

**NHS England
(Kent and
Medway)**



**Direct
Commissioning
Strategy and Two
Year Operational
Plan**

**2015/16
Addendum vs 0.6**

May 2015



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SECTION 1: INTRODUCTION

INTRODUCTION

1. NHS England (Kent and Medway) prepared a Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015. This was prepared in March 2014. It was updated in July 2014 to take account of a number of changing national priorities and to update the financial agreements that had been reached. This plan remains current and should be read in conjunction with this short paper that updates the document to take account of the 2015/16 annual planning round.
2. This document consists of:
 - Updated plans on a page for the key direct commissioning areas
 - A short narrative / commissioning intentions for each area
 - An updated financial position

PUBLIC HEALTH 7A SERVICES

3. The national ambition is to improve and protect health and wellbeing for the population. Specifically, the aim is to improve not only how long we live but also how well we live and to ensure that we support the whole community to live healthily, reducing health inequalities.
4. The Public Health Direct Commissioning Team working with Public Health England, Clinical Commissioning Groups and Local Authorities will contribute to the national ambition by improving accessibility and uptake of:
 - Immunisations that reduce the risk of infectious disease outbreaks targeting areas of lower uptake, working with providers to improve performance to achieve national targets by 2018/19
 - Screening programmes that help improve the early diagnosis of major disease, disabilities and death such as Cancer, Aortic Aneurism and diabetic retinopathy to improve coverage for more vulnerable, harder to reach groups to bring them in line with the rest of the population by 2019 and thus address inequalities
 - Services that improve the health and life chances of children and families to ensure that we transfer robust and sustainable services delivering the nationally agreed outcomes to Local Authorities in 2015
5. A number of aims and objectives have been identified by the public health team in relation to the services they are responsible for, these include:
 - Focus on improving data quality to ensure that the reported achievement of national targets are robust (particularly immunisations)
 - Work jointly with commissioning partners including CCGs and Local Authorities to implement coherent integrated commissioning plans along care pathways.
 - Work with all providers of Section 7A services to ensure service delivery complies with standardised core national service specifications. Where

service providers are not currently working to the national specifications, then services and programmes will be benchmarked against the national service specifications and action plans jointly agreed that clearly outline any gaps in provision, service developments proposals and timescales for alignment.

- Work with partners to apply specific CQUIN schemes to incentivise service improvement for Section 7A related services, focusing on initiatives that improve access for the entire population of Kent and Medway (including those in offender institutions) to tackle inequalities and address parity of esteem. Where appropriate 'stretch' targets will be introduced to improve coverage and uptake
 - Ensure that all services clearly demonstrate how they are delivering improved outcomes for patients. This will include the systematic application of national and locally agreed outcome measures and KPIs.
 - Work with providers and other stakeholders including the South East Coast Strategic Clinical Networks to demonstrate effective patient engagement and user experience informing continuous improvement.
 - Ensure that all commissioned programmes demonstrate value for money in line with QIPP, delivering high quality, evidenced based cost effective services. This will include the systematic application of robust financial and contract performance monitoring and review processes. We will prioritise work with partners to implement pathway/system wide re-design.
6. The following are appended to this plan:
- **Attachment 1:** Public Health Summary Plan
 - **Attachment 2:** Public Health Commissioning Intentions (NHS South / National)
 - **Attachment 3:** Public Health Commissioning Intentions (Kent and Medway)
 - **Attachment 4:** Public Health Programme and Population Risks
 - **Attachment 5:** Public Health Financial Risks
7. The services included in Section 7a are national programmes with the allocations coming under the agreement from Public Health England. Screening and immunisation programmes across Kent and Medway are based and delivered on a population base. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes (as outlined in Attachments 4 and 5).
8. The focus for the public health team is to ensure that these national programmes are delivered according to the national specification and that they deliver good outcomes (protection from infectious disease or early diagnosis of significant disease). The purpose of the service reviews in 15/16 will be to ensure the services are not only good quality but also represent value for money.
9. During 2014/15 there have been a number of cost pressures arising out of national directives, funded by new allocations, including:

- Meningitis C (University)
- Childhood Influenza
- Expansion of the FNP scheme
- Full year costs of the increase in Health Visitors
- The extension to the Bowel Screening Programme

10. The overall effect of these cost pressures and changes was to generate a deficit of £2.4m for 2014/15. 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. This underlying deficit continues into 2015/16. As the total Public Health budget is only circa £54 million, to deliver savings of this magnitude would require a reduction in expenditure of around 4.4%. In addition, the true addressable spend within the public health budget is significantly less than the total £55 million budget as the budget includes expenditure on health visitors, which is effectively ring-fenced, and a significant portion of the remaining budget is locked into contracts where the price has been fixed through recent procurements. However, a range of cost saving QIPP initiatives, including procurement opportunities are being explored but there is a high risk these will not be able to address the underlying deficit.

11. The following table details the investment in Kent and Medway Section 7a programmes:

Investment into Section 7a Services for Kent & Medway	2015/16 Proposal
Immunisation programmes	£14,815,000
Cancer Screening (Bowel, Breast and Cervical)	£8,980,000
Non-cancer screening programmes (Diabetic Eye Screening and AAA)	£2,825,000
Healthy Child Programme (0-5)*	£14,627,000
Family Nurse Partnership*	£434,000
Child Health Information Systems	£218,000
Reserves/Contingency	£202,000
Grand Total	£42,101,000

	2014/15			2015/16		
	Allocation £'000	Expenditure £'000	Variance £'000	Allocation £'000	Expenditure £'000	Variance £'000
Public Health	51,523	53,966	-2,443	39,677	42,101	-2,424

N.B. It should be noted that the 2015/16 expenditure reduces from that in 2014/15 due to the transfer of the 0 to 5 programmes to local authorities, with an associated transfer of funding, from October 2015.

12. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for primary care commissioning. These indicators and the planned performance identified in the plan remain valid.

HEALTH AND JUSTICE HEALTHCARE

13. NHS England (South East) commission healthcare services for people in criminal justice and secure welfare settings across Kent, Surrey and Sussex. Work also continues to ensure the timely and effective transition of commissioning responsibility for healthcare in Police Custody Suites by April 2016.
14. The following are appended to this plan:
 - **Attachment 6:** Summary of South East Criminal Justice Services and Settings
 - **Attachment 7:** Health and Justice Summary Plan
 - **Attachment 8:** Health and Justice Commissioning Intentions (National / NHS South)
 - **Attachment 9:** Health and Justice Commissioning Intentions (Local)
15. The implementation of the national, standard Health and Justice indicators of Performance (HJIPs) in all of our prisons has been successful. We have agreed to pilot the new draft children and young people's HJIPs for the national team in our YOI with development of specific suites for Police custody, SARCS and IRCS just beginning.
16. Identifying and responding to issues of quality and safety for patients has been resource intensive element of this programme of work. Resulting in some necessary re procurements where new service specifications now reflect national standards and expectations, particularly in Sexual Assault Referral Centres and our local Youth Offender Institution. The successful implementation and 'bedding in' of new contracts into some settings are a priority.
17. Increasing coverage of the Police and Court Liaison and Diversion Service across Kent, Surrey and Sussex remains a priority as Surrey and Kent move into Wave 2 of the national pilot. The need to embed the patient voice and their involvement in our commissioning cycle continues to require dedicated time and planning.

18. 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, Immigration Removal Centres (IRC's) and Secure Training Centre (STC) and Secure Children's Homes (SCH's). The implementation of these new IT systems is well underway and our focus now moves to our IRC's, STC and SCH's. E-prescribing is now live in one of our prisons and we have a tight programme to roll E-prescribing out across the Kent, Surrey and Sussex prison estate.
19. Maintaining a visible presence in the settings that we commission services for has added value and provides visible leadership for our partners and helps us as commissioners gain real insight into how services are delivered and experienced by users.
20. NHS England, working with Health Education Kent and Surrey and Sussex and local Universities are developing an educational framework to support health and care staff working within the justice sector. This aims to improve the health outcomes for people in custody by aiding improved recruitment and retention of staff through professional and service development to meet the changing needs of this population.
21. 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

22. The key priorities in commissioning for health and justice from 2015/16, some of which remain the same as those set out in the Everyone Counts, are:
 - Improve the response to managing detained people at risk of serious harm and support the reduction of self-inflicted deaths in detention
 - To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
 - Promotion of continuity of care between establishments and from custody to community working closely with Community Rehabilitation Companies, national probation services, local authorities and CCGs.
 - Continued close collaboration with our partners in the successful implementation of Wave 2 of the Liaison and Diversion Programme in Surrey and Kent.
 - To ensure timely and effective transition of commissioning responsibility for healthcare in immigration removal centres, secure training centre and police custody suites.
 - Procure effective, timely Paediatric Sexual Assault Services in Sussex and Kent that reflect the national Paediatric SARC Service Framework

- Improve the proactive detection, surveillance and management of infectious diseases, blood born viruses, outbreaks and incidents in criminal justice settings
 - Continue to implement and closely monitor national standards of excellence in the delivery of healthcare services to detained Children and Young People
 - Stimulating and supporting Provider development and market engagement in the provision of health and justice settings particularly in preparation for the transfer of responsibility for police custody healthcare services across the South East from the Police Forces.
23. 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.
24. 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.
25. Commissioners need to commission innovative solutions to challenging problems, seeking solutions in a different way. Locally this will mean exploring the potential use of medical technology 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. Integration of street triage with liaison and diversion services in support of mental health crisis concordat work is also being considered.

Parity of Esteem

26. The active pursuit of Parity of Esteem for people with mental health problems who come into contact with the criminal justice system is a key driving factor influencing commissioning activity. This is evidenced by £550,000.00 increased investment in Liaison and Diversion services from 1st April 2015 in Kent and Medway and Surrey, £200,000.00 increased investment in Surrey Prison Mental Health Services and the ring fencing of funds to support access to Talking Therapies for victims / survivors of sexual assault across Kent, Surrey and Sussex who come into contact with Sexual Assault Referral Centres. The review and redesign of mental health services across the Kent and Medway prison estate has really helped to reinforce the need for equivalence of care and access to NICE approved practice for people with mental health problems similar to standards experienced by people with physical health problems. In particular Cookham Wood YOI now provide for Speech and Language Therapy support for those who have difficulties in expressing their thoughts and feelings positively and access to more Talking Therapy group and individual work.
27. Tackling the 20 year gap in life expectancy experienced by people with severe mental illness is being proactively tackled by ensuring, through contract

performance monitoring, that annual physical health checks are given to prisoners who have severe and enduring mental illness and counting the activity provided by the prisons' IAPT (Improving Access to Psychological Therapies) services with particular focus on individuals with medically unexplained symptoms and for prisoners who have mild / moderate depression and anxiety with chronic health conditions. Making sure GP's working in our prisons know how to refer their primary care patients into our local, primary mental healthcare services early on will help to support early intervention. Mental Health Promotion activities like 5 Ways to Mental Health and Well-being are important activities targeted at reducing health inequalities experienced by people with severe and enduring mental illness and offering group activities in our Resource Centres on healthy eating, self-esteem, sleep hygiene all work hard to demonstrate a commissioning approach targeting Parity of Esteem and reducing the 20 year gap in mortality rate for people who experience severe and enduring mental illness.

Prisons / YOI's / Secure Training Centre

28. Surrey Prisons will have a new GP service and Mental Health service starting 1st April 2015 and HMP Lewes will have new primary care and GP Provider from 1st April 2015; ensuring effective implementation and transition is key alongside robust performance management against services specified.
29. Transfer of commissioning responsibility from Youth Justice Board to NHS England on 1st April 2015 for Secure Training Centres will require the re-procurement of existing health services at Medway STC during 2015.
30. Health & Justice Indicators of Performance are a requirement of all adult prison contracts now across the South East and therefore each contract will be monitored using these indicators alongside our local KPI Suites.
31. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Reduced Prison Officer availability for Escorts and Bed watches and enabling prisoner access to internal healthcare appointments	Escorts for all Prisoners who require a hospital appointment	Reduce the number of escorts by bringing services into the prison, develop medical technologies. Continue dialogue with NOMS	18 and 2 weeks waits for treatment met
Workforce; Clinicians and Medics not applying for jobs in prisons	To have a workforce that is fit for purpose	Assist providers in thinking creatively about staff models and recruitment approaches	Less reliance on Locums and agency provision
Aging prisoner population	Social care and healthcare needs for all prisoners are met or equivalence with the community	Estate capital adjustments required (NOMS requirement) to enable Health & Social care to provide a package of care	Equivalence with the community
Access to Consultation and Clinical Rooms at	Clinicians getting access to patients and then being	Formal notification of impact to the YJB	Reduced DNA's and cancelled appointments due

YOI Cookham Wood	able to see patients in an appropriate setting		to access to patients / room availability
Commissioning a Provider of high quality healthcare services into Medway Secure Training Centre	Provision of high quality, integrated healthcare provision	Market development and Provider stimulation. Re-procurement of existing health services	Delivery of excellent healthcare services for children and young people at Medway STC
Highly complex Children within the Secure Estate	To work with Secure Commissioners to ensure rapid access for those requiring CAMHS tier 4	Continue in dialogue with Specialist Commissioners	The most vulnerable children accessing appropriate services

Sexual Assault Referral Centres (SARCs)

32. The South East will continue its involvement in the national programme of Sexual Assault Services development and the coordination of the South East response to the national work commissioned by NHSE examining pathways and ‘who pays’ for which elements of the SARC services offered. This relates to both the acute / forensic provision and the aftercare services.

- Liaison and close working with colleagues at Police & Crime Commissioners Office in order to support their continued engagement in and funding of both Adult and Child ISVA provision.
- Liaison with Providers, Police colleagues, Local Authorities and Service Users to develop local KPI are that reflect qualitative issues rather than quantitative data with regard to SARC services.
- Implementation of sustainable, efficient and effective Paediatric SARC s across the South East which reflect the National Paediatric SARC Framework.

33. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Lack of clarity regarding commissioning responsibility for different element of the victims’ journey.	To get a clear understanding of who is responsible for commissioning different aspects of the victims pathway and work in partnership with other agencies to ensure appropriate and relevant services e.g. Talking Therapies.	To await national guidance. To understand the impact and requirements for each SARC within the South East and the aftercare services in partnership with Providers and other Commissioners. To liaise with other agencies e.g. LA, CCG & Police to ensure appropriate services are accessible to victims.	National Guidance is implemented across the South East area. Victims have a choice of services to meet their individual needs. Multi Agency relationships are in place and effective.
Availability of	To provide timely	To complete an	Provision of

Paediatric Sexual Assault Examiners to delivery best practice service to victims	access to high quality, specialist, age appropriate Paediatric Sexual Assault Examinations and aftercare services	engagement exercise with Paediatricians and Clinicians to inform Service Models for each of the 3 geographical areas, co-development of model and service specification following wider stakeholder engagement on proposed Clinicians model. Followed by procurement of 3 Paediatric SARC services.	Paediatric SARC services across the South East that reflect national guidance and best practice.
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Police and Court Liaison & Diversion (PCLD)

34. The scaling up of the PCLD programme within the South East to meet the national service specification requirements and will predominantly involve for Wave 2 sites (Kent and Surrey):-

- Widening the range of vulnerabilities beyond mental health (i.e. covering learning difficulties, substance misuse and other health and social care vulnerabilities)
- Developing an all age service (youth and adult provision)
- Providing a service across all police custody suites and courts (with a core team of staff in place in both police custody suites and courts to identify and screen vulnerable offenders)
- Delivering a 24/7 service where need is indicated

35. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Recruitment of workforce to deliver the national service specification	To recruit high quality, permanent staff into all roles	To continue to work closely with Providers on developing local workforce and encouraging Practitioners into the court and police custody environment	Implementation of an equivalent liaison and diversion service across the South East by April 2015

Procurement Plan

36. The South East Health and Justice Commissioning Team intend to undertake the following procurements during 2015/16. The following table gives an indication as to the procurements required and the timeline. Continued resources for

procurement are required from 1.4.2015 for the project management and procurement advice to ensure delivery.

	Procurement	Process to commence	Anticipated Contract Start Date
1	Surrey SARC	March 2015	April 2016
2	Medway STC	March 2015	October 2015
3	Surrey / Sussex / Kent Police Healthcare	May 2015	April 2016
4	HMP Bronzefield SMS	April 2015	April 2016
5	HMP Ford SMS	October 2015	October 2016

Financial context

37. In 2014/15, a surplus of £2.0m is projected in line with submitted plan. This surplus will be carried forward into 2015/16.
38. The service has received an increase in allocation, including a net 0.6% for growth adjusted for efficiency and additional funding for the Gatwick Immigration Removal Centres.
39. The service is planning new investments in Paediatric Sexual Assault Services in Sussex and Kent and increasing its investment in Mental Health provision in Surrey. Responsibility of healthcare in Secure Training Centres transfers to NHS England in 2015/16 and funding is anticipated from the Youth Justice Board. There will be increasing coverage of Police and Court Liaison and Diversion Services as Surrey and Kent move into Wave 2 of the national pilot. Funding for this currently sits within the central team and is still to be allocated.
40. Planned Surplus for 2015-16 is £2.3m in line with business rules.
41. The summary financial position is shown below:

Health & Justice	2014/15	2015/16
Previous year outturn	44,521	47,079
Part year effects	-1,511	267
Sub total	43,010	47,346
Inflation uplifts	870	922
Growth	8	199
Provider Efficiency	-129	-666
Service Investments	4,034	3,646
QIPP	-715	0
Total	47,079	51,446
Notified Allocation	49,111	51,730
Surplus carried forward	0	2,030
Total Resources	49,111	53,760
Variance Surplus (+) / Deficit (-)	2,032	2,314

42. The following table summarises the investment in Kent and Medway Section 7a programmes:

	2014/15			2015/16		
	Allocation £'000	Expenditure £'000	Variance £'000	Allocation £'000	Expenditure £'000	Variance £'000
Health & Justice	49,111	47,079	2,032	53,760	51,446	2,314

43. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for health and justice commissioning. These indicators and the planned performance identified in the plan remain valid.

PRIMARY CARE SERVICES

44. 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).
45. 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.
46. Further information is included at:
- Attachment 10: Primary Care Summary Plan
 - Attachment 11: Primary Care National Commissioning Intentions.
47. NHS England believes the areas discussed in this plan 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.
48. 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), many operating as accountable care organisations
49. The following table provides more detail of the strategic intentions for the key primary care services:

General practice	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing</p>
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	<p>costs so will be facilitated.</p> <p>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.</p>
Community pharmacy services	<p>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..</p> <p>Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions.</p>
Dentistry	<p>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.</p>
Optometry	<p>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 LOC and we will work with CCGs to co-commission services that can be moved from secondary to primary care.</p>

50. 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 and co-commissioning arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.
51. 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.
52. 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. This includes supporting the rollout of national and local workforce tools to support workforce planning.
53. In particular, during 2015/16 NHS England will work with CCGs in the active pursuit of Parity of Esteem for people with mental health problems. This includes

in relation to ensuring CCGs are commissioning effective Increasing Access to Psychological Therapies (IAPT) services, as well as exploring a range of other initiatives. This not only includes direct service provision through the national contract but training and awareness raising activities.

Primary care support services

54. 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, through a market testing exercise.

Secondary care dental

55. 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.

56. 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.

Commissioning Intentions

57. Attachment 9 details the 2015/16 national and NHS South primary care commissioning intentions.
58. Locally, NHS England 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), re-procure 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
White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

59. 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).
60. 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. The final phase of this review 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.
61. 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, re-procuring 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 re-procuring interpreting services to support patients in accessing primary care contractor services.
 - Creation of one new primary care and public health direct commissioning team for NHS South East to deliver both Surrey and Sussex and Kent and Medway direct commissioning 2015-16 plans
62. A significant proportion of the primary care budget is accounted for through the national contracts, which means a large amount of the expenditure is pre-determined. However, a range of QIPP initiative will continue to be progressed including:
- The continuation of the successful list cleansing programme that was put in place in 2014/15;
 - Vigorous contract management and taking opportunities to rationalise services (e.g. to reduce rent costs)
 - PMS review (see above)
 - Re-procurement of APMS contracts (see above)

63. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for primary care commissioning. These indicators and the planned performance identified in the plan remain valid.

Financial investment

64. The following table details the investment in Kent and Medway primary care services:

	2014/15			2015/16		
	Allocation £'000	Expenditure £'000	Variance £'000	Allocation £'000	Expenditure £'000	Variance £'000
Primary Care	373,093	369,611	3,482	384,352	376,304	8,048

The allocation for Primary Care is thought to be over-started by £2.123m; if this allocation is removed, the surplus on Primary Care services reduces to £5.925m

PRESCRIBED SPECIALISED SERVICES AND SERVICES AND ARMED FORCES HEALTH

65. Please see NHS South regional return for prescribed services and armed forces health. A summary specialised commissioning plan for NHS England South (South East) is included at Attachment 12.

SUMMARY

66. This paper is an addendum to the Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, and updates the plan to take account of 2015 /16 planning requirements.
67. The following table shows the total planned funding for the direct commissioning services that have been the responsibility of the Kent and Medway Area Team:

	2014/15			2015/16		
	Allocation £'000	Expenditure £'000	Variance £'000	Allocation £'000	Expenditure £'000	Variance £'000
Primary Care	373,093	369,611	3,482	384,352	376,304	8,048
Public Health	51,523	53,966	-2,443	39,677	42,101	-2,424
Health & Justice	49,111	47,079	2,032	53,760	51,446	2,314
Total Kent & Medway	473,727	470,655	3,072	477,789	469,851	7,938

The allocation for Primary Care is thought to be over-started by £2.123m; if this allocation is removed, the surplus on Primary Care services reduces to £5.925m.

68. 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.
69. 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:
- i. addressing any ongoing service performance issues;
 - ii. through the gateway services for prisoners being released from prison back into the community; and
 - iii. secondary care services for the health and justice population.
70. The strategic development of primary care is also being considered at a national level and through the establishment of co-commissioning arrangements with primary care.

2015/16 Public Health Work Plan with Milestones						
Objective	Success criteria: How will you know you have achieved the objective? What evidence will you need?	Actions	Milestones	Date	Achievement	
Immunisation – improved coverage and uptake to reduce the incidences of outbreaks and avoidable disease	Coverage and uptake of childhood and adult immunisations meets national targets <ul style="list-style-type: none"> 95% uptake of childhood immunisation programmes to ensure herd immunity 75% uptake of flu vaccination in over 65 and under 65 at risk Achievement of agreed targets for new programmes for childhood flu, adolescent Men C/university entrants, Shingles. 	Maternal Flu and Pertussis Implementation of maternal flu and pertussis by community midwifery teams across Kent	Work with screening and immunisations team, CSU and maternity providers to deliver within community midwifery	June 2015		
		Immunisations:				
		Childhood Flu Implementation of school based programme 15/16 (subject to funding)	Options appraisal for establishing service.	Mini procurement of existing service or vary existing contracts to include in immunisation teams delivering schools based programme	Sept 15	
		School Based Imms Review in year of school based Imms.		Work with providers to ensure service models are robust	Apr – Sep 15	Awaiting funding announcement
		Adult Flu Establish service models with pharmacies and maternity	Work with key stakeholders to review full Imms and school nursing programmes	April 2016		

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN 2015/16



		Men B introduction	Work with providers to ensure programme fully understood and implemented	TBC	Awaiting funding announcement
		Co-commissioning – impact on immunisation and screening services	Awaiting national guidance	TBC	
Screening – improved coverage and uptake to support early diagnosis and intervention and reduce avoidable ill-health	Ensure all screening programmes achieve national targets Ensure that the programmes achieve value for money and reach all the relevant screening populations including those hard to reach who traditionally don't access screening services	Cervical Screening Undertake an in-depth systematic review of the cervical screening programmes to identify existing provision, review costs and quality targets and make recommendations for commissioning in 15/16. Include access through CASH and women in the military.	Undertake review of services, identify where current contracts and resources are	Jun15	
			Identify where future investment maybe required and look for opportunities for re-commissioning.	Sep 15	
			Undertake Joint Strategic Investigation with NW Surrey CCG to identify options for future for both the symptomatic and national screening services.	Dec 14	In progress
			Review existing pathways for military services	Apr 15	Awaiting review GS
			Identify where future investment maybe required and look for opportunities for re-commissioning.		

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN 2015/16



Healthy Child Programme including Family Nurse Partnership Developed to ensure effective handover to Local Authority	Achieve trajectory target <ul style="list-style-type: none"> 421 health visitors across Kent and Medway Commissioning responsibility ready to be transferred by October 2015.	Continue working with providers and Health Education England, to increase the number of health visitors as required by the national programme and to achieve consistently good outcomes as part of the Healthy Child Programme Ensure contracts are in place jointly with LA for the transfer of commissioning responsibility can happen by Oct 15 Handover of commissioning responsibility	Review Transition Board ToR	Jan 15	Achieved
			Develop Transition Board Plans for transfer to ensure systems and processes in place ready for commissioning transfer by October 2015	Jan 15	Achieved
			Monthly review of provider workforce plans to ensure on track to hit trajectory	On-going	In process
			Working with LA to ensure all legal requirements are met	Feb 15	In process
			Jointly manage contracts with LA until Oct 15	Apr – Sep 15	

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN 2015/16



<p>Improved Child Health information systems and data quality</p>	<p>Complete and robust data sources for children covering the entire child population in Surrey and Sussex</p>	<p>Work with Child Health Information Systems providers to ensure the data is accurate and the benefits maximised.</p>	<p>Programme Board to be established across all providers</p> <p>Deep dive reviews to identify gap in ability to deliver national spec</p> <p>Action plan to be developed based on new service specification</p>	<p>Jun 14</p> <p>March 15</p> <p>Mar 16</p>	<p>Achieved</p> <p>In progress</p>
<p>Collaborative Working with CCGs on improving uptake and coverage for immunisation and screening programmes</p>	<p>Improved uptake of screening and increase in early diagnosis of disease particularly cancers</p>	<p>Ensure collaborative working with CCGs in line with CCG plans to improve early diagnosis of cancers</p>	<p>Establish working links with CCGs to identify how we can work collaboratively on specific issues across the area</p>	<p>Apr 16</p>	<p>In progress</p>
<p>6-8 NIPE Checks</p>	<p>Review delivery of 6-8 week checks undertaken by Kent and Medway GPs</p>	<p>Ensure 6-8 week checks are delivered and data reported to CHIS in a timely manner</p>	<p>Establish working links with GP leads, LAs and providers</p>	<p>April 16</p>	<p>In progress</p>

ATTACHMENT 3: 2015/16 PUBLIC HEALTH COMMISSIONING INTENTIONS (LOCAL)



In 2015/16 NHS England is focusing on

- Improving access to public health screening programmes overall, and with a specific focus on improving access and uptake for people with learning disabilities, and women in the military.
- The transfer of commissioning responsibilities for the Healthy Child 0-5 Programme (Health Visitor and Family Nurse Partnership Services) to Local Authorities by October 2015.
- Working with stakeholders to develop a strategic approach to the future of the Child Health Information System to support the commissioning and delivery of services to children.
- Planning to use the national procurement framework for childhood flu. For adult flu we will increase delivery channels, e.g. pharmacies. Work with maternity providers to deliver clinics for pregnant women.
- We will also work with maternity providers to improve the uptake of pertussis.
- Engage with key stakeholders around access to cervical screening e.g CASH clinics.
- Review in year the delivery of school based immunisations, service model, outcomes and finances.
- Review NIPE 6-8 week check to ensure all GPs are appropriately trained and supplying data to CHIS.
- Ensure parity of esteem which is defined as making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems.² *Source: NHS England, 'Everyone counts'.* Parity extends to dementia or learning disabilities within the wider context of health inequalities.

Introducing Additional Services

- New Born Blood Spot Screening (NBBS) - expanded to screening for 4 more conditions. Completion of full national rollout was in Jan 2015
- Continuation of the temporary programme for maternal pertussis
- Meningococcal B – if vaccine procured at cost effective price
- Childhood flu vaccination programme extended to include 5,6 and 7 year olds (Key Stage 1)
- Rollout of cervical screening to women in the military

ATTACHMENT 3: 2015/16 PUBLIC HEALTH COMMISSIONING INTENTIONS (LOCAL)



The following are the key priorities for the Kent and Medway areas

- Immunisation
 - Data Quality
 - Childhood Flu – implementation of school based programme 15/16
 - Men B introduction
 - Co-commissioning
- Screening Programme Reviews –
 - Cervical Screening
- Transition of commissioning responsibility for Healthy Child Programme to Local Authority
- Child Health Information Service and Record Departments implementation of national specification
- Working with stakeholders to improve the delivery of the 6-8 week NIPE checks delivered by GPs across Kent and Medway
- Collaborative working with Clinical Commissioning Groups and CSU to improve uptake and coverage of immunisations and screening programmes and improve early diagnosis of disease particularly cancer

ATTACHMENT 4: PUBLIC HEALTH PROGRAMME AND POPULATION RISKS 2015/16



Risk Identified	Description	Gross Risk Assessment (Pre-Controls)			Key Controls	Net Risk Assessment (Post-Controls)			Proposed Mitigation Measures	Target Risk Assessment (Post-Mitigation Measures)			Key Risk Indicator to be Monitored	Financial Impact Forecasts		
		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Pessimistic	Most Likely	Optimistic
Immunisation	Delivery of existing programmes not achieving herd immunity resulting in disease outbreak	4	4	16	A review of data collection processes identified data quality issue.. Potential solutions identified to improve quality of data	3	4	12	Once data quality is established, targeting support to providers struggling to deliver to national standards	2	2	4	Roll out and coverage of existing immunisation programmes Implementation plans to be reviewed and monitored by the Kent and Medway Immunisation and Vaccination Committees	£ to deliver better data transfer to improve data quality	£K	£K
Immunisation	Delivery of new programmes not achieving required levels of immunity resulting in disease outbreak	4	4	16	Investigation of which providers are not achieving target immunity levels through analysis of robust information	3	4	12	Targeted support to providers struggling to deliver to national standards	2	2	4	Roll out and coverage of existing immunisation programmes	£	£K	£K

ATTACHMENT 4: PUBLIC HEALTH PROGRAMME AND POPULATION RISKS 2015/16



Risk Identified	Description	Gross Risk Assessment (Pre-Controls)			Key Controls	Net Risk Assessment (Post-Controls)			Proposed Mitigation Measures	Target Risk Assessment (Post-Mitigation Measures)			Key Risk Indicator to be Monitored	Financial Impact Forecasts		
		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Pessimistic	Most Likely	Optimistic
Cervical Screening - Cytology.	Review of cytology as part of cervical screening pathway	2	4	8	A review needs to be carried out in 2015 to identify potential increase in activity within CASH clinics for Kent and Medway women who present for call and recall screening	2	4	8	Discussion will be needed with LAs to understand commissioning and financial implications	2	4	8		£	£	£
Healthy Child Programme (0-5) Family Nurse partnership safe transfer of commissioning responsibility	Local Authorities fail to agree financial envelopes as part of the transfer of commissioning responsibility	4	4	16	Review of workforce and education plans, monthly and quarterly reporting to NHS England Close working with Local Authority	3	3	9	Regular review meetings are held with providers on workforce and service planning. Close working with LA on plans, finance and legal issues	2	2	4	Numbers through monthly monitoring of Electronic Staff Records Audit of workforce to ensure all involved in delivery of HCP (0-5) Quality measures of service performance	£	£	£

ATTACHMENT 5: PUBLIC HEALTH KEY FINANCIAL RISK 2015/16

Key Financial Risks

- Screening and immunisation programmes across Kent and Medway are based and delivered on a population base. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes.
- Over the next 3 years (2015-2018) the predicted changes in population age groups will have the following impacts requiring investment (or disinvestment):

Programme	Age Group	Predicted Change	Impact on commissioning
Cervical Screening Programme	25-49 years (female) 50-64 years (female)	?% increase 10% increase	Some investment is likely to be needed in the short term but this will reduce as HPV vaccination and testing takes effect.
Bowel Screening	60-69 years 70+ years	2% decrease 17% increase	Any reduction in the 60-69 age groups will be offset by increase in age extension. New developments in initial screening process that increases sensitivity & specificity of testing and for bowel scoping will require investment
AAA Screening programme	65 year (males)	15% decrease	Steady state (possible disinvestment)
Diabetic Eye Screening	All Ages	4% increase in population also increase in prevalence	Investment required
HPV vaccination programme	12 year (females)	10% increase	Investment required
Childhood Immunisation	Children up to 12 years	4% increase	Investment required
Flu immunisation	Over 65 years	10% increase	Investment required
Shingles	70 years 79 years	25% increase 11% increase	Investment required

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Prisons

1. As of March 2015 the prison population in the South east was 8,865. This is not a static population; it ranges from those in custody on remand for a matter of days to those in prison for life with associated long term needs.
 - Nationally 70% of adult prisoners said they had used illicit drugs prior to entering prison;
 - In a survey of prisoners released from custody, 12% of prisoners said they had a mental illness or depression as a long-standing illness and 20% reported needing help with an emotional or mental health problem.
 - The age profile of a middle aged prisoner reflects that of someone 10 years their senior in the community. Thus there is a high prevalence of long-term conditions. The older prisoner population is generating emerging social care needs.
 - Female prisoners are more than three times as likely to self-harm as male prisoners.
 - The rates of smoking, drinking and use of illegal drugs are substantially higher among young offenders than among young people who do not offend.

2. Within the South East there are 15 prisons:

Prison	Type	Provider
HMP Elmley	Cat C; Op Cap 1252	IC24 – Primary Care Nursing
HMP Swaleside	Cat B; Op Cap 1112	GP - Minister Medical Practice
HMP Standford Hill	Cat D; Op Cap 464	Oxleas – Mental Health, Pharmacy RaPT – Substance Misuse
HMP/YOI Rochester	Cat C; Op Cap 658	Oxleas – Primary Care Nursing , GP, Mental Health, Pharmacy RaPT – Substance Misuse

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

HM YOI Cookham Wood	Cat B Local; Op Cap 200	Oxleas – Primary Care Nursing , GP, Pharmacy CNWL – Mental Health KCA – Substance Misuse
HMP Maidstone	Cat C Foreign Nationals; Op Cap 650	Oxleas – Primary Care Nursing , GP, Mental Health, Pharmacy
HMP East Sutton Park	Cat C / D; Op Cap 100	RaPT – Substance Misuse
HMP Blantyre House	Cat C / D; Op Cap 122	
HMP Lewes	Cat B; Op Cap 750	Sussex Partnership Trust – Primary Care Nursing, Mental Health, Pharmacy CRI – Substance Misuse MedCo – GP
HMP Ford	Cat D; Op Cap 557	Sussex Partnership Trust – Primary Care Nursing, , Mental Health, Substance Misuse, Pharmacy Dr Robertson / Dr West - GP
HMP High Down	Cat B Local; Op Cap 1103	Virgin – primary care nursing, Pharmacy CNWL – Mental Health RaPT / KCA – Substance Misuse Acor –GP
HMP Down View	Cat C /D; Op Cap 355	<i>As above but different GP Provider</i>
HMP Send	Closed Female; Op Cap 282	Cheam Practice – GP

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

HMP Coldingley	Cat C Trainer; Op Cap 513	Cheam Practice – GP Studholme Practice - GP
HMP Bronzefield	Cat B Female; Op Cap 527	NOMS Commission Sodexo for healthcare, NHSE commission; CNWL – Mental Health Sodexo Justice Services – Clinical Substance Misuse

Police Custody

3. HNAs have been undertaken in both Sussex and Kent and Medway custody suites. The same will be undertaken in Surrey over 2015/16. The number of detentions in custody across the South East is declining as the police continue to use alternatives to arrest including community disposals, restorative justice and voluntary attendances. However, the following is of note:

- Approximately 37.1% of individuals in Kent and 40% in Sussex are seen by the healthcare provider whilst in custody. This is comparable to other forces nationally.
- The largest issue facing healthcare providers in Kent & Medway and Sussex custody settings is substance misuse. 34% of contacts in Sussex and 38.1% of contacts in Kent and Medway related to substance misuse. However using the same methodology on current performance indicates closer to 54% - nothing that this figure will include multiple contacts with the same DP.
- Mental Health concerns are also a significant issue in forces representing 16% of contacts with healthcare provider in Sussex and 8.2% of detainees in Kent presenting with an issue.

4. The following number of police custody suites in each area:

Force Area	Number of Custody Suites	Provider

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Kent	7	Kent Police
Surrey	3	Tascor
Sussex	6	Tascor

Sexual Assault Services

5. Across the South East there are 3 Sexual Assault Referral Centres. All of the SARC's are jointly commissioned with Police. The key points of note are as follows:
- Analysis by the MOJ statisticians revealed that of the estimated 78,000 victims of rape or attempted rape each year, 9,000 are men, equating to 1 in 10 victims being male. They also revealed that 72,000 males were recorded as being victims of sexual offences annually.
 - Although reporting of sex crimes against males is evidentially on the increase, academics and professionals in the field of interpersonal violence agree that sexual abuse and rape of males is one of the most under reported crimes worldwide. In 2012/13 only 1,550 incidents of male rape were recorded by the Police in the UK, equating to a staggering 7,450 rape or attempted rapes of males going unreported. These figures are reflected in both Kent where only 11% of reporting rape victims were men and in Sussex where on 4.2% of victims accessing the SARC were men.
 - Over 90% of referrals to the SARCs in Kent and Medway and Sussex are made by the Police.
 - The NSPCC's 2011 report indicated that:
 - 0.6% of under 11s and 9.4% of 11–17s had experienced sexual abuse including non-contact offences in the past year
 - 65.9% of the contact sexual abuse reported by children and young people (0-17s) was perpetrated by other children and young people under the age of 18
 - Teenage girls aged between 15 and 17 reported the highest past-year rates of sexual abuse.
 - Data from individual SARCs suggest that between 22% and 50% of clients seen are young people under 18 years old (NHS England, 2013, op. cit.).
 - Sexual violence and abuse can cause severe and long-lasting harm to individuals across a range of health, social and economic factors. The effects of sexual violence on victims can include depression, anxiety, post-traumatic stress disorder, drug and

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

substance misuse, self-harm and suicide. In Sussex 53% of victims accessing the SARC were identified as having mental health concerns

6. The following details the Sexual Assault Referral centres in each of the three counties:

Force Area	Sexual Assault Referral Centre	ISVA Provider
Surrey	Care UK	RaSAC
Sussex, East Sussex and Brighton & Hove West Sussex	Mountain Healthcare Limited	Survivors Network Worth Services
Kent	Mountain Healthcare Limited	East Kent Rape Line / Family Matters

Children and Young People's Settings - Secure Children's Homes

7. There are two welfare only - SCHs in the South East Region and health needs assessments have been completed in each in 2014. Key findings are as follows:

- Children and young people in contact within the secure estate have more-and more severe – unmet health and well-being needs than other children of their age. They have often missed out on early attention to health needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems (Healthy children, safer communities, DH, 2009; Evidence of needs paper, Ryan M and Tunnard J, 2011).

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

- The children and young people who find themselves placed in SCH's have often taken high risks which will have had a detrimental effect on their health. This group of young people have often experienced significant abuse and/or are likely to have been a substance misuser, In addition to this they are likely to have engaged erratically with health services and have often missed significant health appointments.
- Physical health needs are generally minimal and well contained/managed
- Children now in SCHs are increasingly complex and have multiple unmet health needs. The reduction of the numbers of young people in custody nationally means that only the most vulnerable are now in secure environments.

8. The following identifies the secure children's homes within the South East:

Area	Secure Children's Home	Provider
West Sussex	Beechfield Secure Childrens Home, Cophorne	Sussex Community Health – Primary Care Sussex Partnership Foundation Trust – CAMHS CRI – Substance Misuse Services
East Sussex	Landsdowne Secure Childrens Home, Hailsham	East Sussex Healthcare – Primary Care Sussex Partnership Foundation Trust – CAMHS East Sussex County Council Substance Misuse

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Children and Young People's Settings - Secure Training Centre

9. Medway STC is the only STC in the South East and has an operational capacity of 76 young people, both girls and boys. G4S are currently the provider of healthcare services and a re procurement for health services at the Centre is underway at the time of writing this document. A recent health needs assessment has indicated the following findings:
- Since 2012 there has been a marked increase in the number of children and young people placed at Medway STC who have committed violent offences. There has also been an increase in the number of young people in the STC who have committed sexual offences and an increase in the number subject to MAPPA arrangements. In terms of the age of the cohort, there are more 17 year olds at Medway than previously, the data showing a year on year upward trend. Together these changes may mean a more challenging, complex and older group of children for staff to care for in 2014 than the cohort who were present in the STC in 2012.
 - The data provided by the YJB placements team shows higher than expected numbers of children and young people placed at Medway with a 'serious medical or health complaint' (7.54% in September 2014)
 - Youth Justice Board statistics appear to show an increase in the number of children and young people demonstrating a risk of self-harm or suicidal behaviour, now over double the figure reported in April 2013. There remain high levels of lower mental health need in combination with a concerning increase in the number of children and young people placed at Medway with severe mental health problems.
 - Data quality has been a significant issue in the collation of this report. SystmOne (or a parallel cohesive clinical IT system) is not yet in place in Medway. The number of late receptions into STC is currently impacting on the ability of staff to carry out the initial Comprehensive Health Assessment Tool (CHAT) screening within 2 hours of admission. This requires monitoring and further discussion at YJB/NHS England level; it is not a Medway specific issue but difficulty across a number of secure settings for children and young people at the moment.

Immigration Removal Centres

10. There are 3 IRCs and 1 Pre-Departure Accommodation (PDA) in the South East and recent health needs assessments have identified the following key findings:
- Detainees require access to a full range of Mental Health services that are commensurate with the needs of those being detained, pending removal. Ensuring early interventions are available to ensure Mental Health issues are dealt with as early as possible.
 - People with Mental Health problems are likely to stay in detention for almost twice as long as those who do not.

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

- Health promotion activities be delivered to ensure increased knowledge is available prior to departure.

11. The detainee population is unique and presents particular challenges for commissioners and providers in identifying and meeting health and wellbeing needs. The picture of health needs that emerges from the individual health and wellbeing needs assessments is of a population that is highly stressed due to their particular circumstances and the fact of being in detention. The following is also of note:

- The potential for communicable diseases to spread or go unchecked due to the likelihood of detainees not having received childhood immunisations;
- Aggravation of long term conditions e.g. diabetes due to detainees having avoided contact with formal healthcare services prior to being detained and/or the lack of access to appropriate health services in their home country;
- High levels of stress resulting in poor mental health and associated physical problems e.g. skin disorders, lack of sleep etc.;
- Risk factors associated with poor health including smoking, alcohol and drug use;
- Cultural and religious barriers making early identification and treatment of sexual and blood borne viruses problematic in particular HIV/AIDS

12. The following details the IRCs within the South East:

Area	Immigration Removal Centre	Provider
Sussex (Gatwick)	Tinsley House – Op Cap: 448	G4S – primary care and GP service
	Brook House – Op Cap: 153	Sussex Partnership Foundation Trust – mental health
	Cedars Pre-PDA for family units – Op Cap: up to 54 (9 units holding max of 6 detainees)	
Kent	Dover – Op Cap: 380	IC24 – primary care and GP service
		Oxleas – mental health and Pharmacy
		RaPT – Substance misuse

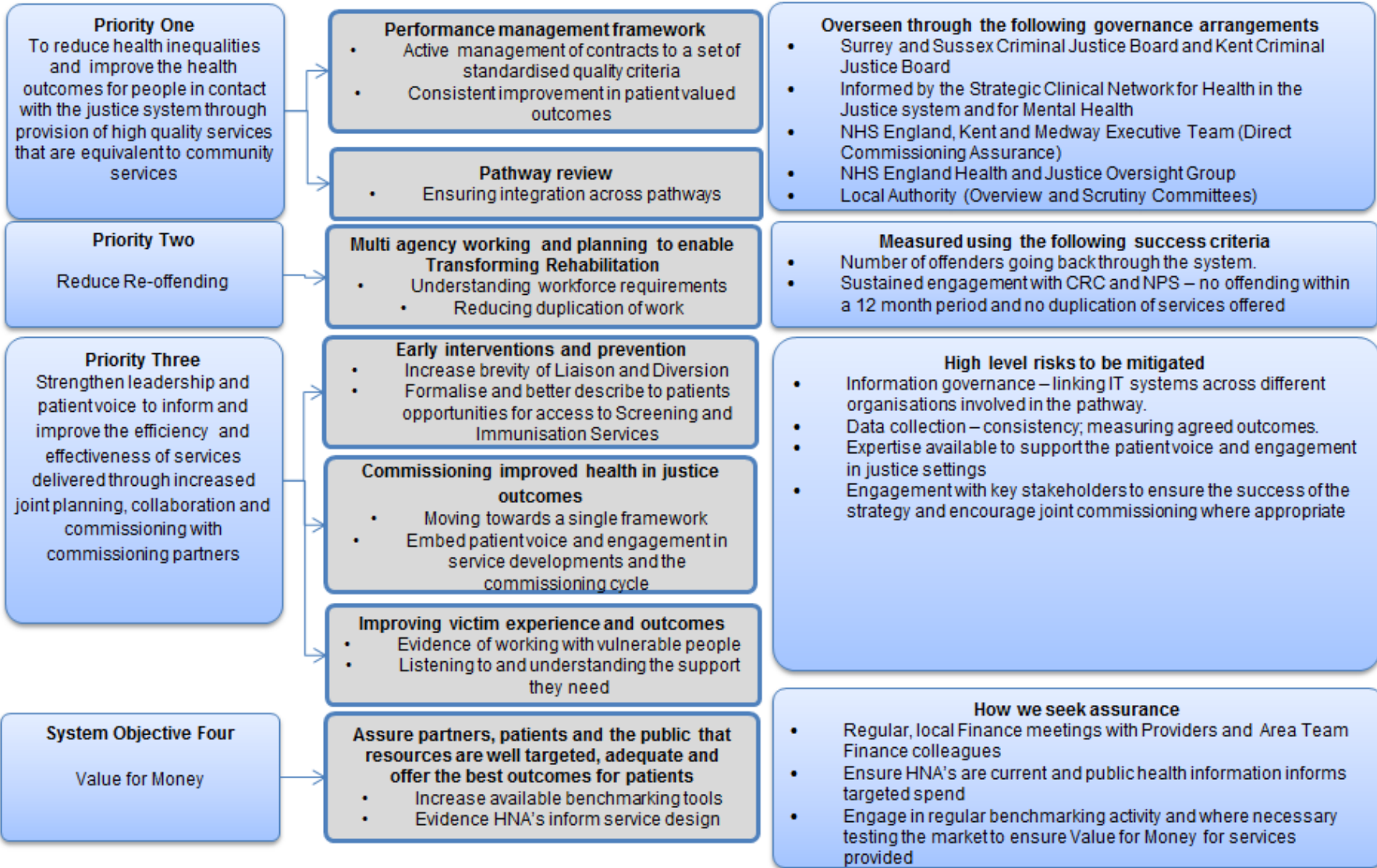
ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Police and Court Liaison & Diversion

13. Police and Court Liaison and Diversion (PCLD) services exist to identify offenders who have mental health, learning disability, substance misuse and/or other vulnerabilities when they first come into contact with the criminal justice system.
14. The need for greater consistency and coverage of Criminal Justices Liaison and Diversions services was highlighted in the Bradley report. The ambition is to have 100% coverage of the country by L&D services by 2017, subject to final approval by HM Treasury.
15. In the South East PCLD services were being commissioned historically but have benefited from being Wave 1 and Wave 2 pilot schemes where additional resources have been received to ensure that pre-existing services now meet the national specification requirements for the service.
16. The National Programme commenced in April 2014 with ten trial sites across the country implementing the national, standard service specification and standard, Sussex was one of these sites. The trial sites were selected on their perceived readiness and ability to scale up their existing PCLD provision to meet the new National Service Specification for L&D.
17. A further wave of trial sites has been announced which will receive 1-year funding from April 2015 to do the same. By April 2016 this means that over 50% of the country will be covered with L&D services that are working to the National Specification.
18. The following shows the healthcare providers that provide services in the police custody suites in the three counties and their status against national service specifications:

Area	Provider	Meets National Specification
Kent Force Area	Kent and Medway Partnership Trust	Yes – from 1.4.15 Wave 2
Surrey Force Area	Surrey and Borders Partnership Trust	Yes – from 1.4.15 Wave 2
Sussex Force Area	Sussex Partnership Foundation Trust	Yes – from 1.4.14 Wave 1

5 Year Strategic Plan and Vision
Working together to achieve excellence in health outcomes and experience in justice settings for people in Kent, Surrey and Sussex



ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)



Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
<p>Implement Best Practice Mental Health Pathways of care in Prisons and YOIs that link with community mental health services</p>	<p>Review existing mental health services in prisons and YOI's to ensure they offer primary care mental health services which reflect the Stepped Care Model reflected in 'Improving Access to Psychological Therapies' (IAPT) services in the Community. Ensure that secondary care mental health services reflect standards of best practice in care. Embed patient outcome monitoring.</p> <p>Monitor timely Section 47 and 48 transfers under the Mental Health Act for prisoners experiencing a mental health crisis who meet criteria under the Act</p>	<p>Review existing service specifications to include primary mental health care services and patient outcomes monitoring.</p>	<p>All Providers of mental health services in prisons and YOI's</p>	<p>Where there is an absence of primary care mental health service Commissioners will need to either move existing resources to promote early intervention and prevention or identify new resources.</p>	<p>Recent ministerial interest has indicated a political drive to improve mental health services in prisons and uptake in Treatment Orders (CTO's, MHTR's) in the community.</p>
<p>Transfer of commissioning responsibility from Police Forces to NHS England</p>	<p>Implementation of the transfer of commissioning responsibility from Police Forces to NHS England by 1st April 2016 – this is reflected in the completion of the Statement of Readiness documentation And its requirements</p>	<p>By 1st April 2016, where contractually possible implementation of the new, standard, national service specification for healthcare services provided into Police Custody Suites.</p> <p>Budgetary and commissioning responsibility for healthcare services into Police Custody transfer to NHS England by 1st April 2016.</p>	<p>All Providers of Healthcare into Police Custody Suites</p>	<p>Should be cost neutral but relies on negotiations between Department of Health and the Home Office</p>	<p>Transfer of commissioning responsibility delayed by 12 months in order to enable all Forces to be ready and able to transfer to NHS England and provides time for cost and budget negotiations to be completed between DH and HO.</p>

ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

<p>Implement effective co-commissioning of Sexual Assault Services for children aged 12 years and under and young people and adults aged 13 years and over.</p>	<p>The effective provision of SARC services relies on effective co-commissioning relationships between a number of Agencies; NHS England, Police Forces, Police and Crime Commissioners, CCG's, Local Authorities. Proactive engagement with Agencies by NHS E will be essential in their role as lead commissioner for the service.</p>	<p>Implementation of the Service Framework for Paediatric SARC Services and implementation of the 13 years and over National Service Specification for SARCs with supporting KPI Suite. This may result in the need to retender some SARCs during 2015/16,</p>	<p>All Providers of SARC's and their associated services.</p>	<p>Uplift provided by DH to support improved service provision of SARC's nationally – particularly for Paediatric provision.</p>	<p>On-going work confirming the financial responsibilities of each co-commissioning agency will provide greater clarity around funding responsibility when partners review existing services.</p>
<p>Implementation of National Health and Justice Performance Indicators</p>	<p>Ensure Providers of health services in criminal justice settings implement the national HJIP Framework for their particular setting when they become available. A national suite of HJIPS for prisons is available and being implemented; HJIPS for IRC's, YOI's and STC's and Police Custody are being developed.</p>	<p>Requires IT systems and templates to populate the indicators</p>	<p>All Providers of healthcare services in criminal justice settings.</p>	<p>Providers may have to resource time in training their staff in populating the HJIP template, learning READ codes., collating data returns and putting the HJIP template onto their computers.</p>	<p>Implementation of the national suite of HJIPs for adult prisons is well underway. Other settings are developing their own, bespoke data suites for implementation during 2015 / 16.</p>
<p>Providers continue to improve the coverage and uptake of health checks</p>	<p>Commissioners continue to review and monitor the delivery of Health Checks in prison</p>	<p>Implementation of Service Specification for Health Checks in prison.</p>	<p>All Providers of primary health care services in prisons.</p>	<p>Cost neutral as built into existing primary care contracts as a requirement.</p>	<p>Training needs of staff and ensuring consistency of what services are offered within the Health Check and how they are recorded is an important feature.</p>
<p>Strengthen the integration and continuity of care between custody</p>	<p>Healthcare Providers in criminal justice settings work with new Community Rehabilitation Companies to deliver continuity of care for prisoners on release –</p>	<p>Sharing of the service specification and model of provision being offered by</p>	<p>All Providers of healthcare services in prisons and</p>	<p>Cost neutral as an expectation within existing Provider contracts.</p>	<p>A national policy that will require close partnership working across a variety of local Agencies. Prison</p>

ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)



and the community	<p>reflecting 'Transforming Rehabilitation' agenda and 'Through the Gate' national policies</p> <p>Police and Court Liaison and Diversion Services continue to develop in line with the national service specification.</p>	<p>CRC's to enable prison healthcare Providers to engage and support the 'Transforming Rehabilitation' agenda.</p>	YOI's.		based Providers must learn to be 'outward' facing.
Improve the proactive detection, surveillance and management of infectious diseases, outbreaks and incidents	<p>Services will review and improve systems for the detection of TB, implement care pathways and processes for the screening, diagnosis and treatment of Hep B, Hep C and HIV, enabling the full roll out of opt out BBV testing by 1st April 2017.</p>	<p>Performance management of existing contracts by Commissioners to ensure delivery and review of specifications to ensure adequate purchasing of services.</p>	All Providers of primary health care.	Potential cost implications where robust services and level of provision do not meet national expectations.	A phased roll out of BBV opt out is active nationally. Commissioners have undertaken local stock takes of their current positions against this requirement in order to determine any local additional resource implications.
Support the delivery of the Social Care Act in prisons.	<p>Commissioners and Providers will support the prison and Local Authorities in the development of systems and services that deliver integrated health and social care.</p>	<p>Provision of social care assessments and interventions for prisoners commissioned by Local Authorities from April 2015.</p>	Providers who may want to be delivering social care assessments and interventions by LA's	None	Variable approaches to provision of social care services to prisoners by Local Authorities nationally i.e. some will provide the service directly; some LA's will commission the services from existing prison Providers of healthcare.
Management of medicines and new psychoactive substances	<p>Prescribers will proactively and continually review their prescribing practice and will introduce the new national formulary for pain management in prisons when published.</p> <p>Implementation of Best Practice Guidance in management of medication queues</p>	<p>Where not already in place implementation of national formulary and best practice guidance.</p>	All Providers of Pharmacy services and Substance Misuse Services working with New Psychoactive	Expected to be cost neutral to NHS England	Close partnership working with Prison Service colleagues will be essential in delivering responses to NPS, reducing the use of some addictive medicines for the treatment of pain and enabling of safe medicine queues.

ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)



	Implementation of Best Practice Guidance regarding new psychoactive substances		Substances.		
Improved response to managing prisoners at risk of serious self harm	Insist that Providers; ensure that Risk is highlighted and early intervention offered and available. Improve management of prisoners at risk of serious self-harm by implementing lessons learnt from Near Misses, local review of ACCT interventions and implementation and repeated monitoring of the implementation of Death in Custody recommendations consistently across Agencies	Reviewing with Partners how effective ACCT implementation is in each establishment, workforce training needs, quality of mental health services offered(i.e. timeliness of access, range of interventions offered) and how robust implementation of Lessons Learnt and PPO recommendations is will influence future service specifications for services and strategies for reducing the likelihood of self-harm and self-inflicted deaths.	All Providers in prisons and YOI's	None anticipated.	This intention is one that can only be delivered in partnership with stakeholders and is far reaching in identifying and supporting improvements in services which minimise the likelihood of serious self-harm and suicide.
Reduce the levels of smoking amongst prisoners	Ensure the consistent implementation of both Smoking Cessation courses, equipment, aids and peer support programmes in secure settings.	Review of service specifications to ensure compliance with expected national standards. Close working with Public Health colleagues to support the increased number quitters.	All Providers of primary care services in prisons and YOI's.	Some additional costs may be experienced where services are not adequate to meet the range of interventions needed ie peer support, NRT.	Preparing for and working closely with PHE will support prisoners and prisons when the settings move to totally smoke free environments.

ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

<p>Ensure Excellence in Delivery of Healthcare Services for Children and Young People</p>	<p>Continue to ensure that the Comprehensive Health Assessment Tool (CHAT) , AssetPlus (an end to end youth justice assessment framework) and SystemOne is implemented in Secure Training Centres and Secure Children's Homes</p> <p>Ensure robust Clinical Substance misuse services are in place in YOI's, SCH's and STC's</p> <p>Ensure the implementation of Standards of Care for CYP in Secure Settings is implemented, audited and actively reviewed</p>	<p>All service specifications should now reflect these requirements and all Providers of CYP services should be actively delivering the expected national standards</p>	<p>All Providers of CYP healthcare in secure settings.</p>	<p>Some additional costs may be experienced where services are not adequate to meet the range of interventions needed or standards expected.</p>	<p>Implementation of the standards for CYP services is being delivered throughout 2015/16</p>
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ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Service User Story	Development of a Service User Story with poem / art work and a short film to use alongside recruitment campaigns for healthcare professionals into Criminal Justice Settings	A new product to use alongside mainstream recruitment campaigns to address workforce shortages in the criminal justice setting	All Providers in Criminal Justice Settings	Funding identified and planned for in 2015/16	A service User in Recovery from active addiction after 17 years has been released from prison and tells their experience of health services within criminal justice settings.
Implementation of Recommendations made by User Voice	Implementation of Recommendations made by User Voice who are undertaking a stock take of how South East H&J Commissioning supports the involvement, engagement and active inclusion of people who use health services in the criminal justice system can inform, influence and help deliver the local Commissioning Programme of Work	Service User and Patients by Experience lead our work plan development and help deliver its outcomes.	All Providers in Criminal Justice Settings in the South East.	Funding identified and planned for in 2015/16	Report with Recommendations expected by May 2015.
Sexual Assault Referral Service for children under 13 years (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassurance of quality of care pathway and service in Surrey To commission bespoke HNA's for Paediatric Sexual Assault in each of the 3 geographical areas	The key stages of the work are service design, development of a Kent and Sussex specific options paper, consultation and procurement of Paediatric SARC services. Sussex Paediatric SARC Services have progressed into developing a bespoke	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

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)



		service specification and Kent Paediatric Service is to start engagement with Clinicians in service design.			
Surrey SARC	To re procure Surrey SARC	To meet national service specification , KPI and Quality measures	Care UK	Cost neutral	Existing Providers contract requires a procurement during 2015 for new service delivery April 2016
Surrey and Sussex Police Forces Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (South East) for 1st April 2016 and the re-tendering of services for 1 st April 2016.	Transfer of commissioning responsibility to NHSE requiring a re-tendering of existing services across Surrey and Sussex Forces. Requiring a proactive Market Development and Provider Stimulation event to ensure new services are in place from April 2016	Tascor	National Team confirming service value and transfer value of services from Police Forces to NHSE to ensure adequate resources are transferred to enable re-commissioning of services.	Preparing Statement of Readiness and organising Market Development and Provider Stimulation Event in early Summer 2014.
Kent Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (South East) for 1st April 2016 and the re-tendering of services for 1 st April 2016.	Transfer of commissioning responsibility from Kent Police Force to NHS England requiring a re-tender of existing services which meet national specification requirements.	Kent Police are the Provider of the FNP service, FME's are employed on an individual contract	National Team confirming service value and transfer value of services from Police Forces to NHSE to ensure adequate resources are transferred to enable re-commissioning of	Preparation for procurement underway whilst confirming OPCC and Kent Police agreement to go out to competitive tender due to change in law not allowing Police Forces to be direct employers of healthcare staff.

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

			basis by Kent Police.	services.	
Surrey Public Prisons – mobilisation of 2 new contracts	Mobilisation of new GP Contracts and new Mental Health Service Contract across the 4 Surrey public Prisons	New Service specifications, KPI's , Quality Dashboard	CNWL Foundation Trust, Cheam Practice, Studholme Practice and Ancor Practice.	As a result of procurements savings will be made from April 2016.	Mobilisation of new services and ensuring fidelity to the new service specifications.
HMP Lewes	Mobilisation of new GP Contract and new healthcare contract	New Service specifications, KPI's , Quality Dashboard	Sussex Partnership NHS Foundation Trust MedCO	As a result of procurements savings will be made from April 2016.	Mobilisation of new services and ensuring fidelity to the new service specifications.
HMPs Kent and Medway : Clinical Substance Misuse Service	Mobilisation of new clinical substance misuse service across the Kent and Medway prisons Estate	New Service specifications, KPI's , Quality Dashboard – particularly new clinical approach to methadone maintenance / detox	RaPT	Cost neutral	New Provider of Clinical SMS Services – close monitoring required by Commissioner required – need to ensure best practice in methadone prescribing is followed
Secondary Care Technology HMPS	Use medical technology in prisons to enable access to pathways for secondary care treatment and assessment. To be trialled and developed with existing secondary care Providers at the Isle of Sheppey and Surrey prisons.	Service innovation and reduce demand for external hospital visits and improve timeliness of intervention	Local Acute Trusts	Cost neutral	Innovative work with partners which will develop capacity and commitment from Acute Clinicians to engage in this approach

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)



Secure Children's Homes (SCH) – welfare only	Implement new CAMHS contract Review primary care services model in light of national expectations and implementation of CHAT Review of substance misuse support in light of national expectations	Service uplift to meet Royal College standards and national specification expectations	Sussex Partnership Trust Crawley Downs practice Sussex Community Trust, E. Sussex Healthcare CRI	Increase in available resources for comprehensive health services.	
Medway Secure Training Centre (STC)	Transfer of commissioning responsibility to NHS England from YJB for health services at the STC from 1st April 2015. Need to re procure health services.	Aim to re procure health services by April 2015 in line with commissioning responsibility transfer.	G4S	Anticipate no cost pressures to NHS England	Unsuccessful procurement of services in January 2015 now requires a re tendering exercise to ensure new service specification is in place as soon as possible after 1 st April 2015.
Surrey and Kent and Medway Police and Court Liaison and Diversion Service (PCLDS)	Implementation of Wave 2 of the National Pilot of Surrey and Kent and Medway PCLDS	Uplift existing services to meet the national service specification requirements	KMPT and SABPT	Financial uplift to existing services for a 12 month Pilot from 1 st April 2015	PCLDS exists across all of the South East – Wave 2 additional monies allows all 3 services to meet national requirements from 1 st April 2015
Roll out E-prescribing across the Secure Estate	In line with national requirements roll out E-prescribing across the secure Estate in the South East	Paperless prescriptions, improved Information Governance	All Providers who Prescribe	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable alongside training for Providers funded by NHS E and delivered by North London CSU

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

<p>Provision of new IT Hardware across Secure Estate</p>	<p>To provide all secure settings with a hardware refresh during 2015</p>	<p>New equipment enabling more timely use of information and data reporting and storing</p>	<p>All Providers in Secure Settings in South East</p>	<p>Cost of implementation during 2015/16 planned for in budget</p>	<p>Programme of work with timetable developed and live.</p>
<p>Implementation of System One (TPP) into; Secure Children's Homes, Immigration Removal Centre's and Medway Secure Training Centre</p>	<p>Implementation of System One (TPP) Electronic Patient Record system into all secure settings which Health and Justice Commission services into.</p>	<p>Allowing electronic record keeping that reflects national standards and requirements in these settings – similar to all other Secure Settings</p>	<p>Providers in SCH's, STC and IRC's</p>	<p>Cost of implementation during 2015/16 planned for in budget</p>	<p>Programme of work with timetable developed and live.</p>
<p>Implementation of standard Information Governance Audit Recommendations across HMPS in the South East</p>	<p>Implementation of recommendations provided to each HMPS site across the South East following an IG audit</p>	<p>Reduce the risks associated with non-compliance with legal Information Governance requirements. New expectations and new method of assessing Providers compliance.</p>	<p>All Providers of healthcare services in HMPS.</p>	<p>Cost neutral for NHS England – may require some investment from Providers e.g. staff training</p>	<p>Implementation of a Memorandum of Understanding (MOU) developed in information sharing between health Providers and non-health Providers in HMPS supports the audits findings</p>

ATTACHMENT 10: 2015/16 PRIMARY CARE SUMMARY PLAN

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		Primary care: future landscape		Key challenges	Improvements
<ol style="list-style-type: none"> <i>Variation in quality and performance</i> <i>Some patients have difficulty accessing primary care services</i> <i>Some patients struggle to navigate the health care system</i> <i>Patients using hospital services inappropriately</i> <i>Significant number of premises fail to meet required standards</i> <i>Significant number of small practices managed by sole practitioner contractors</i> <i>Uneven distribution of resources between practices and across CCGs</i> <i>Community pharmacy plays limited role</i> 		<ol style="list-style-type: none"> <i>Consistent levels of high quality performance</i> <i>Robust patient and public engagement informing commissioning</i> <i>Comprehensive range of services provided in primary care settings including a wide range of diagnostic tests and treatments</i> <i>Services are available at times and places that are convenient to patients and appropriate to need</i> <i>The highest risk patients identified and patient-focussed pathways put in place</i> <i>Premises of consistent quality and meeting minimum standards</i> <i>Sustainable provider landscape with services delivered at-scale</i> 		<ul style="list-style-type: none"> <i>Large geographical footprint with many contractors.</i> <i>Legacy of predecessor organisations and the history and relationships forged with contractor groups</i> <i>Nationally negotiated contracts leave limited scope for savings.</i> <i>Large number of small practices</i> <i>Significant number of elderly sole practitioner contractors.</i> 	<ul style="list-style-type: none"> <i>Driving up quality by reducing variation and tackling unacceptable levels of service</i> <i>Improved access to GP services</i> <i>Wider range of services provided in community pharmacy and general practice</i> <i>Increases in flu vaccination coverage</i> <i>Improvement in the prevalence of depression compared to estimated model</i> <i>Post payment verification and audit activities</i> <i>Review of discretionary payments</i>
<p>General practice in Kent & Medway: current landscape</p> <ol style="list-style-type: none"> <i>Registered population of circa 1.4 million</i> <i>8 CCGs, covering populations ranging from circa 106,000 to 460,000</i> <i>262 GP contractors, 34 PMS 13, APMS. 85% of practices are GMS – unusually high and limits scope of local QIPP</i> <i>3 GP-led health centres. Their future is the subject of review by CCGs and the local area team</i> <i>Some practice premises do not meet minimum standards</i> <i>There are significant GP recruitment issues in parts of Kent and Medway.</i> 					

ATTACHMENT 11: Primary Care Services Commissioning Intentions

Priorities for 2015-17

Strategy

- Work with CCGs in the co-commissioning of primary care services
- Work with CCGs in the development of local Primary Care Strategies to reflect national priorities
- Work with CCGs in developing local Primary Care Estates Strategies to support improved access and the provision of primary Care at scale including new models of care

Quality

- Implementation of the quality improvement strategy for primary care
- Implementation of the web based tool for GP quality indicators has been developed and adopted locally
- Work with the central team to develop the performance assessment frameworks for each provider group
- Work with the central team to develop further a robust reporting system is in place for reporting quality concerns SUIs, never events in primary care
- Ensure Safeguarding systems are embedded in primary care and there is evidence they are operating across all independent contractor groups
- Ensure there is demonstrable evidence of improved patient satisfaction of primary care services
- Working with CQC in relation to the inspection of independent contractors and support for failing practices

General Practice

- Continue with implementation of the Single Operating Model across all provider groups
- Continue to work with CCG and CSU to develop SCR into patient accessible electronic record
- Work with practices to roll out online services, such as access to appointments, prescribing and e consultations
- Continue implementation of equalisation of contracts
- Implement 7 day working in General Practice as part of the Primary Care Strategy
- PMS – Align PMS contracts with local emerging Primary Care Strategy to achieve better outcomes and value for money
- APMS – Align APMS contracts with local emerging Primary Care Strategy to achieve better outcome and value for money

ATTACHMENT 11: Primary Care Services Commissioning Intentions

- **Align premises development plan with emerging Primary Care Strategy**
- **Implementation of changes agreed as part of the annual contract negotiations (see next slide)**
- **Work with CCGs to ensure that a comprehensive premises development plan is developed to assist investment and planning**

Dental Services

- **Work with central team on the development of the Assurance management framework for Dental services**
- **Further embed the single operating model for dental services**
- **Prepare for the implementation of the new Dental Contract**
- **Fully operational LPNs in place**
- **Ensure contracts are in place with acute providers for secondary and community care dentistry**
- **Implement specialty pathways for dental as they are developed**
- **Implement the Assurance Management Framework for Primary care dentistry**
- **Review of care pathways to decrease the number of referrals into secondary care**
- **Review case mix in specialised services and develop new pathways**
- **PDS – rationalise and align KPIs with local priorities**
- **Contribute to national Orthodontic review – resulting in extension of contracts or procurement**
- **Ensure robust OOH /7 day service is in place**
- **Promote access to dentistry ensuring rate of new patient relates to need**

Community Pharmacy

- **Ensure the revised Control of Entry regulations adopted by AT and operational**
- **EPS programme being developed through CCG /CSU**
- **Established LPN in place for Pharmacy and Optometry**
- **Development of the Pharmacy needs assessment working with Local Authority**

ATTACHMENT 11: Primary Care Services Commissioning Intentions

Optical services

- Work with the central team on the development of the assurance management framework for Optical services
- Further embed the single operating model for Optical services

Family Health Services

- National re negotiation of the FHS / SBS Contracts
- Ensure contracted out FHS service meeting all quality, service and financial KPIs

Other services

- Work with the central team to develop the Single Operating for translation and interpretation services
- Work with the central team to develop the single Operating model for Occupational Health services
- Contribute to National review of clinical waste and prepare for tender in 2015/16 – new service in place 2016/17

South Region Operational Plan 2014/16 refresh South East Specialised Commissioning Hub

Background

This report is to be read in conjunction with the two year operational plan developed in 2014/15 and the refreshed strategic “plan on a page”, enclosed at Appendix 1, which articulates the service priorities at a programme of care level. The report is a refresh of the key areas from the two year operational plan with the benefit of a year’s operation and further national guidance on specialised services.

Environmental Context

The Kent, Surrey and Sussex (KSS) geography covers a population of 4.5million based on an area of 4000 sqm. We have 20 clinical commissioning groups across KSS footprint. We hold contracts for specialised services with 12 acute NHS providers and 2 NHS Mental Health providers, with a small number of national contracts for a range of independent sector specialised mental health providers; this will decrease to 11 acute NHS provider contracts in 15-16 as we look to handover the Frimley Park Foundation Trust Hospital contract to the Wessex team. There are significant cross-boundary flows of patients into London providers and smaller population flows to Portsmouth and Southampton from the West Sussex locality, and close working relationships are in place with the London and Wessex teams to support joined up working on patient pathways. Brighton and Sussex University Hospitals NHS Trust is our largest provider of specialised services, and has secured a capital investment for its 3Ts (Tertiary, Teaching and Trauma) full business case of circa £500m. The revenue consequence for specialised care is a small percentage of this overall and relies on repatriation from London for a range of specialities which has been supported in principle by the London regional team.

Our priorities

Our priorities reflect the specialised (prescribed) services 15-16 commissioning intentions, the Five Year Forward View with specific reference to the development of Collaborative Commissioning arrangements with CCGs as key strategic partners, and are outlined by programme of care in Appendix 1.

Our key priorities for 2015/16 therefore are:

- Highest quality safety, outcomes and patient experience in all services provided;
- Achieve NHS Constitutional requirements;
- Ensuring an integrated approach in commissioning of pathways with our CCG colleagues through Collaborative Commissioning;
- Reduction in inequalities in outcomes;
- Securing services within the resources available and best possible value for money;
- Services are as close to home as well as high quality as possible across all specialised services;
- Ensuring service transfers between CCGs and NHS England and vice versa are enacted within the national guidelines, and

- Delivery the contractual requirements within the central guidance on tariffs and contracting, inclusive of the reinvestment plans required through the marginal rate emergency threshold.

We aim to deliver these priorities through continued adoption of the national service specifications and clinical and commissioning policies, working in partnership with our CCG colleagues through the formal Collaborative Commissioning structure that we have established. We view this as being a critical step in delivery of an integrated commissioning system within the South East to support the delivery of these priorities

Patient safety and quality

Within the past 12 months a great deal has been achieved in operationalising the processes to ensure there is a whole system view of patient safety and quality with our partners. This has worked well and will continue to be refined and developed throughout 2015/16. Some key aspects will be:

- Continue with NHS South process for quality reviews of derogation application plans, taking into consideration the revised structural arrangements;
- Continue to operate quality governance framework with our Clinical Commissioning Groups to ensure there is a system wide of patient safety and quality;
- Continues support and adoption of recommendations for the post Winterbourne (now Transforming Care) Care and Treatment Reviews;
- Review the newly forming quality metrics and monitoring for specific quality intelligence on specialised services.

Engaging with the Public and Stakeholders

The South East team support the National Patient Public Voice Assurance Group, through the Assistant Director role. Local delivery of patient and public engagement takes place through a range of mediums, including the strategic clinical network, operational delivery networks and service specific work programmes. The team engage with the Health Overview and Scrutiny committees through attendance at a Kent, Surrey and Sussex group, where the work programme is discussed. We are looking to strengthen patient and public engagement through the collaborative commissioning joint committee structure.

Risks

- Delivery of QIPP for 2015/16, note the reliance on transactional QIPP, recognising requirement through collaborative commissioning to move to more transformational and sustainable schemes as we move into 16-17 and beyond;
- Achieving national service specification/national standards compliance where issues are complex and service reconfigurations are potentially indicated and specific cross boundary flow issues, internal to the South East and on our borders including vascular, specialised cancer (urology/oesophageal), radiotherapy, and interventional cardiology services;
- Reducing the number of service providers in line with national strategy where it is not possible to reconcile factors such as drive time and activity thresholds;

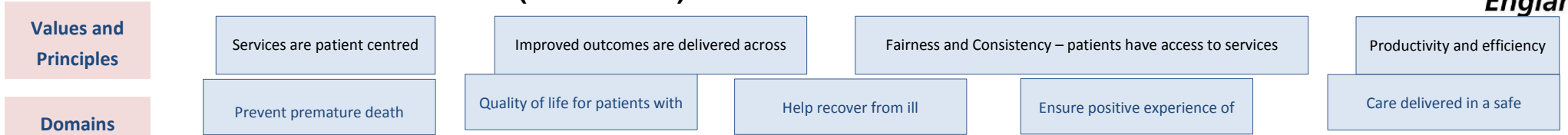
- Availability of appropriate specialised mental health placements, specifically following the outputs of care and treatment reviews and for CAMHS placements, complicated where pathways from tier 3 to tier 4 are broken;
- Referral to treatment times (RTT) for specialised services in order to meet the NHS Constitutional requirements is a challenge in terms of identifying early at a patient level and receiving supporting contract data. However we are working closely with CCGs to ensure that their elements of pathways do not impact on specialised RTT and working with the strategic clinical network for cancer waiting times to support no patients waiting over 52 weeks. At BSUHT specifically working with the provider and CCGs in reviewing the RTT for spinal/neurosurgery for adults. The Trust is extremely challenged on RTT in general, and work will continue in collaboration with the local CCGs to ensure improvements to the whole system, of which spinal surgery is a part.
- In addition we have the challenge of the considerable increase in workload of gender reassignment surgery at Nuffield Brighton as one of only two providers in England to ensure we deliver parity of esteem in terms of RTT.
- Financial balance; working with our CCG partners to understand the spend at a per head of population level across England will support the wider work of needs assessment and capacity across key service areas. Continuing to embed good principles of contract management will support delivery, however support with transformational change to ensure longer term safe and sustainable services will be key.
- Organisational capacity to deliver all of this and specifically at a time of organisational realignment.

Performance

QIPP

Building upon both the success and learning of the QIPP programme during 2014/15 the South Region have developed a regional approach to the planning of QIPP for 2015/16. This is aimed at ensuring both consistency where it benefits and building a stronger delivery platform through a single PMO function within the South with executive oversight through the regional governance arrangements. All national schemes have assessed for local benefits and are integrated within the plans.

ATTACHMENT 12: 2015/16 NHS South (South East) PRESCRIBED SPECIALISED SERVICES SUMMARY PLAN



Pre-existing Priorities	Strategic Context and Challenges	QIPP Improvements	Organisational Development
<ul style="list-style-type: none"> Implementation of Safe and Sustainable Paediatric Cardiac and Paediatric Neurosurgery Services through Network implementation Supporting the PCT/Cancer Network legacy planning and provision of radiotherapy capacity Reviewing equipment replacement/modernisation to improve access for patients and to improve outcomes for patients Continue to implement the review of vascular services to ensure compliance with national standards Continue to support the development of Neonatal Services in line with DH toolkit and national metrics and products 	<ul style="list-style-type: none"> Implementation of single operating model for specialised commissioning underpinned by principles of 5 Year Forward View and Collaborative Commissioning All specialised activity covered by one national contract with each provider based on ‘place based’ treatment, with ‘place based’ budget allocation National core specifications/clinical policies in place for all services or derogations applied for (provider derogation), or led by commissioners (Commissioner led derogation) Requirement to establish effective relationship with key partners, Clinical Reference Groups, CCGs, other Area Teams, Health & Wellbeing Boards, OSCs, providers, Strategic Clinical Networks, ODNs, PHE, PPV and clinical senate 	<ul style="list-style-type: none"> Review and adoption of national and local QIPP/Productivity and Efficiency schemes to meet circa £14-17m challenge National process for review and procurement of excluded drugs and devices Implementation of nationally agreed clinical access policies and commissioning through evaluation Review national service specifications and quality dashboards to identify areas for improvement in conjunction with NPoCs Support clinical and patient engagement to deliver implementation, working in partnership with SCNs, ODNs to support 	<ul style="list-style-type: none"> Integration of specialised services function into the new structure for specialised commissioning as a regional structure with close working relationships with the local NHS England office with specific regard to quality, and whole system management Continue to prioritise the development of contract management skills and expertise within the team Support development of matrix working and networking of teams across the South landscape Lead the team to work to NHS England vision & values Support provider engagement to embed new operating model and clinical engagement

By Programme of Care (PoC)	South East Priorities 2015-16	Expected Outcomes in 15-16	End State Ambition
Internal Medicine	<ul style="list-style-type: none"> Implementation of national service specifications Adherence to National Clinical Policies and Circular Guidance Benchmark local prices to ensure efficiency and productivity Delivery of QIPP schemes to support Commissioning Strategy 	<ul style="list-style-type: none"> Vascular services to meet national specification Achievement of core clinical and quality requirements 	<ul style="list-style-type: none"> All services compliant with national standards to achieve improved outcomes Safe and sustainable services with clear patient pathways and improved outcomes
Cancer and Blood N.B. this will be split into 2 separate PoC	<ul style="list-style-type: none"> IOG /Service Specification/QIPP compliance for cancer and radiotherapy services Review of Urological cancer services, Kent, Surrey & Sussex Implement long term strategy for Oesophageal Cancer Surgery for K&M Cancer Drugs Fund – support Wessex with implementing national process and policies HIV/AIDs - Identify activity and money for the current integrated outpatient services. Work with local authorities to identify HIV costs and ensure there are contractual arrangements that ensures patient experience doesn't suffer and these services remain integrated 	<ul style="list-style-type: none"> Implementation of locally agreed plans to improve access to radiotherapy, seek to resolve Sussex issues on expansion/modernisation of linacs Reduction in differential pricing and variations in service Development of cancer services and designation of providers in line with national clinical policies and service specifications/ IOG Compliance with cancer drug fund guidelines Implementation of Blue Teq to support good clinical practice with high cost chemotherapy drugs 	<ul style="list-style-type: none"> Improved access to radiotherapy Consistent national tariffs in place Patients to receive optimum care consistent and equitable provision of chemotherapy and cancer drugs
Trauma	<ul style="list-style-type: none"> Sussex Major Trauma centre compliance of neurosurgery support delivered through derogation Implement the designated burns facility model and review the implications of the national service specification for local provider Provider specialised T&O & spinal surgery review to understand provision & need Work with Operational Delivery Network (ODN) on adult critical care delivery of QIPP and resilience Support the provider implementation of action plans for Augmentative and Assisted Communication (AAC) Aids 	<ul style="list-style-type: none"> MTC to be fully compliant with national standards and quality requirements London and SE consensus on the configuration of burns services Achievement of national standards and improved waiting times Functioning ODN in delivery of specialised adult critical care compliant and efficient services Patients will have access to AAC equipment in a timely manner appropriate to need 	<ul style="list-style-type: none"> Burn care services compliant with the national model Safe and sustainable spinal surgery services Improved access to spinal surgery and care pathway management Patients with AAC requirements will be fully met
Women and Children	<ul style="list-style-type: none"> Work with ODN on neonatal QIPP & review neonatal services against BAPM/Specification/national products Implementation of networks for Children's Safe and Sustainable Cardiac and Neurosurgery Work with CCGs on level 2 HDU provision and implications on PIC and pathways 	<ul style="list-style-type: none"> Functioning ODN in delivery of neonatal services that are compliant and efficient Neonatal services to achieve national standards 	<ul style="list-style-type: none"> Improved network and pathway management Safe and sustainable services Ensure PIC networks and retrieval are sustained with import to out of geography providers
Mental Health	<ul style="list-style-type: none"> Specialised MH identified as a collaborative commissioning priority topic area with CCGs Focus on CAMHS pathways, implementation of increased case manager support Support review and procurement of low & medium secure services Focus on Care and Treatment Reviews 	<ul style="list-style-type: none"> 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 for people with LD 	<ul style="list-style-type: none"> Case management in place for all specialised MH services Compliant services Improved access to and egress from secure services Provision of high quality, clinically safe services for people with a LD

ATTACHMENT 12: 2015/16 NHS South (South East) PRESCRIBED SPECIALISED SERVICES SUMMARY PLAN

