Implement the national HV & FNP model to improve short & long term outcomes for vulnerable groups
- Rationalise CHIS contracts to deliver economies of scale and support effective delivery of child PH services
- Maximise benefits of technology to improve patient outcomes
Joint working opportunities within & between ATs & with other commissioners to maximise resources and improve outcomes

Organisational Development

-Establish access routes to PH intelligence, & performance data, comms & insight report
-Develop robust working arrangements with clearly defined roles & responsibilities within & across ATs & with key partners
-Avoid fragmentation through collaborative networks
- Development of a true commissioning "system" across the pathway / services with key partners
-AT to become a recognised PH training centre
-managing significant organisational change
- Establish clinical governance arrangements /management of Serious Incidents/ safeguarding arrangements in partnership with Nursing Directorate

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Immunisation	•Ensure services are delivered in line with the Operating Model and national specifications • Implement new programmes including: childhood flu vaccination, rotavirus vaccination for infants <4 months, shingles programme • Improve and meet targets on uptake for seasonal flu vaccination • Form a coherent immunisation coordination/system management model for 14/15 including robust data collection and analysis to improve uptake, reduce variation in provider performance & reduce health inequalities • Establish ways of working to oversee and manage serious incidents	•Improve performance against targets with a particular focus on <65s with LTC and pregnant women where performance has been poorer •Improved patient outcomes and experience across all programmes • Improved access and overall quality of services delivered • Effective delivery to target populations and hard to reach groups • Implementation of new programmes • Arrangements with providers for managing and responding to vaccine preventable outbreaks reviewed and agreed	•Immunisation uptake rates are amongst the best in the country & the highest quality in term of patient safety & experience • Agreement across all providers to fully meet uptake and quality standards with clear improvements across all programmes during 13/14 and 14/15 • Effective delivery to target populations to reduce variation in uptake and protect individuals and others from avoidable disease • Herd immunity levels achieved or on target to be achieved across all programmes •Systems in place to ensure appropriate response to SI and ID outbreaks
Screening Programmes	• Ensure services are delivered in line with the Operating Model and new national specifications • Establish robust data collection and analysis systems • Reduce variation in provider performance and uptake to improve health inequalities • Establish ways of working to oversee and manage serious incidents • Implement developments to existing programmes and new programmes •Work with CCGs to ensure provider trusts fully implement the Maternity & Child Health Minimum Data Set •Continue roll out of AAA screening •Support preparation to implement Flexible sigmoidoscopy in2013 – 15 •Implement developments in existing or new programmes	• Improved performance against targets and national standards incl. maintenance of cervical cancer result turn around in 2 weeks • Improved quality outcomes including patient outcomes and experience • Single Operating Model embedded • Effective delivery to target populations and hard to reach groups • Implementation of new programmes • Established partnership links between screening and treatment commissioning to improve integrity of pathways •Retinal screening fully delivered to national standards •The antenatal and newborn screening programmes are able to provide accurate performance, quality assurance and failsafe data, which assures safe & effective programmes	• Cancer screening uptake rates are amongst the best in the country with cervical exceeding 80%, breast 70% and bowel 60% • Reduced inequalities in access to screening • Deliver consistent, safe, effective programmes • Effective delivery to target populations to reduce variation in uptake and protect individuals and others from avoidable morbidity and long term ill health •Agreement across all providers to fully meet uptake and quality standards with clear improvements across all programmes during 13 / 14 and 14 / 15 •Flexible sigmoidoscopy fully introduced •Systems in place to ensure appropriate response to SI • Reduced inequalities in cancer survival & a reduction in cancer mortality rates
0-5 years Programme (incl HV & FNP)	• Commission HCP & integrate with related pathways • Implementation of HV and FNP expansion • Improve the quality of CHIS to meet national guidance and consider commissioning across a bigger footprint in partnership with other Ats • Ensure safeguarding responsibilities understood and discharged • Establish clear relationships with HWBBs & Las and assist with the implementation of local strategies	•Improve performance against all targets, particularly in relation to breast-feeding as per locally agreed CQUIN and Quality schedules n the 13/ 14 contract re: both initiation and continuation rates •Improved quality outcomes including patient outcomes and experience • Robust partnerships developed • Increased numbers of qualified health visitors maintained • Full national service offer consistently delivered by all providers • More than 90% of families accessing full offer • Increased access to FNP	• HCP outcomes are amongst the best in the country with improved universal & targeted offers for hard to reach groups • HCP services are of the highest quality in terms of both patient safety and experience • High quality CHIS which meets national requirements • Delivery of Health Visitors and FNP Trajectories •Safe transfer of commissioning responsibility of effective HCP (0-5) to LAs by April 2015
NHSCB and PHE agreements	• Develop common strategies to improve outcomes • Implement Every Contact Counts and develop public health advice service • MOU established for provision of screening and immunisation team • Ensure delivery against commitment under Section 7A agreement	• Robust agreements in place clarifying roles & responsibilities • Screening and immunisations programmes delivered by Area Teamwith an embedded PHE Screening & Imms team. • Clear and consistent strategies are developed between both organisations to improve outcomes	•Improved patient outcomes •Reduced health inequalities •Every Contact Counts delivered

Appendix 3: Specialised Commissioning Plan on a page

Specialised Area Team: Cheshire, Warrington, Wirral

Specialised Services Programme

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13

- *Agree model for vascular access across NW*
- *Secure additional capacity in adult cystic fibrosis services and progress implementation of national CF Peer review in children's services.*
- *Implementation of national Safe and Sustainable recommendations for paediatric cardiac services*
- *Address increasing demand for adult neurosurgery in partnership with CCGs*
- *Secure additional capacity in respiratory services*
- *Implement recommendations of NW Cancer Network Strategy*
- *Address need for radiotherapy in Cumbria*
- *Undertake NW CAMHS tier 4 tender*
- *Progress towards BAPM standards and implementation of the toolkit in neonatal services*

Strategic Context and Challenges

•Single operating model for specialised services
•North West specialised commissioning budget for 2013/14 is estimated at £1.7 billion. Significant risks associated with growth and migrated services.
•Importance of establishing effective commissioning relationships with 32 NW CCGs, 2 clinical senates, 22 HWBs and 40+ providers will be a challenge.
•Building strong working relationships with other directorates within Area Team, across NW, regionally and nationally.
•Develop shared outcomes for addressing quality and service improvement with Programme of Care leads, CRGs and both Strategic Clinical and Operational Delivery Networks.
•Impact of service / system reconfiguration across the North West provider landscape
•Address findings of Winterbourne & Frances 2 Report

QIPP Improvements

•Assumption at heart of the QIPP programme is that getting quality right is both more clinically and cost effective. The SAT will produce a Quality Plan for specialised services.
•Utilisation of national Productivity and Efficiency Framework initiatives
•Significant QIPP opportunities in effective management of early parts of patient pathways particularly centred on vascular, neuroscience and mental health services.
•The SAT, in conjunction with providers, will undertake review of national service specifications / policies / quality dashboards to identify areas for improvement or derogation informed by national team.
•Undertake regional / national procurements to drive down costs of drugs and devices and ensure effective medicines management is in place.

Organisational Development

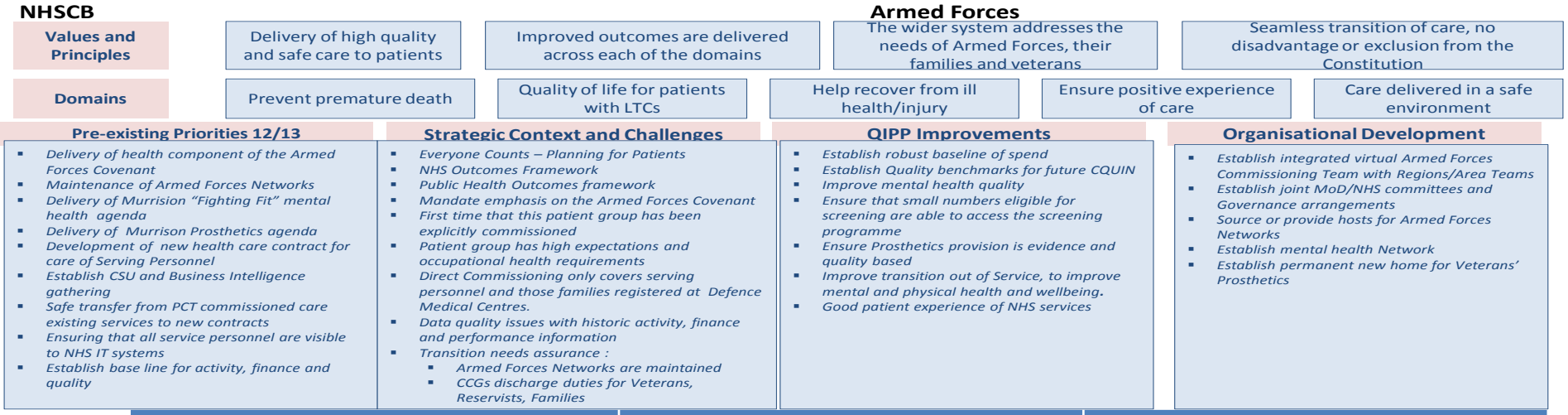
•The SAT aims to be a high performing commissioning organisation with a workforce that has a range of competencies including:
•Expert in assessing need, developing effective relationships, utilisation of evidence in challenging unexplained variations, addressing service improvement and effective contracting across all specialised services.
•A gap analysis against an agreed competency profile will be undertaken and specific training and development secured to address key areas.
•A programme of organisational development across the SAT in conjunction with CCG and CSU colleagues to strengthen partnership working in joint commissioning approaches.
•An evidence based approach to patient / carer engagement and involvement will be developed in partnership with national / local patient groups

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Internal Medicine	1. Promotion of pre-emptive kidney transplantation 2. Implementation of national ACHD recommendations after public consultation 3. Implementation of vascular service model 4. Implement national intestinal failure and HPN framework	1. Increased rates of pre-emptive transplantation undertaken at both NW transplant centres against established baseline. 2. NW implementation plan for ACHD recommendations 3. North West vascular services will be compliant with the national specification 4. Full implementation of the national IF / HPN framework	1. A minimum of 50% of live kidney transplants will be pre-emptive 2. ACHD patients will receive care in line with national best practice. 3. Patients will receive care in the most appropriate vascular service. 4. Patients will receive IF / HPN care at the most appropriate level across pathway
Cancer and Blood	1. IOG compliance for all NHS CB cancer services 2. Implementation of NRAG recommendations for radiotherapy 3. Expansion of PET CT scanning in line with national indications 4. Implementation of new currencies and tariffs for chemotherapy and radiotherapy & national CDF drug list	1. Reconfiguration of surgical / non surgical services to deliver NCAT IOG standards 2. Expansion of IMRT and IGRT capacity in line with national trends. 3. Achievement of a minimum of 1000 scans pmp 4. Reduction in variation of tariff paid and consistency in drug prescribing	1. All patients will receive optimum care and outcomes beyond IOG requirements. 2. Delivery of radiotherapy to 53% of all cancer patients 3. Delivery of optimal reporting for MDTs care planning 4. Consistent national tariffs and drug prescribing in place
Trauma	1. Designation of regional trauma networks and Major Trauma Centres to reduce mortality and improve clinical outcomes. 2. Effective neuro-rehabilitation services 3. Implementation of national service specification for burn care services 4. Develop spinal surgery model and pathway	1. Accreditation of all MTCCs across North West fully compliant with national standards and quality requirements. 2. Utilisation of comparative data including trauma dashboard in agreeing specific actions for development of post acute / neuro-rehabilitation 3. Complete gap analysis and work with North West and North East Area Teams to develop plan to achieve compliance (service configuration of burn care centres and burn care facilities) 4. Progress towards streamlined care across spinal surgery pathway in conjunction with CCGs	1. Significant improvement in clinical outcomes for NW trauma patients 2. Integrated patient centred neuro-rehabilitation services will be in place facilitating streamlined care across each part of the pathway. 3. Clear patient pathways across the network and improved quality of services 4. Spinal surgery services and post rehabilitation in line with national best practice
Women and Children	1. Children's neuroscience networks and epilepsy surgical services 2. Implement recommendations of Children's Rare and Complex brain tumour group	1. a)Effective NW Paediatric neuroscience network established b) Epilepsy surgery provision compliant with national standards 2. The recommendations of the rare and complex brain tumour group will be implemented once published	1. Paediatric neurosurgical patients will flow to the appropriate designated centres in each area. 2. Improved clinical outcomes for children's epilepsy surgery and brain tumours
Mental Health	1. Alignment of policies and practices for high secure services 2. Case management for CAMHs services 3. Continued roll-out of My Shared Pathway and Patient Involvement 4. Offender PD project Development jointly with NOMs	1. Integrated policies and practices for Ashworth Hospital will be in place, compliant with national approach 2. Case management will be in place for NW CAMHS patients 3. My shared pathway will be fully implemented across NW 4. Roll out of national Offender PD work programme	1. Care provided to all patients in Ashworth Hospital will be compliant with national specification. 2. Case management will be used for all CAMHs patients 3. My shared pathway utilisation will be evidenced in showing shared outcomes 4. Review of new Offender PD service infrastructure

Appendix 4: Offender Health Plan on a Page

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
General Prison Healthcare	•Ensure high standards of patient care for commissioned services •Ensure safe care • Drive quality improvement – gaining assurance around the quality of care •Joint working with a range of organisations at a local and national level •Maintain and build the offender health pathway by working with CCG and PHE colleagues •Maintain stability and access high quality health services within all AT prisons. •Review and ensure that all contracts for prison health comply with NHS standard contracts. • Ensure health improvements and value for money in all contracted services	• establish vision and governance arrangements • contribute to the review of guidance into the care and management of those offenders requiring constant observation •More standardised contracts with measurable outcomes. •Drive local improvements on health inequalities for prisoners including older prisoners	• effective offender health strategy in place and being delivered across • quality of offender healthcare services improved • All prison health contracts are compliant with NHS standard contracts. • There are comparable standards of quality and care across all AT area prisons •Prisoners health and social care needs are met
Secondary Care	•Identify secondary care activity •To ensure spend on escort and bed watches is reduced by the effective use of telemedicine and the provision of some prison based clinics.	•Ensure timely and appropriate access to secondary care services according to need. •Reduction in the need for escort and bed watches and subsequent cost •Implementation of more secondary care in-reach provision /telemedicine solutions	• The need for appropriate escort and bed watches is reduced by the implementation of alternative access to services e.g. Telemedicine and prison based clinics. •Activity and spend on secondary care is reduced and replaced with care closer to home.
Substance Misuse	• Ensure high standards of patient care for commissioned services •Ensure safe care • Drive quality improvement – gaining assurance around the quality of care •Joint working with a range of organisations at a local and national level •Maintain and build the offender health pathway by working with CCG and PHE colleagues	• agree co-commissioning arrangements with NOMs/LA • increased cost effectiveness and value for money. •More standardised contracts with measurable outcomes. •Improved integration with primary care and mental health care to enable a seamless transfer into the community settings	• effective offender health substance misuse strategy in place and being delivered • quality of offender substance misuse services improved • Substance misuse contracts compliant with NHS standard contracts. •Comparable standards of quality and care across all prisons
Secure Training Centres	• transfer responsibility for commissioning of health care services in STC from the YJB •Procure NHS equivalent healthcare services in tandem with the YJB	•Develop agreements with YJB in relation to future commissioning •Implement HNA recommendations •Jointly develop public health strategy •Develop partnership Boards and action plans for secure training centres establishments. •Develop and agree Governance framework with partner organisations, in particular the YJB	Successfully procure a federated commissioning model across STC Improve commissioning capability •Improved high quality clinical governance •Improved care pathways
Secure Children's Homes	•Ensure that needs assessments are completed •Effect the transfer of health commissioning to the NHS via Offender Health. •Ensure that services comply with the children's operational framework. •Procure NHS equivalent health care services in SCH's to deliver improved health outcomes for young people	• Develop agreements with LA's in relation to future commissioning framework • Effective on going monitoring of contracts •Implement health needs assessment recommendations	• Transfer of NHS commissioned healthcare completed. •Commission high quality NHS comparable services within secure children's homes •Improved commissioning capability •Improved high quality clinical governance •Improved care pathways
Immigration Removal Centres	• commission services that deliver better outcomes for detainees	Agree co-commissioning arrangements with UKBA Drive local improvements	Comparable standards of quality and care
Sexual Assault Services (* linked to Public Health)	•ensure that SAS are included in the Early Adopter process of transfer of police health care commissioning to the NHS via offender health commissioning. •commission services in line with the agreed service specification and Securing Excellence in Commissioning Sexual assault Services for People who Experience Sexual Violence. •work in partnership in order to achieve the above.	• SAS are an integral component of the partnership agreement to transfer police healthcare commissioning to the NHS. • Support Police Authorities with the tender, procurement and contract award for police healthcare and SARC provision	• Transfer of SARC commissioning to NHS offender health commissioning as a part of the transfer of police health commissioning, in partnership with key agencies and based on NHS standard service specification and contract. •Improves health and reduces inequalities in health care
Liaison & Diversion	• responsible for the commissioning L&D services for courts, PCS, and youth justice to identify and direct offenders with mental health; substance misuse etc away from the criminal justice system into appropriate services and interventions •Commission services that deliver better outcomes for arrestees within the available resource that upholds and promotes the NHS	• Successful Implementation of next phase development in line with agreed new DH funding. •Secure additional resources for project management	• Achieved national roll out across all AT police custody suites and courts against a national service specification and NHS standard contract. •Continuity of care across pathways and back into the community • Offender health needs are known and provided for by appropriate treatment services. • Offenders are diverted from the CJS when appropriate.

Appendix 5: Military and Veteran Health Plan on a page



	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Prosthetics *	▪ Confirm the providers of veterans' prosthetics services ▪ Continuation of the veterans' prosthetics panel to ensure access to high quality components continues	▪ Standard of prosthetics care for veterans' is consistent and improved	▪ Universal and sustainable standard of prosthetic care that can be transferred to the wider NHS as the model of care.
Infertility Treatment	▪ Establish and agree the policy for IVF for serving personnel that covers issues of geographic mobility ▪ Establish and agree the operational model for the provision of IVF for the very seriously injured	▪ Contracts in place ▪ Serving personnel and their families at no disadvantage within IVF care provision	▪ International best practice model for IVF for injured personnel
Armed forces covenant	▪ Embed the principle of No Disadvantage and proper return for sacrifice ▪ Improved access to information about services available to the Armed Forces community	▪ Directory of services for Armed Forces services ▪ Increased coverage of Community Covenants ▪ Inclusion of Armed Forces needs included in JSNA	▪ All areas covered by a Community Covenant ▪ Evidence that Armed Forces health and social care needs are addressed in NHSCB, CCG and HWB planning ▪ Transparent and consistent pathways of care in place
Mental Health	▪ Establish the Veterans' Mental Health network ▪ Ensure services for PTSD are in place ▪ Increase / Improve access to mental health services	▪ Evidence based practice for serving personnel & Veterans' mental health services	▪ Transparent and consistent pathways of care both during and after service
Armed Forces Network	▪ Maintain and improve Armed Forces Network ▪ Armed Forces healthcare and NHS to develop pathways to ensure safe and effective transfer of patients with injury or illness back into the community and care of CCG	▪ Local Armed Forces Network development plans in place ▪ Pathways developed between Armed Forces and NHS to ensure safe transfer back into the community and care of CCG ▪ CCG engagement in and ownership of the Armed Forces Networks	▪ Armed Forces Networks hosted collaboratively by CCGs ▪ Model secures seamless transition from care secured by the NHS CB to care secured by CCGs ▪ Full co-operation between statutory and third sectors to deliver care to the Armed Forces community
Contracting and Operating Procedures	▪ Establish new contracts and baselines for activity, finance and performance for secondary and community health services ▪ Development of clinically appropriate service specifications ▪ Quality of care standards explicit in contracting as CQUINS ▪ Patients experience system in place ▪ Secure Commissioning Support services to build business intelligence	▪ Improved transition between Defence and NHS pathways ▪ Contracts in place to commission secondary and community services ▪ Service specifications revised to reflect model of service ▪ CQUINS agreed with provider and implemented ▪ Patient survey system agreed and running ▪ Commissioning support tendered and in place - tracking patient care across all settings	▪ Integrated pathways between Defence and NHS services ▪ Working towards prime contractor outcome based payment contracts (pilot) ▪ Achievement of CQUINS ▪ Patient satisfaction good to excellent ▪ Business intelligence informing future commissioning

Appendix 6

Area Team Planning

Merseyside Area Team
Commissioning Narrative Pack

Contents Page

Financial Landscape

Nursing Directorate

- Domain 4 – Patient Experience

Medical Directorate

Assurance & Delivery

- CCG Assurance and Delivery

Directorate:	Commissioning Directorate	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-2014	Management Lead:	Tom Knight
Programme Areas:	Primary Care Commissioning (Medical) – Planning, securing and monitoring an agreed set of primary care services. Routine Primary Care Provider contract performance assurance. APMS: Service redesign, procurements and contract monitoring. Working with Clinical Commissioning Groups to drive improvements in the quality of primary care.	Critical Interdependencies:	a) CSU analyst/contract management and procurement support; Health & Well-Being Boards (H&WBB); Medical/Clinical Directors in community Trusts; LMC. b) Significant co-commissioning impacts with Clinical Commissioning Groups (CCG) and with other parts of NHS Commissioning Board (NHSCB) and commissioned providers. c) Link with Emergency Planning and with offender health (prisons).
Key Stakeholders:	Public and Patient Forums, Primary Care Providers, CCGs, HWBs, LPNs, Commissioning Support Unit, PHE	Aspirational Metrics (decided locally):	tbc
Local Metrics:		National Metrics:	NHS Mandate, NHS Outcomes Framework, QOF, NHS Standard

			contract schedules, NHS Constitution
Programme Link to NHS and PH Outcome framework (Specify Domains here):	NHS Framework: domains 1, 2, 3, 4 and 5	NHS Outcome Framework measure (as per attached Mind Map ref):	1.1, 1.2, 1.3, 1.4, 1.5 2.1, 2.2, 2.3, 2.6 3a, 4a I ii iii, 4c, 4.4, 4.9 5a, 5b

Overall Descriptive

NCB Merseyside – Primary Care Commissioning (Medical) team will be responsible for planning, securing and monitoring an agreed set of primary care services as outlined in "Securing Excellence in Primary Care" June 2012. Commissioning activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.

The AT will work in partnership with CCGs to develop transparent and supportive relationships in conjunction with other local networks in planning services which will be measured against national standards, relevant to health and well-being strategies, JSNA's and PNA's. The AT will work closely with and support those CCGs developing initiatives at a locality level and where applicable Local Authorities and the development of integrated provision.

Using the contracting route we will secure services that deliver the best quality and outcomes for patients and we will implement the proposed national assurance measures to monitor, and address any significant variation against the national operating model. Through the NHS Mandate the NHSCB has a responsibility to drive improvements in the quality of primary care and we will work closely with the 6 CCGs who have a duty to support the AT to achieve this.

There will be consistency and fairness in the management of quality and performance and we will engage early, regularly and effectively. One of the aims of the AT will be to ensure that Clinicians spend as much time as possible with Patients
Primary Care Commissioning (Medical) team will also work with the Area Team Medical Directorate to support contract/performance assurance via the performers list and clinical validation.

Crucially, whilst the AT remains accountable for contract management, a co-ordinated practice/CCG/AT/LMC relationship will provide an opportunity for a collaborative discussion across a range of agreed standards. CCGs have a duty to support the AT in driving the quality of Primary Care Medical services and close working at locality level will be critical to this. Triangulation between CCG's (Quality) and AT Medical Directorate in relation to GP Appraisal and Re-validation will provide vital information coupled with Patient Experience can provide a rich picture that will drive improved outcomes for patients.

Draft guidance has now been issued to AT in relation to Performance Assurance and these will be shared with CCGs. There is also "A National Approach to Improve Quality, Access and Patient Experience in Primary Care" due to be issued. These will shape the structures required to facilitate the above.

NHSCB has indicated the assurance approach should be in 5 parts

- The policy
- Guidance to support implementation
- Practice profile (web based)
- Annual Practice E-Declaration
- General Practice High Level indicators' (web enabled)

As outlined in "Tasks and Functions" document June 2012 Primary Care Commissioning (Medical) team will have responsibility for certain functions for example Quality Outcome Framework validation and payment, directly enhanced services etc.

Other mandated responsibilities of the NHSCB AT, including physical payments to contractors, are undergoing change. This includes the replacement of the Quality Management Analysis System (QMAS) with the Calculating Quality Reporting Service (CQRS). The new CQRS system will provide the capability to support other NHS quality related payments such as Directed Enhanced Services (DES).

Responsibility for GP IT systems has been delegated to CCGs with accountability resting with the NHSCB. The AT will work closely with

CCG partners in ensuring the programme is delivered. Connectivity between Primary Care Medial and Secondary Care are a crucial element of transformation and is an area that CCGS and ATs will need to focus on. In 2013/14 the NCB must also consider a number of APMS contracts entering their final year, or having significant planning impacts in 2013/14 due to closure early in 2014/15 FY. There are also a number of key contracts under consideration include the Knowsley Options Service (APMS contract with LCH partnered with UC24 and KIPS), Eldercare and Sherdley MC (2 distinct APMS contracts with Aspect Health Ltd). The patient groups impacted and served by these commissioned services are among the most vulnerable and hard to reach groups. Close working with CCGs where appropriate will be an essential part of the commissioning process given that transformation in Primary Care medical will only be successful if mirrored in Secondary Care. Consideration will be required on planning for the future of these services, whether via contract extension or procurement as required. As well as formalising revised service specifications which consider relevant and related NHS OF domains (All 5 in this case) and the NCBs commitment to securing excellence in primary care, new innovations can and should be included to develop these services further via meaningful input from Public Health Commissioners and LPNs.	
Quality	To support the providers outlined to improve further the quality of services delivered. This can be achieved by taking the opportunity presented by contract closure to revise the KPI and Quality metrics in the related service specifications to include greater consideration of NHS OF domains.
Innovation	To revise or formalise contractually parts of the service through new and innovative ways of working. This would include: **For Knowsley Options**: support for A&E discharge at Whiston, Options GP available for diverts to PC following Whiston Triage team assessment, either to Whiston HCRC or PC Clinic housed or Whiston site subject to agreement. This supplements 6 other GPs linked to CCG A&E support initiative. In a constant drive to improve outcomes, the patient experience and value for money. Revised KPI schedules/contract performance matrix to reflect and incorporate NHS OF domains 1-5, to better drive high quality service for the service user groups. **For Eldercare**: Possible support for, subject to LPN and patients group input, expansion of the service to Halton.

	Consideration of the related patient group in revised contractual quality/performance metrics.
Prevention	Prevents avoidable admissions to A&E, avoids patients being seen in incorrect setting. Vulnerable patients previously unregistered captured by options service 'navigators' and retained by the local primary care system preventing downstream urgent care attendances due to non-management for chronic disease/related LTCs.
Productivity	Savings to be realised through seeing patients in an appropriate (non-urgent) setting. Long term health economy saving via the opportune capture and retention in primary care infrastructure of hard to reach service users (hostel occupiers, homeless, probation service clients). A more robust and challenging range of quality/KPI metrics to ensure enhanced VfM from any re-commissioned/re-procured contracts.

Link to NHS Constitution / Rights

- Choice of GP practice.
- The right for patients to access free of charge, nationally approved screening services that offer high standards of care.
- NHS commitment to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered.
- The right for patients to have informed choice, involvement in their care, respect, consent and confidentiality and not to suffer any discrimination.
- The right for staff to work in a good environment that is safe and offers flexible working opportunities and to be supported in the patient care they provide.
- The right to access services within maximum waiting times - access to a primary care professional within 24 hours or a primary care doctor within 48 hours.

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Directorate:	Commissioning Directorate	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-2014	Management Lead:	Tom Knight
Programme Areas:	Primary Care Commissioning (Medical) – Planning, securing and monitoring an agreed set of primary care services Routine Primary Care Provider contract performance assurance APMS: Service redesign, procurements and contract monitoring. Working with Clinical Commissioning Groups to drive improvements in the quality of primary care.	Critical Interdependencies:	a)CSU analyst/contract management and procurement support; Health & Well-Being Boards (H&WBB); Medical/Clinical Directors in community Trusts. LMC b) Significant co-commissioning impacts with Clinical Commissioning Groups (CCG) and with other parts of NHS Commissioning Board (NHSCB) and commissioned providers c) Link with Emergency Planning and with offender health (prisons)
Key Stakeholders:	Public and Patient Forums, Primary Care Providers, CCGs, HWBs, LPNs, Commissioning Support Unit, PHE	Aspirational Metrics (decided locally):	TBC

Local Metrics:		National Metrics:	NHS Mandate, NHS Outcomes Framework, QOF, NHS Standard contract schedules, NHS Constitution
Programme Link to NHS and PH Outcome framework (Specify Domains here):	NHS Framework: domains 1, 2, 3, 4 and 5	NHS Outcome Framework measure (as per attached Mind Map ref):	1.1, 1.2, 1.3, 1.4, 1.5 2.1, 2.2, 2.3, 2.6 3a, 4a I ii iii, 4c, 4.4, 4.9 5a, 5b

Overall Descriptive

NCB Merseyside – Primary Care Commissioning (Medical) team will be responsible for planning, securing and monitoring an agreed set of primary care services as outlined in "Securing Excellence in Primary Care" June 2012. Commissioning activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.

The AT will work in partnership with CCGs to develop transparent and supportive relationships in conjunction with other local networks in planning services which will be measured against national standards, relevant to health and well-being strategies, JSNA's and PNA's. The AT will work closely with and support those CCGs developing initiatives at a locality level and where applicable Local Authorities and the development of integrated provision.

Using the contracting route we will secure services that deliver the best quality and outcomes for patients and we will implement the proposed national assurance measures to monitor, and address any significant variation against the national operating model. Through the NHS Mandate the NHSCB has a responsibility to drive improvements in the quality of primary care and we will work closely with the 6 CCGs who have a duty to support the AT to achieve this.

There will be consistency and fairness in the management of quality and performance and we will engage early, regularly and effectively. One of the aims of the AT will be to ensure that Clinicians spend as much time as possible with Patients
Primary Care Commissioning (Medical) team will also work with the Area Team Medical Directorate to support contract/performance assurance via the performers list and clinical validation.

Crucially, whilst the AT remains accountable for contract management, a co-ordinated practice/CCG/AT/LMC relationship will provide an opportunity for a collaborative discussion across a range of agreed standards. CCGs have a duty to support the AT in driving the quality of Primary Care Medical services and close working at locality level will be critical to this. Triangulation between CCG's (Quality) and AT Medical Directorate in relation to GP Appraisal and Re-validation will provide vital information coupled with Patient Experience can provide a rich picture that will drive improved outcomes for patients.

Draft guidance has now been issued to AT in relation to Performance Assurance and these will be shared with CCGs. There is also "A National Approach to Improve Quality, Access and Patient Experience in Primary Care" due to be issued. These will shape the structures required to facilitate the above.

NHSCB has indicated the assurance approach should be in 5 parts

- The policy
- Guidance to support implementation
- Practice profile (web based)
- Annual Practice E-Declaration
- General Practice High Level indicators' (web enabled)

As outlined in "Tasks and Functions" document June 2012 Primary Care Commissioning (Medical) team will have responsibility for certain functions for example Quality Outcome Framework validation and payment, directly enhanced services etc.

Other mandated responsibilities of the NHSCB AT, including physical payments to contractors, are undergoing change. This includes the replacement of the Quality Management Analysis System (QMAS) with the Calculating Quality Reporting Service (CQRS). The new CQRS system will provide the capability to support other NHS quality related payments such as Directed Enhanced Services (DES).

Responsibility for GP IT systems has been delegated to CCGs with accountability resting with the NHSCB. The AT will work closely with CCG partners in ensuring the programme is delivered. Connectivity between Primary Care Medial and Secondary Care are a crucial element of transformation and is an area that CCGS and ATs will need to focus on.

In 2013/14 the NCB must also consider a number of APMS contracts entering their final year, or having significant planning impacts in 2013/14 due to closure early in 2014/15 FY. There are also a number of key contracts under consideration include the Knowsley Options Service (APMS contract with LCH partnered with UC24 and KIPS), Eldercare and Sherdley MC (2 distinct APMS contracts with Aspect Health Ltd). The patient groups impacted and served by these commissioned services are among the most vulnerable and hard to reach groups. Close working with CCGs where appropriate will be an essential part of the commissioning process given that transformation in Primary Care medical will only be successful if mirrored in Secondary Care.

Consideration will be required on planning for the future of these services, whether via contract extension or procurement as required. As well as formalising revised service specifications which consider relevant and related NHS OF domains (All 5 in this case) and the NCBs commitment to securing excellence in primary care, new innovations can and should be included to develop these services further via meaningful input from Public Health Commissioners and LPNs.

In the first year

Quality	To support the providers outlined to improve further the quality of services delivered. This can be achieved by taking the opportunity presented by contract closure to revise the KPI and Quality metrics in the related service specifications to include greater consideration of NHS OF domains.
Innovation	To revise or formalise contractually parts of the service through new and innovative ways of working. This would include: **For Knowsley Options**: support for A&E discharge at Whiston, Options GP available for diverts to PC following Whiston Triage team assessment, either to Whiston HCRC or PC Clinic housed or Whiston site subject to agreement. This supplements 6 other GPs linked to CCG A&E support initiative. in a constant drive to improve outcomes, the patient experience and value for money. Revised KPI schedules/contract performance matrix to reflect and incorporate NHS OF domains 1-5, to better drive high

	quality service for the service user groups. **For Eldercare**: Possible support for, subject to LPN and patients group input, expansion of the service to Halton. Consideration of the related patient group in revised contractual quality/performance metrics.
Prevention	Prevents avoidable admissions to A&E, avoids patients being seen in incorrect setting. Vulnerable patients previously unregistered captured by options service 'navigators' and retained by the local primary care system preventing downstream urgent care attendances due to non-management for chronic disease/related LTCs.
Productivity	Savings to be realised through seeing patients in an appropriate (non-urgent) setting. Long term health economy saving via the opportune capture and retention in primary care infrastructure of hard to reach service users (hostel occupiers, homeless, probation service clients). A more robust and challenging range of quality/KPI metrics to ensure enhanced VfM from any re-commissioned/re-procured contracts.

Link to NHS Constitution / Rights
❖ Choice of GP practice. ❖ The right for patients to access free of charge, nationally approved screening services that offer high standards of care. ❖ NHS commitment to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered. ❖ The right for patients to have informed choice, involvement in their care, respect, consent and confidentiality and not to suffer any discrimination. ❖ The right for staff to work in a good environment that is safe and offers flexible working opportunities and to be supported in the patient care they provide. ❖ The right to access services within maximum waiting times - access to a primary care professional within 24 hours or a primary care doctor within 48 hours.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	**PLANNING** Review of existing contracts/PC services to include: **PLANNING** - Planning for how incoming CQRS will support better performance management of PC services and delivery of 2013/14 QOF. **SECURING** -Mapping of other contracts facing expiry/commissioning decision in 2013/14.	01.04.13	31.08.13
2.	**SECURING** Engagement with key stakeholders to progress revised service specifications and associated quality/performance indicators for contracts up for extension/re-procurement (commence CSU procurement support if required). **MONITORING** For routine/non-ceasing contracts, commence monthly contractual monitoring processes and feedback to exec team.	01.05.13	30.07.13
3.	**SECURING** Commence contract extension negotiations/procurement processes as required. **MONITORING** Mid-year reviews for major primary care contactors to review in year performance vs. quality requirements.	01.07.13	31.10.13
4.	**SECURING** Finalise service spec/ quality framework redesign	01.11.13	30.11.13

	with stakeholders for contract extension related services. **PLANNING** Review bidder options for services out to procurements if applicable.		

Directorate:	Commissioning Directorate	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-2014	Management Lead:	Tom Knight
Programme Areas:	Primary Care Commissioning (Medical) – -Patient/Public Engagement (with a focus on hard to reach groups) -Stakeholder partnership in patient/carer engagement	Critical Interdependencies:	a)PALS, Healthwatch, Local Authority engagement teams , GP focus groups b) Requirement for co-engagement and /or information sharing with Clinical Commissioning Groups (CCGs), Contracted/Commissioned providers and with other NHSCB ATs AT Nursing and Medical Directorate.
Key Stakeholders:	Public and Patient Forums, Primary Care Providers, CCGs, HWBs, LPNs, Commissioning Support Unit, PHE, PALS, LINKs, LA Engagement Teams	Aspirational Metrics (decided locally):	TBC
Local Metrics:		National Metrics:	NHS Mandate, NHS Outcomes Framework, QOF, NHS Standard contract schedules, NHS Constitution
Programme Link to NHS and PH Outcome framework (Specify Domains	NHS Framework: Domain 4	NHS Outcome Framework measure (as per attached Mind Map	4a I ii iii, 4c, 4.4, 4.9

here):		ref):	

Overall Descriptive

We will work closely with CCGs and other groups to engage patients and the public so that services commissioned are responsive, appropriate and consistent as described in " Securing Excellence in Commissioning Primary Care" June 2012. Patient experiences will be one of the main drivers in primary care commissioning. Patients will be involved the review, re design, procurement and de commissioning of any service.

This will require close matrix working not only with CCGs, Local Authorities and existing engagement groups but also across the Area Team through matrix working with both the Nursing and Medical Directorates.

The basis for this approach is outlined in The NHS Constitution- Everyone Counts: Planning for Patients, which makes clear the requirement for a patient centred approach viewed via 3 inter-related lenses of which Direct Commissioning by the NHSCB is one. Offer 3 within the patient centred, customer focused approach to planning makes clear the need to 'put patients in control and offer them a world class customer service'.

Beyond the creation of an on-going support for mechanisms/forums via which important patient/carer/customer input can be captured, the Merseyside Area Team also commits, where the contracting opportunity arises, to include within contracts revised KPIs on involving patients in decision making impacting of the delivery of care. This will include a particular focus on services delivering care for traditionally hard to reach and vulnerable groups.

Quality	To support co-commissioners and contracted providers to improve further the quality and scope of patient/customer inclusion in planning services. This will be achieved by taking the opportunity presented by contract reviews to revise the KPI and Quality metrics in related service specifications to include greater consideration of NHS OF domain 4 and the requirement s of the rights and pledges set out in the NHS Constitution.
Innovation	To revise or formalise contractually parts of the service agreements with commissioned providers related to patient experience and engagement. To seek to directly engage with patient groups, supported by key stakeholders (PALS, Healthwatch) so the NHSCB not exclusively reliant on devolved contractually defined patient inclusion/engagement or that undertaken by co-commissioners (CCGs, LAs)

Prevention	Prevents avoidable admissions and attendance to A&E,WIC and Local Practice, avoids patients being seen in incorrect setting or at inappropriate times. Vulnerable patients previously unregistered captured and retained by the local primary care system preventing downstream urgent care attendances due to previous inadequate engagement and inclusion in the planning of their care and resultant non-management for chronic disease/related LTCs.
Productivity	Savings to be realised through enhanced patient involvement of service planning and service delivery. Only through patient buy-in to the NHS planned services provided locally can we expect fulfillment of key patient/public responsibilities in supporting the NHS to work effectively as laid down in the NHS Constitution. These include Patients and public responsibility to: • Keep appointments, or cancel within reasonable time • Participate in important public health programmes such as vaccination • Follow the course of treatment agreed • Taking some personal responsibility for good health and well-being Patient and public fulfillment of these responsibilities, which would be greatly supported by more effective and meaningful engagement and involvement in service planning, will has a positive impact on NHS productivity locally.

Link to NHS Constitution / Rights
❖ The right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this. ❖ The right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services. ❖ NHS commitment to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered. ❖ To ensure that services are provided in a clean and safe environment that is fit for purpose based on national best practice. ❖ To continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments. ❖ The right for patients to have informed choice, involvement in their care, respect, consent and confidentiality and not to suffer any discrimination ❖ The NHS pledge to work in partnership with patients, their families, carers and representatives. ❖ The NHS pledge to provide patients with the information they need to influence and scrutinise the planning and delivery of NHS services.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	First attendance/engagement of AT Primary Care Leads at local meetings inclusive of patients/their representatives.	01.05.2013	On going
2.	Mapping of existing patient/public engagement architecture locally, what has been lost/eroded during NHS transition, what remains/continues via contracted providers, co-commissioners, other key patient-focused enterprises and identification of engagements gaps that will need redress if the NHSCB AT is to meet its responsibilities. Reflection of enhanced requirement s for patient involvement/engagement in the routine contractual review.	01.04.13	01.07.13
3.	Inclusion of patient groups in any direct procurement/contract extension/service development decision making and planning which will reach appropriate stage mid FY. Establishment of on-going direct forums for dialogue and engagement between NCB with patient/carer groups as required/identified by initial mapping exercise.	01.07.13	01.11.13

Directorate:	Primary Care	Area Team Executive Lead:	Tony Leo
Planning Period:	March 2013	Management Lead:	Tom Knight
Programme Area:	Community Pharmacy-Operations	Critical Interdependencies:	Interdependent on PNA and CPAF. Links to practitioner performance
Key Stakeholders:	Local representative committees , public involvement,	Aspirational Metrics (decided locally):	Appropriate processes in place for the management of control of entry and other regulatory requirements
Local Metrics:	Applications for pharmacy contracts and variances are dealt with appropriately, PNA recommendations actioned	National Metrics:	Statutory requirements
Programme Link to NHS Outcome framework (Specify Domains here):	N/A	NHS Outcome Framework measure (as per attached Mind Map ref):	N/A

Overall Descriptive	
The Merseyside Area Team will ensure that its obligations under the NHS Pharmaceutical Services Regulations (2012) and the successor regulations (2013) will be met by establishing a group to manage these processes. The NHS CB will have a statutory obligation to administer processes defined under “the pharmacy regulations”. These include but are not limited to: • Ensuring pharmacies are located where they are needed and open when required • Applications for new pharmacies, relocations of existing pharmacies, changes in opening hours • Monitoring of adherence to the regulations by pharmacy contractors • Issuing of breach and remedial notices where appropriate and dealing with poor performance • Management of the pharmaceutical list • Management of the EPS list. In order to achieve the above, the NCB AT will establish a group to undertake these functions to be known as the Pharmacy Operations Group. This group may consist of the head or primary care, contract managers, contract officer and patient representation. The group will be supported by Central Operations Mersey/Cheshire Health Agency. This group may delegate any function to appropriate officers to deal with if they feel competent to make such a decision in order to allow the NCB to meet the tight deadlines imposed by the regulations. All decisions made by this group under the NHS Pharmaceutical Services Regulations are subject to appeal to the secretary of state via the NHS Litigation Authority. Therefore it is imperative that the processes devised meet the requirements of the regulations and any decisions made are in accordance with the policies of the group. • Activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.	
Quality	The operations group will ensure the quality of services commissioned will be in line with recommendations from the PNA. The policies and constitution of the group will ensure decisions are made in a consistent manner
Innovation	A single framework across the area

Prevention	
Productivity	Decision making process streamlined and delegated to most appropriate level in order for strict timescale to be adhered to

Link to NHS Constitution / Rights

You have the right

- to access NHS services. You will not be refused access on unreasonable grounds.to provide convenient, easy access to services.
- to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.
- to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered
- to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Directorate:	Primary care	Area Team Executive Lead:	Tony Leo
Planning Period:	2013-14	Management Lead:	Tom Knight
Programme Area:	Community Pharmacy Assurance Framework (CPAF)(Monitoring of adherence to contractual framework by pharmacies)	Critical Interdependencies:	Medicines management teams of CCGs/Practice staff/CCG complaints required /GPhC to be engaged to ensure both soft and hard intelligence fed into the system
Key Stakeholders:	NCFB, Local Pharmaceutical Committees, Pharmacy Contractors	Aspirational Metrics (decided locally):	All pharmacies to be monitored on a regular basis

Local Metrics:	Monitoring visits undertaken that lead to an improvement in terms of adherence to contractual framework and hence quality.	National Metrics:	Monitoring processes are in place and area team is delivering as required in “Commissioning Excellence in Primary Care”
Programme Link to NHS Outcome framework (Specify Domains here):	5	NHS Outcome Framework measure (as per attached Mind Map ref):	5.4

Overall Descriptive

The Merseyside Area Team will monitor compliance with the community pharmacy contractual framework by community pharmacies. This will help ensure the following:

- All essential and advanced services are delivered to a consistent quality across the region
- The NHS CB has an assurance that the pharmacy is adhering to its contractual obligations in relation to both the services provided and governance arrangements within the pharmacy
- Underperformance is identified at the earliest opportunity in order to protect the patient and ensure value for money
- Organisations seeking to commission services from community pharmacies have a degree of confidence that an individual pharmacy will be able to provide that service to the standards required.

The NHS CB will undertake monitoring visits to selected pharmacies on an “as and when required basis” e.g. in response to serious complaints or a number of minor issues. During the visit the pharmacy will be required to demonstrate how they are meeting their contractual obligations against a series of indicators defined in The NHS Pharmaceutical Services Regulations (2012).

Where poor compliance is identified the pharmacy will be given the opportunity to rectify the situation. If not undertaken within an agreed time period then a formal remedial notice may be issued. This will require the remedial action to be undertaken within a period specified by the NHS CB. If insufficient progress is made then a financial levy against the pharmacy can be applied. Breach notices can be issued and ultimately the contract can be removed if remedial action is not taken.

The NHS CB will also require pharmacies to supply any information required in order to determine compliance with the contractual framework e.g. details of any investigations they have undertaken, learning actions etc. in response to patient complaints. This is in addition to information that pharmacies are required to supply on a regular basis as part of their terms of service e.g. Patient Satisfaction Survey, Complaints Logs etc.
This process will allow the NHS CB to ensure performance management requirements are met in regard to Patient Experience, Duty to Consult, and the wider responsibility of endorsing Quality Accounts with providers.

Quality	CPAF drives up quality by identifying areas of weakness with a pharmacy and requiring improvements to be made. There are multiple links to the NHS Constitution and The NHS Outcomes framework – domain 5.
Innovation	A consistent approach across the region will help harmonise standards.
Prevention	Pharmacies that are compliant with the contractual framework are less likely to make errors. When errors are made the NCB will have confidence that appropriate action is taken and learning is shared.
Productivity	If CPAF is adhered to the pharmacy is less likely to have complaints and hence can use time in the way intended i.e. delivering high quality services to patients.

Link to NHS Constitution / Rights

- You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.
- You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide.
- The NHS also commits: to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice
- You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.
- The NHS also commits: to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment.

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)			
Directorate:	Primary Care	Area Team Executive Lead:	Tony Leo
Planning Period:	2013-14	Management Lead:	Tom Knight
Programme Area:	Community Pharmacy- Pharmacy Needs Assessment	Critical Interdependencies:	Links to control of entry and commissioning of services Statutory function of HWB/LA
Key Stakeholders:	Public and Patient Forums, Providers, CCGs, HWBs, Local Authority, local representative committees	Aspirational Metrics (decided locally):	Publication of Pharmacy Needs Assessment in each of the LA's across Merseyside
Local Metrics:	Publication of Pharmacy Needs Assessment in each of the LA's across Merseyside	National Metrics:	Publication of Pharmacy Needs Assessment in each of the LA's across Merseyside
Programme Link to NHS Outcome framework (Specify Domains here):	Kinked to domain 1,2,4,5	NHS Outcome Framework measure (as per attached Mind Map ref):	1.1-1.4, 2.,1,2.3,4.4,4.6,5.4

Overall Descriptive
The Merseyside Area Team will be working with the Health and Well Being Boards to assist them in their statutory obligation in relation to the development of a pharmacy needs assessment. This document will underpin the management of the community pharmacy contract, commissioning of pharmacies, pharmacy enhanced services, opening hours etc. It will help ensure that community pharmacy makes a significant contribution to the care of patients and is integrated into primary care. It will inform the commissioning of services by the CCGs and LAs. Initially the HWB boards will need to be briefed to ensure they are aware of their obligations in relation to the PNA, including content requirements, development processes, timeframes, etc. It is imperative that the HWB allocates sufficient resources to this project. Failure to publish a PNA which has been developed in accordance with the regulations may lead to an over or under provision of pharmacies. Either of which will be detrimental to patient care. Strong governance structures are required to ensure the PNA is developed on a collaborative basis, thus reducing the risk of challenge and judicial review. This can be achieved be achieved by Establishment of • an oversight group consisting of appropriate membership with sufficient expertise to ensure the PNA is developed appropriately. This may consist of a pharmacy lead, public heath consultant, public heath analyst, lay representative, CCG representative, Local Pharmaceutical Committee representative, Local Medical Committee representative, NHS CB primary care representative, etc. This group will ensure all stakeholders are represented and have the opportunity fully contribute to the process. They will also be responsible for two way communication between the working group and the organisation which they represent. • a working group to undertake the development work. This group may consist of any of the above members where appropriate and may draw on the expertise from within any of the constituent organisations, especially the LAs and CCG. Once a draft PNA has been produced a statutory consultation process must be undertaken> The final PNA must incorporate any responses received or explicitly state why this has not been done, e.g. the response is not evidence based, is malicious etc. This will

ensure the PNA is developed in a transparent, collaborative and robust manner and will withstand any challenge. The PNA will be published via the LA website and other relevant communication channels.	
Quality	The PNA will help ensure the NCB/LA/CCGs can commission services from pharmacies which meet the needs of the local population. It will ensure pharmacies are located where they are needed and are open when required.
Innovation	
Prevention	
Productivity	The PNA will ensure services are commissioned where they are needed, without duplication
Link to NHS Constitution / Rights	
❖ to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary. ❖ to provide convenient, easy access to services. ❖ to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered. ❖ to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	
Risk and Issues	
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)	

Directorate:	Primary Care	Area Team Executive Lead:	Tony Leo
Planning Period:	2013-14	Management Lead:	Tom Knight
Programme Area:	Electronic Transfer of prescriptions -release 2- EPS2	Critical Interdependencies:	National QIPP but reliant on CCG and GP engagement.
Key Stakeholders:	CCGs/ NHS CB/ North Mersey HIS/ Halton/St Helens/Knowsley HIS/Local Pharmaceutical and Medical Committees/community pharmacies/GP practices	Aspirational Metrics (decided locally):	EPS2 service available in all pharmacies and GP practices across Merseyside
Local Metrics:	EPS2 available in 90% pharmacies and GP surgeries across Merseyside	National Metrics:	EPS2 available in majority of GP and pharmacies
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 4 but reliant on outputs from Domains 1, 2, 3 and 5.	NHS Outcome Framework measure (as per attached Mind Map ref):	2.1, 4.4, 5.4

Overall Descriptive	
The Merseyside Area Team will be working to roll out the EPS2 service. This will allow GPs to send prescriptions electronically to pharmacies nominated by patients. It will dramatically reduce the need to issue paper prescriptions. GPs will be able to authorise monthly supplies of medication on a yearly basis at the click of a mouse. They will be able to determine if the medication has been dispensed by the pharmacy. The pharmacy will receive payment more efficiently from the NHS BSA. Changes in treatment can be actioned immediately and unissued prescriptions cancelled at the touch of a button. Patients will find the service more user friendly and will not have to request medication from the surgery every month. CCGs will need to ensure members are supported through this process. The HIS's will ensure GP clinical systems are ready to utilise this service. Medicines management teams will need to be engaged to ensure the change process does not impact on patient care and to assist in the transition. The NHS CB will provide oversight of the project and that policies and procedures are consistent across the region. The NCB will support the RA function in terms of policy setting and sponsorship models. A Mersey wide EPS2 board has been established to facilitate roll out and provide oversight. This will require representation from CCGs/Medicines Management /The HIS's/ NCB. Sufficient resources will need to be made available as part of the process to cover ad hoc expenses such as venue hire, printing costs etc. Roll out of EPS2 is considered to be a national QIPP priority in that it greatly reduces waste, improves safety by reducing errors, is innovative in nature and will improve productivity. • Commissioning activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.	
Quality	Improved process that reduce workload at surgery, pharmacy and NHS BSA as well as being more convenient for the patient

Innovation	The introduction of a paper light process which transmission of the prescription to the pharmacy is almost instantaneous
Prevention	GPs will be able to determine if medication has been provided by the pharmacy- this will give an indication on patient compliance. Errors in prescribing will be reduced
Productivity	Reduced workload at GP/Pharmacy level. Pharmacies will be able to better manage work flows- prescriptions can be downloaded before patients arrive at pharmacy. GPs will not be required to sign individual prescriptions. They will be able to authorise monthly supplies for a year with one mouse click.

Link to NHS Constitution / Rights

- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
- Supporting staff providing the care.
- Examining how information is used and protected.
- to provide convenient, easy access to services.

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Directorate:	Commissioning Directorate	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14 (if different please specify)	Management Lead:	Tom Knight
Programme Area:	NHS Community Dental Services	Critical Interdependencies:	National Dental Commissioning Steering Group CSU procurement support; Health & Well-Being Boards (H&WBB); Clinical Directors in Community Trusts Link with Emergency Planning and with offender health (prisons)
Key Stakeholders:	LDN, Public and Patient Forums, Dental Hospital Primary Care Providers, Public Health England, Local Authorities	Aspirational Metrics (decided locally):	Better value for money Providers achieving contracted activity appropriately
Local Metrics:	UDA achievement Patients with special care requirements able to access services	National Metrics:	
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 4 with elements of Domain 5.	NHS Outcome Framework measure (as per attached Mind Map ref):	4.10, 4.11, 4.12 5.1, 5.6,

Overall Descriptive
There are currently two providers of Salaried/Community Dental Services across Merseyside; Liverpool Community Health and Bridgewater. Both providers commenced with their current contractual arrangements in April 2011, these were both 3 year contracts running until 31st March 2014. This means these providers are entering the final year of their current contracts so are ideally situated for a review. There are KPIs within the existing contracts that still need to be achieved. Regular contract reviews with the providers will ensure progress continues. **A decision is required whether to**: 1. Tender these contracts or extend for a period of 12 months whilst detailed plans are put in place. This will also enable due notice to be given to the termination of any aspects of the existing contracts. 2. Procure the contracts as they currently exist or as individual elements – e.g. DAC/OOH; Special Care Dentistry, with consideration given to wider/equal access to services +/- providers. 3. Unify these contracts (there are some minor differences in content) and procure across Merseyside. **Key points:** a. The contracts predominantly deal with Children and also Children / Adults with Learning Disabilities; Special Care Dentistry; Dental Access Centres; Out Of Hours Provision; GA Services for Children. These patient groups need additional care, skills and attention that are not routinely available within general dental practices. Further work is required to map patient catchments and ease of access to the existing services. b. Services within these contracts are those which patients are referred to, they do not have direct patient access. c. It is expected that National Care Pathways will be developed for implementation within these service areas within 2013/14. d. Procurement capacity within the AT and local CSU is currently under-resourced. **Recommendation:** Extend the existing contracts to enable the local adoption/procurement of the new nationally developed patient pathway service specifications (when available) thereby avoiding any duplication of work/negotiations and enable service mapping and procurement capacity to be made available to support this initiative. Continue to performance manage existing providers to ensure improvements continue to be made.

Quality	Ensure quality for Special Care Dentistry is the same across Merseyside. Improve access to urgent care across Merseyside and have a unified service model with relevant KPIs.
Innovation	When re-commissioning services such as Dental Access Centre or Out Of Hours service provision, alternative providers and venues will be considered.
Prevention	N/a. Due to the groups treated within the Community Service links to prevention are limited. Patients are referred into this service for specific treatments/procedures.
Productivity	By commissioning services within appropriate settings it will improve efficiency and productivity.
Link to NHS Constitution / Rights	
❖ The right to Access NHS Services. ❖ The right to expect local NHS to assess the health requirements of the local community. ❖ The right to expect the local NHS to monitor and make efforts to improve the quality of services. ❖ The right to not be discriminated against.	
Risk and Issues	
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)	

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	Review of existing contracts: Map provision within existing contracts Decide whether to re-procure or extend contracts Determine support available from CSU Regular meetings with providers.	01.04.13 01.04.13	31.04.13 31.03.14
2.	Engagement with key stakeholders to progress revised service specifications and associated quality/performance indicators for contracts up for extension/re-procurement Inform existing providers of decision to extend/re-procure Advertise services/contracts available.	01.05.13	30.06.13
3.	Commence contract extension negotiations/procurement processes as required.	01.07.13	31.10.13
4.	Finalise service spec/ quality framework redesign with stakeholders for contract extension related services Review bidder options for services out to procurement if applicable.	01.11.13	30.11.13
5.	Appoint preferred provider.	01.01.14	31.01.14
6.	New Service Provision commences (if procured).	01.04.14	TBA

Directorate:	Commissioning Directorate	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14 (if different please specify)	Management Lead:	Tom Knight
Programme Area:	NHS Dental Services Secondary Care Dentistry Community Dental Services Prison Dental Services	Critical Interdependencies:	National Dental Commissioning Steering Group CSU procurement support; Health & Well-Being Boards (H&WBB); Clinical Directors in Community Trusts and Acute Trusts Link with Emergency Planning and with offender health (prisons)
Key Stakeholders:	LDN, Public and Patient Forums, Dental Hospital Primary Care Providers, Public Health England, Local Authorities, Public Health Commissioning, Area Team finance, Patient Experience team, LETB	Aspirational Metrics (decided locally):	Better value for money Providers achieving contracted activity appropriately (metrics to be further defined)
Local Metrics:	UDA achievement Children receiving fluoride varnish applications Patients accessing services	National Metrics:	Access to Dental Services using number of patients treated in 24 month period UDA Activity/achievement DMFT Rates National Tools to enable consistent care pathways Percentage of patients satisfied with the dentistry that they have received. (Common dataset under development)
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 4 with elements of Domain 5.	NHS Outcome Framework measure (as per attached Mind Map	4.1, 4.2, 4.3, 4.4, 4.5, 4.7, 4.11, 4.12 5.1, 5.6,

		ref):	

Overall Descriptive

NHS Dental Services in Primary, Secondary and Community Care settings need to have robust commissioning and monitoring processes. The monitoring and audit processes will ensure there are improvements in quality, productivity and patient outcomes. Commissioning activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.

Key to the improvement of Dental Services and oral health is the development of the Local Dental Network (LDN). The LDN will provide clinical leadership and guidance on service developments to improve oral health; access to services; implementation of the prevention agenda and the implementation of nationally agreed care pathways. The LDN will be clinically led, working with Consultants in Dental Public Health and Practitioners and where appropriate in partnership with local CCGs.
Consistent and high quality care is required across Merseyside to ensure patients receive care in line with the principles of Securing Excellence in Commissioning Dental Services. There are robust contract monitoring assurance processes in place across Merseyside based on the Department of Health/Primary Care Commissioning Dental Contract Management Handbook. These processes are designed to be flexible to enable their adaptation to any future changes in national policy. As part of the on-going programme of contract monitoring, practices will have to demonstrate they are registered appropriately with the Care Quality Commission (CQC).

Initiatives such as Toothpaste Mail-outs and Fluoride Varnish Programmes are provided in parts of Merseyside and not others. Prevention programmes such as these are pivotal to the improvement of oral health and the improvement of the DMFT for the area in line with the Public Health agenda to reduce tooth decay on children under 5years old. The toothpaste mail out programme will be rolled out across Merseyside and the age bands standardised before this is transferred to the Local Authority and payment for the varnish programmes will be standardised.

Presently Primary Care Dental Services are commissioned Monday to Friday generally between the hours of 9am and 5pm. However, there are a number of providers with access times outside this. Evenings and weekend services are currently provided by the Out of Hours Provider. There are different models of in-hours access and out of hours access for urgent treatment across Merseyside and unifying this provision is a priority.
Everyone Counts introduces the move towards 7 day access to routine care, including primary and community based services. This will

be the most challenging area of commissioning Dental services, if it is considered essential. National clarification on the appropriateness of this mandate to dental services is to be sought. At present, local demand for such a service is not evidenced in JSNA plans. Without additional resource it is unlikely existing providers of Primary Care Dental Services will open seven days per week. If routine Dental services are to be provided by routine providers across 7days then one possible way to make additional resource available will be to reduce contracts with providers who have chronic under performance and re-commission this with practices that can deliver, but this could be better allocated to services being provided within the existing 9-5pm framework. Progress in this area needs further consideration before being progressed.

Orthodontic waiting times across Merseyside are reaching crisis point, 2 years to assessment is the minimum wait. Via the Orthodontic Engagement Group a piece of work is taking place with the aim of addressing the current situation. An initial document for consultation is being drafted by the local Orthodontic Providers and is to be progressed within 2013/14.

Currently there are two providers of Salaried/Community Dental Services across Merseyside; Bridgewater and Liverpool Community Health. Both these contracts are due for renewal on 1st April 2014. It is recommended that these are both given a 1 year extension to allow the national development of service specifications that can then be adopted by the LDN and locally procured. The AT will also ensure the patient groups affected by these pathways are able to access appropriate care, linking with the patient experience team to ensure appropriate communications and patient input takes place.

Secondary Care Dental Services are primarily provided by the Liverpool Dental Hospital (LDH) which is a relatively small part of the Royal Liverpool Hospital (FT). Working with local CCGs, service provision is being secured within the 2013/14 contract negotiation round. Further collaborative pathway work and robust patient real-time feedback needs to be developed to ensure service provision is appropriate.

An Oral Surgery Research Project is to commence in the Sefton area of Merseyside. The aim is to improve quality of services by identifying inappropriate referrals in the first instance and ensure patients are treated in the appropriate setting. Manchester University are leading the research. The project is to assess the benefits of a referral management system. Patients will be assessed and banded into either: Treat In Primary Care, Treat By Oral Surgeon In Primary Care Setting or Treat in Secondary Care Setting. The 3 secondary care providers are on board with this project (Aintree, Liverpool Dental Hospital and Southport & Ormskirk). The initial phase will gather baseline data from the acute settings to see what currently goes through to the hospitals and then as the project moves forward an assessment of relevant changes to this will be assessed. If additional Oral Surgery is required in a Primary Care Setting this will be funded via PbR savings from inappropriate referrals into secondary care.

Quality	Through robust contract monitoring assurance processes comparing provision across practices to ensure high quality provision is available across Merseyside. Continued use of the Merseyside Contract Monitoring Paperwork (subject to any national templates) will record standardised information. When commissioning additional activity or new services KPIs to enable quality improvement will be included to meet the NHS OF domains. Commissioning for prevention.
Innovation	The development of a robust evidence base for referral management for minor oral surgery will support the implementation of the national pathway and ensure that patients receive care in the most appropriate and cost effective venue.
Prevention	Commissioning toothpaste mail-outs across Merseyside and not just within pockets of the area will enable all children to have access to fluoride toothpaste preventing caries and tooth decay. Weight any future KPIs to prevention and oral health improvement.
Productivity	By improving oral health the need to treat is reduced with the knock on effect of enabling more patients to access services. Savings from General Dental Contracts could be realised if provider under-activity is clawed back and new activity standards agreed.

Link to NHS Constitution / Rights
❖ The right to Access NHS Services. ❖ The right to expect local NHS to assess the health requirements of the local community. ❖ The right to expect the local NHS to monitor and make efforts to improve the quality of services. ❖ The right to not be discriminated against.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Directorate:	Primary care	Area Team Executive Lead:	Tony Leo
Planning Period:	2013-14	Management Lead:	Tom Knight
Programme Area:	Optical Contractor Monitoring	Critical Interdependencies:	Local Optical Committee, CCG complaints to be engaged to ensure both soft and hard intelligence fed into the system, optical contractors, LPN
Key Stakeholders:	NCFB, Local Optical Committees, Optical Contractors	Aspirational Metrics (decided locally):	All pharmacies to be monitored on a regular basis
Local Metrics:	Monitoring visits undertaken that lead to an improvement in terms of adherence to contractual framework and hence quality.	National Metrics:	Monitoring processes are in place and area team is delivering as required in “Commissioning Excellence in Primary Care”
Programme Link to NHS Outcome framework (Specify Domains here):	5	NHS Outcome Framework measure (as per attached Mind Map ref):	5.4

Overall Descriptive

The Merseyside Area Team will monitor compliance with the optical contract. This will help ensure the following

- Services are delivered to a consistent quality across the region
- The NHS CB has an assurance that the opticians are adhering to its contractual obligations in relation to both the services provided and governance arrangements within the practice.
- Underperformance is identified at the earliest opportunity in order to protect the patient and ensure value for money

- Organisations seeking to commission services from optical practices have a degree of confidence that an individual provider will be able to deliver services to the standards required

The NHS CB will undertake monitoring visits to selected practices on an "as and when required basis" e.g. in response to serious complaints or a number of minor issues. During the visit the practice will be required to demonstrate how they are meeting their contractual obligations against a series of indicators defined in the regulations.

Where poor compliance is identified the practice will be given the opportunity to rectify the situation. If not undertaken within an agreed time period then a formal remedial notice may be issued. This will require the remedial action to be undertaken within a period specified by the NHS CB. If insufficient progress is made then breach notices can be issued and ultimately the contract can be removed if remedial action is not taken.

The NHS CB will also require optical practices to supply any information required in order to determine compliance with the contract e.g. details of any investigations they have undertaken, learning actions etc. in response to patient complaints.

This process will allow the NHS CB to ensure performance management requirements are met in regard to Patient Experience, Duty to Consult, and the wider responsibility of endorsing Quality Accounts with providers.

- Commissioning activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.

Quality	Monitoring drives up quality by identifying areas of weakness with a practice and requiring improvements to be made. There are multiple links to the NHS Constitution and The NHS Outcomes framework – domain 5a
Innovation	A consistent approach across the region will help harmonise standards
Prevention	Practices that are compliant with the contractual requirements are less likely to make errors. When errors are made the NCB will have confidence that appropriate action is taken and learning is shared
Productivity	If contract is adhered to the practice is less likely to have complaints and hence can use time in the way intended i.e. delivering high quality services to patients

Link to NHS Constitution / Rights
❖ You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality. ❖ You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide. ❖ The NHS also commits: to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice ❖ You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure. ❖ The NHS also commits: to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Directorate:	Primary Care	Area Team Executive Lead:	Tony Leo
Planning Period:	2013-14	Management Lead:	Tom Knight
Programme Area:	Local Professional Network (LPN)	Critical Interdependencies:	
Key Stakeholders:	CCGs/ NHS CB/Local Representative Committees/community pharmacies/dentists/Opticians, public	Aspirational Metrics (decided locally):	Functional LPNs contributing to quality improvement of clinical pathways and services redesign
Local Metrics:	LPNs established and contributing to the quality improvement agenda	National Metrics:	LPN established
Programme Link to NHS Outcome framework (Specify Domains here):	Links to all domains 1,2,4,5	NHS Outcome Framework measure (as per attached Mind Map ref):	1.1,1.2,1.3,2.1,2.2,2.3,4a, 4.4,4.6,4.7,5.4,5.6

Overall Descriptive

The Merseyside Area Team will be establishing Local Professional Networks-(LPNs).Three such networks will be established, one for dental, one for pharmacy and one for optical practitioners. These networks will be managed by a clinician who will be employed by the NHS Commissioning Board.

Commissioning activity will focus on the improvement of patient outcomes driven by clinical engagement. Primary Care is a critical part of the health system and the work of the AT is underpinned by the NHS Mandate.

LPNs will operate system-wide and work in partnership with CCGs, where relevant, Health and Wellbeing Boards, Public Health England, patients and the public. They will complement and support the JSNA and PNA processes and local commissioning plans. They will:

- Develop system wide momentum for change and improvement in outcomes
- Support the implementation of national strategy and policy at local level
- Work with other key stakeholders on the development and delivery of local priorities, some of which go beyond the scope of primary care commissioning
- Provide local clinical leadership and, as well as being accountable within local
- Area teams to the Medical Director, there will be a professional line of accountability to the NHSCB's chief professional officers.

LPNs will have three key characteristics:

- A small, clinically-led commissioning team at the core of the network to support the local area team to secure dental, pharmaceutical and optical services
- Opportunities for more clinicians to get involved in service improvements and redesign work through local (and larger) networks and focused projects as the need arises
- Engagement with the wider community of practitioners, practice owners and others involved in providing services.

LPNs will have the following functions in common:

- Support the NHSCB in commissioning these services by providing credible clinical input to decision making, advising on priorities and innovations and contributing expertise to reviews to maximise performance, addressing inequalities, driving continuous improvement to deliver better outcomes.
- Provide clinical leadership and facilitate wider clinical engagement at grass roots, a key principle of the NHSCB. Clinically led local professional networks are probably the best means to do this, as they understand the provider perspective.
- Provide a mechanism for engaging patients, carers and the public.
- Establish solid and productive local commissioning relationships with CCGs, health and wellbeing boards and others to ensure the provision of high quality, appropriate services.
- Advise and work in partnership with the health and wellbeing boards, for example, to deliver improvements in oral and general health and to promote healthy living through initiatives like "making every contact count".
- Support providers by providing a mechanism by which resources and risk can be shared, standards set and different perspectives are heard, in the improvement of local services.

• Feed into other clinical networks. Local area team LPNs will be a potential resource for clinical senates and strategic clinical networks and will provide professional development opportunities for clinicians working with the NHSCB. • Engage with local representative committees (local dental committees, local optical committees and local pharmaceutical committees), and ensure contractors' perspectives are considered in how best to meet the needs of patients.	
Quality	LPNs will improve quality by focusing on activity which will improve patient outcomes by a programme of service redesign and provision of high quality advice to commissioners of services
Innovation	The LPNs will draw on a large pool of talent which has traditionally contained a significant number of innovative clinicians. This will result in innovation
Prevention	The LPNs will contribute to service redesign and improvement of clinical pathways. Their work will contribute to reducing errors, reducing inappropriate hospital admissions etc.
Productivity	Productivity will be improved by simplification of clinical pathways and processes.
Link to NHS Constitution / Rights	
❖ **The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.** ❖ **The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.** ❖ **The NHS aspires to the highest standards of excellence and professionalism.**	
Risk and Issues	
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)	

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14	Management Lead:	Julie Kelly (Manager) Neil Gaye (Lead officer)
Programme Area:	Public Health – Child Health Information System	Critical Interdependencies:	CCG – commissioners of Maternity services and lead commissioners for community contracts. LA – commissioners of CHIS from 2015 and commissioners of Healthy Child Programme 5-19 from 2013, in particular DsPH and their teams. Primary Care providers – Impact on Vaccination & Immunisation Programme. Maternity Services. Community providers.
Key Stakeholders:	Public and Patient Forums, Providers, CCGs, HWBs, LA's, HEE, PHE, Primary care providers, Health Informatics Services, System Suppliers	Aspirational Metrics (decided locally):	None identified currently – further work required.
Local Metrics:	None identified currently – further work required	National Metrics:	Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS Outcome framework (Specify Domains here):	All Domains, as all contain elements that relate to Children's Health	NHS Outcome Framework measure (as per attached Mind Map ref):	1.6,2.3,3.2,3.3,4.4,4.5,4.8,5.5,5.6

Overall Descriptive
CHIS are patient administration systems that provide a clinical record for individual children and support a variety of child health and related activities, including universal services for population health. For example, immunisations and childhood screening as well as support for children with Special Educational Needs (SEND). They are operated at a local level and priority to 2013 commissioned by PCTs. They take a variety of forms from a spreadsheet with manual entry processes to a more advanced database relying on many automated inputs and outputs. From April 2013, NHSCB takes responsibility for ensuring CHIS are commissioned effectively. The long-term location of the service will be considered as part of the transfer of responsibility for children's public health services 0 – 5 to Local Authorities in 2015. It has been identified that there is an inconsistent approach across the country and the NHS CB's single operating model provides the opportunity for consistency in the future. The current CHIS' do not necessarily meet the needs of the various programmes they support and the systems are not necessarily suitable for specialist services, such as community paediatrics. This has led to the production of Information requirements for child health information systems. This document outlines requirements needed for the CHIS and details major milestone to be met by April 2014, *Maintain coverage of local delivery of Child Information Systems, with a plan to implement defined minimum standards as far as possible by April 2014 and encourage future attainment*. The second major milestone being that the system meets the gold standard as set out in the specification by April 2015. The CHIS will need to ensure that all existing information systems and associated support for child health information are able to continue to function during and after transition, including maintaining links with the Personal Child Health Record ('red book') and continuing to exchange data where appropriate with legitimate partners to facilitate the delivery of child health services. The system will need to be resilient going forward and take into account and support future changes to services (e.g. a change to an existing, or introduction of a new, routine immunisation programme). The changes and new services themselves would be clearly described in revisions to and/or new service specifications. The need to work closely with the stakeholders defined above cannot be under-estimated to ensure risks are minimised. On Merseyside there are two CHIS running: HSW (in Liverpool & Sefton) and Paris (in Knowsley, St Helens & Halton). HSW is a dedicated Child Health System, while Paris is an integrated Community System.

The AT will conduct an initial base-lining exercise to scope out the details of the two current CHIS in use in Merseyside with current system managers. It will also work in partnership with the stakeholders detailed earlier to identify current gaps, risks and develop plans to mitigate these, assess what works well and agree a pace of change and delivery plan for CHIS developments in order to ensure it meets the requirements of the new specification and is fit for purpose locally. The AT will establish a stakeholder engagement group that will oversee the development of a realistic and achievable roadmap for progression of the CHIS during 2013/14 to ensure that the first milestone at April 2014 is met and following achievement of this, will then develop plans for progression to "gold standard" during 14/ 15 for safe transfer to Local Authorities in April 2015.	
Quality	Consistent timely information will improve data quality which in turn will enable commissioners to assess performance, address this in a timely manner with providers and thus lead to improved patient outcomes. A gold standard for CHIS across the country to ensure consistency of approach.
Innovation	Develop the CHIS to support a range of Services that have not had access to such information in a consistent format in one location.
Prevention	The information will support a range of health indicators that meet the prevention agenda, including vaccinations and immunisations and will provide intelligence for services that provide support for particularly vulnerable and/ or "at risk" children.
Productivity	A more robust CHIS will assist with improved delivery of the Healthy Child Programme.

Link to NHS Constitution / Rights
❖ Supporting staff providing the care. ❖ Encourage feedback from patients with a more open working culture. ❖ Examining how information is used and protected. ❖ Making every contact count, so that healthcare professionals take every suitable opportunity to talk to patients about improving their health. ❖ You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme. ❖ You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

ID	Task Name	Start	Finish	Duration	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
1	Meet with current system owner/ mangers, to assess current provision.	28/02/2013	12/03/2013	2 Week													
2	Collate information regarding support, hosting arrangements and contracts etc.	12/03/2013	13/03/2013	1 Day													
3	Compare current service with the Specification, perform gap analysis, risk assessment and develop an action plan.	13/03/2013	22/03/2013	1 Week													
4	Ensure risks are minimised or mitigated for 31/03/2013, identify system owners from 2013/14	13/03/2013	29/03/2013	2 Week													
5	Identify budget, costs and where finances will sit in the new system and ensure that they are transferred to the correct budget holders.	22/03/2013	29/03/2012	1 Week													
6	Have robust Contracts and support in place/ continuing to ensure stability and continuity - Identify current provision	22/03/2013	29/03/2012	1 Week													
8	After gap analysis has been performed look to see what developments need to occur to ensure that the system will meet the national specification requirements.	29/03/2013	Apr-13	1 Month?													
7	Where the Specification demands more than current system delivers, identify what changes need to be made, costs, timescales, etc	Apr-13	Apr-13	1 Month?													
9	Identify key stakeholders and set up a stakeholder engagement group to ensure that all intersted parties are involved in devolping the action plan.	May-13	May-13	Ongoing													
10	Work with system providers / Deveolpers and System Managers to ensure that the system will meet the national spec by April 2015 deadline	May-13	Apr-15	Ongoing													
11	Consider future developments such as changes to hosting etc., i.e. Is it appropriate for Community Providers to host this system/service. Should it be in HIS, CSU or NCB?	May-13	?	Ongoing													

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14	Management Lead:	Julie Kelly (Manager) Lara Ashton (Lead officer)
Programme Area:	Public Health – Family Nurse Partnership (FNP)	Critical Interdependencies:	FNP National Unit – hold licence for the programme and will oversee role out of additional FNP places AT Nursing directorate – overlap with increasing HV workforce and also in relation to safeguarding which is at the heart of children's public health CCG – commissioners of Maternity services and lead commissioners for community contracts LA – commissioners of FNP from 2015 and commissioners of Healthy Child Programme 5-19 from 2013, in particular DsPH and their teams Community providers – essential to achieve transformational change
Key Stakeholders:	Public and Patient Forums, Providers, CCGs, HWBs, LA's, HEE, PHE, local Safeguarding forums	Aspirational Metrics (decided locally):	None identified currently – further work required
Local Metrics:	CQUINs - TBC FNP Activity data	National Metrics:	FNP dashboard indicators Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 1 but reliant on outputs from Domains 3, 4 and 5.	NHS Outcome Framework measure (as per attached Mind Map ref):	1.6 (i)(ii), 3.2, 4c, 5.6

Overall Descriptive			
The Family Nurse Partnership programme (FNP) is an evidence-based, preventive programme for vulnerable first time young mothers. FNP is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to. Structured home visits, delivered by specially trained family nurses are offered by the programme from early pregnancy until the child is two. Participation in the FNP programme is voluntary. When a mother joins the FNP programme, the Healthy Child Programme is delivered by the family nurse instead of health visitors. The Family Nurse Partnership programme is the 'targeted' offer within the 0-5 Healthy Child Programme pathway, and as such close synergy's exist between FNP and universal health visiting services and furthermore the *HV Implementation Plan; A Call to Action 2011-15.* FNP has a strong body of research evidence developed over 30 years in the USA with evidence reviews consistently identifying it as the most effective preventive early childhood programme for improving the health and development of vulnerable young mothers and their children. FNP has been tested in England since 2007; an independent evaluation of the first 10 pilot sites showed FNP could be implemented well in England, in accordance with the programme model and in the context of the NHS. A large scale randomised control trial to assess the programme's effectiveness in an English context is underway and due to report initially in early 2014. The FNP programme works with the mother as well as the father and wider family to understand their baby, make changes to their behaviour, increase their parenting capacity, develop emotionally and build positive relationships, with the overall aim to reduce inequalities in pregnancy outcomes, child health and development and parents' economic self-sufficiency. Currently, Merseyside has two existing FNP sites; one in Liverpool and one in Knowsley. This is beneficial as there will be a huge amount of experience and learning which can be drawn from these pilot sites to inform the FNP expansion plan over the next two years and ensure a sustainable approach is developed. In 2013/14 and 2014/15 the NHS Commissioning Board has responsibility for commissioning public health services for children under 5, and the Family Nurse Partnership programme expansion commitment falls within this area. The NHS Commissioning Board will be responsible for commissioning providers to deliver the FNP programme and delivering the commitment to increase the number of FNP places available to at least 13,000 places. The FNP National Unit has confirmed that existing FNP sites will be centrally funded and that this will be recurrent. Currently, it is the understanding that from April 2015 this FNP funding will transfer into LA Public Health. In		

addition, NHS CB Area Teams will receive funding centrally to resource the FNP expansion so the target of 13,000 places by 2015 can be achieved. This funding will also be recurrent and transfer to LA public Health in 2015. The additional funding will be used to commission new FNP sites or to expand existing sites in line with an agreed expansion strategy between the DH and the NHS CB. At the time of writing this narrative, work is underway with the FNP National Unit to understand what proportion of the additional 13,000 places and associated funding the Merseyside Area Team will receive. It is expected that by the end of March 2013 Merseyside Area Team will have a clear picture of what this actually translates to locally in terms of financial resource. In addition, further National Guidance on FNP expansion is expected during March 2013. At which point, more detailed implementation plans will be developed in order to deliver this commitment to the Merseyside population by 2015. It will be essential to work in close partnership with a number of key stakeholders to ensure the successful expansion of Family Nurse Partnership; the following stakeholders have been identified. Patient and Public forums will be an important mechanism in understand the 'appetite' for the Family Nurse Partnership locally, and will build upon the wealth of feedback which has already been gained from client's who have been supported by existing FNP sites in Merseyside. Clinical Commissioning Groups as lead commissioners of Maternity services will be an important partner, to improve the quality of existing and future FNP sites e.g. through improving patient information transfers to FNP services which will support the improvement of timely uptake to the FNP programme. From April 2015, Family Nurse Partnership is expected to transfer to Local Authorities; therefore it is essential that Public Health colleagues are engaged with the planning from the outset to agree a shared vision. Finally, it will be important to feed the learning from our existing community providers of FNP into the plans to expand FNP locally to ensure we make best use of existing resources whilst maintaining the fidelity of the FNP programme.	
Quality	The Department's commitment to expand FNP will improve quality of service delivery in the early years by increasing specialist expertise across Merseyside's early year workforce, and provides an opportunity to strengthen the sharing of evidence based tools and approaches into universal health visiting services. A combination of both FNP client feedback and making use of Patient and Public Forums will support the FNP programme to further build on and improve the quality of the service offered in line with Domain 4 of the NHS Outcomes Framework.
Innovation	The expansion of FNP across Merseyside will require close partnership working with Local Authorities and CCGs and innovative planning to ensure that expansion to existing sites and the commissioning of new sites is sustainable into the future and mindful of increasing budget pressures post 2015 once the service moves to the Local Authority. E.g. are there opportunities to commission across a Merseyside footprint, whereas previously this has been done on a locality footprint.
Prevention	The expansion of FNP places across Merseyside will strengthen the targeted offer in the early years across Merseyside by increasing the number of places available to the eligible population. By supporting more first time young mothers, the

	programme should, in turn reduce inequalities in improve outcomes and ensure a strong focus on prevention, health promotion and early identification of needs. Specifically the programme aims to improve outcomes in pregnancy by helping young women improve their ante-natal health and the health of their unborn baby; improve children's subsequent health and development by helping parents to provide more consistent competent care for their children and improve women's life course by planning subsequent pregnancies, finishing their education and finding employment.
Productivity	There are opportunities to improve productivity in the commissioning of FNP from April 2015, with commissioning of the programme moving from two (historic PCTS) to one commissioning body (NHS CB); this may promote more opportunities for joined up approached to training, governance structures and meetings to support the programme.

Link to NHS Constitution / Rights
❖ Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. ❖ Emergency admissions for children with Lower Respiratory Tract Infections (LRTI). ❖ Friends and Family Test. ❖ Right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS provided national immunisation programme. ❖ Making every contact count, so that healthcare professionals take every suitable opportunity to talk to patients about improving their health.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

FNP Delivery Timescales.xlsx

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013/14	Management Lead:	Julie Kelly (Manager) Karen Maughan (Lead officer)
Programme Area:	Public Health: Healthy Child Programme 0-5	Critical Interdependencies:	AT Nursing directorate – overlap with increasing HV workforce who will have key role in delivery of this programme and also in relation to safeguarding which is at the heart of children's public health CCG – commissioners of Maternity services and lead commissioners for community contracts LA – commissioners of Healthy Child Programme 0 – 5 from 2015 and commissioners of Healthy Child Programme 5-19 from 2013, in particular DsPH and their teams Community providers – essential to achieve transformation change
Key Stakeholders:	Public and Patient Forums, Providers, CCGs, HWBs, LA's including social services and early years settings, HEE, PHE, local Safeguarding forums	Aspirational Metrics (decided locally):	None identified currently – further work required
Local Metrics:	CQUINS – Breastfeeding	National Metrics:	Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 1 but reliant on outputs from domains 3, 4 and 5	NHS Outcome Framework measure (as per attached Mind Map ref):	1.6 (i) / (ii), 3.2, 4c, 5.6

Overall Descriptive
Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years has lifelong effects on many aspects of health and well-being, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities through targeted intervention for vulnerable and disadvantaged children and families. The Healthy Child Programme (HCP) is the universal clinical and public health programme for children and families from pregnancy to 19 years of age. Responsibility for commissioning the 5 – 19 element of the programme e.g. school nursing service is the responsibility of Local Authorities from April 2013. In 2013/ 14 and 2014/ 15 the NHSCB will commission public health services for children under 5 including: • The HCP from pregnancy and the first 5 years of life working closely with NHS services such as maternity services, general practice, early years settings and with children's social care • Health promotion and prevention interventions by the multi-professional team • The expansion of transformation of health visiting services and to meet the training and workforce trajectories (please refer to initiative re: Health Visiting) • The Family Nurse Partnership programme to meet the Governments expansion commitment (please refer to initiative re: FNP) • Child Health Information Systems (please refer to initiative re: CHIS) Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims to 'improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest'. Specifically children's public health contributes to: • Health Improvement - Breastfeeding initiation and prevalence at 6-8 weeks after birth (PHOF 2.2) - Child development at 2-2.5 years (PHOF 2.5) - Excess weight in 4 – 5 year olds (PHOF 2.6) - Hospital admissions caused by unintentional and deliberate injuries in under 5s (PHOF 2.7)

    - Access to non-cancer screening programmes (PHOF 2.21) – refer to initiative re: antenatal and newborn screening
- Health Protection
    - Population vaccination coverage (PHOF 3.3).
- Healthcare Public health and preventing premature mortality
    - Infant mortality (PHOF 4.1)
    - Tooth decay in children aged 5 (PHOF 4.2).
- Improving the wider determinants of health
    - School readiness (PHOF 1.2).

Children's public health services operate at a population and individual level with activities taking place to promote children's health within communities as well as with individuals. At a population level commissioners will need a systematic, reliable and consistent process for assessing needs that provides the basis for configuring services and allocating resources including delivering the expansion and transformation of health visiting services, in line with the Government's commitment and ensuring that the new health visitors are effectively supported and deployed. However, not all elements of this programme are delivered by Health Visitors. As a priority, the AT will establish or use existing children's forums to ascertain who, in addition to NHSCB and CCGs, is responsible for commissioning those services that impact on the delivery of the HCP 0-5 programme. The AT will use legacy documents and soft intelligence from current/ previous Children's commissioners to establish who the key providers are against all elements of the HCP programme and establish current performance against targets.

In relation to establishing need, the AT will work closely with PHE who are responsible for providing Public Health intelligence to NHSCB to ensure that assessments are undertaken in partnership with local agencies as part of the Joint Strategic Needs Assessments which will be undertaken by LA Public Health teams.

The Public Health AT will work with the Nursing Directorate to ensure that services commissioned are embedded into local safeguarding arrangements with health and local authorities.

Because the programme is broad and far reaching and involves a plethora of commissioners and providers, priority action will be to establish and make contact with commissioners for all elements of the HCP 0 – 5 pathway and wherever data is available ascertain current performance. Only then can the AT begin to prioritise where action needs to be focussed during 13/ 14 and develop plans to address areas of greatest concern/ risk accordingly.

Quality	The Department's commitment to transform Health Visiting, key deliverers of HCP, will improve quality of service delivery by ensuring there is adequate capacity of Health visitors to meet the needs of children and families across Merseyside. Commissioning the whole HCP 0 – 5 programme across the Mersey footprint not only provides an opportunity to look at differences in current practice and thus identify what works well and commission this on a wider footprint thus driving up quality and improving patient outcomes but also gives the opportunity to focus attention on areas of greatest need
Innovation	The NHSCB service specification for HCP 0 – 5 makes it clear that for the universal elements of the programme, a flexible approach should be taken by commissioners to ensure that services can target specific vulnerable groups or families to deliver suitable packages of support. The AT will encourage provider innovation within the resource envelope agreed
Prevention	Health promotion and prevention are key components of the HCP as detailed earlier. It is well documented that preventative public health interventions in early years can have a significant positive impact on health outcomes not just for children and young people at that stage in their life but throughout the life course.
Productivity	Commissioning evidence based preventative interventions should lead to not only an improvement in health outcomes for children and young people but also a reduction in preventable illnesses and consequently reduce burden on other parts of the health and social care system

Link to NHS Constitution / Rights
❖ You have the right to access services within maximum waiting times." ❖ You have the right to access NHS services. You will not be refused access on unreasonable grounds". ❖ You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental). ❖ to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge); and to continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments.
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

To be developed

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14	Management Lead:	Julie Kelly (Manager) Lara Ashton (Lead officer)
Programme Area:	Public Health: Health Visiting	Critical Interdependencies:	AT Nursing directorate – overlap with increasing HV workforce and also in relation to safeguarding which is at the heart of children's public health CCG – commissioners of Maternity services and lead commissioners for community contracts LA – commissioners of HV from 2015 and commissioners of Healthy Child Programme 5-19 from 2013, in particular DsPH and their teams Community providers – essential to achieve transformation change
Key Stakeholders:	Public and Patient Forums, Providers, CCGs, HWBs, LA's, HEE, PHE, local Safeguarding forums	Aspirational Metrics (decided locally):	None identified currently – further work required
Local Metrics:	CQUINs - TBC HV Activity data	National Metrics:	Health Visitor workforce growth trajectory determined nationally/ NHS North Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 1 but reliant on outputs from Domains 3, 4 and 5.	NHS Outcome Framework measure (as per attached Mind Map ref):	1.6 (i)(ii), 3.2, 4c, 5.6

Overall Descriptive
In 2010, the Department of Health set out their commitment to expand and strengthen health visiting services in *The Health Visitor Implementation Plan 2011 – 2015; A Call to Action.* This was in recognition of overwhelming evidence that the start of life is a crucial time for children and parents in laying the foundations for good health and well-being in later years. Good, well-resourced health visiting services are essential to ensure that families have a positive start, with early intervention to ensure additional support for those who need it by working in partnership with GPs, maternity and other health service such as Children's Centres and other early year's services. Frank Field's Independent Review on Poverty and Life Chances and Graham Allen's Independent Review on Early intervention highlighted the importance of good, joined up support for children and families at the start life. In addition, Health Visitor numbers have been in decline across England and therefore there are insufficient practitioners to offer all families the support they need. The lack of capacity means that health visitors are often unable to perform the wider public health role - working with communities to improve health outcomes. Health Visitors are trained nurses or midwives with specialist training in family and community health and are key to meeting the needs of families. They are skilled at spotting early issues which may develop into problems or risks to the family are not addressed for example a parent struggling to cope or a child health issue which needs special attention. Health Visitors are public health nurses who are trained to work at community, family and individual level and in doing so contribute to improving health outcomes in the early years. The Health Visitors will lead and deliver the Healthy Child Programme 0-5 years(HCP), which is designed to offer a core, evidence based programme of support, starting in pregnancy through the early weeks of life and throughout childhood; at the same time providing or acting as the gateway to other services which families may need. A Call to Action commits to invest in the workforce by expanding the health visitor workforce by an extra 4,200 FTE heath visitors by 2015 and outlines a new service vision, which describes a four level service offer which strengthens and maximises the contribution of health visiting teams and provides a consistent approach to delivering the Healthy Child Programme to all children and families. From April 2013 to March 2015 the NHS Commissioning Board Area Teams will take responsibility for commissioning Health Visiting Services working partnership with the North West Local Education and Training Board to expand the workforce. NHS North of England have set Health Visitor growth trajectory targets covering each financial year up to 2015 for each Area Team, broken down by provider and this will be mechanism by which progress against trajectory targets for each provider are monitored. (Copy of growth figures is embedded below) Commissioners will work closely with the Merseyside Area Team Nursing directorate and Finance

Team to develop robust plans to support Health Visitor growth during 13/14 and 14/15 in line with agreed trajectories. Work is underway to understand progress against these trajectories for each provider and finalise financial plans for providers during 13/14.

Health Visitor Implementation Plan -

The new service model will be delivered through a new service specification, working in partnership with providers and key stakeholders during 2013-14. The new service specification will follow the nationally defined specification *Number 27 Children's public health service (from pregnancy to age 5)*. From April 2013 work will begin to assess provider readiness against the new model and work with the provider to agree a pace of change to move towards the new model of delivery.

The ambition is, to have implemented the new model of health visiting and reached the agreed HV growth trajectories by March 2015 in readiness to hand over to Local Authorities in April 2015.

It will be essential to work in close partnership with a number of key stakeholders to ensure the successful expansion and implementation of the new model of service delivery; the following stakeholders have been identified. Patient and Public forums will support providers to localise the new health visiting model across Merseyside and in doing so improve quality e.g. shaping how services are delivered to make them more accessible. Clinical Commissioning Groups as lead commissioners of maternity services will be an important partner in improving the quality of the Healthy Child Programme, for example by improving the way in which patient information is transferred to from maternity to health visitor services so that this is seamless for mothers and families. From April 2015, Health Visiting is expected to transfer to Local Authorities; therefore it is essential that Public Health colleagues are engaged with the planning from the outset to agree a shared vision. Finally, it will be important to take advantage of the Liverpool Community Health's Early Implementer Site status to share best practice and evidence based approaches across providers throughout Merseyside.

Quality	The Department's commitment to transform Health Visiting will improve quality of service delivery by ensuring there is adequate capacity of Health visitors to meet the needs of children and families across Merseyside. The increase in the Health visitor workforce will underpin implementation of the new national model of delivery which will ensure a consistent approach across Merseyside underpinned by a robust evidence base.
Innovation	Although the new national Health Visiting model provides a standardised model of delivery, the overall vision supports and encourages local providers to use it as the basis upon which to innovative to engage children and families – particularly families who are disengaged and have the highest level of need. The 'communities' element of the new health visitor

	service model will be a key element of the new service specification and this will be where providers will particularly need to demonstrate innovation in service delivery.
Prevention	Prevention and early intervention are key principles of health visiting. The transformation of Health Visiting services over the next two years across Merseyside will enable service providers to place a greater emphasis on prevention and early intervention at an individual, family and community level; thus taking a three pronged approach to improve health outcomes in the early years by identifying health issues at the earliest opportunity. For example, early identification of postnatal depression by the HV will initiate a package of support tailored to meet the needs of the mum, baby and family which aims to prevent the problem escalating further and give the family.
Productivity	The expansion and transformation of health Visiting will improve productivity by providing a clear vision for the service which is underpinned by a strong evidence base. This will enable the service to focus on the interventions which are placed to achieve the health outcomes described in the 2013/14 service specification, therefore releasing capacity to deliver the new model of delivery, comprehensively to all children and families across Merseyside.

Link to NHS Constitution / Rights

- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s.
- Emergency admissions for children with Lower Respiratory Tract Infections (LRTI).
- Friends and Family Test.
- Right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS provided national immunisation programme.
- Making every contact count, so that healthcare professionals take every suitable opportunity to talk to patients about improving their health.

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level (Please see imbedded document)

HV Delivery Timescales.xlsx

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013/14	Management Lead:	Julie Kelly (Manager) Karen Maughan (Lead officer)
Programme Area:	Public Health: Public Health services for people in prison or other places of detention, including those held in the Young people's secure estate	Critical Interdependencies:	Lancashire NHSCB AT – lead commissioners for Offender Health CCGs – commissioners for some aspects of healthcare for prisoners LAs – particularly those responsible for commissioning Health Improvement services Providers of prison health care services - including primary care Prisons and other places of detention including YOIs Wider criminal justice system
Key Stakeholders:	Public and Patient Forums, Lancashire NHSCB AT, Providers, CCGs, HWBs, LA's, HEE, PHE, local Safeguarding forum, Home Office, NOMS, Merseyside Police, Youth Justice Board	Aspirational Metrics (decided locally):	None identified currently – further work required
Local Metrics:	As identified in individual prison Health Improvement plans	National Metrics:	Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 1 but reliant on outputs from domains 2 and 4	NHS Outcome Framework measure (as per attached Mind Map ref):	❖ Potential Years of Life Lost from causes considered amenable to healthcare ❖ U-75 mortality from Cancer ❖ One and five year survival rates ❖ Life expectancy for males ❖ Life expectancy at 75 for males and females ❖ Under 75 mortality rate from CHD

			❖ Under 75 mortality from respiratory disease ❖ Under 75 mortality rate from liver disease ❖ Excess under 75 mortality rate in adults with serious Mental Illness ❖ Health related quality of life for people with long terms conditions Patient experience in primary care

Overall Descriptive

Background and level of need

The aim of this programme of work is to deliver public health programmes to those in prison and other accommodation of a prescribed description, including those held in Young People's Secure Estate that reduce health inequalities, provide advice and expertise to facilitate healthy choices and support them to live healthy lives with continuity of care on return to the community.

The NHSCB in partnership with NOMS (National Offender Management Service) has a responsibility to ensure that prisoners have access to health services that are broadly equivalent to those the pubic receives from the comprehensive health service. This responsibility will extend between 2013 – 2015 to include police custody suites, Immigration and removal centres, and Secure Training Centres and Secure Children's homes. All places of detention must provide health education, patient education, prevention and other health promotion interventions within that general context. The lead commissioning AT for Offender Health is Lancashire and this programme will be delivered in partnership with Lancashire and the practicalities and logistics of how this arrangement will work is still being finalised.

People in prisons and other accommodation of a prescribed description have much poorer health outcomes than the rest of the population. For example, a large proportion of the prison population have engaged in high-risk behaviour (unprotected sex, multiple partners and injecting drugs), the prevalence of Blood Borne Viruses (BBVs) and Sexually Transmitted Infections (STIs) is higher than in the general population; 15% have had or have an STI. In the prison population, 8% of males and 12% of females are Hepatitis B positive and 9% of males and 11% of females are Hepatitis C positive. At least 80 per cent of prisoner's smoke. In addition, problematic drinking is generally far more common among offenders than the general population. More than one third of women and almost two-thirds of men entering prison have an alcohol problem. 69% of prisoners received into prison have used at least one drug during the year before custody

Public Health and Primary Health services in prison and other accommodation of a prescribed description should work alongside other custodial staff and include public health programmes/ services that specifically address:

- Health Promotion including:
  - Mental health promotion and well-being
  - Smoking cessation/ reduction
  - Healthy eating and nutrition, to include BMI assessment
  - Healthy lifestyles including relationships
  - Sexual health and parenting
  - PHSE for young people aged 10 – 17
  - BBV prevention
  - Peer education
  - Physical activity programmes
  - Rebuilding of fragmented family and peer relationships.
- Smoking Management
- Suicide and self-harm prevention
- Screening programmes and Health Checks programmes
- Substance misuse services
- Communicable disease control
- Vaccination and immunisation
- Sexual Health
- Management of TB
- Hepatitis
- User Involvement.

All services and interventions commissioned will be based on evidence of need as per local prison population needs assessments and in line with national and local policy to ensure that they meet the needs of the population and are evidence based.

Currently there are a number of groups and forums that performance manage the work within the prisons and custody suites across Merseyside and these include the following :-

- Police Health Care Partnership Board
- Prison Health Care Partnership Board(HMP Liverpool and HMP Kennet) – NHS Commissioner for all Health services
- HMP Altcourse partnership Board –NHS commissioning responsibilities for mental health and substance misuse.

These are sub groups of the Strategic Merseyside Offender health and Social care Board which has overhaul responsibility for Offender Health across Merseyside.
There is however a gap In relation to the Secure estate for Children and Young people and discussions have begun with Lancashire to address this.

Lancashire have identified a number of key areas for immediate priority action across the North West (which may not necessarily all affect Merseyside) as follows:

1) Consolidation where possible of Prison Contracts (e.g. merge North Lancashire and Central Lancashire)
2) Agree with providers of general healthcare the insertion of Escort & Bed Watches budgets' in to contracts (currently this budget with the exception of Manchester and Central Lancashire sits with the commissioner who has not control over the budget)
3) SLA agreement for healthcare services with St Marys and Merseyside SARCS (draft SLA ready for St Marys but needs agreement with GMP regarding Forensic Medical Examiners)
4) SLA agreement for healthcare services for with Secure Children's Estate, (no SLA's in place and ad hoc service provision)
5) Web Based Performance Management Framework for all prison establishments with Cheshire CSU, (similar to NE model to enable comparison across the North)

As stated earlier, clarity on commissioning arrangements are still being finalised. Merseyside AT will have a key role in supporting the Lancashire AT to take forward the Offender Health public health agenda with the expectation that the PH team within Mersey will undertake the technical, contracting side of this work. In partnership with Lancashire, the Merseyside team has identified existing provision in Merseyside for both the adult and child population and has begun to document key risks and mitigations needed, challenges, stakeholders, gaps and potential opportunities for future service development. Area teams will work collaboratively to support the development and implementation of commissioning plans in accordance with the common single operating model set out in "Securing Excellence in Commissioning – Offender Health". This will include ensuring that robust performance management and governance arrangements are in place with providers. In addition to these services, Lancashire will be the lead commissioner for Sexual Assault Referral Centres (SARCs) and the Merseyside AT has been working with Lancashire to agree the practicalities of how this arrangement will work.

Quality	Commissioning services in accordance with the single operating model set out in “Securing Excellence in Commissioning – Offender Health” provides a real opportunity address current variations in provision which should in turn lead to improved outcomes
Innovation	Commissioning across a wider footprint does provide the opportunity to explore innovative commissioning arrangements e.g. consolidation of some contracts
Prevention	Some of the key public health programmes to be delivered within prisons have a preventive focus and those that are not specifically primary prevention focussed still have a secondary and tertiary prevention elements e.g. smoking cessation services
Productivity	Prevention of illness, early detection of some conditions and better management of long term conditions and harm reduction programmes should lead to a decrease in avoidable pressures on other parts of the health and social care system

Link to NHS Constitution / Rights
❖ You have the right to access services within maximum waiting times.” ❖ You have the right to access NHS services. You will not be refused access on unreasonable grounds”. ❖ You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental). ❖ to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge); and to continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments.
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

To be developed in partnership with the Lancashire Area Team (Lead Area Team)

Directorate:	Direct Commissioning: Pubic Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14	Management Lead:	Daniel Seddon (Managerial) Claire Elliott (Screening and Immunisation Coordinator)
Programme Area:	Public Health: Antenatal and newborn screening programme	Critical Interdependencies:	The programme is delivered by a plethora of providers in a range of settings and these services have a number of commissioners including CCGs and Primary Care commissioning within the AT. The need for robust co-commissioning and performance management arrangements is critical Robust analytical support will be crucial as will close links with the CHIS developments (see separate initiative)
Key Stakeholders:	Public and Patient Forums, CCGs, LAs, HWBs, UK National Screening Committee (UKNSC), regional QA teams, PHE, CHIS, maternity providers, community health providers e.g. health visitors, and laboratory services.	Aspirational Metrics (decided locally):	All screening programmes have a set of quality standards against which they are measured. Each Standard has a minimum and achievable (the higher value) metric. Our aspiration is: • To achieve all of the higher quality standards across all programme as our norm. • Where a standard is missed for corrective action to be taken immediately • To be able to demonstrate for each programme, the health

			benefit • For all staff involved to know the programme performance and outcomes.
Local Metrics:	UKNSC KPIs UKNSC quality standards Further development needed	National Metrics:	There is a large suite of UK National screening Committee KPIs for these screening programmes: They include • the proportion of women offered and taking up the antenatal screening tests for foetal anomaly, infectious disease in pregnancy, haemoglobinopathies • uptake of newborn hearing screening and quality standards such as timeliness • newborn blood spot unnecessary repeats Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS Outcome framework (Specify Domains here):	Domain 1 **- preventing people from dying prematurely**; mortality from causes amenable to health care, infant mortality, neonatal mortality and stillbirths. Domain 4 - **Ensuring that people have a positive experience of care**; improving women and their	NHS Outcome Framework measure (as per attached Mind Map ref):	NHS Outcomes framework: Domain 1 – 1a (ii), 1.6 i, ii Domain 4 – 4.5 PH outcomes framework: 2.2 i, ii, iii, iv, v, vi 3.4 and 4.1

	families' experience of maternity services.		

Overall Descriptive

There are currently seven national antenatal and newborn screening programmes:

- NHS infectious diseases in pregnancy programme
- NHS down's syndrome screening programme
- NHS foetal anomaly screening programme
- NHS sickle cell and thalassaemia programme
- NHS newborn bloodspot screening programme
- NHS newborn hearing screening programme
- NHS newborn and infant physical examination programme

Although the programmes outlined above are distinct with differing key stakeholders (depending on how screening services are provided) there are some significant organisational interdependencies. Fostering a whole system approach and promoting communication between organisations and professional groups will be key to the success of this initiative and associated objectives, which are outlined below.

There are a number of key challenges some of which require immediate attention to ensure the continuity of safe and effective screening services.

Key challenges:

- Local providers are required to align to the seven national service specifications for antenatal and newborn screening and the corresponding UKNSC commissioning frameworks.
- Organisations and professional groups responsible for different elements of the screening pathways will require clarity from the NHS CB responsible teams on maintaining and developing services following transition on the 1st April 2013.
- Organisations and professional groups will require clarity on organisational interdependencies both current and proposed following

transition on the 1st April 2013.

- NHS CB responsible teams are required to establish strategic coordination of the antenatal and newborn screening programmes following transition on the 1st April 2013.
- Regional QA audit outcomes 2012/13 with regard to antenatal and screening programmes report that service improvements are required with regards to IT systems, documentation and communication.

This local initiative and associated objectives will ensure that the Merseyside antenatal and newborn screening programmes are high quality, safe, effective and meet the policy, recommendations and standards of the UK National Screening Committee (UKNSC).

Objectives

- Review routine and failsafe screening pathways with providers and develop action plans to ensure pathways are fit for purpose; timescales to be agreed on an individual basis with providers.
- Define and agree roles and responsibilities for all responsible organisations and professional groups including cross organisational responsibilities to ensure continuity and sustainability of the screening pathways.
- Ensure appropriate communications are in place between organisations and professional groups responsible for all elements of the screening pathways.
- Work with local providers to ensure written protocols are in place so that best practice is consistently applied; actions and timescales for achieving this objective to be agreed on an individual basis with providers.
- Develop annual plans with local providers detailing strategies for service improvement.
- Avoidable repeat rates for NBBS screening should be reviewed locally and action plans developed and monitored to ensure avoidable repeats are ≤0.5%.
- Review current IT systems across screening pathways with local providers and develop recommendations to promote service improvement.
- Develop joint audit and monitoring processes with local providers to include assessments relating to equity of access.
- Define participation in local monitoring arrangements for all responsible organisations and professional groups to include Programme Board development and consequences of a breach.
- Ensure providers facilitate, provide and support local education and training needs.

Quality	Review and develop provider contracts to ensure alignment to relevant national service specifications and commissioning frameworks resulting in improved programme quality.
Innovation	Audit local IT systems and make recommendations to promote service improvement; recommendations could include new ways of working or adoption of improved IT systems.
Prevention	Audit provider routine and failsafe pathways and support providers to develop action plans to promote alignment to national policy/guidance/recommendations. Adequate auditable failsafe pathways will ensure improved programme safety.
Productivity	Development of programme pathways by alignment to national policy, guidance and recommendations and ensuring defined roles and responsibilities throughout the screening and treatment pathways will streamline pathways and promote their effectiveness from beginning to end.

Link to NHS Constitution / Rights
❖ NHS PLEDGE to provide screening programmes as recommended by the UKNSC. ❖ Friends and Family test. ❖ Reduce avoidable hospital admission.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed delivery timetable

QIPP strategy for service improvement	Timescales
Review and develop provider contracts to ensure alignment to relevant national service specifications and commissioning frameworks.	Immediate start, contracts renewed as for 2012/13 with providers with a view to complete alignment to national specifications and commissioning frameworks by 31st March 2014.
Audit provider routine and failsafe pathways and support providers to develop action plans to promote alignment to national policy/guidance/recommendations.	Immediate start, mapping of current pathways, review best practice and develop individual provider action plans within 9-12 months (31st March 2014).
Audit local IT systems and make recommendations to promote service improvement.	Immediate start, mapping of current systems and make recommendations within 6-9 months (31st December 2014).
Set up local Programme Boards and clarify responsible organisation participation.	Immediate start, mapping of current systems, basic design within 3 months, consultation and implementation by nine months (31st December 2014).

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14	Management Lead:	Dan Seddon (Managerial lead)
Programme Area:	Public Health : Cancer Screening Programmes	Critical Interdependencies:	Partnership working • CCG cancer screening leads, • supporting partners e.g. cytology laboratories, • screening hubs, • breast screening units, • Primary Care Commissioning • Analyst support • NHSCB AT Resilience Team • Cancer screening QA teams • Cancer Network
Key Stakeholders:	Public and Patient Forums, CCGs, LAs, HWB, North West QA, National Screening Committee, Laboratory services, Screening Hubs, COM, NHS Trusts and other providers	Aspirational Metrics (decided locally):	a) to meet national targets not just for Mersey as a whole and for individual boroughs, but also to minimise the number of individual practices falling below these targets b) For practices below target, to achieve increased uptake year on year c) Demonstrate health gain in terms of e.g. lives saved, cancers detected d) Demonstrate that all eligible individuals are offered e) Ensure access for prisoners otherwise eligible (bowel screening only)
Local Metrics:	Screening programmes have explicit standards that summarise quality and performance Further development needed	National Metrics:	Coverage targets: Cervical Screening – 80% (currently average is below this by 1-3%) Breast screening – 70% (currently average is above this by 1-4% Bowel – 60% (currently average is below this by 2-7%)

			Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement “Public health functions to be exercised by the NHS Commissioning Board”
Programme Link to NHS Outcome framework (Specify Domains here):	NHS Outcome Framework Domains 1. 4 , 5 linking to Public Health Outcomes Framework Domain1, 2 + 4	NHS Outcome Framework measure (as per attached Mind Map ref):	4a.1. 4b. 4c 4.4

Overall Descriptive

National Screening programmes:
Breast, bowel and cervical

The National Committees for cancer screening develop standards, screening pathways, and QA approaches. External QA is currently delivered by either regional teams or national teams, depending on the programme, with the co-operation of local programmes and commissioners.

Accountability for QA for cancer screening will be with PHE from April 2013.

A national set of key performance indicators (KPIs) for cancer screening programmes currently exist. Data collection and monitoring is a

key factor in identifying coverage rates, areas for improvement and gaps in the service provision

From April 2013:

- The local Director of Public Health will be a champion for screening and providing challenge on whether the local service meets the needs of the population and whether there is equitable access, and contributing to the management of serious incidents.
  .

Contract arrangements re Breast screening, bowel screening assessment centres and cervical cytology laboratory costs are within acute trust contracts.

Bowel cancer screening programme has clear contract and funding streams.

Specifications for breast screening programmes have been developed.

Work is underway to develop clear specifications for the laboratory elements of cervical screening programmes and for the call/ recall service.

Screening pathways are complex, with multiple partners. Cervical screening is carried out in general practice and reproductive health clinics; samples are processed and tested in one or more laboratory settings; Call/ recall is undertaken by support agencies; and treatment is in specialist colposcopy clinics. Treatment is variably part of the screening pathway but is often commissioned separately

Cancer screening programmes are delivered by a plethora of providers in a range of settings and these services have a number of commissioners including CCGs and Primary Care commissioning within the AT. The need for robust co-commissioning and performance management arrangements is critical

Quality	Patient user views are key to identifying quality standards, these are obtained by insight work and public and patient forums. Public experience influences the service provision and outcomes of views must be shared with key providers QA North West ensure the overall quality of service meet all identified standards.

	Specific Quality Standards are assessed externally at regular QA visits, with subsequent action plans for improvement. All our programmes have very positive current QA reports. The AT will strive to maintain and improve on these achievements The relevant multi agency groups are responsible for performance and quality standard reporting.
Innovation	There needs to be action to remove barriers to screening including inequalities to access e.g. people with learning disabilities. This requires joined working, sharing good practice. New ways of promoting the screening services; making them less fearful as often perceived by some –public education. Making every contact count – widening the remit of public health and health protection to more clinical and non-clinical staff e.g. physiotherapists being aware of the three cancer screening programmes -basic information supplied in cancer screening card and information leaflet to give to patient .
Prevention	National Target attainment: Approaches /ways of ensuring people attend for screening, e.g., active GP follow up for women who DNA breast screening appointments in line with the same/similar approach to cervical screening and COM involvement. Reduce exception reporting in Primary Care relating to cervical screening therefore maintain activity to engage with women who do not attend
Productivity	Proving quality services that people want and can access will improve coverage rates, identify pre-cancerous and cancerous changes at an earlier stage. Early detection and treatment is key to increased survival rates.

Link to NHS Constitution / Rights
❖ Involving patients in decisions about their care. ❖ Supporting staff providing the care. ❖ Encourage feedback from patients with a more open working culture. ❖ Examining how information is used and protected. ❖ Making every contact count, so that healthcare professionals take every suitable opportunity to talk to patients about improving their health.
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed delivery timetable / milestone level

1.	Review cancer screening handover information collected from PCTs	01.03.13	31.04.13
2.	Meet with key stakeholders to identify transition issues	21.03.13	31.05.13
3	Identify training needs and how to deliver these	1.5.13	1.6.13
4.	Produce draft report with recommendations and circulate to key stakeholders for agreement/buy-in	01.06.13	30.06.13
5.	Finalise report and recommendations and circulate widely	01.07.13	31.07.13
6.	Support local screening programmes and other screening colleagues as necessary to implement recommendations	01.08.13	28.02.14
7.	Cervical: Work with multiagency groups and co commissioners to introduce pilot HPV testing as primary screening modality	1.4.2013	1.9.2013
8.	Cervical: Make safe the maintenance of smear taker registers and smear taker training	1.4.2013	30.6.2013
9.	Bowel: identify top sliced health promotion monies for promoting bowel screening and develop plan for use for purpose	1.4.2013.	1.5.2013
10.	Breast: review performance in the two programmes and QA action plans.	1.4.2013	1.6.2013

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-2014	Management Lead:	Daniel Seddon (Managerial lead) Marie Coughlin (Lead officer)
Programme Area:	Public Health: NHS Diabetic Eye Screening Programme	Critical Interdependencies:	a) Primary care commissioning; analyst support; Health & Well-Being Boards (H&WBB); Medical and Nursing Directors in Trusts; Public Health England (PHE) b) Significant co-commissioning aspects with Clinical Commissioning Groups (CCG) and with other parts of NHS Commissioning Board (NHSCB), plus some freestanding contracts c) Link with Emergency Planning and with offender health (prisons)
Key Stakeholders:	Public and Patient Forums, CCGs, LAs, HWBs, UK National Screening Committee (UKNSC), regional QA teams, call and recall agencies, PHE, health care providers both NHS and non-NHS and laboratory services.	Aspirational Metrics (decided locally):	There are 12 national quality standards linked to the programme which cover identification of people with diabetes, their invitation, the test and grading of photographs, timely referral and treatment elements of the screening pathway. These standards have targets at a minimum and achievable (higher) level. Our local aspiration is: • To meet all standards at the higher level by the end of 2013/14 • To demonstrate the number of people who have received sight saving laser eye treatment.
Local Metrics:	Further development needed	National Metrics:	There are 12 national UK National Screening Committee key performance indicators and quality standards to be achieved.

			They include • Identification of cohort • Annual invitation • Uptake • Grading standards • Timely referral timely assessment timely treatment Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS and PH Outcome framework (Specify Domains here):	NHS Framework: domains 2, 4 and 5 PH Framework: domains 1, 2, and 4	NHS Outcome Framework measure (as per attached Mind Map ref):	2.3; 4.9; 5.4 1.8, 1.9; 2.17, 2.21; 4.3, 4.12

Overall Descriptive

Diabetic retinopathy is the most common cause of blindness in the UK's under 65 age group. If diabetic retinopathy is diagnosed and treated at an early stage, the outlook for the condition is good. Research has found that treatment can prevent severe vision loss in 90% of cases of diabetic retinopathy. Retinal screening is proven as an effective way to reduce or prevent diabetic retinopathy.

The NHS Diabetic Eye Screening Programme was set up by the Department of Health and has developed over time through the introduction of National Service Framework targets. The programme aims to reduce the risk of sight loss among people with diabetes, aged over 12, by early detection (and treatment if needed) of diabetic retinopathy as part of a systematic screening programme.

The Numbers Needed to Treat are very low (good) for the definitive treatment of sight threatening diabetic eye disease. For every two treatments, one sight is saved.

The role of the national office is to ensure a programme that meets national standards. The national office also assists local screening

programmes in procuring appropriate digital cameras and management software to ensure minimum specifications are met. The responsibilities of local screening programmes include the establishment and regular maintenance of a database which securely identifies people eligible for screening. Screening can be provided at various locations such as hospitals or diabetes centres. Mobile Screening services can also be provided at a range of locations. Optometry-based services are a further option.

Locally there are three Diabetic Eye Screening Programmes covering the Merseyside population and parts of Warrington and Central Lancashire with some elements of the programmes to be commissioned by NHSCB and other elements will be commissioned by acute trusts and the national office. Due to the volume and range of providers involved, commissioning and contracting arrangements can be complex and often fragmented. The need for robust partnership working arrangements between commissioners and providers cannot be emphasised enough.

A 2012 review of the programmes in Merseyside by QA teams reported that local screening programmes are safe and run well.

Regular external QA visits result in local action plans. There are no local red rated actions in any of these plans. The Southport and Ormskirk programme is, however, below the recommend size for a programme. The Central Mersey Programme has a specific handover risk to the programme management function.

Quality	There are comprehensive quality standards in place and NHSCB will ensure that local service meet these standards are reached in partnership with national and regional QA arrangements
Innovation	The three programmes are very different in their design and organisation. Commissioning across a Mersey footprint provides an opportunity to review what works well, redesign and transform service and ensure this is delivered across the health economy
Prevention	Service transformation will enable us to increase uptake rates, detect a higher proportion of sight-threatening retinopathy at an appropriate time and to treat diabetic eye disease effectively within an appropriate timescale.
Productivity	Higher uptake rates will result in increased productivity as more people access and will be treated as part of the programmes, thus reducing future burden on both patients in terms of improved health outcomes and the system, in terms staff time, estate and financial resource
Link to NHS Constitution / Rights	

- The right for patients to access free of charge, nationally approved screening services that offer high standards of care
- The right for patients to have informed choice, involvement in their care, respect, consent and confidentiality and not to suffer any discrimination
- The right for staff to work in a good environment that is safe and offers flexible working opportunities and to be supported in the patient care they provide

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	Review Diabetic Eye Screening handover information collected from PCTs	01.04.13	31.04.13
2.	Meet with key stakeholders to obtain 'softer' intelligence	01.05.13	31.05.13
3.	Produce draft report with recommendations and circulate to key stakeholders for agreement/buy-in	01.06.13	30.06.13
4.	Finalise report and recommendations and circulate widely	01.07.13	31.07.13
5.	Support local screening programmes and other screening colleagues as necessary to implement recommendations	01.08.13	28.02.14

Directorate:	Commissioning Directorate: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-14	Management Lead:	Dan Seddon (Managerial lead)
Programme Area:	Public Health: Overall system and relationship management of screening and immunisations and new programmes	Critical Interdependencies:	Screening and immunisation programmes are delivered by a plethora of providers in a range of settings and these services have a number of commissioners including CCGs and Primary Care commissioning within the AT. The need for robust co-commissioning and performance management arrangements is critical Robust analytical support will be crucial as will close links with the CHIS developments (see separate initiative)
Key Stakeholders:	Public and Patient Forums, CCGs, LAs, HWB, North West QA, National Screening Committee, Laboratory services, Screening Hubs, COM, NHS Trusts and other providers, communications and media	Aspirational Metrics (decided locally):	Further work required
Local Metrics:	Targets and measures exist for all immunisation and screening programmes. Local metrics still be agreed	National Metrics:	Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement “Public health functions to be exercised by the NHS Commissioning Board”

Programme Link to NHS and PH Outcome framework (Specify Domains here):	NHS Framework: Domain 1 reducing deaths in babies and young children Domain 4 Improving experience of maternity services Domain 5 Reducing avoidable harm, safety incidents PH Framework: Health Protection Domain Population vaccination coverage Health Improvement Domain Cancer screening coverage, access to non-cancer screening Wider Determinants Domain Sickness absence rate Healthcare domain infant mortality, cancer mortality, liver disease mortality, communicable disease mortality, preventable sight loss	NHS Outcome Framework measure (as per attached Mind Map ref):	1.4, 4.9, 5.1, 5.4 H Prot. 3, H Impr. 20, 21, Impr Wider Determinants. 9, Health care. 1,3,5,6,8,12

Overall Descriptive

- Screening and immunisation programmes are delivered by a plethora of providers in a range of settings and these services have a number of commissioners including CCGs and Primary Care commissioning within the AT. The need for robust co-commissioning and performance management arrangements cannot be emphasised enough.

The aim of this initiative is to

- give leaders in Merseyside, including CCGs and Health and Wellbeing Boards, confidence in their screening and immunisation programmes
- promote across the system how much good they do
- show that all programmes are managed effectively and delivered fairly
- show that incidents, when they happen, are handled appropriately with lessons learnt
- provide assurance of effective rollout of new Screening and Imms programmes

Objectives: from April 1st 2013

- Design and manage an elegant, streamlined system of Multi Agency Programme Boards, Oversight Groups, and tactical Action Groups that ensures high quality, safe screening and immunisation programmes: immediate start, mapping of current systems, basic design within 3 months, consultation with key stakeholders as described above and implementation by nine months
- Select and manage a set of key performance indicators: immediate start, basic design by six weeks, consultation with key stakeholders as described above by three months, monthly or quarterly reports (Requires effective information analyst support)
- Produce briefings and concise reports, for target audiences, that demonstrate what is achieved in terms of health outcomes and avoided health care events or expenditure: Monthly or quarterly performance reports plus monthly briefings with a story, key facts or figures, and action message (example: half of new cervical cancer cases occur in women eligible for screening who do not attend)
- Act to tackle effectively problems in the delivery of screening and immunisation programmes: immediate start: prioritise and tackle risks identified at handover, by three months agree forward plan to resolve these, and to work with system leaders and QA to identify productive capacity (after Steven Covey's seven habits)

New Screening and Imms programmes:

- There is one non cancer screening programme to be introduced in 2014/15 or sooner: Flexible sigmoidoscopy offered to 50 year old people as once only investigation for bowel cancer or pre cancer. This will be delivered in accredited local sites under one of two programme admin hubs based at Royal Liverpool Hospital or Aintree Hospital. The Bowel Cancer Screening Programme Board is actively preparing for Flexi Sigmoidoscopy: their involvement and leadership will continue.
- There is one new non cancer screening programme being introduced in March 2013. Abdominal Aortic Aneurysm Screening will be delivered from a centre in Royal Liverpool Hospital. The S&I team will be involved with the Programme Board and ensure safe roll out in Mersey. A named individual within the Area Team S&I team will be nominated for this role
  - Other programmes to be introduced during 2013-14 include:
  - a) a new rotavirus vaccination programme,
  - b) a new shingles vaccination programme, and
  - c) partial implementation of the extension of the seasonal influenza vaccination programme to children.

New national service specifications are being drawn up for these and the AT will work with other commissioners and providers to ensure smooth rollout

	Strengthening a culture of excellence and celebrating success/ progress. Many of the screening programme standards demonstrate this: Regular and systematic quality assurance embeds high standards.
Innovation	Creating an elegant and effective system of the minimum high level screening and immunisation co-ordination meetings will be efficient and effective. Bringing neighbouring programmes and staff leaders together will raise standards. New performance reporting will link activity to health outcomes: for example, we can describe the number of lives saved each year by the bowel screening programme (between five and ten in Halton and St Helens)
Prevention	For example, the superb achievement of 95% or near coverage for primary immunisations, two week turnaround for cytology results, and sight saved through the Diabetic Eye Screening Programme. Childhood TB is increasing in the NW, by implementing a targeted programme of neonatal BCG immunisation we will prevent deaths.
Productivity	Rationalising multi agency meetings to a minimum of formal high level meetings, with tactical and operational action teams, will improve productivity. Working with other commissioners and providers to re-design immunisation pathways

Link to NHS Constitution / Rights
Unplanned hospitalisation Emergency admissions of children Friends and Family Test Right to receive vaccinations
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Directorate:	Direct Commissioning: Public Health	Area Team Executive Lead:	Anthony Leo
Planning Period:	2013-2014	Management Lead:	Dan Seddon/Julie Byrne
Programme Area:	Public Health: Seasonal Immunisation Programme	Critical Interdependencies:	• Primary Care Commissioning • GP Practices • Analyst support – (PHE, NHSCB, Cheshire and Commissioning Support Unit) • Medical and Nursing Directors of Acute, Community and Mental Health Trusts • Public Health England (PHE) • Clinical Commissioning Groups (CCGs) • Local Authorities – (Emergency Planning, Health Protection, Infection Control teams, Schools) • NHSCB AT Resilience Team • Maternity Units • Pharmaceutical Companies • Health and Wellbeing Boards (H&WBB)
Key Stakeholders:	• GP Surgeries • CCGs • PHE • H&WBB; • quality assurance teams in PHE Northern region; • Acute, community and mental health trusts • Local authorities	Aspirational Metrics (decided locally):	In addition to national metrics, the AT will strive to: • Minimise differences between boroughs and practices in their flu vaccine uptake in the three groups: at risk under 65, over 65, and pregnant women • Achieve the uptake targets earlier in the season in 2013/14: shifting the cumulative uptake percentage to the left by weeks or months. • Achieve staff uptake over 70% on some organisations,

	• Patients & carers • Communications and media • Maternity units		and not less than 50% in any
Local Metrics:	Acute, community and mental health trusts have locally agreed targets for staff vaccination uptake. Some CCGs have locally agreed targets with GP practices for patient uptake for over 65s and under 65s with a long term condition	National Metrics:	75% uptake for the three groups for each borough in Merseyside: At risk, over 65s and pregnant women Public Health Outcomes Framework indicators Metrics defined in Section 7A agreement "Public health functions to be exercised by the NHS Commissioning Board"
Programme Link to NHS and PH Outcome framework (Specify Domains here):	NHS Framework: domains 1, 2, 4 and 5 PH Framework: domains 3, and 4	NHS Outcome Framework measure (as per attached Mind Map ref):	2.3, 2.4, 4.4, 4.5,5.2 3.3, 4.8, 4.15

Overall Descriptive

Influenza immunisation has been recommended in the UK since the late 1960s, with the aim of directly protecting those in clinical risk groups who are at a higher risk of influenza associated morbidity and mortality. In 2000, the policy was extended to include all people aged 65 years or over. In 2010, pregnancy was added as a clinical risk category for routine influenza immunisation. The Department of Health announced in 2012 that it will extend the flu campaign to cover all children aged 2-17 years, although an implementation date has not yet been confirmed.

It is recommended that all frontline health and social care staff are vaccinated, to reduce the transmission of influenza within health and social care premises, to contribute to the protection of vulnerable individuals, and to avoid disruption to services that provide their care.

GP practices are presently responsible for ordering flu vaccines for their patients, however, there is a current review taking place that is looking at the advantages of nationally procuring flu vaccines for the programme.

Influenza activity is monitored in the UK through reports of new consultations for influenza-like illness from sentinel GP practices, combined with laboratory surveillance. Reporting of vaccination uptake for staff and patients is a mandatory requirement for both GP practices and all NHS Trusts. Uptake is closely monitored via a national online system (Immform).

Merseyside has performed above the national average for patient uptake, and in recent years has consistently exceeded the 75% target for over 65s. Uptake in those who are under 65 with a long term condition and pregnant women, although slightly better than the national average, is still a long way from reaching the national target.

The major challenge for Merseyside is to increase uptake for patients under 65s with a long term condition and pregnant women; in addition it must address the wide variation in uptake across GP practices. This will form a major part of the work stream for this programme.

Staff Uptake

In 2012/2013 the aim was for 70% of Healthcare Workers to receive the flu vaccination. Uptake varied greatly between different trusts, but overall uptake was similar to or better than the national average, but for a significant number of trusts was some way below 70%

Locally agreed targets for uptake varied for each of the trusts, based on previous performance. The ambition for the 2013/2014 flu season is to embed frontloaded targets into all trust contracts to encourage vaccination to take place as early as possible, and to increase uptake for trusts in line with Department of Health trajectories.

Quality	To build on aspects of the local programmes where quality standards and uptake rates standards are high and to reduce variation and inequalities in flu vaccination uptake rates
Innovation	To work with NHSCB AT primary care team, GP practices and maternity units and other trusts to impart effective and efficient models of vaccine delivery.

Prevention	Service transformation will enable us to increase uptake rates, therefore preventing excess winter deaths, unnecessary hospital admissions and high numbers of GP consultations.
Productivity	Higher uptake rates will result in less flu circulating therefore reducing pressures on hospital departments, less bed spaces being used, reducing workload for GPs thus reducing wastage in staff, estate and financial resource.

Link to NHS Constitution / Rights
• The right for patients who are at risk to access free of charge, nationally approved immunisation services that offer high standards of care • The right for patients to have informed choice, involvement in their care, respect, consent and confidentiality and not to suffer any discrimination • The right for staff to work in a good environment that is safe and offers flexible working opportunities and to be supported in the patient care they provide
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	Review Seasonal Immunisation handover information collected from PCTs	01.04.13	31.04.13
2.	Meet with key stakeholders to obtain 'softer' intelligence	01.05.13	31.05.13
3.	Produce draft report with recommendations and circulate to key stakeholders for agreement/buy-in	01.06.13	30.06.13
4.	Finalise report and recommendations and circulate widely	01.07.13	31.07.13
5.	Support local immunisation programmes and other colleagues as necessary to implement recommendations	01.08.13	28.02.14

Financial Landscape

2013-2014 brings significant change to the commissioning landscape with the establishment of Clinical Commissioning Groups and the National Commissioning Board with responsibility for commissioning healthcare for their populations. Responsibility for commissioning public health functions has been distributed across Public health England, Local authority and NCB Area team commissioners. These planned changes have driven an associated resource re-allocation process.

The cost base for the Mersey Cluster in 2012-13 is £2.525 billion and includes Liverpool, Halton and St Helens, Sefton, and Knowsley PCT's. These costs have been mapped to successor commissioner bodies broadly as follows:-

Successor Body	£m	%
CCG's	1,875	74.3%
NHSCB	556	22.0%
Local Authority Public Health	88	3.5%
Public health England	5	0.2%
Other	1	0.0%
Total	2,525	100%

2013-2014 Financial plans

Indicative allocations have been issued by the NCB including Primary Care, Dental, Public Health and CCG's. However there is potential for these to change until the approval of commissioning and expenditure plans by the NCB in May.

National planning assumptions for 2013-2014 require a minimum 0.5% contingency reserve to support the mitigation of emerging risks. All CCG's and the Area Team have met or exceeded this minimum requirement. Additionally there is a requirement for 2% non-recurrent headroom whereby only approved expenditure schemes can be committed on a non-recurrent basis. CCG plans outlining their intended application of this non-recurrent resource are included within plans. In relation to the Area Team the 2% headroom has been excluded from allocations within the plans, it is expected that NCB will provide an element of this resource to support Area Team non-recurrent costs, but this is not confirmed at this stage.

Net growth uplifts for planning purposes are:-

Primary care 1%
Primary care IT 0%
Public health 2.6%
NHS Property services commissioned service costs 1%
PbR net deflator -1.1%
Non PbR net deflator – 1.3%.

Each CCG within Mersey has planned to achieve a 1% cumulative surplus and all have exceeded the requirement for a 2% recurrent surplus by the end of 2013/14. With regard to the Area Team current plans show a planned £4m deficit. This is currently under review alongside potential use of non-recurrent headroom and resource alignment corrections.

The CCG's have planned for the continuation of the 30% tariff for non-elective admissions, including the administration of the 70% balance by the Area Team.

A key focus of the NHS reorganisation has been to continue reduction in management and running costs maximising resource available to support direct patient care. Each organisation must deliver costs within its running cost target. Mersey CCG's plans comply with the £25 / head maximum allowance.

The NHSCB local area team is required to plan for the direct commissioning responsibilities it holds locally and to work with other area teams who have responsibility for the commissioning of NCB services on a broader footprint, for example Cheshire Warrington and Wirral Area Team commission specialised services, Lancashire Area Team commission offender health to ensure equitable provision of health services for the Mersey population.

In addition the area team has a responsibility to review and oversee Mersey CCG commissioning and financial plans.

Current 2013-2014 planned expenditure, reflective of those services for which the Mersey Area Team has direct commissioning responsibility along with the expenditure plans of the 6 Mersey CCG's is summarised below.

	Mersey		
	CCG's	Area team	Total
	£000's	£000's	£000's
Secondary & community	1,404,542	22,240	1,426,782
Primary care	251,596	311,237	562,833
Public Health		50,056	50,056
other	123,272		123,272
totals	1,779,410	383,533	2,162,943

Expenditure plans include provision for demographic and non-demographic growth in line with local intelligence. For the Area Team, for example, this includes anticipated growth in 0-5's in line with ONS projections in addition to planned investment in line with Health Visiting Call to Action growth trajectories.

CCG's have identified local risk pooling arrangements for key risk areas, for example continuing health care. Risk are identified, quantified and risk mitigation plans identified.

Directorate:	Nursing Directorate	Area Team Executive Lead:	Gaynor Hales
Planning Period:	2013-14	Management Lead:	Michelle Creed
Programme Area:	Domain 4 Patient Experience	Critical Interdependencies:	Domains 1,2,3 & 5 NHS Mandate Direct Commissioning, Primary, Dental, Optometry and Pharmacy Provision. CCG Commissioning
Key Stakeholders:	• Health Watch • Patient and Public Forums • Health and Wellbeing Partnership Boards • NHSCB • CQC • Monitor • Academic Providers • LETB's • CCG's • NHS Funded Care Providers • Direct Commissioned Services	Aspirational Metrics (decided locally):	
Local Metrics:	N/A	National Metrics:	Patient Experience Delivery Plans – Domain 4 • **Overarching indicators** • **4a** Patient experience of primary care

			• GP services • GP Out of Hours services • NHS Dental Services • **4b** Patient experience of hospital care • • **Improving people's experience of outpatient care** • **4.1** Patient experience of outpatient services • • **Improving hospitals' responsiveness to personal needs** • **4.2** Responsiveness to in-patients' personal needs • • **Improving people's experience of accident and emergency services** • **4.3** Patient experience of A&E services • • **Improving access to primary care services** • **4.4** Access to **I** GP services and **ii** NHS dental services • • **Improving women and their families' experience of maternity services** • **4.5** Women's experience of maternity services • • **Improving the experience of care for people at the end of their lives** • **4.6** *An indicator to be derived from the survey of bereaved carers* • • **Improving experience of healthcare for people with mental illness** • **4.7** Patient experience of community mental health services

			• • **Improving children and young people's experience of healthcare** **4.8** *An indicator to be derived from a Children's Patient Experience Questionnaire*
Programme Link to NHS Outcome framework (Specify Domains here):	Primarily Domain 4 but reliant on outputs from Domains 1, 2, 3 and 5.	NHS Outcome Framework measure (as per attached Mind Map ref):	4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7. 4.8, 4.9

Overall Descriptive

OVERVIEW

The NHS Commissioning Board (NHSCB) Merseyside Nursing Directorate will provide system clinical leadership to ensure that patients, the public, carers and families experience a high standard of care; and hence a positive healthcare experience. This leadership will be via system assurance, working in collaboration with clinical commissioning groups (CCGs) and providing oversight of NHSCB Directly Commissioned services. To ensure the outcomes in Domain 4 are achieved the Nursing Directorate have recognised that there are a number of opportunities for commissioners to build the need for positive patient experience into the vision, strategy, systems and structures for commissioning.

WHY IS IT BEING DONE?

During recent years, several documents and initiatives have highlighted the importance of the patient's experience and the need to focus on improving these experiences where possible. Lord Darzi's report High quality care for all (2008) highlighted the importance of the entire patient experience within the NHS, ensuring people are treated with compassion, dignity and respect within a clean, safe and well-managed environment.

The development of the NHS Constitution (2009–2010) was one of several recommendations from Lord Darzi's report. The Constitution describes the purpose, principles and values of the NHS and illustrates what staff, patients and the public can expect from the service. Since the Health and Social Care Act came into force in 2012, service providers and commissioners of NHS care have had a legal obligation to take the Constitution into account in all their decisions and actions.

The Equality Act 2010 replaces all previous anti-discrimination legislation, and includes a public sector equality duty requiring public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework which should improve the experience of all patients using NHS services.

The Health and Social Care Bill (2012) advocates for a greater patient voice. The Government aims for there to be “no decision about me, without me” for patients and their own care. The same goes for the design of health and social care services at both a local and a national level. A key part of patient empowerment is to offer increased choice about their care

EVIDENCE FOR NEED

Despite these policy initiatives, there is evidence to suggest that further work is needed to deliver the best possible experience for users of NHS services. The Government signaled in its White Paper Equity and Excellence: Liberating the NHS (2010) that more emphasis needs to be placed on improving patients' experience of NHS care.

The Kings Fund, NHS Institute for Innovation and the Department of Health (2012) undertook research which showed that many senior leaders and others charged with improving quality in the NHS either do not know, or do not believe, that there is an evidence base on patient experience. The research showed that they are not confident about measuring patient experience themselves, and do not necessarily understand that there are real and important conceptual differences between different types of measure (measures of satisfaction, experience, patient reported outcomes (PROMS), and patient defined outcomes). The research highlighted that within the

NHS much time is spent on determining what systems and processes should be used and that this dominates the approach towards improving patients' experiences.

They suggest that NHS organisations collect feedback from patients without first asking the fundamental question, 'What problem are we trying to solve?' and 'When we have the data, what will we do with it?' They found very few NHS organisations with an overall strategy for improving patient experience, a defined budget, personnel with relevant expertise to collect data, analyse and present it, and an education and training plan with a budget for improving patient experience.

In this respect, patient experience differs from other dimensions of quality (clinical quality and patient safety) where the debate is rightly less about measures and measurement, and more about what needs to be done to respond to the evidence and what works in terms of change management. A national definition is a move in the right direction.

NICE GUIDANCE

NICE have developed clear guidance on the components of a good patient experience. This guidance provides the evidence and the direction for creating sustainable change that will result in an 'NHS cultural shift' towards a truly patient-centered service. A NICE quality standard for patient experience has been developed alongside this guidance, they set out aspirational, but achievable, markers of high-quality, cost-effective care. Quality standards are derived from the best available evidence and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

NICE clinical guidelines are usually shaped around both clinical and economic evidence, and include recommendations concerned with ensuring a good patient experience, with the recognition that such advice should sit alongside evidence of clinical and cost effectiveness. The recommendations in the current guidance have been informed by research evidence, recommendations in previously published NICE clinical guidelines, national survey data and consensus processes that have identified the key elements that are important to patients and how these can be improved to ensure a good experience of care. The guidance draws on multiple evidence and data sources in developing the recommendations, which are further distilled into commissioning guidance in the quality standard.

The recommendations in this guidance are directed primarily at clinical staff, but patient experience is also significantly affected by contacts with non-clinical staff such as receptionists, clerical staff and domestic staff. Services need to ensure that non-clinical staff are adequately trained and supported to engage with patients in ways that enhance the patient experience.

POLICY GUIDANCE

Everyone Counts: Planning for Patients 2013/14

The NHS Operating Framework 201314 specifically states that the NHS should collect and use patient experience information in real time and use it for service improvements: "NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real time' data techniques". The aim is to ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015.

Developing the culture of compassionate care: Creating a new vision and strategy for nurses, midwives and care-givers.

Care, compassion, competence, communication, courage and commitment. These are the six Cs set out in the Chief Nursing Officer's strategy. As the NHS helps people to live longer, care needs are changing, and our health and care services are evolving to meet these needs. What hasn't changed is the fundamental human need to be looked after with care and compassion, by a professional who is competent and communicates well, by someone with the courage to make changes that improve people's care and deliver the best and the commitment to deliver this all day, every day.

The NHS Outcomes Framework

The purpose of the NHS Outcomes Framework is to provide a national level overview of how well the NHS in performing, to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change culture and behaviour.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. One of the domains (domain 4) is about ensuring that people have a positive experience of care".

NICE Quality Standards for Patient Experience in Adult NHS Services

To deliver the best possible experience for patients who use NHS Services, high quality care should be clinically effective and safe. Launched in February 2012, this quality standard and accompanying clinical guidance aim to ensure that patients have an excellent experience of care from the NHS.

Commissioning for Quality Innovation Scheme (CQUIN)
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. The 'Friends and Family Test' is a nationally mandated CQUIN for 2013/14 and will be measured on all NHS Standard Contracts.

Quality Accounts
Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

NHS Constitution
The NHS Constitution commits the Government to providing a statement of NHS accountability. The NHS Constitution underpins patient experience; it reinforces the need for patient-centered care, where "there is no decision about me without me".

Section 242 – The Statutory Duty to Involve
The Duty to Involve sets out how the NHS is expected to involve and consult communities in the planning and development of services

Essence of Care
Essence of Care aims to support localised quality improvement, by providing a set of established and refreshed benchmarks supporting front line care across care settings at a local level. The benchmarking process outlined in Essence of Care 2010 helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.

Equity and Excellence – Liberating the NHS
The White Paper and legislative framework sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay.

Healthy Lives, Healthy People
The White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership

OUTCOME MEASURES

- In February 2012 the NHS National Quality Board (NQB) published the NHS Patient Experience Framework. This framework has been developed based on patient and carer views of what matters to them and it outlines those elements which are critical to the patients' experience of NHS Services and will the Framework used and implemented by the NHSCB Merseyside Nursing Directorate. The NHS National Quality Board (NQB) agreed on a working definition of patient experience to guide the measurement of patient experience across the NHS. The framework is based on a modified version of the Picker Institute Principles of Patient-Centered Care, an evidence based definition of a good patient experience. When using the framework the NHS is required under the Equality Act 2010 to take account of its Public Sector Equality Duty including eliminating discrimination, harassment and victimisation, promoting equality and fostering good relations between people.

- **NHS patient experience framework:**

9. **Respect of patient-centered values, preferences, and expressed needs**, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making;
10. **Coordination and integration of care** across health and social care system;
11. **Information, communication, and education** on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion;
12. **Physical comfort** including pain management, help with activities of daily living, and clean and comfortable surroundings;
13. **Emotional support** and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances;
14. **Welcoming the involvement of family and friends**, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers;
15. **Transition and continuity** as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions;
16. **Access to care** with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

DELIVERY

The NHSCB Merseyside Nursing Directorate will act in a clinical leadership role to ensure delivery across the system. Patient Experience should be a 'Golden Thread' that runs through the commissioning cycle and patients and carers seen as partners in the process. For this purpose the Nursing Directorate will support CCG's and NHSCB Direct Commissioning to embed the cultural change required to deliver "no decision about me without me". The work programme will be determined by the commissioning intentions and priorities of

commissioners. In the first instance assurance will be required that governance, process and systems are in place.

Initially, strong **governance structures** are required to allow a cohesive health system to work together for the common gain of improving all patient experience regardless of area of need or specialty. The NHSCB Merseyside team will work with all stakeholders to ensure enhancements can be made to current methodologies to ensure all experience data is captured, recorded, centralised, co-ordinated and, most importantly, utilised to improve experience and outcomes.

Currently, across the Merseyside area, Patient Reported Outcome Measures (PROMs) are utilised with varying degrees of consistency, depending upon the nature of the service being delivered. Ultimately, this means there is no natural "one size fits all" approach. Each PROM is tailored to ensure the service user has a meaningful and relevant PROM to feedback on. Surveys are often used to obtain feedback. Real Time measures are used such as voting type systems used during consultation events; focus groups; and 1:1 structured feedback sessions. Real time feedback is crucial and will be used by Clinical Commissioning Groups (CCG's) and NHSCB for directly commissioned services whilst working collaboratively with the providers to ensure swift responses are made whilst comments are logged to demonstrate where this has impacted on service delivery.

Standardisation is key to enable clear, transparent and honest choices to be made by patients, carers, families, providers and commissioners. This work has begun with the implementation of the 'The Friends and Family Test' which represents data collection on a national scale in a systematic way to enable comparative data to be analysed. From 1st April 2013, all hospitals in England will be expected to give every discharged adult inpatient or A&E attendee the opportunity to complete the Friends and Family Test. Given a target response rate of 15-20%, this is close to four million responses a year nationally. The key requirement is for one question: *'How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?'*. Responses to this question will be collated nationally and acute trusts will be paid under CQUIN arrangements for conducting the test and increasing their response rate within the year. Payments will also be made based on trusts' results for a similar question in the NHS Staff Survey.

Further to this, the GP NHS Choices site will be monitored and support offered to GP practices to improve patient choice and experience. This system should work in with their respective practice patient group which are active in every GP Practice across the region. Practice meetings also ensure wider surgery level issues can be shared and mutually resolved.

There is an identified need to procure an **electronic system** such as for example, REACT for commissioners to use in developing, redesigning and reviewing patient feedback on services that are directly commissioned. Such a web based system would enable real time recording of engagement activity and effective monitoring of consultations carried out. One of the major drivers behind the development of systems such as REACT has been an identified need from our Commissioners and Provider services for real time data, to

encourage greater collaborative working, preventing duplication of work and to support identification of gaps in engagement and feedback.

Furthermore, an **annual commissioning conference** could be organised collaboratively across CCG's and NHSCB to share where services have aligned themselves according to local need and local feedback. Public members should be allowed to join tender panels whilst being involved throughout the procurement process which demonstrates transparency in the decision making process.

In terms of **quality assurance** and rigorous adherence to the Patient Experience, proven models of practice should be utilised, such as the SENSE model for example. This methodology was rated as 'World Class' during the Department of Health's World Class Commissioning performance management periods. Proven practices should be utilised across the Merseyside area through collaborative commissioning ventures (primary, secondary and tertiary). The strategic SENSE model is a robust and transferable model and supports performance management requirements in regard to Patient Experience, Duty to Consult, and the wider responsibility of endorsing Quality Accounts with provider services. Additionally, it is the collective duty of all commissioners to identify any gaps in consortia intelligence via regular engagement with CCG leads and other providers of care, to ensure a smooth transition takes place and a quality assurance system is developed and adopted.

Working with clinical colleagues, stakeholders and partners the Nursing Directorate will implement the 6 C's outlined in the nursing strategy Developing the culture of compassionate care: Creating a new vision and strategy for nurses, midwives and care-givers. Modeling a collaborative leadership style and working closely with patients, carers and relatives and between nurses, doctors, therapists, managers and support staff who look after them to improve patient experience.

Quality	NHSCB Merseyside will ensure that through capturing all available feedback from patient contact is collated, shared and utilised in service review, redesign, decommissioning and procurement, this will ensure that any commissioned services are patient centred with the patient voice being central to all development. This, in theory, should enable a level of quality to flow through the healthcare system and be reflected in demonstrable improvements in Domain 4 outcome measures.
Innovation	Through devising a centralised system that captures all patient feedback and comments, across full provider and commissioner landscape, will be innovative in itself. There is a plethora of patient information within the health sector but to enable it to be centralised and co-ordinated, whilst allowing for direct access for service delivery will allow a higher degree of certainty that patient voice is heard. Directly commissioned services by NHSCB Merseyside will require providers to demonstrate the use of technology to

	improve patient experience and outcomes. NHSCB Merseyside will also seek assurance form CCG's that the same approach is being utilised in all directly commissioned services by CCG's.
Prevention	NHSCB Nursing Directorate will support implementation of the Health Visiting programme, Family Nurse partnerships programme and School Nursing programme to ensure the Public Health self-care programmes are embedded into communities.
Productivity	Listening to the patients, public, carers and their families can have significant impact on service provision. Through investing and utilising latest medical and assistive technologies in conjunction with evidenced best practice, treatment of for example long term conditions can be moved from acute to community providers. This will allow treatment to become more personalised and directed whilst also contributing to a reduction in acute beds and thus a reduction in overall secondary care spend. Furthermore, there is evidence to demonstrate a 25% increase in productivity, through community based treatment centres, whilst maintaining improved expenditure levels.

Link to NHS Constitution / Rights
• Involving patients in decisions about their care. • Supporting staff providing the care. • Encourage feedback from patients with a more open working culture. • Examining how information is used and protected • Making every contact count, so that healthcare professionals take every suitable opportunity to talk to patients about improving their health.
Risk and Issues
• See Risk Log

Directorate:	Medical Directorate	Area Team Executive Lead:	Dr John Hussey
Planning Period:	2013-14	Management Lead:	Nicola Allen
Programme Areas:	Responsible Officer: - GP Appraisal and Revalidation - Managing Poor Performance and Remediation - Controlled Drugs Accountable Officer - Maintenance of the NHS Performers List	Critical Interdependencies:	
Key Stakeholders:	Independent primary care providers. Patient and public forums CCGs Community Health Trusts Mersey Deanery Local Professional Networks Local Intelligence	Aspirational Metrics (decided locally):	

	Networks for controlled drugs (LIN) Quality Surveillance Group		
Local Metrics:	100% of GPs appraised annually 5 year programme for GP revalidation	National Metrics:	
Programme Link to NHS and PH Outcome framework (Specify Domains here):		NHS Outcome Framework measure (as per attached Mind Map ref):	

Overall Descriptive

Appraisal

The drive for formal appraisals came from the introduction of clinical governance outlined in the 1998 consultation document "A First Class Service – Quality in the New NHS". In 1999, the consultation document "Supporting Practitioners, Protecting Patients" proposed that all practitioners working in the NHS should be required to take part in regular appraisal. Participation in the appraisal process was made a contractual obligation of general practitioners and is required as part of inclusion on the Performers List, NHS (Performers List) Regulations apply.

Appraisal is a positive process to give practitioners feedback on their past performance, to chart their continuing progress and to identify development needs.
The aims of appraisal are to:

- To provide a safe environment for personal and professional development needs of the practitioners to be discussed, agreed and for the outputs of appraisal to be met, (PDP, summary of appraisal discussion, practitioners / appraiser statements).
- Review regularly a practitioner's work and performance utilising, where possible, relevant and appropriate comparative operational data from local, regional and national sources.

- Consider the practitioners contribution to the quality and improvement of services and priorities delivered locally.
- Optimise the use of skills and resources in seeking to achieve the delivery of general, personal and specialty medical services.
- Provide an opportunity for practitioners to discuss and seek support for their participation in activities for the wider NHS, and commissioning organisations.

NHS England (Merseyside) has 85 appraisers who have attended the Revalidation Support Team "Top up" training in order to undertake strengthened appraisal for the purpose of Revalidation.

Revalidation

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by NHS England (Merseyside) and the GMC to ensure they are fit for purpose and concerns are recognised and responded to. Licensed doctors will have to revalidate, usually every five years, by having annual appraisals that are based on the General Medical Council core guidance for doctors, (Good Medical Practice). Patients can help their doctors improve their practice by providing them with regular feedback about the care they have received.

The Responsible officer (Medical Director) is integral to improving the quality of care and ensuring a focus on the three core components of quality

1. Patient Safety – by ensuring that doctors are maintaining, and raising further, professional standards.
2. Effectiveness of care – by supporting professional ethos to improve further the effectiveness of clinical care.
3. Patient experience – by ensuring that patients' views are integral to evaluations of a doctor's fitness to practise.

The core mechanism underpinning revalidation is a strengthened appraisal system, which is designed to elicit the necessary information about a doctor's practice. The appraisal process will include information from multi-source feedback, Continuing Professional Development (CPD) portfolios and verified clinical performance information, along with the outcomes of any investigation of complaints, concerns, patient safety incidents and other available indicators that can be reliably related to the performance of the individual doctor.

Where there is justified cause for concern about a doctor's fitness to practise it will be managed through a poor performance and remediation processes.

Management of Poor performance and Remediation

Whilst most health care professionals practise to a very high standard, some independent contractors may occasionally work in ways that pose a serious risk to patient safety. NHS England (Merseyside) will act in accordance with the Policy for identifications, management and support of primary care practitioners whose performance gives cause for concern. The policy applies to general medical practitioners (GPs), general dental practitioners (GDPs), ophthalmic medical practitioners (OMPs) and optometrists included in a performers list for the provision of clinical services in primary care. It also applies to pharmacy contractors and dispensing appliance contractors (DACs) on a pharmaceutical list.

Concerns about a primary care performer or contractor may relate to any one of a number of areas, including:

- Poor clinical performance;
- Patient Complaints;
- Ill-treating patients;
- Unacceptable behaviour such as harassing or unlawfully discriminating against staff or patients;
- Breaching sexual or other boundaries with patients, colleagues or staff;
- Poor teamwork that compromises patient care;
- Personal health problems leading to poor practice or conduct;
- Not complying with professional codes of conduct;
- Not complying with medical revalidation requirements
- Poor management or administration that compromises patient care or;
- Suspected fraud or criminal offence

All those within the NHS England (Merseyside) who are involved with the handling of concerns about performance in primary care will seek to ensure that their working arrangements and procedures comply with these key principles.

- Protecting patients and the public, and enhancing their confidence in the NHS;
- Identifying the possible causes of underperformance;
- Ensuring equality and fairness of treatment and avoiding discrimination;
- Being supportive of all those involved;
- Confidentiality;

- Ensuring that action is based on reliable evidence; and
- Being clearly defined and open to scrutiny.
- Ensure that doctors who provide care continue to be safe clinical care
- Ensure that doctors are properly supported and managed in sustaining and, where necessary, raising their professional standards

For the very small minority of doctors who fall short of the high professional standards expected, ensure that there are fair and effective local systems to identify them and ensure appropriate remedial, performance or regulatory action to safeguard patients; and increase public and professional confidence in the regulation of doctors.

Cases handled under these arrangements could range from primary care performers or contractors needing temporary support whilst they resolve a short-term issue to more complex cases involving quite clear clinical, professional, management or organisational underperformance. It is important that all parties have confidence in the process and accordingly NHS England (Merseyside) will seek to raise awareness and understanding amongst primary care performers and contractors and others about this policy

Governance Structures for managing concerns
In order to manage performance concerns it is important to maintain a separation of responsibilities between the identification and analysis of performance issues and the responsibility for the final decisions regarding primary care performers or contractors.

NHS England (Merseyside) will establish a performance screening group (PSG) who will manage the identification and analysis of performance concerns and a performer's list decision panel who will take responsibility for the final decisions regarding primary care performers or contractors, subject to the right of appeal in accordance with NHS England policies and procedures.

The performance screening group (PSG) will be a repository of expertise provided by individuals with in-depth knowledge of performance procedures and professional standards and able to provide advice on handling individual cases. The group will review on a monthly basis all new and on-going cases of performance concerns.

The performers list decision panel (PLDP) will take overall responsibility for the management of primary care performer's or contractor's performance, to decide on actions required on individual performance cases, in line with statutory regulations, and to make referrals to other bodies where appropriate.

Controlled Drugs

The Medical Director is the Accountable Officer for Controlled Drugs and is responsible for ensuring the local arrangements for the disposal of controlled drugs are fully compliant with the Operating Model for NHSCB Area team's responsibilities in relation to Controlled Drugs. An interim process has been introduced for April 2013, pending agreement across Merseyside and Cheshire Area Teams with regards to the future arrangements for support to the CDAO

Quality	This work stream supports patient safety and clinical effectiveness by ensuring that all general practitioners participate in the annual appraisal process and are prepared for and undergo revalidation on a regular basis. This process ensures that the general public and patients can be satisfied and reassured with regards to the level of scrutiny and support given to individual clinicians practice. In addition to ongoing CPD for the individual and additional remediation support where capability gaps are identified, this process also supports the identification of wider training and development needs of professional practice locally, informing training and development programmes and the contracting process.
Innovation	
Prevention	
Productivity	

Link to NHS Constitution / Rights

❖

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	Governance infrastructure to support NHS (Performers List) Regulations	March 2013	April 2014
2.	CDAO – Support infrastructure agreed and developed	March 2013	May 2014
3.	Appraisals process 2013/2014	April 2013	March 2014
4.	Revalidation	Jan 2013	Ongoing

Directorate:	Medical Directorate	Area Team Executive Lead:	Dr John Hussey
Planning Period:	2013-14	Management Lead:	Nicola Allen
Programme Areas:	Clinical Quality	Critical Interdependencies:	
Key Stakeholders:	Independent primary care providers. Patient and public forums CCGs Community Health Trusts Local Professional Networks Quality Surveillance Group	Aspirational Metrics (decided locally):	
Local Metrics:		National Metrics:	
Programme Link to NHS and PH Outcome framework (Specify Domains here):		NHS Outcome Framework measure (as per attached Mind Map ref):	
Overall Descriptive			

This work stream will ensure the Oversight role of the Medical Director is fully met whilst facilitating continuous improvement of the clinical quality of health services across Merseyside through:
Working with CCGs to develop a local minimum threshold with regard to clinical standards within primary care
Triangulation of all quality data and feedback regarding providers (including general practice) to build up provider profiles that encompass contractual data, complaints, appraisals, reports from external regulators etc.
Development of a local Clinical Governance Framework
Routine meetings between the Medical Director and senior clinicians within CCGs to review collective priorities and performance.
Establishment of a local NHS England Quality Group to develop an integrated work programme for the Area Team

Quality	This work stream will contribute to the ongoing clinical quality improvement agenda across all commissioned services, with a particular focus in year one (2013/14) on primary care services as a shared area of development for both NHS England direct commission and CCGs
Innovation	Through triangulation of information and the development of provider profiles direct commissioners will be better informed than ever before with regard to service delivery, safety and overall patient experience. The development of minimum local standards (at a threshold above the national minimum standard, building on best practice already developed by PCTs and latterly CCGs locally) will ensure primary care across Merseyside is at the forefront of quality nationally
Prevention	
Productivity	

Link to NHS Constitution / Rights

❖

Risk and Issues

Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	Mapping of all available quality data with regard to primary care	March 2013	April 2013
2.	Development of provider profiles for all general practices	March 2013	June 2013
3.	Sharing of appraisal patterns/trends with CCGs for 12/13	March 2013	March 2013
4.	Development of Merseyside Clinical Governance Framework	February 2013	May 2013
5.	Establishment of internal NHS England Quality Group	March 2013	Ongoing
6.	Development of local minimum Quality Standards for primary care	March 2013	July 2013

Directorate:	Medical Directorate	Area Team Executive Lead:	Dr John Hussey
Planning Period:	2013-14	Management Lead:	Nicola Allen
Programme Areas:	Clinical Strategy	Critical Interdependencies:	
Key Stakeholders:	Patient and public forums CCGs Providers Local Professional Networks Specialised Services Clinical Senates Clinical Networks ODNs	Aspirational Metrics (decided locally):	
Local Metrics:	To be developed in 2013/14	National Metrics:	
Programme Link to NHS and PH Outcome framework (Specify Domains here):		NHS Outcome Framework measure (as per attached Mind Map ref):	

Overall Descriptive

The need for a cohesive strategy to enable local commissioners and providers to collectively navigate the challenges to the local health economy over the next 5-7 years is recognised by local stakeholders. In addition to the challenges shared locally and on a national

footprint of constricted financial resources, limited availability of expertise in some clinical areas and disciplines, changing demographic with regard to an increasingly aging population with increased morbidity and changing social context with regard to public expectations and norms, there are also some unique characteristics with regards to the provider landscape across Merseyside which introduce additional challenges when considering the on-going reconfiguration of services driven by the introduction of service specifications for key specialised services and "safe and sustainable" reviews. Facilitation of clinical strategy development and implementation is a key priority for the NHS England (Merseyside) team which is to be progressed through a collaborative approach led by CCGs on a collective and network basis. The broad work plan is to establish the Governance infrastructure, key priority areas and the metrics to support these in the first part of 13/14 with subsequent service developments and improvements to be worked up and embedded in contracts (where necessary) for 14/15 on a rolling programme basis. Running alongside this will be the impact of self-assessment and subsequent accreditation with regard to the national CRG (Clinical Reference Groups) for specialised services specifications, the outcome of which will determine the service providers who will be accredited to continue to deliver specialised services from 14/15 onwards. The impact of this work will inform the local clinical strategy. April 2013 will see the launch of Operational Delivery Networks, of particular relevance to Merseyside health services is the success of the Major Trauma and Critical Care ODNs, Merseyside AT will work closely with Cheshire AT to ensure this transition to a new organisational form is managed as smoothly as possible.	
Quality	This work stream will remain focused on the need to ensure any service development or change to service delivery is predicated on a firm evidence base of patient outcomes and is informed by national and international best practise
Innovation	The role of the Area Team will be to facilitate and support providers and local commissioners to consider new technologies and alternative and new means of service delivery to gain better outcomes for patients
Prevention	The central premise agreed by local commissioners for a successful strategy (determined by the health economy collectively continuing to operate within financial limits whilst delivering improved quality of services and patient outcomes in 5 years' time) is to facilitate the shift from treatment of ill health to an increased focus on prevention and management of conditions outside the acute sector.
Productivity	The clinical strategy will be built on an expectation that services operate within specified efficiency margins, recognising that gains in this area cannot be the sole responsibility of the acute provider sector.

Link to NHS Constitution / Rights
Risk and Issues
Please complete the dedicated risk log via the mapping template directly (excel spread sheet - 2nd tab)

Proposed Delivery Timeline / Milestone Level

No.	Task Name	Start	Finish
1.	Launch of ODNs	Feb 2013	April 2013
2.	Development of Clinical strategy	Oct 2012	Oct 2013
3.	Implementation of Clinical Strategy	April 2013	Ongoing
4.	Transition of Major Trauma Network and Rehabilitation Networks to new commissioning system	March 2013	June 2013
5.	Data flows with regard to outcomes of reconfigured service drawn into NHS England local intelligence (Major Trauma, Vascular, Rehabilitation etc). Establishment of a data suite	April 2013	May 2013

Directorate:	Assurance and Delivery Directorate	Area Team Executive Lead:	Johanna Riley
Planning Period:	2013-14	Management Lead:	Leigh Thompson-Greatrex
Programme Area:	CCG Assurance and Delivery	Critical Interdependencies:	All Area team directorates
Key Stakeholders:	National/Regional Team CCG's LA's Public health England Specialised Commissioning Health Watch NHSTDA	Aspirational Metrics (decided locally):	
Local Metrics:		National Metrics:	
Programme Link to NHS Outcome framework (Specify Domains here):	Linked to all Domains of the Outcomes Framework	NHS Outcome Framework measure (as per attached Mind Map ref):	Linked to all Outcome Framework

Overall Descriptive

NCB Merseyside Assurance and Delivery team will be working across Merseyside with the 6 CCGs to ensure that they are authorised with minimum conditions, that they all have clear and credible plans, that we work collaboratively across the health economy, that we gain the necessary assurances from our co commissioners that patient experience and good outcomes are paramount. Our Aim is to have the best CCG's with the best (improved and sustainable) health services and outcomes for our patient population.

CCG Assurance

The process of CCG assurance needs to strike the balance between being sufficiently robust and rigorous to secure NHS delivery (national consistency) whilst being simple enough to reduce the burden of bureaucracy and safeguard the assumed liberty of performing CCGs (local autonomy).

Building on the approaches taken during CCG authorisation and the 2013/14 planning round, the construction of the assurance process has taken an iterative approach, with an on-going dialogue between NHS CB and CCG colleagues. It also aims to draw the links between CCG authorisation, the Mandate, the NHS Outcomes Framework, the NHS Constitution and Everyone Counts.

Necessarily, the first year of assurance will feel different to subsequent years and the process will continue to evolve with assurance for 2014/15 building on the lessons learned during 2013/14, refining the process as we better understand the landscape and building a developmental approach as CCGs pursue excellence in delivery.

The process combines the application of a transparent, rules based approach with the ability to apply local discretion and judgement, and seeks to minimise the scale of upward reporting for CCGs (except where this is required under an intervention regime).

The minimal requirement for most CCGs will be self-certification of key elements, alongside data requirements to supply information to NHS CB. Assurance will help to identify outlier organisations and focus the whole system on providing support to secure safe and sustainable services for patients

Authorisation and Planning

There are currently two processes in progress between the NHS Commissioning Board and CCGs, to consider organisational competence and delivery:

- CCG authorisation process - which provided a thorough assessment of a CCG's legal compliance, readiness for statutory duties and effective arrangements for commissioning

- Planning round for 2013/14 - *Everyone Counts* sets out the delivery challenge for commissioners over the coming year

CCG assurance will be about ensuring that the outcomes from both of these processes remain strongly embedded - i.e. CCGs operate as highly competent organisations and deliver against their operational plans. Fundamentally, the two processes are being brought together to provide assurance against 6 key areas of delivery competence.

These will be underpinned by robust data streams and informed by the relevant criteria from the initial authorisation domains.

The 6 domains of CCG assurance are:

- The NHS constitution
- Quality and Safety
- Stakeholder Engagement
- Organisation Capacity
- Finance
- NHS Outcomes Framework

An Integrated Approach

Fundamentally, oversight of delivery will be best understood through the regular interactions between the NHS CB and CCGs and it is vital that both day to day interactions and the key elements of assurance are led and owned by Area Teams and CCGs.

To underpin these conversations, there are regular checkpoints to gain formal central insight into performance delivery - in year assurance and annual assurance.

We propose that both in year and annual assurance are led locally and designed to deliver a rounded assurance that organisations are high performing, delivering high quality, safe services within their existing budgets.

By March 2013, we aim to produce:

- A finalised proposal for in-year assurance to be rolled out to CCGs and Area Teams
- A draft proposal for annual assurance to be tested further with CCG and Area Team stakeholders with a view to producing a finalised proposal by June 2013

CCG In-year Assurance

Description
In-year assurance will take place on a quarterly basis. We expect in year assurance to be led locally and to provide a formal checkpoint in the on-going relationship between CCGs and Area Teams.
For practical reasons, the in-year assessment will be based around available and timely data but will assess the following:

- Continued delivery of the NHS Constitution
- Progress against NHS Outcomes Framework (as indicated in Annex A of *Everyone Counts)*
- Finance performance
- Quality in local providers (as measured by CQC intervention)
- Progress against authorisation & Delivery - removal of conditions of authorisation and maintenance of existing standards

Approach
Based on feedback from CCG and Area Team stakeholders, the proposal is for a balanced score card approach which would be coordinated centrally from local input and underpinned by national data. The approach will be based on the Monitor model of self-certification. Where an organisation assesses itself as not performing against an element of the balanced scorecard, support will be agreed based on national criteria and local knowledge to set meaningful trajectories for improvement.

CCG Annual Assurance

Annual assurance will be led locally and will take place in the Q1 following the end of the performance year in March. The process will build on in-year assurance and plan development and will take elements of the CCG authorisation to inform the design. It should be collaborative in nature and cut across organisational, professional and geographical boundaries.

We anticipate that the process will be minimal for most CCGs who are continuing to perform strongly without authorisation conditions or performance concerns.
In future years, the process will be developed in response to feedback and to recognise delivery of excellence across the balanced scorecard.

The annual assurance will satisfy the Commissioning Board's statutory requirement to meet with CCGs on an annual basis. Learning

lessons from the CCG authorisation process, the primary means of assurance will be a site visit informed by the following:

- Balanced Scorecards from previous quarterly reviews
- Self-certification by CCGs against statutory obligations
- 360 degree feedback survey - refined from the CCG authorisation process

The panel for the site visit will be co-ordinated by Area Teams but must include independent representation from an approved list of trained individuals

Support Framework

The Act sets out a duty of assumed liberty for CCGs.
The Act sets out a range of interventions the Board can implement which give it broad powers. Where it has reason to believe a CCG may be failing or might fail the NHS CB can:

- Request information, explanations or documents from CCGs

Where it is satisfied the CCG is failing or is at significant risk of failing to discharge its functions the NHS CB can :

- Direct the CCGs as to how it discharges its functions
- Direct the CCG or the Accountable Officer to stop carrying out any functions for a defined period
- Terminate the AO's appointment and appoint a new AO
- Vary a CCGs constitution
- Carry out certain functions on behalf of a CCG or arrange for another CCG to do so
- Dissolve the CCG
- The Board needs to set out its procedures it must follow before it can exercise its powers of intervention.
- The framework will therefore be more rules based
- Need to balance this against the ability to use soft intelligence and local judgement

Suggested Approach

The support framework should be designed to promote CCGs asking for support before it is necessary to apply the intervention regime.

Levels of possible support in line with levels as specified for conditions :

i Model document guidance, with informal advice available if needed
ii Make advice/expertise available to the CCG - more structured and proactive than under
iii CCG decisions must be signed off or approved by the Board, either at local, regional or national level
iv. The Board will provide or insert a specific team or individual to give in-house support to the CCG
v. The Board does not ratify the appointment of the proposed AO and appoints an alternative AO
vi. The CCG has specific functions removed - these could be carried out by another CCG or by the Board (there are particular legal considerations to be made in this case)
vii. All functions removed

Whilst the emphasis will be on early identification of issues through on-going dialogue between CCGs and Area Teams the Assurance Framework will set the thresholds for formal support. However, the first step before triggering formal support will always be a discussion on whether AT actually needs to intervene. It may that a local decision is made that informal support is more appropriate and for example with support, the CCG is given time to improve.

Quality	The Assurance & Delivery team are an enabler to the CCG's and to the planning process. The teams work programme will ensure that CCG's are strong and viable organisations. Via the authorisation process and planning round 13/14 we will ensure CCG plans and Direct Commissioning plans are aligned and produced to the highest standard to ensure that the population of Merseyside receive high quality services.
Innovation	The CCG's are required to be innovative as part of authorisation domain 4. It is essential for the future of the NHS to be innovative and have radical ways of working, all be it in a much smaller financial envelope. The CCG's will need to work in collaboration with partners across the health and social care sector to achieve their aspirations. The Assurance and Delivery team will be encouraging this approach but will also be maintaining a system overview to ensure this doesn't have a negative impact on service delivery and quality.
Prevention	The CCG's and partners will require working collaboratively to deliver a different health service. In light of the NHS reforms and Francis report it is evident that services will have to be delivered differently. The CCG's will be required to move care closer to home and invest in primary care services to ensure patients can readily access services.
Productivity	The Assurance and Delivery team will ensure the CCG's are supported to commission high quality services. The team will also ensure that the CCG delivers against the authorisation domains. The team will have a light touch approach and will tailor their support to individual CCG's as and when required.

Link to NHS Constitution / Rights
The Assurance and Delivery Team will ensure that CCG's achieve the following areas within the NHS Constitution • Full compliance of the NHS Rights and pledges of the constitution • Full compliance of the Mandate • Full compliance and adherence to the national indicator sets and outcome frameworks • Including ➢ Referral to Treatment (18weeks) ➢ HCAI ➢ A&E waits ➢ Cancer Waits – 62 days ➢ Category A Ambulance calls
Risk and Issues
Please complete the dedicated risk log

Proposed Delivery Timeline / Milestone Level

To be developed

Appendix 7.

Mersey Cluster - Public Health Performance

Halton

Life expectancy at birth – males

The data in the chart is based on rolling three year pooled data using the local Public Health Mortality File. The trend has shown a gradual increase over the last four years, mirroring the England and Merseyside trends. Male life expectancy at birth has increased from 74.7 years at Q3 2008/09 to 76.3 at Q2 2012/13. Although the Halton rate is still significantly lower than England, the gap has narrowed. The Public Health team and Clinical Commissioning Group (CCG) are continuing to focus on prevention and management of chronic conditions which will help to improve life expectancy and quality of life.

Life expectancy at birth – females

The data in the chart is based on rolling three year pooled data using the local Public Health Mortality File. The trend has shown a gradual increase over the last four years, mirroring the England and Merseyside trends; the Halton value is now on a par with the Merseyside average. Female life expectancy at birth has increased from 78.8 years at Q3 2008/09 to 80.1 at Q2 2012/13. Although the Halton rate is still significantly lower than England, the gap has narrowed. The Public Health team and CCG are continuing to focus on prevention and management of chronic conditions which will help to improve life expectancy and quality of life.

All age all-cause mortality – males

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in Halton has seen a gradual reduction over the last few years; noticeably in the last year to Q2 2012/13 where the rate has dropped from 818.4 per 100,000 to 743.8. This is positive and focus on a reduction in male deaths should be continued.

All age all-cause mortality – females

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in Halton has seen some fluctuation, with a rise during 2008 followed by a steady reduction. There has been a slight increase in the rate during the last year, although this is not a statistically significant change; focus on a reduction in female deaths will be continued so performance will be monitored closely.

Premature mortality – cardiovascular disease

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in Halton has seen some fluctuation, with a rise during 2010 followed by a steady reduction, bringing rates very close to the England average. There

has been a slight increase in the rate during the last year, although this is not a statistically significant change; we need to continue to ensure we make focus on a reduction in CVD deaths so will monitor the performance closely.

Premature mortality – cancer

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in Halton has seen some fluctuation but has been declining since 2010, bringing the rate in line with the Merseyside average. Rates are still significantly higher than England, so we need to continue to ensure we make focus on a reduction in cancer deaths.

General commentary for AAAC, cancer and cardiovascular disease mortality

Halton has a successful smoking cessation and tobacco control programme which has contributed to the reduction in death rates from both circulatory disease and lung cancer. The introduction of Bowel Cancer Screening and the local early detection efforts that are under way, with improvements in treatment and falls in smoking amongst men, are amongst the most significant reasons for the improvement. Health Checks Plus has been successful in detecting risk factors early and cancer remains a local health priority.

Alcohol-related hospital admissions

The data in the chart is based on a rolling one year standardised rate using local data from the Secondary User System. The Halton trend has mirrored the England data showing a steady increase of approximately 500/100,000 admissions relating to alcohol, from 2008/09 to 2011/12. Rate is still significantly higher than England, so we need to continue to ensure we make focus on a reduction in hospital admissions, in conjunction with the CCG and other agencies. Alcohol is a local health priority and therefore considerable work has already in progress and will continue with the development of an action plan.

Year 6 childhood obesity National Child Measurement Programme (NCMP)

The data in the chart is based on an academic school year and presents the percentage of Year 6 children that are obese, of those weighed and measured. The trend in Halton has fluctuated from year to year, but there was an increase in 2010/11. However, data is now available for 2011/12 and shows a reduction to 19.4% in Halton, bringing it more in line with England (19.2%) and the North West (19.8%). This is positive, although work needs to continue to ensure the percentage declines each year. Child development is a local priority for Halton, which is designed to improve this outcome along with specific health improvement programmes around healthy eating and exercise in schools.

St Helens

Life expectancy at birth – males

The data in the chart is based on rolling three year pooled data using the local Public Health Mortality File. The trend has shown an increase over the last four years, at a faster rate to the

England and Merseyside trends, meaning the gap to the England average appears to be narrowing. The Q2 2012/13 three year pooled life expectancy figure for men in St Helens now stands at 77.4 years. Further work to improve this will come from the local Health and Wellbeing Strategy, including tackling alcohol misuse, reducing obesity and early detection and effective management of long term conditions.

Life expectancy at birth – females

The data in the chart is based on rolling three year pooled data using the local Public Health Mortality File. As for male life expectancy, female life expectancy has been increasing and now sits between the Merseyside and England averages. The Q2 2012/13 three year pooled life expectancy figure for women is now 81.6 years in St Helens. The same priorities are being targeted through the health and wellbeing strategy.

All age all-cause mortality – males

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in St Helens has seen a gradual reduction over the last few years; though there does appear to have been a slight increase over the last 12 months up to a figure of 739.5 per 100,000 in Q2 2012/13. While not increasing enough to reach the male mortality highs of 2009/10 and earlier, this is still an important issue and further analysis of this data is about to start to identify the reasons for this in St Helens.

All age all-cause mortality – females

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The rate in St Helens has been very stable over the last 18 months, and currently stands at a figure of 512.9 per 100,000 in Q2 2012/13.

Premature mortality – cardiovascular disease

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in St Helens saw a downward trend between 2008/9 and 2011/12. It reached the average for England in 2011/12 and has now stabilised. The rate in Q2 2012/13 is 63.7 per 100,000.

Premature mortality – cancer

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. The trend in St Helens has seen some fluctuation but rates are in line with those for England at 115.9 per 100,000.

General commentary for AAAC, cancer and cardiovascular disease mortality

Smoking is still a significant avoidable cause of early mortality in St Helens Data from the Merseyside Lifestyle Survey indicates that smoking levels are still high in St. Helens. There will be a focus on reviewing and reinvigorating the Tobacco Control programme over the next year. This is expected to lead to improvements in mortality and life expectancy.

Alcohol-related hospital admissions

The data in the chart is based on a rolling one year standardised rate using local data from the Secondary User System. The St Helens trend has mirrored the England data showing a steady increase from 2008/09 to 2011/12. Rates are still significantly higher than England; however they are less than anticipated. Work continues to embed the core alcohol treatment service Addaction and the Whiston Alcohol Liaison Nursing Scheme. Alcohol Action Plans have been developed to deliver the alcohol harm reduction element of St Helens Health & Wellbeing Strategy.

Year 6 childhood obesity National Child Measurement Programme (NCMP)

The data in the chart is based on an academic school year and presents the percentage of Year 6 children that are obese, of those weighed and measured. The trend in St Helens has fluctuated from year to year, and there was an increase in 2008/09. However, data remained similar between 2008/9 and 2010/11, and remains close to the Merseyside average.

Liverpool

Life expectancy at birth – males

The data in the chart is based on rolling three year pooled data using the local Public Health Mortality File. Over the last year of reporting, male life expectancy in Liverpool has increased from 75.16 to 76.14 years.

Life expectancy at birth – females

The data in the chart is based on rolling three year pooled data using the local Public Health Mortality File. Over the last year of reporting, female life expectancy in Liverpool has increased from 79.6 to 80.2 years.

All age all-cause mortality – males

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. Over the last year of reporting, Liverpool's male rate has fallen from 850.1 to 802.8 deaths per 100,000 population which represents a 6% reduction.

All age all-cause mortality – females

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. Over the last year of reporting, Liverpool's female rate has fallen from 619.2 to 559.3 deaths per 100,000 population which represents a 10% reduction.

Premature mortality – cardiovascular disease (CVD)

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. Premature CVD mortality rates have fallen steadily over recent years. In the last year of reporting, Liverpool's rate has fallen from 91.4 to 76.4 deaths per 100,000 population which represents a 16% reduction.

Premature mortality – cancer

The data in the chart is based on a rolling one year standardised rate using local data from the Public Health Mortality File. Premature cancer rates have fluctuated in recent years, although in the last year of reporting Liverpool's rate has fallen from 152.8 to 143.2 deaths per 100,000 population which represents a 6% reduction.

General commentary for AAAC, cancer and cardiovascular disease mortality

Some of the reduction in mortality rates can be attributed to the revised mid-year population estimates which were released following the 2011 Census results.

Alcohol-related hospital admissions

Liverpool's alcohol-related hospital admissions rose over 2011/12 after showing signs of decline in 2010/11. To help address this issue alcohol is one of the key priorities of Liverpool's Health and Wellbeing Board.

Year 6 childhood obesity National Child Measurement Programme (NCMP)

The data in the chart is based on an academic school year and presents the percentage of Year 6 children that are obese, of those weighed and measured. Despite an increase in the obesity level between 2009/10 and 2010/11, Liverpool's rate is in line with the rest of Merseyside.

Knowsley

Life expectancy at birth – males

The male life expectancy at birth trends on the chart are quarterly updates based on a three-year pooled calculation based on public health mortality files. In the period (almost 4 years) covered in the chart, male life expectancy has increased steadily. However, over the latest 12 months, life expectancy has been relatively steady. Male life expectancy in Knowsley is now higher than the Mersey cluster as a whole.

Life expectancy at birth – females

Female life expectancy has increased steadily in Knowsley since Q3 of 2008/09 as can be seen in the chart. As with males, female life expectancy at birth has remained relatively stable over the latest 12 months and is now higher than the Mersey cluster.

All-age all-cause mortality – males

Since 2006/07 Q3 the rolling annual all-age all-cause mortality rate for males has fallen steadily. Knowsley's rate has dropped below the NHS Merseyside rate in 2011/12 and over the latest reported 12 months has dropped by 4%. However, Knowsley's rate remains significantly higher than England.

All-age all-cause mortality – females

Over the last three reporting years, the rolling annual all-age all-cause mortality rate for females has been relatively static. Prior to this there had been a steady decline in the mortality rate. In the last 12 months, Knowsley's female mortality rate has increased by 2% and remains significantly higher than the comparative rate for England. Two of the main reasons for the increase in female mortality are the increase in female cancer and female respiratory disease mortality over the last year.

Premature mortality – cardiovascular disease

The age-standardised mortality rate in Knowsley for people aged under 75 years of age has dropped by 40% since 2006/07 Q3. This has led to Knowsley's rate falling below the NHS Merseyside rate but even with such large reductions, Knowsley's rate remains significantly higher than England.

Premature mortality – cancer

Premature cancer mortality in Knowsley has remained relatively constant since the beginning of 2007/08. Latest analysis shows that the reason for this is an increasing female mortality rate whilst at the same time male mortality has been falling. Knowsley's rate remains higher than the NHS Merseyside area as a whole and also significantly higher than England.

General commentary for AAAC, cancer and cardiovascular disease mortality

Some caution must be applied to the mortality and life expectancy results as 2011 population estimates have been calculated using 2011 Census population figures. It is proposed that 2002-2010 population estimates will be revised by the Office for National Statistics later in 2013.

Alcohol related hospital admissions

Alcohol related hospital admissions in Knowsley are significantly higher than nationally and have been on the increase since 2008/09 Q4. However, for four consecutive quarters between 2010/11 Q2 and 2011/12 Q2 the alcohol related admission rate fell for the first time since analysis was started, but has now started to rise once more. Alcohol is one of the priorities from the local Joint Health Needs Assessment and for Knowsley's Health & Wellbeing Strategy.

Year 6 childhood obesity

The level of childhood obesity in year six children derived from the National Child Measurement Programme is high in Knowsley. It has risen steadily since 2006/07 from 18.3% and the latest available data for 2011/12 shows an increase to 25.2% in 2011/12. Knowsley has the 2nd highest levels of obesity amongst year six children in the North West region.

Sefton

Life expectancy at birth – males

The data in the chart is based on rolling three year pooled data using the official Office for National Statistics (ONS) annual deaths data and data from the quarterly Primary Care Mortality Database. Over the last year of reporting, male life expectancy in Sefton has increased from 77.4 to 78.0 years.

Life expectancy at birth – females

The data in the chart is based on rolling three year pooled data using the official ONS annual deaths data and data from the quarterly Primary Care Mortality Database. Over the last year of reporting, female life expectancy in Sefton has increased from 82.7 to 83.1 years.

All age all cause mortality – males

The data in the chart is based on a rolling one year standardised rate using local data from the official ONS annual deaths data and data from the quarterly Primary Care Mortality Database. Over the last year of reporting, Sefton's male rate has fallen from 710.5 to 589.5 deaths per 100,000 population which represents a 20.5% reduction.

All age all cause mortality - females

The data in the chart is based on a rolling one year standardised rate using local data from the official ONS annual deaths data and data from the quarterly Primary Care Mortality Database.

Over the last year of reporting, Sefton's female rate has fallen from 457.5 to 428.2 deaths per 100,000 population which represents a 6.8% reduction.

Premature mortality – cardiovascular disease

The data in the chart is based on a rolling one year standardised rate using local data from the official ONS annual deaths data and data from the quarterly Primary Care Mortality Database. Premature CVD mortality rates have fallen steadily over recent years. In the last year of reporting, Sefton's rate has fallen from 71.6 to 53.3 deaths per 100,000 population which represents a 34.3% reduction.

Premature mortality – cancer

The data in the chart is based on a rolling one year standardised rate using local data from the official ONS annual deaths data and data from the quarterly Primary Care Mortality Database. Premature cancer rates have fluctuated in recent years, although in the last year of reporting Sefton's rate has fallen from 113.5 to 110.8 deaths per 100,000 population which represents a 2.4% reduction.

General commentary for AAAC, cancer and cardiovascular disease mortality

The trend for all age all cause mortality indicators from Q1 of 2011/12 onwards looks so different to the trends pre 2011 due to the population estimates used to generate the rates on the charts. Rates for 2011 onwards use 2011 Census based population estimates. Rates pre 2011 were calculated using Mid Year population estimates. These take are produced using both official births and deaths data and modelled migration data from the last Census in 2001 in order to estimate the size of the population. The use of migration data from the last Census in 2001 is problematic for Sefton in that it pre dates the 2004 accession of EU countries, when workers from EU-accession countries were granted freedom of movement, allowing them to enter the UK. Therefore the Mid-Year estimates do not accurately take into account the change in population due to migration. During March 2013, the Office for National Statistics plans to revise earlier Local Authority population estimates for the period 2002-2010 using the 2011 census data, accompanied with a report explaining how differences between the Census results and the existing mid-year estimates for local authorities have been distributed over the decade. Once the populations revisions have been released, the rates will be revised, and we would expect to see the lines on the charts for Sefton pre 2011 to fall lower, nearer to the post 2011 rates.

Alcohol-related hospital admissions

Sefton's alcohol-related hospital admissions rose over 2011/12 after showing signs of decline in 2010/11 but are still below 2010/11 levels. Sefton targeted a 1% reduction in the rate of increase in admissions seen in recent years, and narrowly missed this target (actual rate for 2011/12 was 2,319.1, against a target rate of 2,285.7 – the actual rate was within 1.5% of the target)

Year 6 childhood obesity (NCMP)

The data in the chart is based on an academic school year and presents the percentage of year six children that are obese, of those weighed and measured. Despite an increase in the obesity level between 2009/10 and 2010/11, Sefton's rate is in line with the rest of Merseyside.

Appendix 8 – Merseyside JSNA Hyperlinks

Below are the hyperlinks to all of the current JSNA's across Merseyside:

Halton

http://www3.halton.gov.uk/healthandsocialcare/healthandmedicaladvice/healthjointstrategicneedsassessment/

Knowsley

http://www.knowsley.nhs.uk/jsna/

Liverpool

http://liverpool.gov.uk/council/strategies-plans-and-policies/adult-services-and-health/joint-strategic-needs-assessment-2012/

Sefton

http://www.sefton.gov.uk/pdf/jsna_draft_2012.pdf

St Helens

http://www.sthelens.gov.uk/what-we-do/social-care-and-health/health/

First published 22ND March 2013
Published to Name, in electronic format only.