NHS England

NHS England (Kent and Medway)

Direct Commissioning Strategy and Two Year Operational Plan

2014 to 2016

THE NHS CONSTITUTION
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CONTENTS

SECTION 1: INTRODUCTION

1. This paper provides information about NHS England (Kent and Medway)'s commissioning plans for 2014/15 and 2014/15.
2. NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government. Through its twenty-seven local area teams, NHS England is responsible for directly commissioning:
    - primary care services (GP, dental, optometry and pharmacy services);
    - secondary care dental services;
    - specialised healthcare services;
    - healthcare services for offenders and those within the justice system;
    - a range of public health service on behalf of Public Health England (e.g. covering pregnancy to age five public health programmes, screening and immunisation programmes, sexual assault referral centres); and
    - some healthcare services for the armed forces.
3. NHS England (Kent and Medway) is the local arm of NHS England (also known as the Kent and Medway Area Team).
4. In regards to its direct commissioning functions, NHS England's focus is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.
5. NHS England also works closely with local clinical commissioning groups (CCGs) to support them to use their local knowledge and understanding of the needs of local patients to commission a wide range of other community and hospital services.
6. Work is taking place to develop five year commissioning plans. It is important that this two year plan, which needs to be submitted to an earlier timescale is also presented within the context of, and fits within, the overarching strategic direction of travel. Therefore, this document contains information on the strategic direction for the services directly commissioned by NHS England (Kent and Medway) and this document should also be read in conjunction with NHS England (Kent and Medway)'s Strategic Framework for Primary Care.

The national context

7. Each year the Government publishes the NHS mandate setting out ambitions for the National Health Service. This can be viewed at https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015. The mandate details the outcomes that the Government wants the NHS to achieve for patients but gives clinical commissioning groups (CCGs) and NHS England (through its direct commissioning role) flexibility on how these are delivered.

8. Much of the basis for the Government's mandate originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

   a. We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.

   b. We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.

   c. We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.

   d. We want to ensure patients have a **great experience** of all their care.

   e. We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

9. Delivering these identified long-term ambitions will require transformational change across health and care systems and in the way health services are delivered. That is why in July 2013 NHS England (along with our national partners) launched *A Call to Action* which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. We need to find ways to raise the quality of care for all in our communities to the best international standards, while closing a potential funding gap of around £30 billion by 2020/21.

10. On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled Everyone Counts: Planning for Patients 2014/15 to 2018/19. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to ***make high quality care for all, now and for future generations*** into a reality. The planning guidance can be viewed at http://www.england.nhs.uk/2013/12/20/planning-guidance/ and will be used to inform the development of local health services in Kent and Medway.

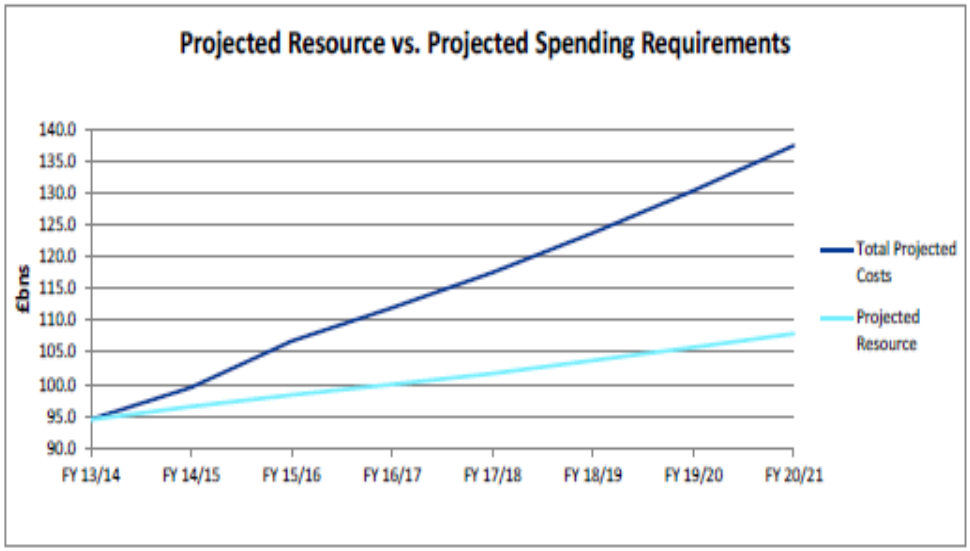
11. Change will need to be achieved through:

    - Listening to patient views
    - Delivering better care by realising the benefits of the digital revolution
    - Transparency and sharing data about local health services
    - Transforming primary care services
    - Ensuring tailored care for vulnerable and older people
    - Delivering care in a way that is integrated around the individual patient
    - Ensuring access to the highest quality urgent and emergency care
    - A step change in the quality of elective care
    - Providing specialised services concentrated in centres of excellence
    - Improving access to services (e.g. moving to seven day service provision)
    - Supporting research and innovation
    - Developing an integrated training model

12. NHS England is focused on ensuring equity and consistency of provision but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally. The following sections provide information on the development of commissioning plans and intentions for those services that NHS England directly commissions for the population of Kent and Medway, taking account of the national planning guidance and commissioning intentions.

The financial challenge

13. Nationally there is a forecast national financial gap of circa £30 billion by 2020/21. This is shown on the graph below. This details projections around the raising costs of NHS healthcare, largely due to an aging population (described later in this document) and projected resources (i.e. funding) that will be available to meet this demand.



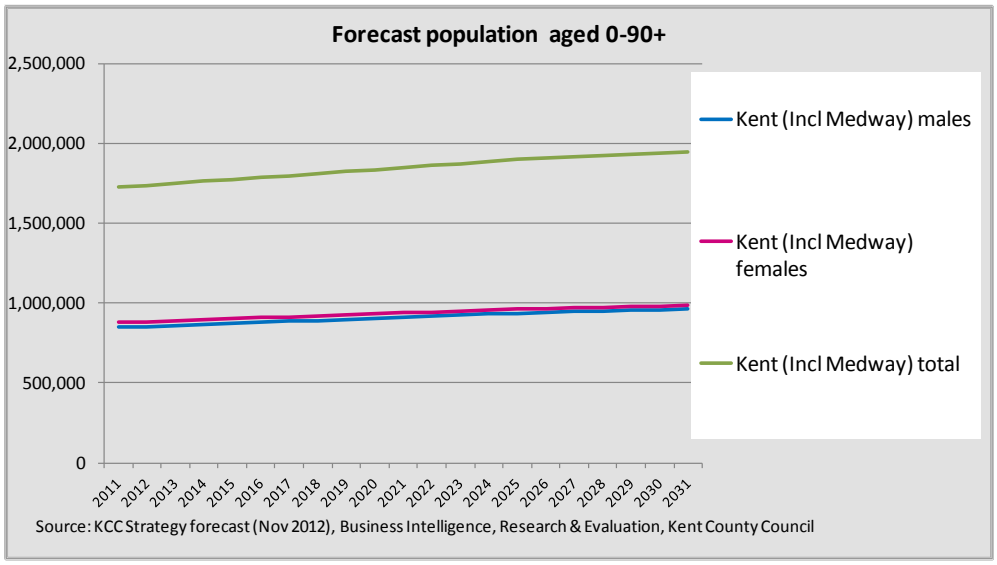
14. As a crude approximation the Kent and Medway weighted population is 3.14% of the national population, so our financial challenge is circa £1 billion of the £30 billion call to action challenge across all NHS commissioners.

15. The affordability challenges (or more accurately the demand challenges) in 2014/15 and 2015/16 are real and urgent. The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases, presents a significant challenge to the way we currently commission and provide care.

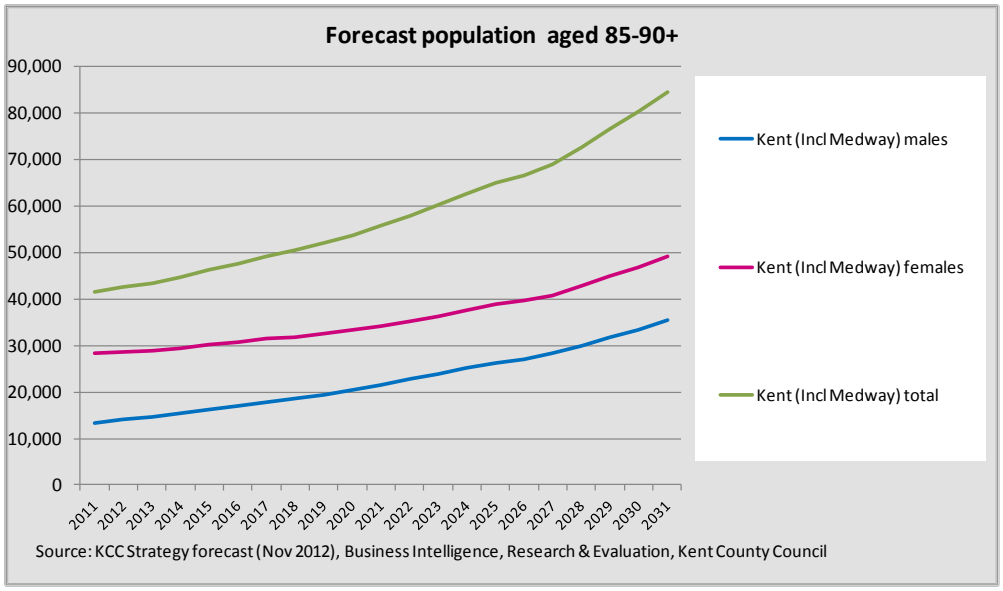
SECTION 2: THE KENT AND MEDWAY POPULATION

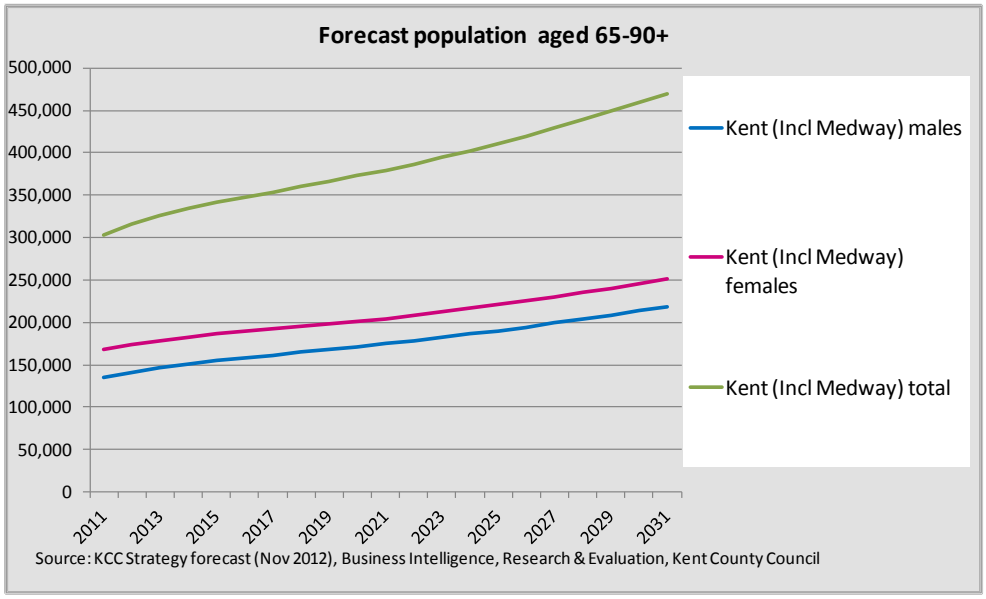
A changing population

16. By 2021 it is projected there will be a 5.4% increase in the total Kent and Medway population, which is shown on the following graph:



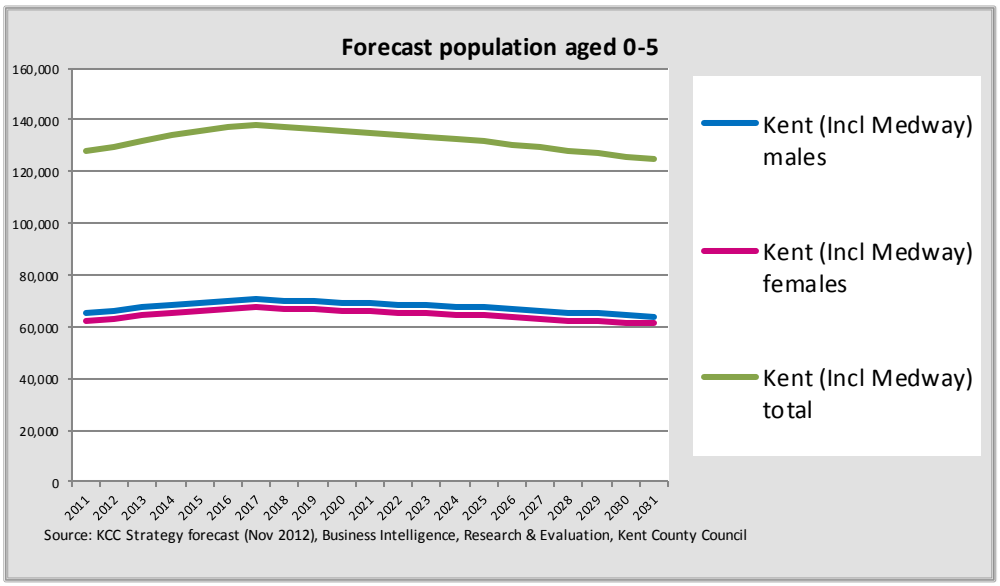
17. Whilst this increase in total population in itself is significant, it masks a more significant issue in that it is projected that over the same time period there will be a 25.5% increase in number of people aged over 65 years and a 34.1% increase in number of people aged over 85 years. This is shown on the following graphs:





18. In practice this means the percentage of older people in the total population is increasing; this is often referred to as "an aging population". This presents two challenges in that older people generally require more health and social care support, plus the percentage of the population who are of working age and paying taxes diminishes (i.e. there is less income from taxes to fund public services). It is this situation that is driving the financial challenge that was outlined earlier in this plan.

19. The area team, through its public health commissioning functions, also has specific responsibilities for children aged 0 to 5 years old. The change in this population is shown on the next graph. Whilst there is a short term increase projected in the number of 0 to 5 year olds, this growth is expected to plateau in the next 3 to 4 years (although further modelling is needed to assess the impact of immigration), after which this population will start to decrease.

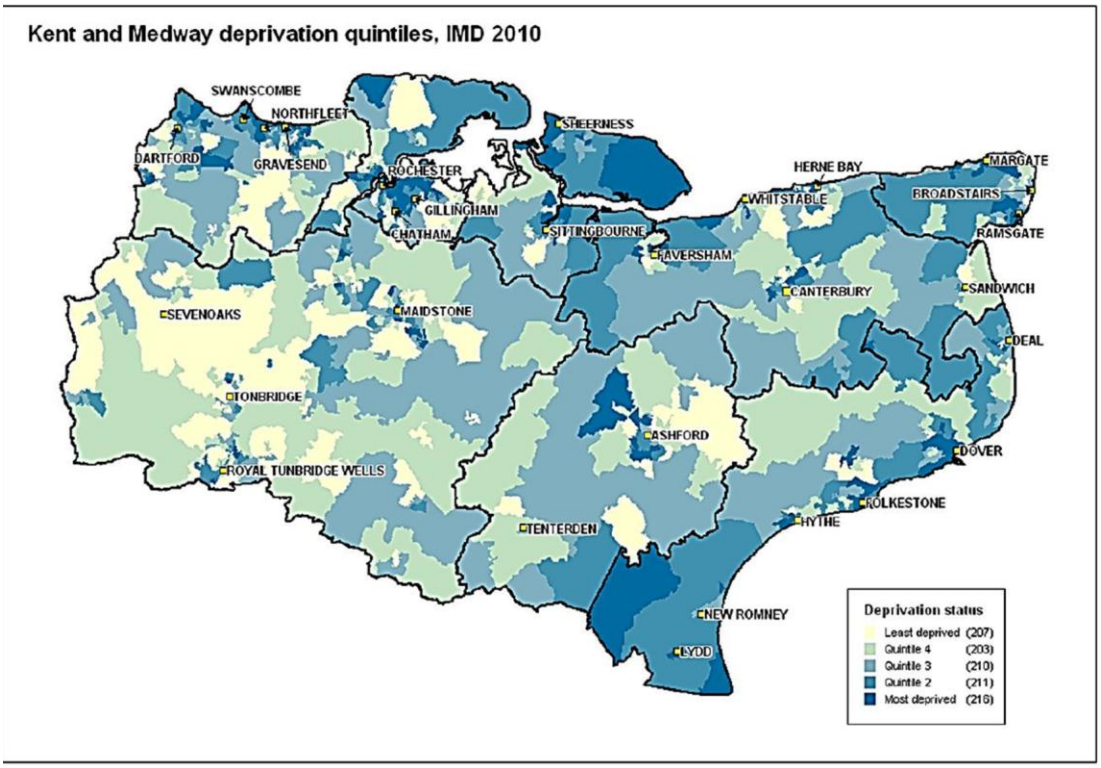


Inequalities

20. Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population.

21. Health inequalities start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a top governmental and local priority for NSH England, as well as for our partners. Tackling health inequalities is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall.

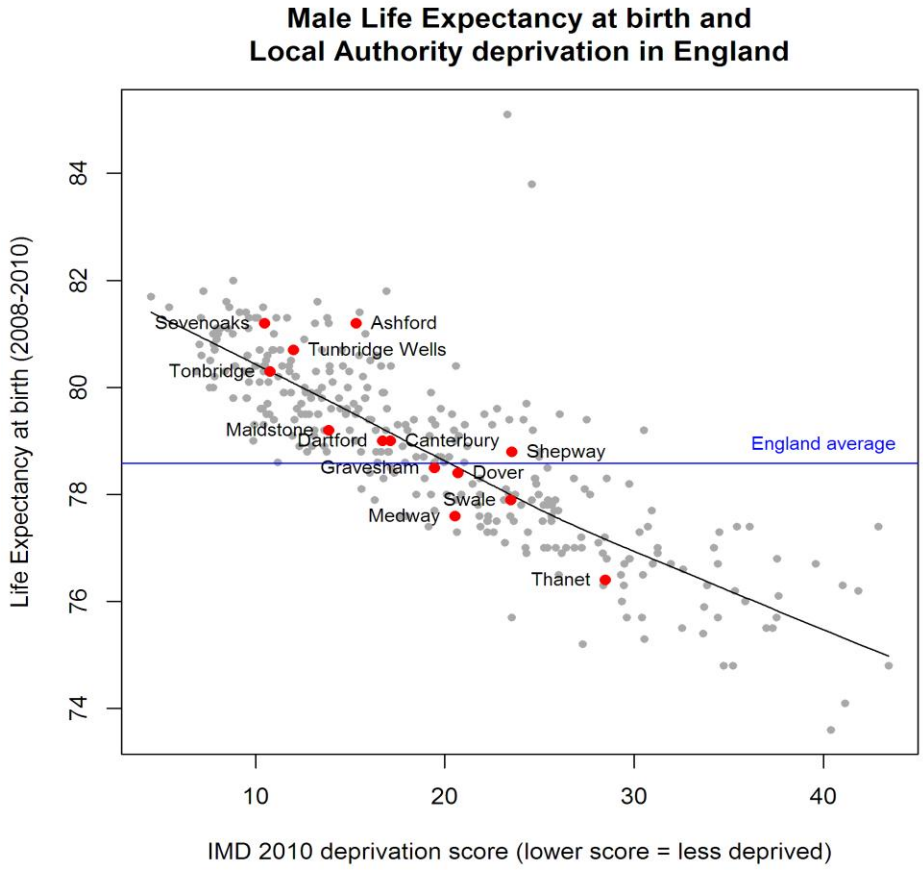
22. Within Kent and Medway there are significant health inequalities. The following map gives an overview of deprivation across the area. The darkest areas are the most deprived.



23. Whilst many areas of Kent and Medway are affluent, with higher levels of "wellbeing" (this includes indicators on life satisfaction, how worthwhile life is considered to be, happiness and anxiety) there are also a significant number of areas in the most deprived quartile of the population This is illustrated in the following table which shows life expectancy and the "slope of index inequalities" (a measure of deprivation) by CCG.

Clinical Commissioning Group	Average Life Expectancy	Slope index of Inequalities (SII) (is calculated by taking into consideration Indices of Multiple Deprivation (IMD) and Life Expectancy at birth and is an indicator of the gap between the most and least deprived).
Ashford CCG	82.6	3.0
Canterbury And Coastal CCG	81.6	4.6
Dartford, Gravesham and Swanley CCG	80.9	5.8
Medway CCG	80.3	4.9
South Kent Coast CCG	80.7	5.0
Swale CCG	79.8	5.5
Thanet CCG	79.4	7.1
West Kent CCG	82.3	4.2
Kent and Medway	81.1	5.6

24. This variation in health inequalities is further illustrated by the following chart that shows a correlation between deprivation and male life expectancy (i.e. this shows the link between deprivation and reduced life expectancy).



25. Whilst the information above shows a difference of about 5 years in life expectancy between the least and most deprived areas (e.g. between Thanet and Sevenoaks), this data is presented at CCG or district council level and hides

the greater disparity between the least and most deprived wards. More information on this is in CCG and local authority plans (including the Annual Public Health Report and the Joint Strategic Needs Assessment).

SECTION 3: MAINTAINING A FOCUS ON QUALITY

26. Knowing that patients are safe in our care is of paramount importance and one of the main categories from the NHS Outcomes Framework relates to keeping patients safe and protecting them from avoidable harm.

27. Everyone Counts describes the key components of quality (effectiveness, patient experience and safety). This focuses on the fundamental principles of the:

    - Francis report and the need to improve high quality, safe care.
    - Berwick report and the need to foster a safety culture
    - Winterbourne report describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.
    - Transforming Care: A national response to the Winterbourne review describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.
    - Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework: Promote partnership working to safeguard children young people and adults at risk of abuse at all levels. Ensuring professional leadership and expertise including the responsibility of named professionals for safeguarding children and adults, recognising that safeguarding is everybody's business. Lead with partner agencies to implement national policies to prevent child sexual exploitation, female genital mutilation, sexual violence and domestic abuse.
    - Clwyd-Hart report on NHS complaints

28. In response to the need to continuously improve patient safety and reduction of avoidable harm we will continue to:

    - develop the Quality Surveillance Group oversight across Kent and Medway;
    - implement the new patient safety alerting system;
    - drive to reduce the incidences of Healthcare Associated Infection (HCAI);
    - implement of the new Patient Safety Collaborative Programme;
    - implement the new patient safety thermometers;
    - promptly action Care Quality Commission notices and enforcement notices;
    - learn from Serious Incidents and Death in Custody reviews; and
    - innovate and utilise national models to support safe staffing delivery

29. Intelligent, collaborative commissioning will be undertaken with partners, including regulators of health care services. Within Kent and Medway we will manage a quality work programme for Health and Justice and Primary Care. Through this we will promote a positive experience of care, ensuring the patient's voice is heard, listened to and acted upon. This includes timely responses to and learning from complaints.

30. Wherever possible we will support people in maintaining their own health and thus not requiring healthcare services but where necessary. We want to ensure that every patient has a positive experience of health care and we will continue to:

- be proactive in response to complaints;
- ensure the patients voice in heard, listened to and responded to;
- improve the experience of carers;
- support Friends and Family Test (FFT);
- develop the concept of no decision about me without me and implement patient centred approach;
- implement the Compassion in Practice and methodology of the six Cs;
- safeguard those patients who are the most vulnerable working collaboratively with multi-agency partners;
- enhance the ability of patients and the public to care for their own health;
- ensure full respect for patient autonomy in decision making and ensure patients can access advanced care planning options; and
- ensure our systems are simple and straightforward to access and that appropriate choices and option are clearly signposted.

31. The quality and nursing team are concentrating on three areas of work for the next two years:

- Quality governance
- Health improvement
- Safe workforce

Quality Governance

32. Many of the organisations that we directly commission can be placed into one of four levels of development in quality governance:

Level zero	The Organisation is working in isolation, tends not to engage in local programmes or Area activities. They do not have any quality governance meetings and only report incidents if requested by commissioners.
Level one	**Foundation level** Multiple and disparate action plans in place, basic clinical governance meetings held intermittently with poor attendance and no clear outcomes. The organisation reports only Serious Incidents when a death in custody occurs or a death on the premises in primary care. No reports into clinical governance for incidents and no risk register is presented. No identification of changes to practice as a result of root cause analysis investigations.

Level two	**Intermediate Level** Strategic action plan starting to be developed and quality governance meeting reviewed and in place attended by all partners delivering care. Risks are starting to be identified and a process for mitigation is in place. The organisation is starting to show an open and transparent reporting culture. The organisation engages with area and local events and networks.
Level three	**Mature Organisation** The quality governance meeting is well organised, attended by all partners, receives regular appropriate reports and proactively monitors the review and implementation of the strategic action plan. Clear safety reporting structure is in place and reporting is encouraged by the organisation. There is a clear open safety culture with the organisation proactively assessing the culture at least annually. The organisation routinely examines and where necessary implements changes to policy and practice as a result of incidents reported, complaints or from staff and patient survey analysis. Dynamic process of identifying, reviewing and mitigation identified risks. They are a system leader for improvement programmes.

33. The aim is to have all directly commissioned organisations to be at level 2 by March 2015 and 75% of organisations starting to or achieving level three by the end March 2016.

Health improvement programmes

34. Existing data collection methodologies (e.g. friends and family test, safety thermometer, healthcare acquired infection returns) will be used to establish dynamic health improvement programmes initially focused on pressure ulcers, healthcare acquired infection. A serious incident learning network will also be established by July 2014 led by a CCG and or a local provider by July 2014. In addition:

    - by March 2015 there will also be improvement programmes for venous thromboembolism, medication errors and sepsis; and
    - by March 2016 there will be an improvement programme for the emerging safety thermometer work streams of mental health and maternity harms.

35. The aim is these will all have the overall impact of achieving zero avoidable harm in patient care. This work is also a precursor to the Patient Safety collaborative being established.

Safe Workforce

36. Francis and Berwick both highlighted the importance of a well- trained and well-staffed establishment to ensure safe patient care. We will work with our partners in health education England Kent Surrey Sussex, to ensure there are sufficient learning opportunities for staff in our directly commissioned services.

37. We will also ensure that safe staffing is reviewed within the service specification and commissioning process and will seek opportunities to work nationally in the assessment and review of such staffing levels.

38. The Kent and Medway area team will pursue a longer term strategy for work force development and work with national professional organisations to commission specialist education in order to raise standards and quality of care.

39. Throughout the work of the Nursing and Quality team we will work under the principle of collaboration with our own internal partners within NHS England, CCGs and local providers to ensure stronger engagement for quality throughout the commissioning cycle.

Quality in primary care

40. We intend to support clinicians to provide optimum care for patients by facilitating the development of a strong governance culture throughout the area. This will include more integration to prevent clinical isolation and the development of stronger processes to identify variation in performance and offer early support and intervention. We have taken learning in this area from our work in clinical governance and from incidents that have occurred in primary care. To improve the quality of primary care and to keep patients as safe as possible from avoidable harm, our areas of focus are to:

    - improve the way that safeguarding training is implemented to ensure that all clinicians who need training have been trained. In addition, to improve the way the safeguarding training is embedded in practice so that people really understand what it means and how and when to raise a concern;
    - improve the complaints systems for primary care. We need to ensure that verbal complaints (not just written ones) are recorded, considered and acted upon, and reported to identify trends that need to be addressed;
    - improve the way in which informed consent is given by patients for procedures performed in primary care;
    - empower all clinical staff to challenge inappropriate or questionable behaviour;
    - embed better two way communication about concerns with Care Quality Commission;
    - ensure that GPs with Special Interests (GPwSI) are appropriately monitored for the work that they do; and
    - improve practice manager's skills and core competencies.

41. In order to mitigate risks the Medical Directorate actively leads the Quality Hub and ensures appropriate links are made both internally and externally. Complaints are also actively monitored and reviewed to see if there are any performance concerns.

42. In relation to raising the quality of primary care in general, we are aware that Kent and Medway struggles to attract the best applicants to work in the area. There are many reasons for this, one key problem is the lack of a University with a Medical and Dental school as quality applicants tend to live post-qualification in the area in which they trained. Poor quality applicants are more likely to be of concern later on in their careers. NHS England (Kent and Medway) is looking to work with Health Education England, CCGs and the local Medical Committee to develop a primary care workforce plan for general practice. We are also working with CCGs, including utilising the Better Care Fund (BCF), to look at skill mix, using a range of skills in primary care, and a health and social care workforce plan.

43. Professional isolation is a significant factor in poor performance. In General Practice, this risk can be ameliorated by federation of practices and premises and co-location of primary care services. We have agreed a set of principles with the CCGs to support this direction of travel.

44. We believe that we have a robust system of appraisal and revalidation in place in Kent and Medway, which we will continue to develop in conjunction with our lead appraisers. The system is appropriately quality assured and assists with raising quality of primary care and in triangulation of any concerns that are raised.

45. In summary, our quality ambitions for primary care focus on ensuring a more positive experience of [integrated] care for patients by:

Ambition	**Date**
Full implementation of the Friends and Family Test (FFT) in primary medical, dental, optical and pharmacy services; ongoing improvement in the proportion of positive recommendations to friends and family by people receiving NHS treatment for the place where they received this care.	Mar-15
Use of the FFT to drive improvement in patient experience, both at the relevant touch points in primary care, but also as part of a higher systematic approach, linked to QSG, to support identification and action required to improve patient experience along pathways.	2015/16
Improved satisfaction with the quality of consultation, overall care and access to primary medical services as measured by the annual GP Survey]	2015/16
Reduction in the incidence of avoidable harm attributed to primary care services; HCAIs, medication errors, delayed diagnosis, etc.. • Open and honest cultures across primary care • Reduction in complaints	2014/15 – 2015/16

• Improvement in the proportion of positive recommendations to friends and family by people receiving NHS treatment for the place where they received this care • CQC compliant primary care services	
• Competent primary medical care workforce that has accessed multi-agency safeguarding training • A primary care workforce that is fully engaged in, and learns from, Serious Case Reviews and Domestic Homicide Reviews • Reduction in safeguarding incidents • CQC compliant primary care services	2014/15 – 2015/16
All reviews required by Winterbourne Concordat are undertaken and people are appropriately placed	June 2014

Quality in health and justice

46. To improve the quality of health and justice services and to keep patients as safe as possible from avoidable harm, our areas of focus are to:

- Improve the governance of health care in health and justice settings, including all providers and prison authorities to ensure high quality care pathways.
- Continue to ensure that the quality of health and justice is well governed by the area team, including the continued development of the Health and Justice Quality Group.
- Improve the provision of continuous professional development for all professionals in health and justice settings working with RCGP, national clinical reference group for Health and Justice and Health Education England.
- Ensure robust systems for the appointment of clinical reviewers, which include training, are in place.
- Support providers in the reporting of incidents and serious incidents to promote safety and learning.
- Actively influence the quality specifications for all health and justice commissioning especially the new NHS commissions.
- Ensure a timely and robust process is in place for the investigation of deaths in custody

47. In summary, our quality ambitions for health and justice commissioning will focus on:

Ambition	**Date**
All prisons we commission from have partnership quality governance meetings that include all healthcare providers and prison governors to ensure safety and	All be in phase 2 by March 2015

quality.	
All prison settings report incidents and serious incidents; share investigations and learning. Learning forum for serious incidents in place, to support the development of a culture of learning and improvement.	For all health and justice directly commissioned services by March 2015
Future ambition zero tolerance for death in custody due to suicide for prisoners on ACCT The bank of Clinical reviewers for death in custody is increased and linked to standards for clinical review.	December 2014
The RCGP secure environment group revised guidelines are considered for inclusion as quality standard	2015/16
Improvement in quality of care in Sexual Assault Referral Centres (SARCs), including improvements in the timeliness and availability for all relevant assessment treatment (e.g. paediatric assessment, safeguarding, self-referrals and HIV and hepatitis prophylaxis).	March 2015
Ensure appropriate healthcare skill mix and competency levels in custody suites, with clear service pointers / triggers for public health intervention i.e. alcohol abuse support	2015/16

Quality in public health

48. To improve the quality of the public health services commissioned by NHS England (Kent and Medway) and to keep patients as safe as possible from avoidable harm, our areas of focus are to ensure that:

- All services are commissioned in line with revised national service specifications and monitored through robust clinical governance frameworks (i.e. Kent and Medway Programme specific clinical committees),
- Programmes participate in the national public health quality assurance programme and that learning and feedback from national Quality Assurance team is acted upon.
- Any quality concern identified through the screening and immunisation committees and the national quality assurance report are acted upon and information shared appropriately – i.e. Kent and Medway Quality Board, relevant CCG and Local Authority.
- All providers use Serious Incident reporting frameworks and that incident reporting and investigation is robustly managed with findings and lessons learned acted upon to improve services and programmes.
- Incident reporting and investigation involves all relevant organisations, Public health England, commissioners, Local authority and providers.

- Joint working strengthened cross directorates and teams within NHS England (Kent and Medway).
- The Health Visiting Programme is delivered in collaboration with providers, improving outcomes for children and families as part of the transition towards responsibilities being passed to local authorities in October 2015.

SECTION 4: PUBLIC HEALTH SERVICES (e.g. national screening and immunisation programmes, public health services 0-5 years)

49. Responsibility for the commissioning of public health services is split between Public Health England (PHE), local authorities and NHS England.

50. It is NHS England's responsibility to commission a number of public health services as agreed with the Department of Health and built into the Government's Mandate to the NHS and the NHS Outcomes Framework. An agreement between the Secretary of State for Health and NHS England, made under Section 7a of the National Health Service Act 2006, details the public health commissioning functions that are carried out by NHS England. Known as the '7A agreement', these services sit within a number of programmes:

    a) Immunisation programmes
    b) Screening programmes
    c) Cancer screening programmes
    d) Children's public health programmes (Healthy Child Programme pregnancy to age five)
    e) Child health information systems
    f) Public health services for people in prison and other places of detention including those held in the young people's secure estate
    g) Sexual assault services

51. These programmes are nationally mandated supported by thirty-two national service specifications.

Strategic intent

52. NHS England's ambition is that everyone has greater control of their health and their wellbeing. We want everyone to be supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and continually improving.

53. The summary plan for public health is included as Attachment 1. The public health services commissioned by NHS England directly support the achievement of the NHS outcomes framework domains and ambitions, in particular:

Domain 1 - Prevent premature deaths and increase life expectancy	The preventative immunisation and screening programmes enable interventions to stop people from dying prematurely, securing additional years of life for people with treatable conditions (outcome ambition 1).
Domain 2 - People with LTCs get the best possible quality of life	Screening programmes support the early identification of health conditions, enabling people to receive treatment and support much sooner, improving their quality of life (outcome ambition 2). Immunisations (such as the flu vaccine) can also improve the quality of life for those in particular at-risk groups. In addition, early diagnosis can

	ensure more planned and integrated care can be put in place, reducing avoidable hospital stays (outcome ambition 3).
Domain 4 - Patients have a great experience of their care	Continual performance management, working with providers and other partners, ensures the highest standards of patient experience from the public health services we commission.
Domain 5 – Patients in our care are kept safe and protected from all avoidable harm	Keeping patients safe from avoidable harm is the core purpose of our public health services.

Roles and responsibilities

54. Responsibility for commissioning public health services is commissioned by a number of key bodies:

NHS England	Is accountable for letting contracts and ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. We are responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.
Public Health England(PHE)	Develops the national standards and operational guidance and provides expert leadership and advice to NHS England teams. They also play a leading role in collecting and sharing data and monitoring quality assurance.
Local authorities	In addition to leading the local public health system, they provide information, advice and scrutiny on the public health arrangements of NHS England, PHE and providers through local programme boards and health and wellbeing boards. They also commission sexual health services where some cervical samples are taken and public health programmes for children and young people aged 5-19 years, including the school nursing service which carry out school based immunisations. From October 2015 commissioning responsibility for public health programme covering pregnancy to five years old will transfer to local authorities.
CCGs	Are responsible for quality improvement in services delivered by GP practices, such as immunisation and screening services. As commissioners of treatment services for patients who receive positive screens, they have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen-positive patients and meet quality standards. CCGs also hold the contracts for maternity services which provide antenatal and newborn screening.

Partnership working

55. The *Immunisation and Screening National Delivery Framework and Local Operating Model* sets out clear guidance for the commissioning of the 7A public health programmes. It also covers working arrangements between the embedded Public Health England Screening Immunisations Teams and NHS England. Alongside this guidance, there continues to be a need for continual close working between all the organisations responsible for public health at a local level. The implementation of the national service specifications needs to be carried out in collaboration with CCGs and local authorities to reflect local need.

56. The complex public health commissioning arrangements mean that effective partnerships and continual collaboration between all organisations responsible for public health at a local level, including CCGs, are essential in order to ensure that implementation of national service specifications reflects local need.

57. Joint working is between area teams, local authorities and CCGs to identify areas of inequalities and address variation in uptake and coverage across communities will be critical to success in increasing access, information and choice, in particular for disadvantaged communities.

58. While the commissioning of all national immunisation and screening programmes is undertaken by NHS England, certain elements (such as antenatal and newborn screening services) are included in contracts led by primary care contracting, CCGs, specialised commissioners and in some cases local authorities (e.g. sexual health service contracts). Strong links are needed between area teams and these contract leads to ensure the strategic commissioning requirements of immunisation and screening programmes are addressed through these contractual routes.

59. Joint working is also important with the commissioners of treatment pathways (e.g. paediatric services for children identified with congenital hip dysplasia or ophthalmology outpatients in the case of the diabetic eye screening programme) to ensure that any changes through re-tendering of services do not adversely affect the referral pathway for screen-positive patients.

Priorities

60. Everyone Counts sets two overarching ambitions for public health commissioning:

    - to increase the pace of change for the full implementation of the national service specifications; and
    - to set performance 'floors' to address unacceptably low performance by local providers.

61. The guidance sets out the following priorities to achieve these ambitions:

    - New trajectories for roll out of the family nurse partnership and the health visitor programmes
    - A revised specification for pneumococcal vaccination
    - The roll out of the pilot introduction of HPV testing in women with mild/borderline changes in their cervical screening
    - Revised performance baselines for bowel and diabetic eye screening
    - The extension of the bowel screening programme for men and women up to age 75

- A minor change to the service specification for seasonal flu
- A meningitis C catch up programme for university entrants
- The continuation of a time-limited MMR campaign for people over 16 and a catch-up campaign for teenagers
- The continuation of the temporary programme for pertussis for pregnant women
- The implementation of DNA testing for sickle cell and thalassemia screening
- A shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds
- Developments for sexual assault referral centres to develop the service and make it more equitable

62. In addition, NHS England intend to extend flu vaccinations to all children over time. Plans are subject to an assessment of NHS England's commissioning capacity and the development of robust workforce models for delivery of the programme which will be completed in early 2014 and will be confirmed through a variation to the section 7A agreement. Prior to this, NHS England shares the ambition to offer vaccines to all children between 2 and 4 years old and as many secondary school aged children as possible in 2014/15.

63. Attachment 1 provides details of the local commissioning intentions that relate to these national requirements.

64. *Everyone Counts* identifies a number of key performance indicators for public health commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
EF1	Do the plans ensure that Dtap / IPV / Hib (1 year old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19.	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF2	Do plans ensure that MenC (1 year old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19	The planned performance level is above the 93% threshold set in the *Everyone Counts* technical guidance
EF3	Do plans ensure that PCV vaccination coverage (1 year old) will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF4	Do plans ensure that Dtap / IpV / Hib (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

EF5	Do plans ensure that PCV booster (2 years) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF6	Do plans ensure that Hib / MenC booster (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF7	Do plans ensure that MMR for one dose (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF8	Do plans ensure that MMR for one dose (5 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF9	Do plans ensure that MMR for two doses (5 years old) vaccination coverage will meet the national standard throughout 2014/15 and 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF10	Do plans ensure that Hib / Men C booster (5 years) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF11	Do plans ensure that Hepatitis B (1 years old) vaccination coverage will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance. However, it should be noted that there are significant data accuracy issues. However, locally we are confident we will hit the target threshold as we have developed a local monitoring system.
EF12	Do plans ensure that Hepatitis B (2 years old) vaccination coverage will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance. However, it should be noted that there are significant data accuracy issues. However, locally we are confident we will hit the target threshold as we have developed a local monitoring system.
EF13	Do plans ensure that HPV vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF14	Do plans ensure that PPV vaccination coverage will meet the national standard throughout	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

	2014/15 to 2018/19?	
EF15	Do plans ensure that Flu (aged 65+) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF16	Do plans ensure that Flu (at risk individuals) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	Delivery of this target remains a challenge and alternative means of delivering these vaccinations are being established (e.g. beyond reliance on the patients GP). Plans are informed by timely acquisition of data and analysis and understanding of the position is improving.
EF17	Do plans ensure that the percentage of pregnant women eligible for infectious disease screening who are tested for HIV will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF19	Do plans ensure that the percentage of pregnant women eligible for antenatal sickle cell and thalassemia screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF20	Do plans ensure that the percentage of babies who are eligible for newborn blood spot screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF21	Do plans ensure that the percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks or 5 weeks will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF22	Do plans ensure that the percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth will meet the national acceptable standard throughout 2014/15 to 2018/19?	There is currently no reliable data collected across most of England against this target. Therefore, it is not possible to offer assurance that this target will be achieved, However, it is part of the local workplan to implement this programme in line with national guidance and work with providers, maternity commissioners, national and local colleagues to improve data

		collection.
EF23	Do plans ensure that the percentage of those offered screening for diabetic eye screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF25	Do plans ensure that breast cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF26	Do plans ensure that cervical cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is currently not indicating that the threshold set in the *Everyone Counts* technical guidance will be met. Performance dipping below the 80% threshold is part of a long term downward trend nationally. Despite local actions this trend has not altered for Kent and Medway. In order to improve this there will need to be significant resource deployed in media campaigns, health promotion and publicity and targeting of GP surgeries. NHS England (Kent and Medway) will seek to work with national and local colleagues to address this under-performance.
EF27	**Do plans ensure that bowel cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?**	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF28	What number of family health service visitors are planned from 2014/15 to 2018/19?	The planned level of performance is in line with agreed trajectories: **Year** — **No. of Full Time Equivalents (FTEs)** 2014/15 — 421 2015/16 — 421 2016/17 — 421 2017/18 — 421 2018/19 — 421

65. The financial context for public health commissioning is covered next in this plan. Significant financial pressures remain in the public health budget and these have the potential to disrupt service provision and the delivery of the performance trajectories outlined in the above table. The planned performance detailed in this document is subject to the financial pressures being resolved.

Financial context

66. By commissioning effective screening and immunisation programmes with improved coverage and up-take, the public health programme will contribute to delivering financial efficiencies across the health economy by disease prevention, reduced incidence and early identification of cancers (e.g. breast bowel and cervical cancers) and life threatening disease e.g. abdominal aortic aneurisms.

67. The public health team will ensure that all commissioned programmes demonstrate value for money and that high quality, evidenced based cost effective services are delivered including:

    - introducing relevant public health CQUIN (Commissioning for Quality and Innovation payments) targets to new contracts, including reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease;
    - identifying risk of disease and disability early through the commissioning of safe and effective screening programmes;
    - working with providers to demonstrate the value of the universal Healthy Child Programme to improve life chances and access to services for children and families through Health Visiting and Family Nurse Partnership Programmes;
    - ensuring commissioned services represent best value for money and are evidence based;
    - benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and beyond to ensure and equity of provision;
    - reprocurement of schools based immunisation teams for Kent and Medway; and
    - using revised data sets to ensure screening programmes (e.g. newborn blood spot first and second line testing) is costed on the basis of accurate birth data.

68. In 2013/14, a surplus of £0.5m is projected. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent deficits are carried forward.

69. There are a number of cost pressures arising out of national directives, funded by new allocations. This includes meningitis C (University) and childhood influenza programmes. The expansion of the Family Nurse Partnership (FNP) scheme, the full year costs of the increase in health visitors and the additional cohorts in 2014/15 have also been fully funded. Funding has been received for delivering an extension to the bowel screening programme. However, the funding received is less than the expected costs of these programmes and the shortfall has been included as an unfunded risk.

70. The costs of the 15 % QOF previously chargeable to public health is now included under primary care, for which a transfer of allocation has been made.

71. The overall effect of these cost pressures and changes is to generate a deficit of £2.4m, which reflects a movement of £2.9m from the 2013/14 outturn. This is attributed to the cost of vaccines charged by the NHSBSA which were deducted from CCG budgets by the Department without passing the funding on to Area Teams. The target position is to break even.

72. The summary financial position is shown below:

Public Health		
	2014/15	**2015/16**
Previous year outturn	51,516	53,966
Part year effects	-3,733	-980
Sub total	47,783	52,986
Inflation uplifts	908	1,343
Growth	442	317
Provider Efficiency	-365	-1,483
Service Investments	5,198	1,841
QIPP	0	0
Total	**53,966**	**55,003**
Notified Allocation	51,314	51,314
Deficit carried forward	209	-2,443
Total Resources	**51,523**	**48,871**
Variance Surplus (+) / Deficit (-)	**-2,443**	**-6,132**

SECTION 5: HEALTH AND JUSTICE HEALTHCARE SERVICES (e.g. healthcare services provided in secure estate settings such as prisons)

73. NHS England (Kent and Medway) commission healthcare services for people in prison and other justice settings across Kent, Surrey and Sussex.

74. We are also working to ensure the timely and effective transition of commissioning responsibility for healthcare in Immigration Removal Centres, Police Custody Suites, Children and Young Peoples Secure Training Centres, Secure Children's Homes (welfare only) and Sexual Assault Referral Services is moving apace. On-going work is underway to develop and implement national service specifications and key Performance Indicator (KPI) monitoring data suites covering the delivery of healthcare services in secure estate settings, such as prisons.

75. Identifying and responding to issues of quality and safety for patients has been a resource intensive element of this programme of work. Resulting in some necessary reprocurements. The successful implementation and 'bedding in' of new contracts into some settings are a priority – particularly where delivery of healthcare services by the Prison Service has recently been transferred to a new healthcare Provider.

76. Increasing coverage of the Police and Court Liaison and Diversion Service across Kent, Surrey and Sussex remains a priority and the need to embed the patient voice and their involvement in our commissioning cycle continues to require dedicated time and planning.

77. Implementation of new IT systems for prescriptions, smart cards and the refresh of national systems (e.g. System1) are important to maintain infrastructure in our prisons and manage risk.

78. Maintaining a visible presence in the settings that we commission services for has added valuable and provides visible leadership for our partners and helps us as commissioners gain real insight into how services are delivered and experienced by users.

Strategic intent

> *"True justice for the most vulnerable is about pulling people into treatment, not pushing them away from the support they need. People should get the same quality of services in prison as they do in the community...we have to do more in early intervention, to support children and young people before they reach crisis point...we need diversion services to be a cornerstone of better care and support for offenders with mental health problems"*
>
> The Secretary of State for Health, speaking about health and justice commissioning at a joint event with the Ministry of Justice, March 2011

79. NHS England aims to commission services that offer care of the very highest standard and the best health outcomes for people in prisons and other justice

settings. Ensuring that these people receive the same standards of care that they would in the community is a core principle that underpins our approach. In addition, we want to drive quality improvements in the care and outcomes delivered. The summary plan for health and justice is included at Attachment 2.

80. Through the services we commission, we want to make progress towards the government's objectives of reducing violence - in particular by improving the way the NHS shares information about violent assaults and supports victims of crime - and developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community.

81. People in prison and other justice settings tend to have poorer health and worse health outcomes than the average population. We will work, together with out partners, to commission services in ways that will help to tackle these inequalities. In addition, we will continue to develop our commissioning approach in response to the *Bradley Report*'s recommendations to address the over-representation of people with mental health problems in prisons.

82. Through a single operating framework (developed jointly with the National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) we are responsible for commissioning health services in the following places:

- Prisons
- Young offender institutes
- Secure children's homes
- Immigration and removal centres
- Police custody suites
- Court liaison services

Roles and responsibilities

83. Responsibility for commissioning health and justice services is shared between the NHS England, CCGs and local authorities:

NHS England	Responsible for the direct commissioning of health services for people who are detained. Also responsible for some public health services (such as substance misuse services) for prisons. Area teams may devolve this responsibility to existing local joint commissioning arrangements in order to support more joined up services and continuity of care where they are satisfied that this will deliver their required outcomes.
CCGs	Responsible for commissioning health services for people engaged with the justice system but not in detention. Have a duty to co-operate in multi-agency youth offending teams. CCGs also responsible for commissioning emergency care services for "every person present in its area" including those in detention.
Local	Responsible for commissioning many public health services for people in their

authorities	area including those engaged with the justice system. Local authorities also commission sexual health services that may be used by victims of sexual assaults.

Partnership working

84. Effective partnerships are crucial to enable us to achieve our aims of commissioning excellent, equitable, integrated health services that deliver the best outcomes for people engaged with the justice system.

85. Partnership working already exists through local prison partnership boards and health and criminal justice boards, bringing together NHS England, CCGs, prisons, the police, local authorities and NOMS. These partnerships are able to ensure the effective use of resources, support continuity of care during the transition from custody to the community and can monitor and support equity of access.

86. These partnership approaches need to be further developed and expanded to ensure they are able to reflect the increased focus on the integration of services and the inclusion of reducing re-offending rates and other related indicators in the public health outcomes framework. However, it is also important to streamline governance arrangements to reduce the number of meetings that take place in recognition of the reduced management resource.

87. The NHS England, CCGs and local authorities (public health, children's services and social services) need to work together to commission integrated pathways of equitable health and social care for people whose lives intersect with justice services and to develop outcomes aligned to local joint strategic needs assessments and health and wellbeing strategies.

88. For the majority of people in prisons and other justice settings, their engagement with these services is temporary. Most will transition back to the community, although some will go back and forth. To ensure the best, most equitable health and outcomes for them, it is essential that health and justice services are not commissioned in isolation, but are seen as part of a continuum with the services these individuals would receive in their local community.

Priorities

89. The key priorities in commissioning for health and justice from 2014/15, set out in the Everyone Counts, are:

- To ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of resettlement prisons.
- To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
- Promotion of continuity of care from custody to community and between establishments, working closely with probation services, local authorities and CCGs.

- Development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs.
- Continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.
- A number of developments for sexual assault referral centres to develop the service and make it more equitable (listed as a public health ambition in the *Everyone Counts* five-year strategy planning guidance).

90. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice. For example, changes in the use of the custodial estate (for example from a prison to an immigration and removal centre) can happen at short notice, leading to a fundamental change in the health needs profile of the people who will be accommodated there.

91. Commissioners also need to consider the on-going development of the market for the provision of healthcare in justice settings, ensuring that there are sufficient providers able to offer quality, innovation and value for money.

92. Commissioners need to commission innovative solutions to challenging problems, seeking solutions in a different way. Locally this will mean exploring the potential use of telemedicine within prisons in order to reduce the need for costly and timely escorts and bed watches and in term reduce delays in receiving secondary healthcare out-patient care.

93. Attachment 2 provides details of the local commissioning intentions that relate to health and justice services.

94. *Everyone Counts* identifies a number of key performance indicators for health and justice commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
EG1	Do plans ensure that the national standard for health commissioned services for long term conditions will be delivered throughout 2014/15 to 2018/19?	Each prison now has a Health Improvement Plan (HIP) shared across all Providers and reported on at quality meetings. The development of a bespoke long term condition strategy for each prison forms part of the HIP. We are confident of delivery within the required standards.
	Do plans ensure waiting times will be delivered throughout 2014/15 to 2018/19	NHS England (Kent and Medway) has indicated this standard around waiting times for treatment for individuals in secure estate will not be met. Enabling prisoners to access secondary care is a significant challenge nationally due to the number of escort and bed

		watches cancelled by prisons due to staff availability. A number of streams of works are in place to support the delivery of this target including : - We have commissioned a review of telemedicine to support the delivery of this target but this will not report until summer 2014. - We will liaise with regional and national colleagues to explore the feasibility of a national MOU between NOMS and NHS England to reduce cancellations (e.g. by improving the availability of escorts and bed watches). - We are also sharing data and concerns directly with NOMS as impacting on delivery of timely healthcare. - We are discussing with Acute Providers appointment times for prisoners that best match the prisons 'core day' regime to maximise opportunities for attendance. - Ensuring providers have formal call back processes if prisoners fail to attend appointments.
EG3	Do plans ensure that the national standard for patients with a learning disability will be delivered throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EG4	Do plans ensure that the national standards for patients under Section 117 will be delivered throughout 2014/15 to 2018/19	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

Financial context

95. In 2013/14, a surplus of £1.7m is projected, arising from a combination of delayed starts to schemes, reduced demand for substance misuse services and other savings. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent surpluses are carried forward.

96. The service has received an increase in allocation, including 2% for growth and additional funding for developing liaison and diversion services, sexual assault referral centres (SARCs) and prison reconfigurations. In addition to these developments, there are also improvements in the provision of primary care in some prisons and the responsibility for some services in immigration removal

centres (IRCs) is expected to transfer from the Prison Service, although no funding has yet transferred. The cost of these services is marginally less than the growth funding received and savings identified, hence the surplus increases to £2.0m, achieving a surplus in excess of the 1% target.

97. The summary financial position is shown below:

Health & Justice		
	2014/15	**2015/16**
Previous year outturn	44,521	47,079
Part year effects	0	-246
Sub total	44,521	46,833
Inflation uplifts	870	1,358
Growth	8	392
Provider Efficiency	-129	-111
Service Investments	2,623	257
QIPP	-815	0
Total	**47,079**	**48,729**
Notified Allocation	49,111	49,338
Surplus carried forward	0	2,032
Total Resources	**49,111**	**51,370**
Variance Surplus (+) / Deficit (-)	**2,032**	**2,642**

SECTION 6: PRIMARY CARE SERVICES (e.g. core services from general practitioners, community pharmacies, dentists and optometrists)

98. The delivery of core primary care services is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy).

99. Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping recovery from episodes of ill health and injury. Primary care professionals are best placed to make effective preventative interventions and to impact positively on the quality and efficiency of the whole health service.

Strategic intention

100. NHS England's ambition is to deliver, through excellent commissioning:

- 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 and engagement visibly driving the commissioning agenda.
- The right balance between standardisation/consistency and local empowerment/flexibility.

101. This document should be read in conjunction with NHS England (Kent and Medway)'s draft Strategic Framework for Primary Care.

102. The recently published "Improving General Practice - A Call to Action Phase1 Report" sets out 5 ambitions for general practice and wider primary care. The ambitions are:

- Proactive, coordinated care
- Holistic, person centred care
- Fast, responsive access
- Health-promoting care
- Consistently high quality care

103. We can achieve this ambition and vision through our new commissioning arrangements, our approach to engaging with and understanding our patients, strengthened primary care clinical leadership and by developing innovative approaches that challenge the ways of the past.

104. A clear case for change, coupled with a desire from general practice to transform services, has emerged and has been reinforced through the *Call to Action* on

primary care:

- Population changes - including an aging population, an increase in people living with multiple long term conditions and changing public expectations – are increasing demand for health services.
- Improving our primary care services will improve patient care and will cost less. Better care, closer to home is the only way to maintain quality of care in the face of increasing demand and limited resources.
- Addressing inequalities in access, quality and outcomes will require new and innovative ways of coordinating services.
- Action is needed to address emerging workforce pressures including recruitment and retention problems for GPs and practice nurses.

105. NHS England (Kent and Medway) believes the areas discussed in this plan (and in our Draft Strategic Framework for Primary Care) can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review.

106. A federated model of general practice, delivering integrated primary care services to large populations and communities, would appear to be a potential solution to the future configuration and role of general practice. This is an emergent approach that has been proposed by the RCGP and others within the profession.

107. It is suggested that general practice is on a journey that will take it along a development path, progressing through a number of stages:

i. Current state

ii. An extended skill mix in practices and across a range of primary care providers

iii. Federation of practices

iv. Co-location of practice / merger of practices to form larger partnerships / primary care units

v. Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations)

108. The Everyone Counts sets out the following key characteristics of high-quality care in primary care:

- Proactive coordination of care, particularly for people with long-term conditions and more complex health and care problems.
- Holistic care: addressing people's physical health, mental health and social care needs in the round.
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing.
- Involving patients and carers more fully in managing their own health and

care.

- Ensuring care is of a consistently high quality: effective, safe and with a positive patient experience.

109. The following table provides more detail of the strategic intentions for the key primary care services:

General practice	General practice is the cornerstone of the NHS. Improving the nature of services provided outside hospital and supporting the public in self-care will be key ingredients for a sustainable NHS. Transformation in general practice must seek to maintain the internationally recognised strengths of the general practice model. Improving access is a priority, ensuring prompt access to GP services through 111, services that are available from 8am to 8pm seven days a week, and more rapid response to patient concerns through the use of telephone consultation. There will also be more personalised care and equality of access to services for everyone irrespective of where they live or their social status. We will work with CCGs, providers and other partners to identify and address inequalities. To achieve these ambitions will require a more scaled-up approach to general practice. This will mean working towards fewer, larger practices or federations or groupings of smaller practices where expertise is pooled and there can be increased focus on efficiency and innovation. This will enable patients to have seven-day-a-week access to a greater range of high quality primary care services. There will also need to be increased capacity in general practice and workforce plans need to include realistic projections for the number of GPs and practice nurses required, taking consideration of the presently aging workforce and changes in the career aspirations and expectations of newly qualified staff. Data and information are fundamental to providing high-quality, personalised care, improving productivity and empowering patients and clinicians to transform local services. It will be essential that GPs are supported by effective, efficient and integrated information technology systems. Patient access to electronic health records has been shown to improve health outcomes and reduce workload and costs so in line with the national strategy this will be supported. Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing costs so will be facilitated. Primary care services operate within communities and have strong links with the voluntary sector and community services. Strengthening and further integrating these can ensure resilient healthy communities addressing the root causes of ill health.
Community pharmacy services	Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E.

	Working with the LPC to ensure that we have the right number of pharmacists, with the right roles, working from the right locations will be important if we are to take advantage of the opportunities to provide a wider range of professional services from community pharmacies. Call to Action has also identified with the LMC an opportunity for pharmacists to undertake a more clinical role as part of the primary care team. Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions.
Dentistry	NHS England commissions dental services in both primary and secondary care, providing an opportunity to commission services across the whole patient pathway. We will look to move work such as minor oral surgery out of secondary care to primary care where we can so it is closer to home and more convenient for patients. We will also work with primary care dental providers and through the LPC to ensure that referrals continue to be made and handled appropriately.
Optometry	Many services provided in secondary care ophthalmology, such as for glaucoma and special needs optometry, could be carried out more efficiently and conveniently in high street optometry services. Core contracts for optometry will be developed and refined with the LPC and we will work with CCGs to co-commission services that can be moved from secondary to primary care.

Partnership working

110. Our aim is to create sustainable NHS services that provide more integrated care for patients, built around the registered populations served by groups of practices. To do this NHS England is developing joint arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.

111. It is important that this co-commissioning approach is developed to ensure the right balance between standardisation and flexibility in order that local primary care services can be planned in the context of CCGs' commissioning strategies, health and wellbeing strategies, JSNAs, PNAs and so citizens and communities can influence and challenge how services are provided.

112. Local professional networks (LPNs) for pharmacy, dentistry and eye health have been established and chairs appointed. As the committees' work gets underway it is essential that they support NHS England in commissioning these services by ensuring representative and robust clinical input to decision making and leading the profession in peer review and support, maximising performance, addressing inequalities and driving continuous improvement.

113. We will work with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment.

Primary care support services

114. NHS England is responsible for primary care support (PCS) services and wants all practitioners to have access to a standard range of modern, efficient and effective PCS services without the current variations in quality and cost. NHS England is continuing to work with staff and stakeholders to achieve the required changes in PCS services.

Secondary care dental

115. National criteria and care pathways are currently being developed by NHS England for all dental specialties following which commissioning of secondary and primary care services will be reviewed. Until these are in place steady state commissioning will continue with existing providers.

116. There are currently no CQUIN specifically for dentistry and these are to be developed at a national level; the 2014/15 CQUIN indicators that Kent and Medway will be using relate to collection of the relevant data flows to enable these to be developed.

117. Referral management arrangements are in place for oral surgery and endodontic treatment as ongoing QUIP delivery. Once national care pathways are in place, it is anticipated that further referral management will be introduced for other dental specialties.

Priorities

118. For general practice services a number of changes have been agreed to the national GMS contract, including:

- **Having a named, accountable GP for people aged 75 and over.** As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.
- **Out-of-hours services.** There will be a new contractual duty for GPs to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.
- **Reducing unplanned admissions.** There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

  - improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
  - ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions;
  - carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management;
  - provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator;
  - work with hospitals to review and improve discharge processes; and
  - undertake internal reviews of unplanned admissions/readmissions.

- **Choice of GP practice.** From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. NHS England's area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.
- **Friends and Family Test.** There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.
- **Patient online services.** GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments for local GP practices.
- **Extended opening hours.** The extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access to services.
- **Patient participation.** The patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.
- **Transparency of GP earnings.** The British Medical Association's General Practitioners Committee (GPC) will join a working group with NHS England and NHS Employers to develop proposals on how to publish (from 2015/16 onwards) information on GPs' net earnings relating to the GP contract. The first published data would be based on 2014/15 earnings and publication of this information will be a future contractual requirement.

- **Diagnosis and care for people with dementia.** There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.
- **Annual health checks for people with learning disabilities.** There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.
- **Alcohol abuse.** There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.
- **Support for innovation: Innovation pioneer hub** (Robert Stewart's work which we can share)

119. Locally, NHS England (Kent and Medway) is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), reprocure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2016). The following APMS contracts are scheduled to end during the next two years are:

Practice Name	CCG Area
DMC Sheppey Healthcare Centre	Swale
DMC Walderslade Surgery	Medway
College Health-Boots	Medway
College Health –Sterling House	Medway
DMC Medway Healthcare Centre	Medway
The Broadway Practice	Thanet
White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

120. NHS England (Kent and Medway) has a relatively high percentage of general practices on General Medical Services (GMS) contracts. In this respect 82% of GP contractors across Kent and Medway hold GMS contracts with only 13% of practices holding Personal Medical Services (PMS) contracts and a further 5% holding APMS contracts. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

121. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of

PMS contracts was undertaken throughout 2012/13 by the former Cluster PCT. This resulted in the vast majority of PMS contracts being successfully reviewed. A further review of PMS contracts across Kent and Medway will be undertaken in three phases:

- Phase 1 will be to facilitate any transfer back to a GMS contract that PMS contractors wish to make.
- Phase 2 will be to comprehensively review those contracts where the previous review was not concluded to the satisfactions of the NHS England.
- Phase 3, which will be undertaken in 2015/16, will be to review the objectives of other PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

122. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Reviewing and, if appropriate, reprocuring the occupational health service for GPs and other primary care contractors.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Extending the delivery of flu vaccinations in community pharmacies in order to help boost take up of the vaccine amongst at risk patients.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.
- Reviewing and where appropriate reprocuring interpreting services to support patients in accessing primary care contractor services.

123. *Everyone Counts* identifies a number of key performance indicators for primary care commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
ED1	What is the planned satisfaction with the quality of consultation at GP practices throughout 2014/15 to 2018/19?	Satisfaction with GP consultations, care at surgery and access to primary care is expected to continue deteriorating to 2016/17 before recovering. This is felt to be a realistic position reflecting the national trend and the challenges facing general practice in which the current experience of recruitment difficulties, locum utilisation and expected practice closures/mergers which are not necessarily popular with patients and communities. Some structural change is necessary and expected
ED2	What is the planned satisfaction with the overall care received at the surgery throughout 2014/15 to 2018/19?	
ED3	What is the planned satisfaction with access to primary care throughout 2014/15 to 2018/19?	

		and consequently we anticipate it taking 2-3 years to halt the existing downward trajectory in patient experience before we start to see some marginal improvement).
ED5	What is the planned of flu vaccination coverage for those at risk throughout 2014/15 to 2018/19?	
ED6	What is the planned distance between expected depression prevalence and reported depression prevalence from 2014/15 to 2018/19?	This indicator looks at depression prevalence and a trajectory has not yet been set due to data collection problems. This is a national issue and NHS England (Kent and Medway) is working with national colleagues to agree how this should be tackled and the indicator monitored.
ED7	What is the planned percentage of the population which have seen a dentist in the past 24 months for years 2014/15 to 2018/19	The planned level of performance is: Year — % of population who have been seen by a dentist in the past 24 mths 2014/15 — 51.0% 2015/16 — 51.5% 2016/17 — 52.0% 2017/18 — 52.5% 2018/19 — 53.0%
ED8	How many dental courses of treatment are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	Dental treatment rates are unlikely to increase without increased expenditure and this is not built into the plan at this point and, as such, delivery against this target is a risk.
ED9	What is the planned level of positive responses on dental services from the GP Survey from 2014/15 to 2018/19?	The planned level of performance is: Year — % of positive responses 2014/15 — 81.2% 2015/16 — 81.2% 2016/17 — 81.2% 2017/18 — 81.2% 2018/19 — 81.2%
ED10	How many sight tests are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	The local trajectory for sight test shows a very marginal increase in activity volumes per 100,000 population. Detailed plans will be developed in 2014/15 to address this
ED11	How many sight tests are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	This projects a roll-forward of historic activity.

ED12	How many repairs and replacements per voucher are planned to be delivered throughout 2014/15 to 2018/19?	This projects a roll-forward of historic activity.
ED13	How many prisms per voucher are planned to be delivered from 2014/15 to 2018/19?	This projects a roll-forward of historic activity.

General Practice Information Technology

124. General Practice Information Technology (GP IT) covers a broad spectrum of areas. The GP IT operating model 2013/14 provided by NHS England breaks GP IT into three areas:

1. Core and mandated service provision	This includes the following and the hardware required to deliver the services: • GP Clinical systems – new provision and upgrade • GP Extraction Service • Nationally mandated systems e.g. Electronic Prescription Service • Software licenses required – new provision and upgrade • Underpinning Information Governance • Networking and connectivity services required • Hardware required – provision and replacement • Hardware and System maintenance, along with the provision of a service/help desk • Registration Authority services • Core administrative services to underpin the service • Clinical safety and assurance required
2. Local strategic and discretionary service provision	GP IT provision to support local strategic initiatives to improve service delivery and support local commissioning objectives and any items provided under discretionary funding.
3. General Practice business systems service provision	GP IT funded by the general practice or other funding services to support corporate business delivery functions in the GP.

125. Further national guidance on GP IT has just been received and needs to be considered. However, it is highly likely that the capital allocation will not cover the required capital refresh (especially noting that Microsoft will stop supporting Windows XP and a large volume of computers are using this operating system).

This means a key priority is to develop a robust IT strategy for primary care that both enables the benefits of technology to be exploited whilst managing a difficult financial position. In addition, further developing the service support arrangements (e.g. from the Commissioning Support Unit).

126. The desired outputs from the GP IT strategy work have been identified as follows:

- a GPIT strategy document that provides strategic road map for the development and deployment of IT to support General Practices, and underpinning framework(s) for the strategy; and
- a costed actionable plan that describes the strategy in terms of annual priorities and potential programme of work.

Financial context for secondary care dental

127. This service is currently over-performing, although demand management controls are in place to try to contain expenditure. This trend is likely to continue into 2014/15 and this is reflected in the summary financial position shown below:

Secondary Dental		
	2014/15	**2015/16**
Previous year outturn	21,464	21,576
Part year effects	0	-91
Sub total	21,464	21,485
Inflation uplifts	480	623
Growth	214	214
Provider Efficiency	-673	-859
Service Investments	91	88
QIPP	0	0
Total	**21,576**	**21,550**
Notified Allocation	20,480	20,880
Deficit carried forward	-2,260	-3,356
Total Resources	**18,220**	**17,524**
Variance Surplus (+) / Deficit (-)	**-3,356**	**-4,026**

128. Although the 'headline' allocation has increased over 2013/14 levels, the need to absorb the previous year's deficit has led to an increased deficit in the following year. Therefore the forecast outturn in 2013/14 of a £2.2m deficit has increased by approximately a net million pounds in subsequent years.

Financial context for primary care

129. In 2013/14, a surplus of £1.7m is projected. This surplus is carried forward into 2014/15, as are future surpluses and deficits.

130. There are a number of significant changes to reporting of expenditure between 2013/14 and 2014/15. Expenditure on GP IT was included in the spend and allocation in 2014/1. However, the allocation has not been included in 2014/15 and the expenditure has, therefore, been excluded. The public health element of general practice Quality Outcome Framework (QOF) of £5.4m was reported under public health in 2013/14, but is now to be reported under primary care matched by a transfer of allocation.

131. Primary care services are most directly affected by changes in population. GPs' income is largely based on list sizes and demands for pharmacy, dental and ophthalmic services also change as the population changes. Kent & Medway is projecting a 1% annual growth in population and this creates a cost pressure of £2.7m per year. There are also a number of cost pressures arising out of national directives. For example, an Enhanced Service is proposed for a named GP for those aged 75 and over, and there is to be greater choice of GP practice with Area Teams responsible for any in-hours urgent medical care. These initiatives are expected to cost £0.3m per year.

132. Primary care services are subject to annual pay and price increases. The Doctors and Dentists Review Body has recently announced the pay increases for 2014/15. A 1% increase had been assumed, costing £3.3m. Although the overall package is expected to increase income by 1% the actual change to GP fees is an increase of 0.28% and to dental fees is an increase of 1.6%. This has increased the surplus on primary care services by £1.040m.

133. Despite including all these cost pressures there are a still a number of risks which sit outside of the expenditure plans. The principle risk relates to property charges. The rents charged during 2013/14 by Property Services reflected the values included in baseline. Moving to actual rents, plus increased costs since the baseline was calculated, could add a further £1.2m to costs.

134. The allocation has been increased in 2014/15 by 2.42% growth. However, since the carried forward surplus in 2013/14 is greater than that projected to be carried forward into 2014/15, there is a reduction of £1.7m in allocation for this factor. The net increase in allocation is £15.7m. Comparing this to the identified cost pressures produces a surplus of £6.8m.

135. The summary financial position is shown below:

Primary Care		
	2014/15	**2015/16**
Previous year outturn	343,222	348,035
Part year effects	1,818	-2,048
Sub total	345,039	345,986
Inflation uplifts	2,198	2,211
Growth	2,772	2,775
Provider Efficiency	-1	-1
Service Investments	1,082	1,914
QIPP	-3,056	-1,900
Total	**348,035**	**350,985**
Notified Allocation	352,896	359,888
Surplus (+) / Deficit (-) carried forward	1,977	6,838
Total Resources	**354,873**	**366,726**
Variance Surplus (+) / Deficit (-)	**6,838**	**15,742**

SECTION 7: PRESCRIBED SPECIALISED SERVICES AND SERVICES AND ARMED FORCES HEALTH

Prescribed specialised services

136. NHS England (Surrey and Sussex) is responsible for commissioning prescribed specialised services on behalf of the populations of Kent and Medway and Surrey and Sussex. Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Specialised services provided by Kent and Medway providers include:

- East Kent University Hospital NHSFT (£65m, Renal, Cardiovascular Services, Haemophilia)
- Maidstone & Tunbridge Wells NHST (£52m, Cancer Services)
- Kent and Medway Social Care partnership Trust (£18 secure and forensic Mental Health)

137. In addition, to the above Kent and Medway residents access a range of other specialised services in other areas, particularly London.

138. NHS England is committed to ensuring that such services are commissioned on behalf of patients in a nationally coherent and equitable way. Commissioning intentions for specialised services have therefore been developed nationally and can be viewed at: http://www.england.nhs.uk/wp-content/uploads/2013/10/comm-intent.pdf.

139. Six key strategic strands are identified as part of these commissioning intentions:

a. Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.

b. A Clinical Sustainability Programme with all providers, focused on quality (this includes the need to achieve and maintain compliance with full service specifications and to keep these specifications under review in order to deliver a continuous improvement in health outcomes for patients).

c. An associated Financial Sustainability programme with all providers, focussed on achieving better value in the use of NHS resources.

d. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.

e. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways.

f. A systematic rules-based approach to in-year management of contractual service delivery.

140. Locally, these strategic intentions have been translated into a number of service priorities:

Consolidating cardiovascular expertise	Secure additional years of life by consolidating acute cardiovascular expertise in a reduced number of emergency care centres (e.g. primary PCI and interventional cardiology)
Addressing avoidable admissions / reducing lengths of stay	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, specifically by reducing the need for inappropriate high cost specialised treatment by working with primary care and public health to reduce demand through increasing capacity in primary care to detect and refer people at an early stage.
Efficiency targets	Efficiency targets needs to be set at around 4.5% (£23m) given expected allocation for 2014-15 with the 2015-16 level on a par with 2013-14 outturn without investment
Commissioning for quality and Innovation (CQUIN)	Focusing of local CQUIN schemes on fewer initiatives with clear opportunities for local improvement and performance management. Contract performance management remains challenging without comparable historic and granular current activity data being consistently reported by providers and analysed by Commissioning Support Units

Armed forces health

141. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) commission armed forces health services on behalf of all areas in the South of England, including in Kent and Medway. The identified vision of the team is to provide high quality and safe care for armed forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

142. Armed forces healthcare is for serving members of the armed forces, reservists, veterans and all of their families who form part of a larger 'armed forces community'. In terms of the armed forces population:

- 51% of the population is aged under 30;
- 82% is aged under 40;
- 9.7% of the serving population is female;
- 58% of the serving population is in the army, 20% in the Navy or Royal Marines and 22% in the RAF;
- 17% of the serving population are officers (14% army to 22% RAF); 83% other ranks (78% RAF to 86% army); and
- overall 7.1% of the serving population are from a BME group (2.4% of officers, 8.1% of other ranks).

143. Whilst armed forces healthcare is commissioned by NHS England there are a range of commissioning responsibilities that sit with different statutory bodies:

- **NHS England** – NHS England is responsible for the direct commissioning of secondary and community health services for Armed Forces and families registered with the Defence Medical Service (DMS) Medical Centres. It assumes responsibility for commissioning some public health services through a Section 7 agreement with the Secretary of State, which Armed Forces and their families will be able to access.
- **CCGs** - CCG's are responsible for commissioning health services for veterans and families of members of the armed forces registered with NHS GP practices. CCG's are also responsible for the commissioning of emergency care services for 'every person present in its area', which includes for members of the Armed Forces and their families. It is also recommended that the responsibility for hosting Armed Forces Networks transfer from NHS England by agreement to appropriate lead CCG's to sustain the work of the 10 Armed Forces Networks currently in place. Given the strong focus on veterans and armed forces family healthcare, CCGs are well-placed to lead Armed Forces Networks, with support from NHS England. Further discussions will be needed with Armed Forces Networks to agree their transition and leadership arrangements for the future.
- **Local Authorities** – Local authorities are responsible for commissioning the majority of public health services for people in their area including members of the armed forces, their families and veterans. The exceptions to this are screening services, immunisations, public health services for children aged 0-5 years, public health services for prisoners and other detainees and Sexual Assault Referral Centres (SARCs). These services will be commissioned directly by NHS England. Local authorities will also commission open access sexual health clinics and genito-urinary clinics.

144. Members of the armed forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculoskeletal injury. Combat-related injuries aside, armed forces healthcare needs can usually be met by standard NHS services.

145. The families and dependants of serving armed forces members have health needs typical of their age and gender. Maternity services and children's health services, in particular, must be planned and commissioned with the needs of military families in mind where they are present in large numbers in a community.

146. Members of the armed forces may also have specific health needs that relate to their occupation or employment and require extensive occupational health support. Where the services needed for occupational health exceed the normal NHS services or standards, they will remain the responsibility of Defence Medical Service to commission, pay for or deliver.

147. There is a public perception that the Armed Forces community have a range of mental health problems and in particular suffer from Post-Traumatic Stress Disorder (PTSD). In 2009 the Academic Centre for Defence Mental Health undertook a useful review of evidence on the health and social outcomes - and

the health service experiences - of UK ex-service personnel. Their findings highlighted that:

- the ex-service population has comparable health to the general population and a broadly similar prevalence of mental health-related conditions;
- current UK military personnel have higher rates of heavy drinking than the general population;
- the most common mental health issues experienced by ex-service personnel are alcohol misuse, depression and anxiety disorders;
- military personnel with mental health problems are more likely to leave the armed forces and are at increased risk of adverse outcomes in post-service life;
- the minority who leave the military with psychiatric problems are at increased risk of social exclusion and ongoing ill health;
- the overall rate of suicide is no higher than for the general UK population, with the exception of male veterans aged 24 or younger who are at increased risk compared to their general population counterparts;
- early service leavers are more likely to have adverse outcomes and carry out risk taking behaviours than longer serving veterans; and
- deployment to Iraq or Afghanistan is associated with adverse mental health outcomes for some groups, particularly those with pre-service vulnerabilities, those who experience a high level of combat and reservists.

148. Armed forces commissioning will have a particular focus on those patients with the most complex care needs. NHS England will work to ensure that:
    - a modern model of integrated care is in place;
    - the date of discharge from the armed forces has no impact on the care decisions made, regardless of how far in the future the date may be;
    - area teams facilitate and support a multi-disciplinary team (MDT) approach for those service leavers that have complex health needs or are considered to be a seriously Wounded Injured or Sick (WIS) individual (this may include organising for continuing health care assessments to be made);
    - WIS individuals have an agreed personal health plan prior to service discharge and are clear as to the NHS offer and their rights and responsibilities; and
    - CCGs understand the needs of WIS individuals and their rights under the Armed Forces Covenant.
149. Access to urgent and emergency care. We will work with DMS, Clinical Networks and local CCGs and providers to ensure that:
    - the armed forces community is able to access appropriate services and cost effective out of hours primary care services;
    - the armed forces community is able to access appropriate out of hours services for those in mental health crisis;

- appropriate services are included in NHS 111 directories;
- the views and needs of DPHC are represented at Urgent Care Working Groups, where there is a sizeable Population at Risk (PAR) within the community;
- where there is a sizeable PAR their needs are reflected in the plans that CCGs and Health & Wellbeing Boards agree for the Better Care Fund; and
- the redesign of emergency care systems where there is an associated movement of DMS staff does not result in a destabilisation of providers.

150. NHS England will also be working with DMS, local authorities and colleagues in Public Health, both Public Health England and within NHS England, on the health inequalities agenda. Specific areas of focus are:
    - access to national screening programmes;
    - access to the child health information system;
    - smoking cessation;
    - alcohol misuse;
    - maternity - vulnerable & disadvantaged families; and
    - access to mental health services during and after transition.

151. It is recognised that military personnel put themselves in harm's way in the service of their country, risking risk injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were recently set out in the *Armed Forces Covenant*, a framework for the duty of care Britain owes its armed forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation.

SECTION 8: SUMMARY OF NHS ENGLAND (KENT AND MEDWAY) FINANCIAL POSITION

152. The following tables provide a summary of the projected financial position for 2014/15 and 2015/16:

Kent & Medway Summary Financial Position

2014/15				
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Target Surplus £'000**
Primary Care	354,873	348,035	-6,838	-3,549
Secondary Dental	18,220	21,576	3,356	-182
Public Health	51,523	53,966	2,443	0
Health & Justice	49,111	47,079	-2,032	-491
Total Kent & Medway	**473,727**	**470,655**	**-3,072**	**-4,222**

2015/16				
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Target Surplus £'000**
Primary Care	366,726	350,985	-15,742	-3,667
Secondary Dental	17,524	21,550	4,026	-175
Public Health	48,871	55,003	6,132	0
Health & Justice	51,370	48,729	-2,642	-514
Total Kent & Medway	**484,492**	**476,267**	**-8,226**	**-4,356**

154. The plans for the different direct commissioning areas had certain financial targets to meet, and the initial targets, are shown above. However, over time, and in response to the emerging national position, these have been moderated, such that collectively primary care, secondary dental and public health are now required to show breakeven plus £1.040m savings arising from the DDRB pay award. Health & Justice was required to show improvement upon the 2013/14 outturn to produce a £2.0m surplus.

155. NHS England (Kent and Medway) has used the outputs of the issued finance planning templates to drive the financial position shown above, and this plan is

consistent with those finance templates. The position above is therefore potentially impacted by the issues that are now described in this section.

Allocations

156. NHS England has issued allocations to NHS England (Kent and Medway) for each service but the source and content of each does vary. Whilst most use the allocation as at September 2013, that for public health is based on April 2013.

157. The allocations are adjusted for recurrent transfers made since September 2013 and growth has been added in all except public health, although funding for health visitors and meningitis C (four month dose) has been provided. . The allocations are adjusted for recurrent transfers made since September 2013, and growth has been added in all except Public Health, although funding for Health Visitors and Meningitis C has been provided.

158. Allocations for 2015/16 have also been issued. Those for primary care and secondary dental show a 2% uplift, whilst that for health and justice shows a 0.5% uplift and public health is the same as for 2014/15.

159. The difference in approach and content leads to different impacts on the financial position for each service.

Balances brought forward

160. The financial templates automatically adjust for balances brought forward. All surpluses and deficits generated in 2014/15 onwards are automatically carried forward, and, particularly in the case of deficits, unless the deficits are corrected either by reduced expenditure or allocation adjustments (whichever is most appropriate), there is a multiplier effect in subsequent years.

161. However, there is inconsistent treatment of carried forward balances in 2013/14. Surpluses generated in primary care are carried forward, but those in health and justice and public health are not; deficits generated in secondary dental are carried forward.

Outstanding allocation Issues

162. There are a number of service developments and changes which have not been matched by allocation adjustments:

- In 2013/14, CCGs received a central deduction to their allocations for drugs prescribed for services commissioned by local authorities and NHS England. However, the Area Team did not receive the allocation to pay for these drugs. An allocation was received late in 2013/14 to offset these costs. The net additional allocation required is £ 2.9 million.

- The responsibility for some health and justice services is expected to transfer from the Home Office to NHS England, mostly relating to Immigration Removal Centres. The costs of the services have been included in plans as a risk, but no allocation transfer has been assumed. The cost in 2014/15 is £0.4 million.

Cost pressure to be funded from central reserves

163. There has been an increase in public health allocations for the increase in health visitors employed and the Family Nurse Partnership (FNP) programme. However, as yet there is no increase for meningitis C (University), HPV vaccine and childhood influenza. Some funding, for example for bowel screening and FNP, appears to be less than is required to fund the increased level of service, and the balance is shown as a risk.

Section 7a public health agreement

164. The realignment of public health costs between public health and primary care has meant that £5.4 million of costs and allocation are shown under primary care in 2014/15, whereas they were included under public health in 2013/14.

Expenditure

165. The plans have been drafted assuming that the expenditure outturn for each year will be the total sum spent for that service. As such, this drives a current position which includes all significant risks.

166. NHS England (Kent and Medway) has made a number of assumptions regarding cost pressures impacting on 2014/15 spend. These will be reviewed with the aim of achieving consistency with other area teams in the NHS South area where necessary.

167. The plan reflects the savings which have been identified to date. Work will continue in-year to identify further opportunities, for example, by taking account of wider bench-marking across NHS England.

168. NHS England (Kent and Medway) is expected to identify 2.5% non-recurrent expenditure ("Headroom"). Given the challenges apparent in the current financial planning templates, the area team is currently applying this resource to the reported expenditure and is not expecting to declare unapplied Headroom.

SECTION 9: SUMMARY OF KEY RISKS

169. There are a number of risks and assumptions that are inherent within this plan. These are outlined in this section and are under ongoing review.

170. The following table highlights the key risks that are inherent in this document:

Area	Risk	Mitigation
Corporate	Management capacity is constrained and further financial savings needs to be delivered in 2014/15 and 2015/16. This constraint may limit the ability to deliver this plan.	Plans are being developed to deliver required efficiencies and ensure core functions can be maintained.
Corporate	Further development of the complaints function is critical to ensure that "hidden" complaints are formalised and used to inform a complete picture of provider performance.	Local plans to further develop the complaints function to be identified and presented to QSG
Clinical advice	The availability of clinical advisors presents a risk to a number of core activities. This includes determining the employment model for clinical advisors and ensuring appropriate indemnities are in place.	Discussions taking place with national policy colleagues on how to ensure clinical advisor capacity is in place
Commissioning Support	Business intelligence support has been put in place but arrangements are still immature and a number of data accuracy issues have been identified (e.g. public health trajectories, secondary care dental, secondary care health and justice services). These impact on the ability to robustly commission and monitor delivery.	Work taking place to further develop business intelligence support.
Public health	Significant financial pressures remain in the public health budget and these have the potential to disrupt service provision and the delivery of the performance trajectories outlined in the above table. The planned performance detailed in this document is subject to the financial pressures being resolved.	Ongoing work is taking place with regional and national colleagues to address allocation issues. Work is also taking place to review this within the mandate of 7a agreement.
Commissioning Support	NHS England has only had limited access to information governance support, which has presented risks around information governance compliance.	A service level agreement has been established with Kent and Medway Commissioning Support
Health and justice commissioning	The development of the Kent and Medway Sexual Assault Centre has been priotised in 2013/14 following the previous service coming to an end. However, work now needs to focus on	Interim protocols are now in place and joint working group in place to determine the

	putting in place robust arrangements for paediatric victims of sexual assault and abuse.	commissioning pathway
Health and Justice	Cancelled secondary care appointments impacting on access to secondary care due to prison staff not being available to escort patients or undertake bed watches	Under discussion locally and nationally with a view to putting in place agreements between agencies / organisations to improve performance
Primary care	Lack of capacity and capability in primary care services to support a shift from secondary to primary care (including a range of workforce issues such as recruitment and skill-mix)	To be addressed in 5 year plans
Primary care	The GP IT capital allocation will not cover the required capital refresh (especially noting that Microsoft will stop supporting Windows XP and a large volume of computers are using this operating system).	Development of a robust IT strategy for primary care that both enables the benefits of technology to be exploited whilst managing a difficult financial position.
Primary care	Limited scope for efficiency saving, partly due to the predominance of GMS contract in Kent and Medway (85%) and as PMS reviews have already been undertaken.	Other savings opportunities identified but these largely relate to ensuring robust contract management.
Primary care	Sustainability of general practice is at risk in some areas as we anticipate a number of practice closures over the next 2-5 year period as a result of decreasing margins, increased regulation, ageing workforce and difficulty in recruiting new GPs.	To be addressed in 5 year plans
Primary care	Patient experience has been decreasing year-on-year while expectations have increased. Improving patient experience is likely to require some significant changes to be made in some areas. This means improvements in patient experience are unlikely to be seen immediately in all services.	To be addressed in 5 year plan.
Primary care	Primary care support (PCS) services (provided by Kent Primary Care Agency) are subject to a significant change programme, dependent on approval of plans by the NHS England Board. This introduces business continuity risks (e.g. in relation to payments, management of patient note, etc...)	Mitigations being established through the PCS programme

Secondary care dental	Current secondary care dental contracts are over-performing and the ability to address this is partly constrained by poor business intelligence and partly by the ability to invest in community dental services.	Plans to be developed.

171. The risks in this plan will be reviewed and migrated to the NHS England (Kent and Medway)'s risk register to ensure they are robustly managed on an ongoing basis.

SECTION 10: SUMMARY

172. This paper details the commissioning plans of NHS England (Kent and Medway). Comments from stakeholders and partners are welcomed.

173. It is important that this plan is not read in isolation and should be read in conjunction with:

- Kent and Medway CCG two year operational plans
- The NHS England (Kent and Medway) strategic framework for primary care
- The Kent Annual Public Health Report
- The Medway Annual Public Health Report
- The Kent Joint Strategic Needs Assessment
- The Medway Joint Strategic Needs Assessment
- The Kent Health and Wellbeing Plan
- The Medway Health and Wellbeing Plan

174. These plans will continue to be refined and in particular there will be a focus on working with the three local planning footprints (e.g. the East Kent CCG Federation, the North Kent CCG Alliance and West Kent CCG) to develop five year strategic plans for submission in June 2014.

175. For Health and justice healthcare commissioning and public health commissioning the strategic direction will largely be determined through national work programmes. Local plans will be shaped around these national documents but local strategic focus in the five year plans prepared with CCGs are likely to focus on:

a. addressing any ongoing service performance issues;

b. through the gateway services for prisoners being released from prison back into the community; and

c. secondary care services for the health and justice population.

176. The strategic development of primary care is also being considered at a national level, building on the engagement that has taken place through the Call to Action, and further information on the strategic development of primary care services will be released during 2014/15. However, the development of local plans is also necessary and NHS England (Kent and Medway) has produced a strategic framework for the development of primary care. This will now be built upon to support the development of local strategic plans.

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN

NHS England

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

- Promote a healthy start in life through universal delivery of the national Healthy Child Programme from pregnancy to - 5 years , including Health Visiting and Family Nurse Partnership and robust Ante Natal Newborn (ANNB) screening
- Deliver national Immunisation Programmes and improve uptake to increase herd immunity and reduce the risk of infectious outbreaks
- Deliver the National Cancer Screening Programmes to help improve early diagnosis of breast, bowel and cervical cancer
- Deliver the non-cancer screening programmes (e.g. diabetic eye screening, abdominal aortic aneurism (AAA) screening.
- Improve support to victims of sexual assault , enabling timely access to care, prevention/prophylaxis treatment and recovery support.
- Working with Health and Justice Teams to improve access to public health programmes in the prison population

Strategic Context and Challenges

- Using improved data sets Identify variation in immunisation and screening coverage
- Review all provider contracts benchmarking against national services specifications and strengthening contract and performance monitoring systems
- Ensure safe transition of universal healthy child programme to Local Authorities commissioning
- Implementation of new programmes and work with partners to take account of pace of change across wider systems
- Improving uptake of section 7a commissioned services for marginalised and at-risk groups.
-

QIPP Improvements

- Introduce relevant CQIN targets to new contracts
- Reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease.
- Identify risk of disease and disability early by commissioning of safe and effective screening programmes
- Work with providers to demonstrate the value of the *universal* Healthy Child Programme
- Ensure commissioned services represent best value for money and are evidence based
- Benchmarking the payment and contracting mechanisms of our commissioned services to ensure and equity of provision.
- Reprocurement of schools based immunisation team

Organisational Development

- Continued work with the PHE embedded Screening and Immunisation team to maximise skills , expertise and resources, define roles, accountabilities to deliver the work programme
- Develop and implement a programme management approach to the public health commissioning programme to ensure an integrated approach to the programme
- Build collaboration across wider other Area Team commissioning and contracting teams (Primary Care, Specialised Commissioning, Armed Forces, & Health and Justice) in order to maximise resources, nursing and quality directorates and operational delivery.
- To continue to develop relationships with CCG and local authority commissioners and providers in the local health economy
- To provide training and development opportunities to the Public Health team to develop skills and improve team resilience
- The continuation of the partnership approach developed with the local authority and Health & Well-being boards.

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN

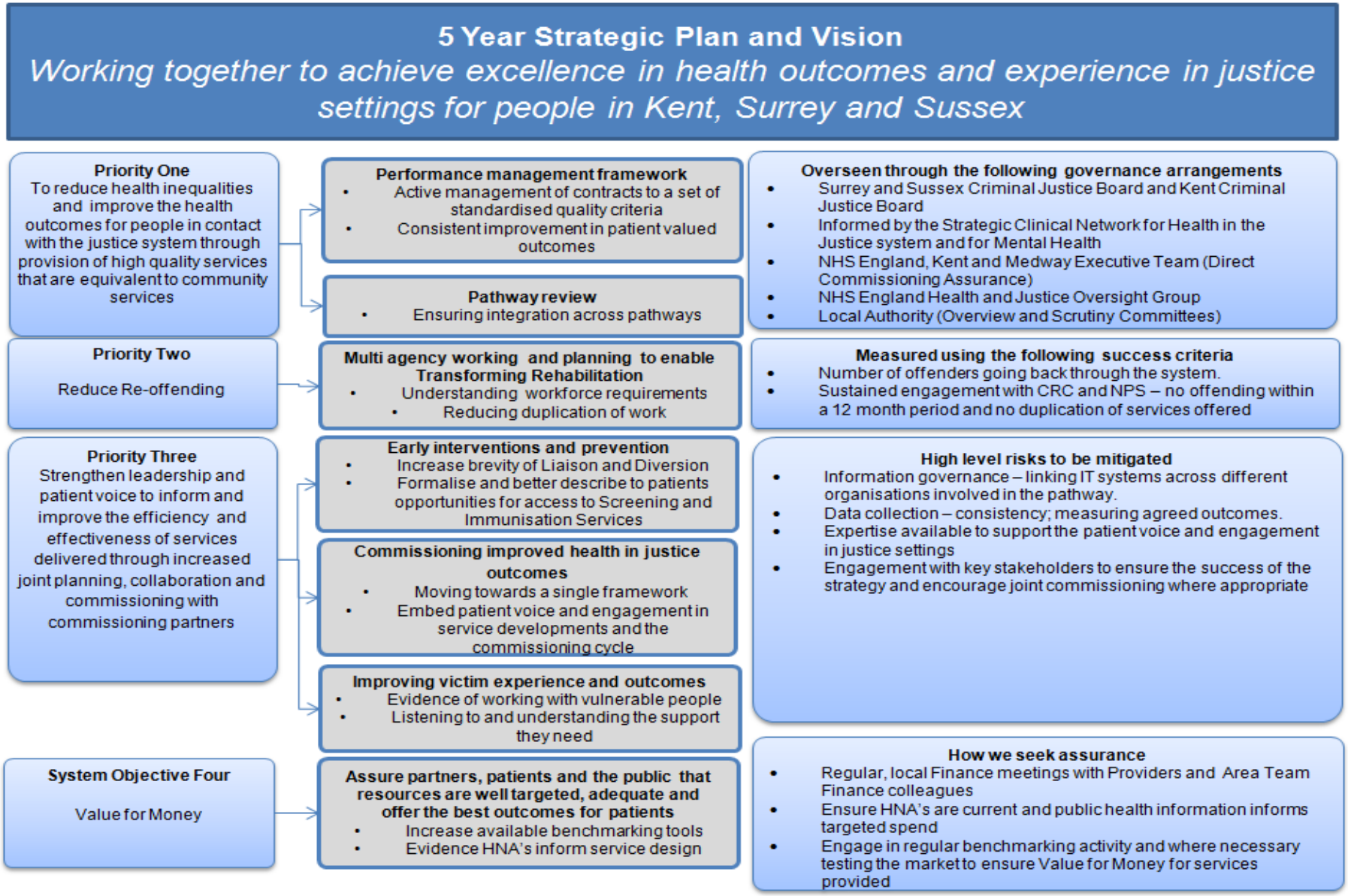
	National Priorities 2014-15	Expected Outcomes of Implementing National Guidance locally in 2014-15	End State Ambition 2015-16	Additional Local Priorities 2014-2018
Immunisation	• Seasonal Flu Programme for children is to be further rolled out to include 4 years olds with piloted programme for year 7 children. • Embed the Men C adolescent booster programme in school immunisation programme • Commission the extension of Men C immunisation for University entrants, • Continuation of MMR catch up, Pertussis in pregnant women, Shingles in 70/79 year olds • Continued improvement of flu vaccinations in healthcare workers, at risk children, pregnant women and at risk over 65s' • Implement pneumococcal vaccination specification	• Increased participation in the flu vaccination programme, reduction in avoidable hospital admissions and severe complications in at-risk patients. • Improved immunisation uptake particularly for at risk and marginalised groups. • Increased herd immunity and reduction in improvements in public health as a result of the extension of the childhood flu programme	• High uptake levels and reduction in variation in up-take • Reduction in vaccine avoidable disease. • Improved timely data available at GP practice level with national benchmarking and trend analysis • Systems in place for fully auditable immunisation payment mechanism in primary care	• Alignment of health visiting programme to support improved childhood immunisation up-take • Evaluate performance and set local improvement targets for new and existing programmes • Review and revise all local contracts and contracting mechanisms to improve performance • Access the school-age immunisation provision against capacity and other competing targets • Implement CQRS as a mechanism for data collection and payments for primary care

Screening Programmes (Non-Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Introduction of the new performance baselines for Diabetic Eye Screening • Implementation of the DNA test as part of the Sickle Cell and Thalassemia Screening Programme • Ensure that the payment for the antenatal and new-born screening and immunisation programmes are recognised within the Maternity Pathway Payment and that there is not a subsequent reduction in activity or quality. • Changes to QOF points in relation to diabetic eye screening	• Increased participation in screening programmes with reduced variation between local populations • Review of the participation in antenatal and new born screening services, analysis of the root causes of variation and the spreading of identified best practice • Benefits across of early detection and diagnosis of disease and disability.	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and early detection of disability, and an overall more positive experience from the health service • Full participation in screening programmes to support goal of giving every child a healthy start in life	• Continue to develop governance process for assuring improvements in non-cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary • Benchmark programmes across the region with a view to standardise payments and improve VFM

Screening Programmes (Cancer)	• Review existing services to identify areas of non-compliance against national specifications and risks to programme delivery (to ensure compliance by March 2015). • Age extension for existing Bowel Screening Programme (men and women 75 years) • Introduction of HPV testing as part of the Cervical Cancer Screening Programme for women with mild / border line changes • Age extension for breast screening (randomisation by GP practice) all women who 70-73 or 47-50.	• Full rollout of age extension bowel and breast screening programme with sustained timely access to diagnostics and subsequent treatment • Increased participation in screening programmes with reduced variation between local populations • Benefits across the health system of early detection and diagnosis of cancer	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and an overall more positive experience from the health service	• Continue to develop process for assuring improvements in cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary • Re-commission the cervical screening programme for armed forces personnel to represent a fair and equitable programme across the system.
NHS England and PHE agreements	• Develop common strategies to improve outcomes • Continue to strive for improved and timelier data collection and better commissioned 7a services.	• Close partnership working with coordinated and integrated commissioning intentions	• Full utilisation of Public Health Advice Service by public to measurably improve domain outcomes	• Continue to develop governance arrangements • Ensure local prison services have appropriate access to public health services

0-5 years Programme (including HV and FNP and Child Health Information System)	• Implement the 14/15 workforce trajectory for Health Visiting Call to Action, and continue to review and report performance on a monthly basis. • Continue to collect and monitor the quarterly data in relation to Healthy Child Programme Outcomes • To plan and work towards the transition of the Healthy Child Programme (0-5) to local authority. Transition Boards/Groups will provide regular updates to all stakeholders • Implement the new trajectory for Family Nurse Partnership expansion	• Increase in Health Visiting workforce and resultant improvements in service delivery • Expansion of Family Nurse Partnership to improve outcomes for young vulnerable first time mothers and their families. • Healthy child programme (0-5 year olds) transition to local authorities with commitment to sustain programme	• In October 2015, commissioning responsibility for this aspect will transfer to Local Authorities (the aim is for the expected service capacity and all national standards to be sustainably delivered prior to transfer).	• Ensure safeguarding and quality arrangements in place reported through Quality Surveillance • Commissioning and implementation of existing and planned new Family Nurse Partnership Programmes.

ATTACHMENT 2: HEALTH AND JUSTICE SUMMARY PLAN



ATTACHMENT 3: PRIMARY CARE SUMMARY PLAN

NHS England

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

Primary care: current landscape

1. *Variation in quality and performance*
2. *Some patients have difficulty accessing primary care services*
3. *Some patients struggle to navigate the health care system*
4. *Patients using hospital services inappropriately*
5. *Significant number of premises fail to meet required standards*
6. *Significant number of small practices managed by sole practitioner contractors*
7. *Uneven distribution of resources between practices and across CCGs*
8. *Community pharmacy plays limited role*

General practice in Kent & Medway: current landscape

1. *Registered population of circa 1.4 million*
2. *8 CCGs, covering populations ranging from circa 106,000 to 460,000*
3. *262 GP contractors, 34 PMS 13, APMS. 85% of practices are GMS – unusually high and limits scope of local QIPP*
4. *3 GP-led health centres . Their future is the subject of review by CCGs and the local area team*
5. *Some practice premises do not meet minimum standards*
6. *There are significant GP recruitment issues in parts of Kent and Medway.*

Primary care: future landscape

1. *Consistent levels of high quality performance*
2. *Robust patient and public engagement informing commissioning*
3. *Comprehensive range of services provided in primary care settings including a wide range of diagnostic tests and treatments*
4. *Services are available at times and places that are convenient to patients and appropriate to need*
5. *The highest risk patients identified and patient-focussed pathways put in place*
6. *Premises of consistent quality and meeting minimum standards*
7. *Sustainable provider landscape with services delivered at-scale*

Key challenges

- *Large geographical footprint with many contractors.*
- *Legacy of predecessor organisations and the history and relationships forged with contractor groups*
- *Nationally negotiated contracts leave limited scope for savings.*
- *Large number of small practices*
- *Significant number of elderly sole practitioner contractors.*

Improvements

- *Driving up quality by reducing variation and tackling unacceptable levels of service*
- *Improved access to GP services*
- *Wider range of services provided in community pharmacy and general; practice*
- *Increases in flu vaccination coverage*
- *Improvement in the prevalence of depression compared to estimated model*
- *Post payment verification and audit activities*
- *Review of discretionary payments*

ATTACHMENT 3: PRIMARY CARE SUMMARY PLAN

	Priority objectives	Key Area Team outputs in: 2014-16	End State Ambition 2019-20
1.	QIPP	• PMS reviews • Procurement of APMS contracts that will come to an end • Tackling list inflation • Probity program • Review of minor surgery and anti-coag' DES/LES schemes • Ensuring all practices are being charged appropriately for occupation of NHS PS premises • Dispensing patient review	• Reduced variation in spend on primary care across CCG areas and between GP practices • Unacceptable levels of PMS premiums removed • More consistent set of commercial terms across APMS contract
2.	Drive continuous quality improvement	• Quality of care can be measured and benchmarked • Definition of what good looks like agreed with public, CCGs and other key stakeholders • A continuous quality improvement strategy & delivery plan overseen by ATs Primary Care Quality Hub • Agree a consistent, rigorous and risk-based approach to monitoring quality through practice inspections and deep dive reviews • Maintain and further develop Local Professional Networks (LPNs) and produce work plans and support delivery of key strategic objectives	• Reduced level of variation • Numerous examples of where unacceptable levels of quality have been addressed successfully • CCG facilitated learning networks supporting peer-to-peer challenge and learning • LPNs leading strategic change and improvement

3.	Developing infrastructure and reconfiguring primary care	• Address short-term pressures in workforce • Promote improvements in primary care premises by completing a stocktake of general practice premises and developing an strategy for premises/estates in conjunction with patients, public and other key stakeholders • Improve use of IT systems to improve primary care in collaboration with CCGs • Review of Minor Surgery DES/Les service specification • Review of anti-coagulation LES and use of PGD/development of pharmacy prescribers • Roll out EPS in general practice • On-line booking, access to medical records on-line, order repeat prescriptions on-line	• General practice delivered from fewer premises and reduced number of practices operating from premises that do not meet minimum standards • Much wider range of services delivered in community pharmacy and general practice
4.	Improving access and services	• Methods for engaging patients and the public in contracting changes and procurements enacted by the Area Team • PMS review to be completed in collaboration with CCGs • Procurements for a number of existing APMS contracts, OH services, interpreting services and clinical waste. • Piloting innovation e.g.: 8am – 8pm working, 7 days per week, e-consultations • Ways of enabling registration at GP practice of choice are introduced	• QSGs are successfully identifying and addressing quality issues in a whole systems, collaborative and supportive manner • A robust system for managing contracts and performers whose performance gives rise to concern is well established • Methods for patient and public engagement in contracting changes and procurements are robust and well established • PMS & APMS contracts reflect strategic direction • Improved choice, and access to and satisfaction with general practice

5.	Perform assurance role	• Maintaining up-to-date contract documentation • Annual GP practice reports received and reviewed • Work closely with CQC in responding to evidence of poor quality • QoF assurance program • Self-funded probity function established and program agreed • Effective management of counter fraud activity • Review contractors' business continuity arrangements and ensure that these are robust at both individual service and whole system levels	• Robust and effective counter-fraud mechanisms well established • Targeted QoF visits and self funded probity program • All contractors have clear and up-to-date business continuity arrangements

ATTACHMENT 4: SPECIALISED COMMISSIONING SUMMARY PLAN

NHS England

Values and Principles	Services are patient centred and outcome based	Improved outcomes 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 Long Term Conditions	Help recover from ill health / injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 13/14

- Implementation of national service specifications
- Resolution of derogation programme with a focus on commissioner led derogations
- Provision and modernisation of radiotherapy capacity to improve access for patients and to improve outcomes for patients
- Continuing review of vascular services to ensure compliance with national standards
- Compliant rare cancer services, e.g. specialised urology
- Delivery of compliant major trauma centre in Sussex in regard to neurosurgery
- Implementation of recommendations from Winterbourne Review

Strategic Context and Challenges

- Review the implications at a local level of the financial challenge of operating within a deficit budget
- Support national review of single operating model for specialised services ensuring local effective engagement
- Engage proactively with the Call To Action strategic planning, being clear on local implications
- Supporting good access to mainstream specialised services for Kent, Surrey and Sussex patients
- Continue to strive for effective relationships with key partners, Patient and Public, Clinical Reference Groups, CCGs, other Area Teams, Health & Wellbeing Boards, HOSCs, providers, Strategic Clinical Networks, ODNs, PHE and clinical senate

QIPP Improvements

- Review and adoption of national and local QIPP/Productivity and Efficiency schemes to meet the challenge of 9% over 2 years front loaded in 14-15
- Input into national process for procurement of high cost drugs and devices
- Implementation of nationally agreed clinical access policies
- Support clinical and patient engagement with the innovation, health and wealth ambition

Organisational Development

- Continue to develop contract management skills and expertise within the team
- Support development of matrix working and networking of teams, across national, regional and local landscape
- Continue to support staff to embrace NHS England vision and values
- Work with SCN colleagues embedding local process to support patient and public voice through engagement and participation
- Support provider engagement, in particular regard to strategy, for specialised services, contracting and data quality improvement

ATTACHMENT 4: SPECIALISED COMMISSIONING SUMMARY PLAN

	National and Local Priorities 2014-15	Expected Outcomes of Implementation in 2014-2015	End State Ambition 2015-16 and onwards to 2018-19
Internal Medicine	• Cardiac – Review of TAVI audit and implement recommendations • Review specialised cardiology provider landscape • Implementation of vascular reviews in Sussex and Surrey, commence review of Kent & Medway services	• Achievement of core clinical and quality requirements • All cardiac and vascular services to meet national service specification	• All services compliant with national standards and achieving improved outcomes for patients • Safe and sustainable services with clear patient pathways understood
Cancer and Blood	• Implementation of national recommendations for radiotherapy and increased access to IMRT and IGRT • Work with region and providers to ensure compliance with e-prescribing for chemotherapy • Ensure compliance to national specifications of specialised cancer services • Cancer Drugs Fund – support Wessex with implementing national process and policies • HIV/AIDs - review provider landscape following sexual health reviews working with Public Health and Local Authorities	• Implementation of locally agreed plans to improve quality and access to radiotherapy for patients • Working with Brighton & Sussex University Hospitals Trust (BSUHT) to review provision of radiotherapy and integrated chemotherapy service at Western Sussex Hospital's Trust • E-prescribing operating effectively across all providers as relevant • To be clear on HIV/AIDs treatment and care pathways supported by adequate resources	• Improved access to radiotherapy • Consistent national tariffs in place • Patients to receive optimum care • Consistent and equitable provision of chemotherapy and cancer drugs • High quality HIV/AIDs services in place

Trauma	• Support Major Trauma Centre (MTC) at BSUHT , ensure all codependent services are meeting national service specifications through derogation as required • Work with regional lead to review the implications of the national service specification for Queen Victoria Hospital • Oversee the outputs of the Operational Delivery Networks (ODN) for adult critical care in relation to specialised services	• MTC to be fully compliant with national service specification, standards and quality requirements • London and SE consensus on the configuration of burns services • Effective ODN in place for adult critical care (specialised)	• Safe and sustainable services in place • Burn care services compliant with the national model • Effective network model of adult critical care for specialised services in place
Women and Children	• Oversee the outputs of the Operational Delivery Networks (ODN) for neonatal providers • Implementation of networks for Children's Safe and Sustainable Review (Cardiac and Neurosurgery) • Review paediatric shared care model across Kent, Surrey and Sussex, working with other ATs as relevant	• Effective Operational Delivery Network (ODN) in place for neonatal care • Neonatal services to achieve national service specifications, standards and quality requirements • Implement outputs of the paediatric cardiac surgery review • Implement prime contractor model for paediatrics as relevant	• Improved network and pathway management • Safe and sustainable services
Mental Health	• Embed secure service and CAMHS Case Management and gate keeping • Review of compliance to service specifications and clinical polices • Assess capacity in low & medium secure services	• Continued focus on these areas to manage demand • Improved quality and consistency of services • Review of identified priority areas • Local assessment of capacity • Provision of high quality, clinically safe services	• Case management in place for all specialised MH services • Compliant services • Improved access to and egress from secure services

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
School based immunisations	To commission a school immunisation team for Kent and Medway to provide school based immunisation programmes. Current provision is through Medway NHS Foundation Trust (MFT) and Kent Community Health NHS Trust (KCHT) who provide a mixed model of school based immunisation programmes, i.e. via school nursing service in the east of the county and a standalone immunisation team in the west.	Review the need to decommission the current programme and procure a single school based Kent and Medway immunisation service in order to ensure consistency in delivery of vaccinations across the county.	KCHT and MFT	Costs are not identified at present. Reference costs are being sought from providers to inform service redesign.	School based immunisations are part of a block contract at present. Both providers have been extracting costs of current provision. This commissioning intention has implications for school nursing services which are currently commissioned by Medway Council and Kent County Council. An immunisation team is already in place for West Kent.
Meningitis C (MenC) immunisation programme MenC adolescent booster school year 9 - starting January 2014	Current school nursing team to be commissioned to provide MenC at 14-15 years, with GP's immunising children that did not receive vaccine via school nursing.	Commission KCHT and Medway NHS Foundation Trust (MFT) school nursing team to deliver Men C adolescent booster. Issue Local Enhanced Service for MenC to GP's for those that did not receive vaccine via school nursing.	KCHT & MFT school nursing and GPs	National guidance proposes that funding to deliver the adolescent Men C programme will be transferred from primary care where the second dose (now ceased) has been funded within GP contract/global sum.	To enable Men C to be commissioned from current providers we are currently seeking reference costs from Medway providers and will benchmark against KCHT and other areas to ensure VfM in the commission.

MenC catch up for first time university entrants under the age of 25	From mid-August 2014 there will be a catch up programme of limited duration (possibly up to 5 years) to offer the vaccine to first time university entrants under the age of 25.	Likely to be commissioned via a GP Local Enhanced Scheme (LES); further national guidance awaited	GPs - this programme will be mainly delivered through primary care.	Further information will follow relating to funding and vaccine supply arrangements for the catch-up.	Awaiting further information relating to the funding and vaccine supply.
Men C Removing 2nd 4 month dose	Childhood immunisations are classified as additional services in the GP contract and the infrastructure costs of delivering these are covered by the GP practices global sum payment or baseline PMS funding. GPs are also eligible for target payments if they have vaccinated 70% to 90% of their 2 year cohort.	Decommission 2nd MenC dose in line with national policy around clinical effectiveness	GPs (with a need to inform other providers who provide patients with advice and information)	NHS England plans an adjustment to those target payments to reflect the change from 2 doses to 1 dose, however this adjustment will not be made until 2015/16, reflecting that vaccination status is not assessed until children reach 2 years.	
Human papillomavirus (HPV) - Local Enhanced Service contract ended in August 2013. This service is for children who were not vaccinated under the school programme	Area Team to issue an HPV local enhanced scheme (LES) for general practice to reflect new commissioning arrangements for Jan 2014	Specification to be written	GPs	£9.00 per item	

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

HPV - School Nursing Team	School nursing team to be commissioned to provide HPV at 14-15 years (with GPs immunising children that did not receive vaccine via school nursing - see the row above).	Revised contract in year	KCHT and MFT school nursing teams		
Additional childhood flu vaccination	The national Joint Committee on Vaccination and Immunisation (JCVI) has recommended that the seasonal influenza programme be extended to all children from aged two up to the age of 17. This programme has been rolled out to all healthy two and three year olds in the 2013/14 flu season as part of a gradual step to full implementation. This programme is in addition to the existing routine seasonal influenza programme.	Service redesign and service specification. Make provision for 4 year olds. Commence delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible.	Best vaccination uptake among 5-16 year olds is likely to be achieved through a school based programme – involving school nursing teams and GPs.	Awaiting further information and funding from NHS England.	

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

Health visiting	NHS England (Kent and Medway) and Health Education England Kent, will work together to increase the number of health visitors as required by the national programme, monitored by the Department of Health. In Kent and Medway the increase in the number of health visitors is planned to be in line with the nationally agreed trajectory of 421 whole time equivalent (wte) health visitors by April 2015. This represents 342.2 wte employed within Kent Community Health NHS Trust (KCHT) and 78.8 wte for Medway Community Healthcare (MCH). This equates to an increase of 68.2 wtes for KCHT and 7.7.wte for MCH in 2014-15.	A national service specification is in place with local trajectories in term of delivery of the new model aligned to the Healthy Child Programme (HCP 0-5 years)	KCHT and Medway Community Health (Social Enterprise)	Additional costs of £1,544,190 for 2014/15.	Mandated programme in line with Department of Health
Family Nurse Partnership (FNP)	Expansion of FNP by one team in both Kent and Medway, thus increasing the number of places by 100 for each area. Kent and Medway are both on the national expansion plan and will therefore contribute to the Department of Health planned increase to 16,000 places nationally. Linked to Public Health Outcomes Framework.	Nationally driven programme aligned to the Health Visitors Programme using a sub license. There is therefore no service change, but just an increase in the number of FNP places	KCHT and MCH	Awaiting costs	Awaiting confirmation of funding

Child Health Information System (CHIS)	The current Careplus CHIS will be replaced by the new SystmOne system during 2014. This system is being deployed across the entire South of England region. This will provide an integrated IT system across Kent and Medway. Work is needed to integrate the Medway Child Health Record Department (CHRD) with the Kent team under a single management structure. This will provide: • a strengthened governance arrangements for CHRD with improved performance monitoring process; • the potential to increase opportunities for learning and development within the team; • efficiency and streamlining as a result of having one single, larger team; and • support robust project plan for implementation of SystmOne.	The service charge relates to the integration of the CHRDs in Kent and Medway.	KCHT and MFT	Full costs to be confirmed following regional and national review of associated costs of new system procurements	
Diabetic Eye Screening service re-procurement.	Continue with and complete the diabetic eye screening re-procurement. The service is being reprocured as the existing contract for the local diabetic eye screening service is nearing the end of its period of operation and under procurement rules, NHS England's Kent and Medway Team is required to re-tender. The objective is to ensure that appropriate services are in place to support the prompt identification and effective treatment of sight threatening diabetic retinopathy. The priorities are to: - ensure effective contract transition processes are in place;	Re-commissioning	Pending outcome of tendering process	Costs to be confirmed subject to the procurement	The new contract is due to be let at the end of May 2014.

	- identify transition risks and ensure mitigating actions are implemented; - ensure services are delivered in line with national service specifications; and - any gaps in service provision are addressed in order				

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Paediatric Sexual Assault Referral Service (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassure of quality of care pathway and service in Surrey by April 2015	The key stages of the work are service design, development of an options paper, consultation and procurement of Paediatric SARC services	Services delivered on a cost per case basis, anticipate there will be a limited impact on current providers due to low volume	Funding has been identified for the health element of the paediatric SARC from budget uplift received	National funding arrangements, roles and responsibilities across Partners to be clarified
Sussex Sexual Assault referral Centre (SARC)	Re-procure Sussex SARC Phase 1 (health element) by June 2014, Part 2 (social care element) by April 2015	Re procure service	Tascor	Sussex Police and local authorities transfer their budgets to NHS England	Further development of Forensic Medical Examiner (FME) service necessary
Kent Sexual Assault Referral Centre (SARC)	Re procure Kent SARC Forensic Medical Examiner (FME) and Forensic Nurse Practitioner (FNP) element by June 2014 and deliver FME and FNP training programmes . Extend service to be able to receive self-referrals by Autumn 2014.	Re procure FME / FNP element Review Kent SARC care pathway	FMEs paid on a retainer, no contracts in place	Kent Police confirmed financial envelope available, NHS England anticipating contributing to uplift	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.
Kent Sexual Assault Referral Centre (SARC)	Agree development plan for the new Kent and Medway SARC, including the move to self-referral January 2015	Review service specification and review care pathway	Kent and Medway Partnership Trust, Family Matters, East Kent Rape Line and Kent Police	Uplift received will ease any cost pressures that the review and further development of an excellent Kent SARC may require.	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Surrey Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (Kent and Medway) for 1st April 2015	Transfer of commissioning responsibility anticipate novation of contract to NHSE	Tascor	None known	Preparing Statement of Readiness
Kent Police Custody Healthcare Commissioning Transfer	Re procure FME provision into Kent and Medway police custody suites and prepare for transfer of commissioning responsibility of FNP service to NHS England (Kent and Medway) for 1st April 2015	Implement a re procured FME service into police custody by Summer 2014	FMEs paid on a retainer, no contracts in place	None known	Market testing underway
Sussex Police Custody Healthcare Commissioning Transfer	Support Sussex Police to uncouple FME and FNP element of block custody contrac by July 2014	Activity on-going to extrapolate health element of contract in order to re-procure	Tascor	None known	Preparing Statement of Readiness
Surrey Prisons - Virgin Healthcare	Review and redraft service specifications, key performance indicators (KPIs) and service delivery improvement plans (SDIPs) for healthcare provision for each of the four Surrey prisons. Incorporating a formal review of in-patient services at HMP Highdown by June 2014	Service specification, KPI's , Quality Dashboard and SDIP	Virgin	None anticipated	NHS England (Kent and Medway) working to embed partnership working with the provider
Surrey Prisons - Surrey and Borders NHS Foundation Trust	Review and redesign of mental health Service and contractual supporting documents September 2014	Service specification, KPI's , Quality Dashboard and SDIP	Surrey and Borders Partnership Foundation Trust	Commissioner may seek uplift in funding if identified as necessary for a comprehensive mental health service i.e. improving access to psychological therapies (IAPT) service	Provider aiming to being a Phased implementation from 1st April 2014
Surrey Prisons - Virgin Healthcare	Re procure clinical and psycho-social elements of substance misuse services across Surrey Prisons fro implementation by 1st May 2014.	Re procurement completed, contract awarded and announced	Virgin	A saving of no more than 3100,000.00 per annum is anticipated	Contract transition and mobilisation planning underway.

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Review of Discipline Officers enabling healthcare functions across all Kent, Surrey and Sussex prisons	Review the role and function of Discipline Officers who enable healthcare functions across all Kent, Surrey and Sussex prisons and plan with Governors for the transfer of funding responsibility from 1st April 2014	Novate commissioning responsibility from NHS England to Prison Service	Prison Service / National Offender Management Services (NOMS)	Cost pressure for NOMS, release of funds for NHS England to reinvest in clinical services	National programme of work but adopting a local delivery plan
HM Prison Lewes and Ford health services re procurement	Re procurement of healthcare services for 1st April 2015	Re procurement	Sussex Partnership NHS Foundation Trust	Unknown until procurement complete	Current Provider and NOMS advised of intention.
HM Prison/ Young Offenders' Institute (YOI) Rochester and HMYOI Cookham Wood reprocurement	Re-procurement of primary healthcare, pharmacy and child and adolescent mental health services (CAMHS) (Cookham only) for 1st April 2014	Re procurement	Prison Service	Anticipated this will be cost neutral	New ways of working fully implemented at Rochester, Cookham operational capacity increase and Rochester re-roll to 70% adults. Procurement completed and contract awarded and announced.
Telemedicine	Develop a business case and feasibility test regarding the introduction of telemedicine in the Kent, Surrey and Sussex prison estate. Report expected Autumn 2014.	Service innovation	Miscellaneous	Anticipate it will be cost neutral	NHS England (Kent and Medway) need to progress development work with key stakeholders
HM Prison Bronzefield - primary healthcare and psycho-social substance misuse services	Close partnership working with NOMS to support the prison to review its existing service specifications and associated contract document suite i.e. key performance indicators (KPIs), service deliver improvement plans (SDIP), quality dashboard, adopt serious incident reporting framework, complaints process and Prison Health Performance and Quality Indicators (PHPQI) framework	Review and refresh of Service specs, KPIs, SDIP, Quality Dashboard, intro of use of PHPQI's, serious incident reporting framework, NHS complaints process	Sodexo	None	NOMS retain the budget, commissioning and contract management responsibility for the delivery of primary healthcare and psycho-social services at HMP Bronzefield. NHS England is working to support Sodexo and NOMS to prepare to transfer commissioning responsibility to the NHS when negotiations with

					Sodexo regarding uncoupling of healthcare element of main budget is completed.
Mental health services across Kent and Medway prison estate	Re-procurement of mental health services across all Kent, Surrey and Sussex adult prisons for 1st July 2014	Re procurement	Oxleas	Anticipated this will be cost neutral	Re-procurement well advanced
Gatwick Immigration and Removal sites (3 sites)	Transfer commissioning responsibility from UK Border Forces (UKBF) to NHS England and re procure health services by Sept 2014	Transfer commissioning responsibility and re procure	G4S	Anticipate will be cost neutral for NHS England	NHS England's London Area Team are taking the lead on a multi-site procurement, Kent and Medway actively supporting
Secure Children's Homes (SCH) – welfare only	Formalise East Sussex and West Sussex local authorities retaining commissioning responsibility for SCH whilst NHS England (Kent and Medway) take accountability through a formal memorandum of understanding (MOU). Contractually implement service uplift September 2014	Service uplift due to increase in residents and in response to refreshed health needs assessment (HNA). Area Team commissioners to confirm budget transfer value for commissioning transfer to Area Team from 1st April 2014.	Local authorities and local healthcare providers to SCH in East and West Sussex	Increase in available resources for comprehensive health services. NHS England (Kent and Medway) may need to incorporate local authority commissioning service costs into service baseline (if required by local authorities).	Local authority commissioners keen and content to carry on their local commissioning function of these bespoke placements and services for individualised packages of care

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Medway Secure Training Centre (STC)	Provide on-going support in preparation for transfer of commissioning responsibility to NHS England from 1st April 2015 anticipating a re procurement of health services by 1st April 2015	Re procurement by April 2015, transfer of commissioning responsibility December 2014	G4S	Anticipate no cost pressures to NHS England	Position regarding transfer of commissioning responsibility to NHS England still fluid as is reprocurement timetable
Surrey Police Court Liaison and Diversion Service (PCLDS)	Commission Phase 2 of Surrey PCLDS to include some court coverage and enhance existing police custody coverage April 2014	Commission	Surrey and Borders Partnership NHS Foundation Trust	Planned for service uplift	Surrey is the last PCLDS to become established across Kent, Surrey and Sussex

ATTACHMENT 7: ARMED FORCES HEALTH AMBITIONS

NHS Outcomes Framework	Outcome Ambition for AF Health	How Outcome will be monitored
Domain 1 Prevent people from dying prematurely, with an increase in life expectancy for all sections of society	**Outcome ambition 1** Mortality of the armed forces population is currently split (roughly equally) between operational causalities, accidents and other illnesses. Therefore only a very small percentages are within the powers of NHS England to affect – but we will seek additional years of life for these. We will work with the MoD to increase screening and immunisation coverage	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify Potential Years of Life Lost (PYLL) data to look at PYLL rates: • From causes considered amenable to healthcare (adult and children) • The rate per 100k population
Domain 2 People with LTCs, including those with mental illnesses get the best possible quality of life	**Outcome ambition 2** There are very few in the armed forces population who have LTCs as this will normally preclude military service. Any measures are likely to be statically meaningless Mental Health conditions are managed by DMS for serving personnel however, we will look to reduce the impact of transition from service life to civilian life and avoid discontinuity of care issues	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify average health status (EQ5D) score for individuals who identify themselves having a LTC Easy & rapid access to appropriate mental health services

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NHS Outcome Framework	Outcome Ambition for AF Health	How Outcome will be monitored
Domain 3 Ensure patients are able to recover quickly and successfully from episodes of ill health or following an injury	**Outcome ambition 3** Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, in for example Regional Rehabilitation Units (RRUs)	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify emergency admissions for acute conditions that should not usually require hospital admission
	Outcome ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	NHS England will work with the MoD to develop as alternative measure around discharge of veterans
Domain 4 Ensure patients have a great experience within all of their care	**Outcome ambition 5** Increasing the proportion of people with physical and mental health conditions having a positive experience of hospital care	Armed Forces health team will work with Nursing Directorate and P&I to develop measures and baseline for AF population. Seek to benchmark against CCG patients Links to 15 questions from the national inpatient survey Rate of responses of a poor experience of inpatients care 100 patients
	Outcome ambition 6 Increasing the proportion of people with physical and mental conditions having a positive experience of care outside hospital, in general practice and the community	We will work with DPHC to reduce poor patient experience of primary care (GP and OOH services) where the NHS is in a position to influence patient experience Rate of responses of a fairly poor or very poor experience across GP and OOH services per 100 patients
Domain 5 Ensure patients in our care are kept safe and protected from all avoidable harm	**Outcome ambition 7** Working with co-commissioners in making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	NB: small dispersed population which may make information and trends statistically not significant. Monitored through SI reports