Draft Operational Plan 2014-16 & Emerging Strategy Update

NHS England
(Leicestershire & Lincolnshire)

THE NHS CONSTITUTION
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NHS England (Leicestershire & Lincolnshire) Operational Plan 2014-16, Emerging Strategic Plans 2014-2019 & Strategy Update

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Foreword

This document sets out proposed plans for services commissioned by NHS England's Leicestershire and Lincolnshire team. It sets out which services we commission, which communities we serve and how these plans compliment the plans and work of other bodies that are responsible for related health and social care services. It provides an overview of relevant aspects of our communities' health needs, & the current state of our healthcare services.

National priorities for healthcare are set by a mandate from the government to NHS England. NHS England has set out its response to achieving those priorities in 'Everyone counts' guidance, & in National commissioning intentions for some services, reflected in these plans.

National regulators govern aspects of how services are commissioned: Monitor sets national prices for many services, and determines rules governing to whom and how contracts to deliver healthcare services may be awarded. Core Quality standards are set out by the Care Quality Commission directly to health and social care providers. The National Institute for Clinical Excellence assesses treatments for clinical and cost effectiveness to recommend which treatments should be made available, & provide guidelines for their use. The contracts with independent contractors who provide primary care (General Practitioners, Optometrists, Pharmacists and Dentists) are nationally negotiated.

Our plans apply locally those national priorities and standards for which we have local responsibility, prioritised within the financial and human resources made available to us, focused on those things that we believe will achieve the greatest impact on health outcomes, given the particular challenges and opportunities we face.

This is the first draft of these plans. The draft reflects early and on-going consultation with other local partners with commissioning responsibilities, and will be further refined as we receive feedback from partners and from regional and national stakeholders. They reflect and will inform related work scheduled for completion after operational plans are concluded, by June 2014: The national primary care strategy and national strategy for specialised services, the Leicestershire & Lincolnshire primary care strategy, and further work on the health system plans for Leicestershire Leicester & Rutland, and Lincolnshire Sustainable Services Review, including outcome ambitions and 'commissioning for prevention' goals.

The NHS at its best is a shared endeavour in pursuit of our vision: "*High quality care for all, now and for future generations*". This purpose is even more important at a time when resources are constrained. It is our intention through these plans to make this vision a reality for the people in our communities who fund, use & work within or in partnership with the NHS.

Peter Huskinson
Director of Commissioning

Executive Summary

NHS England commissioning plans cover primary care, public health services (immunisation, screening and health visiting) and specialised acute and mental health.

For Lincolnshire, Leicester, Leicestershire and Rutland authority areas the key health needs the plans respond to are **life expectancy** below peers in the 2 large county authorities and low in absolute terms in Leicester city, **years of life lost from causes amenable to healthcare** below peers in Leicester city, Lincolnshire and Rutland, and surveyed GP experience below peers in Leicestershire and Lincolnshire, and low in absolute terms in Leicester city, along with poor oral health.

Specialised services has a provider profile of large tertiary trusts (2 acute and 2 mental health providers account for over 70% of spend) as well as some services at 7 other acute and 7 other mental health providers. NHS England are the largest single commissioner of University Hospitals of Leicester NHS Trust, Nottingham University Hospitals NHS Trust, and Nottinghamshire Healthcare NHS Trust.

The key issues for east midlands providers are relatively high Care Quality Commission risk ratings and financial sustainability. Service prices reflect generally good levels of efficiency and more established clinically based access policies now migrated to national consistent policies, making the achievement of further financial savings require more innovative solutions than other regions without this track record.

Commissioning plans implement national commissioning intentions, including plans to converge prices for specialised care where this is outside national tariff, and to make better use of the NHS' national purchasing power for drugs and devices. Of particular importance is the adoption of national clinical service specifications in 2013/14. Providers have areas with time limited permission to become compliant in order to continue to provide services so monitoring action plans in 2014/15 are a key to ensure all patients enjoy consistent standards of care. The national strategy for specialised services is likely to recommend consolidating services to a much smaller number of providers than today, providing improved clinical outcomes through centres of excellence, and a means to achieve 7 day working in a financially sustainable way.

Quality improvement is integral to commissioning plans, and embedded in accountability processes for contracts and via multidisciplinary medical, nursing and primary care contracting review as well as through local and regional Quality Surveillance Groups and close partnership with the Care Quality Commission (CQC). In addition to adopting national Clinical Quality and Innovation (CQUIN) incentive schemes, the area team are working with partners to adopt the chief nursing officer strategy Compassion in Practice (care, compassion, competence, communication, courage and commitment), to further develop learning from complaints, through listening events, and the new data on patient experience available to us from the new year, with priority work plans on healthcare acquired infection, incident reporting, harm free care, and staff satisfaction as levers for change.

Plans also reflect a range of issues specific to the east midlands and to partner commissioners:

1. Addressing the national capacity issues in Child and Adolescent Mental Health (CAMHS) Services through appropriate capacity at each tier. East Midlands has few Tier 3+ services, although some areas now have plans in place to commission them.
2. Aligning capacity across pathways for obesity, weight management and bariatric surgery to ensure patients gain appropriate access to specialist services after first line treatments commissioned by Clinical Commissioning Groups (CCGs) and local authorities have been tried.
3. Provision of appropriate radiotherapy capacity and configuration of related cancer pathways in the South Midlands, reflecting new clinical partnerships between Northampton and Leicester, and Milton Keynes and Oxford.
4. Ensuring the sustainability of HIV services in east midlands providers is not adversely affected by local authority commissioning intentions for sexual health services given the service and workforce dependencies.
5. Appropriate service access to community and inpatient perinatal services following notice given by LPT for a service unable to meet core service standards.
6. Responding to the national review of children's and adult cardiac services
7. The completion of rollout of the East Midlands major trauma network with patients taken to the Major Trauma centre at Nottingham, which will significantly improve survival rates for patients

Specialised service commissioning is adopting a number of innovative interventions including 'NHS Improving Quality' support to providers for establishing 7 day working, internationally proven evidence based clinical decision support systems to improve hospital workflow, beginning in critical care at the 2 largest centres, and a national pilot for hand hygiene technology with promising evidence of reductions in rates of infection.

For public health services, plans build on the excellent progress in becoming the largest national pilot site for the Fluenz vaccination programme for children, making plans for transferring commissioning responsibility for the under 5 health visitor services to local authorities and continuing to expand health visitor and family nurse partnership services to support more families, and the introduction of bowel scoping to the bowel cancer screening programme.

Primary healthcare providers face distinct challenges. For GPs significant variations in patient surveyed satisfaction, major differences in opening hours and ease of access, and services geared around Monday to Friday despite progress in evening and Saturday appointments by some. The national service direction is for wider primary care services provided at scale, recognising the challenge that smaller standalone providers face in dealing with rising population need within constrained financial resources.

Plans for primary care are set out based on a number of ambitions developed through working with professionals and partners, including health watch which will inform the strategy for primary care:

<u>To reduce unjustified variation in quality of services</u> – including working with CCGs to ensure patients with more complex needs benefit from national changes to the GP contract requiring new models of care delivery, and a systematic approach to monitoring quality and addressing outlier practices, and working to tackle capacity issues.

To reduce unjustifiable inequalities in health outcomes and access to services for vulnerable groups, including implementing reviews of enhanced services for dementia, health checks for people with learning disabilities, and alcohol abuse to incorporate assessments for depression and anxiety, working to improve oral health in Leicester city and producing an eye health needs assessment to inform future plans.

To increase citizen participation and empowerment in primary care services, including the friends and family test for GP practices, relaxation of boundaries to extent patient choice of where to register, and full rollout of online booking prescriptions and medical record access, and others.

To improve the quality of life for older people and those with long term conditions though implementing GP contract changes focusing on the 2% of patients at highest risk of unplanned admission

To improve access to primary care services and secondary care dental services including supporting pilot practice groups in the prime minister's challenge fund to deliver new models of access and 7 day working.

To reduce unjustified variation in funding received by providers, and secure the highest quality care and best outcomes for every pound invested. This will involve implementing national contract changes, such as phasing out minimum practice incomes, to ensure resources follow patients, and undertaking a review of all PMS contracts to ensure the higher funding is reflected in higher service standards than GMS practices, and where this is not the case releasing resources to support the strategic development of primary care.

Based on international evidence reviews undertaken for NHS England by Nuffield, a number of care delivery models will be supported, with further work to take place:

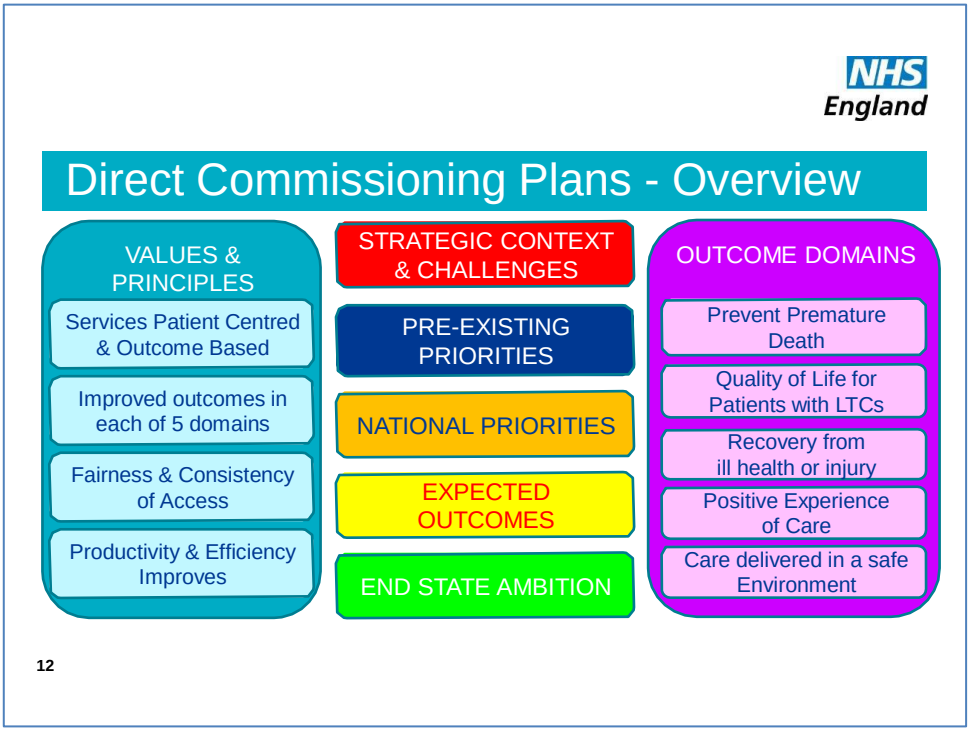
- Integration around specific medical conditions
- Integration across a wide range of conditions in a geography (neighbourhood)
- Colocation and mergers of practices to gain synergies
- Creative use of rural primary care with other public sector and community services
- Federation to manage core services and functions on a shared basis
- Specialist GP services for targeted populations and conditions.

The commissioning plans deliver financially balanced plans in a challenging financial climate whilst responding to a wide range of new ambitions and initiatives set out in 'everyone counts' planning guidance.

Further work with local authority and CCG partners is anticipated using the 'commissioning for prevention' methodology provided nationally to set improvement ambitions jointly with all partners. The area team has prioritised demand management and prevention in its use of monies from emergency care tariffs, and will engage local authority partners in the next months to contribute to refreshing the programme of work in this area.

Overview

Our plans for services sit within a common national framework:



For all services, NHS England's values and principles are that:

- Services should be patient centred and outcome based
- Plans should drive improved outcomes in the five domains set out by government
- Fairness and consistency of access to address health inequalities
- Improvements in productivity and efficiency allow improved quality within available resources

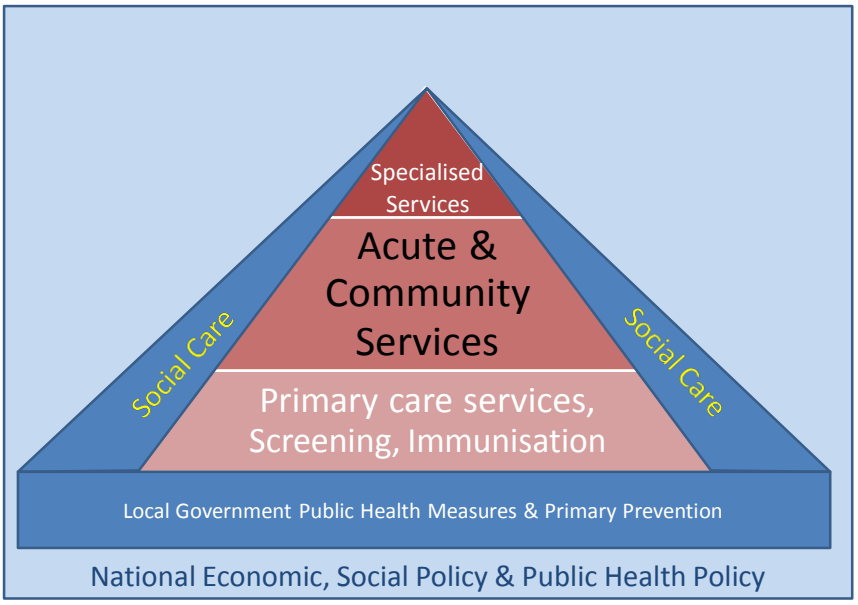
Section one and two set out the strategic context and challenges faced by our population and by providers and commissioners of healthcare. Section three outlines our priorities, the emerging direction for services and the expected outcomes of our plans. Section four focuses on delivery with financial framework for the next two years, and the impact of our change programme for Quality, Innovation, Productivity and Prevention.

Our direct commissioning plans, and those of our CCGs, operate in tandem with a full and active programme of quality improvement led through the NHS England area team and its partners. The outline of the programme is set out in the appendices to these commissioning plans.

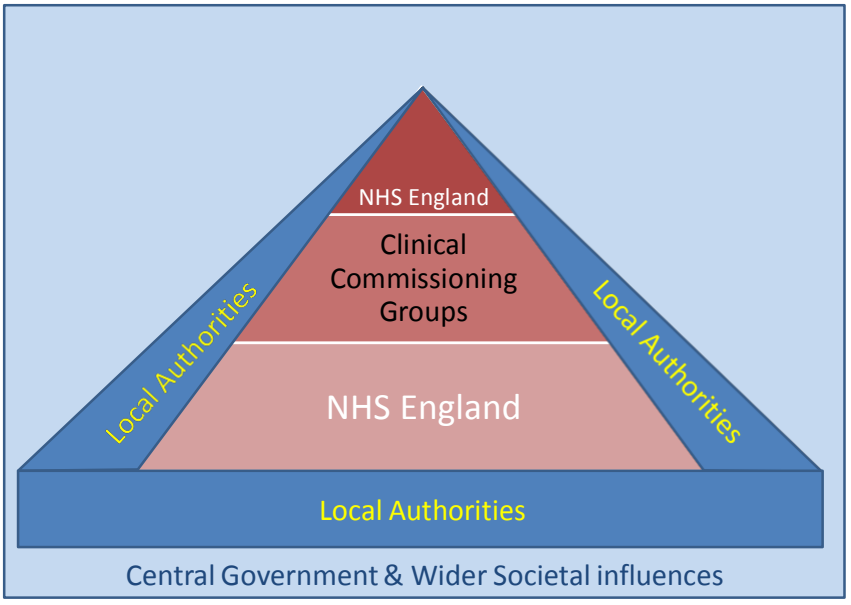
SECTION ONE: NATIONAL AND LOCAL CONTEXT

NHS England's Directly Commissioned Services – An Overview

The NHS in England provides comprehensive healthcare treatment for the whole population for, on average, £34 per person per week, or £1,770 per year. These services, alongside a wide range of other factors, contribute to our life expectancy and the quality of life we live:



A range of public bodies are responsible for these different aspects of care:



At a national level, spend on NHS healthcare in the year ahead is broken down as follows[1]:

NHS Commissioner	Total Spend	Spend Per Person in Population
Specialised Commissioning – NHS England	£13.5bn	£247
Acute and Community Care – CCGs	£64.3bn	£1,179
Primary Care – NHS England	£12.3bn	£225
Immunisation, screening & health Visiting – NHS England	£1.8bn	£33
Other (Better care fund, Health & Justice, National Programmes)	£4.7bn	£86
TOTAL (54.55m People)	**£96.6 bn**	**£1,770**

In Context:

- Two thirds of this money is planned and spent by clinical commissioning groups
- Just under £1 in every £6 is spent on complex and specialised care,
- Around £1 in £8 is spent on Primary Care, and
- Just below £1 in every £50 is spent on NHS Public Health Services (Immunisation, screening & health visiting)

Together the services commissioned by NHS England comprise around £1 in every £4 of spending on the NHS.

Our plans describe NHS England's intentions for Primary Care and NHS Public health Services for the 1.8 million people of Leicester, Leicestershire, Lincoln and Rutland and for all Providers of complex & specialised acute and mental healthcare who are based in the East Midlands, who primarily serve the 4.9 million people in this region, but also some services on a national basis.

Primary care and public health services plans inform the wider population based plans for Leicester Leicestershire & Rutland that all commissioning bodies in the NHS and local authority are developing. The plans for specialised services reflect a national approach to commissioning to ensure nationally consistent access and quality, and complement the local health system population based plans, with all services contributing to the overall outcomes goals the government has set for health and social care.

[1] Source: ONS Population projections, NHS England Allocations working paper 2014

Our Three Commissioning Responsibilities

Direct Commissioning of Specialised Services: Context

In April 2013, NHS England became the sole direct commissioner of all specialised services, with a related budget of some £13.5 Billion (14/15). Specialised services are services which are provided for less common disorders and need to be concentrated in centres of excellence where the highest quality care can be provided – care that is clinically effective, safe and offers a positive experience for patients. It is important that these services are connected to research and teaching.

NHS England is now the sole commissioner of specialised services with a clear responsibility to show leadership in delivering the best outcomes and experience of care for patients. In doing so, NHS England is keen to demonstrate its commitment to working in partnership with patients, the public, clinicians, patient organisations, providers, industry, academia and others, to develop its priorities in the coming years. To support the delivery of this commitment, NHS England is working with the Specialised Healthcare Alliance and Rare Disease UK to develop a national 5 year strategy.

Ten of NHS England's 27 area teams have direct commissioning responsibility for specialised services. They account for over 10 per cent of the overall NHS budget. Area teams are required to implement these national policies at a local level, managing contracts with their providers on behalf of all patients in England.

The Leicestershire, Lincolnshire area team is one of these area teams with commissioning responsibility for commissioning specialised services for the population of England for all providers in the East midlands. This operational plan provides an account of the first two years of the five year strategy from the perspective of the Leicestershire Lincolnshire Area team.

The Strategic direction of NHS England is to deliver quality specialised services for all. This includes ensuring there is access to services for all, the services must be clinically and financially sustainable. To achieve this we are undertaking a systematic and coordinated review of all of the specialised services that we commission. This will involve exploring capacity, capability and access associated with all of the services in the East Midlands. The co-dependency of services and the relationship between those that provide services and commission them is a fundamental to the success of this process. This will inevitable involve adopting new approaches to the delivery of care and the integration of services from both a provider and commissioning perspective. As an Area Team we are working with one of our constituent CCGs (Southern Derbyshire) to pilot one of five national pathfinder projects looking at pathways of care that transcend commissioning boundaries. A project board has been established and project initiation document has been developed in line with the project brief. The focus of the project on commissioning and development of commissioning tools that can be adopted nationally for the management of Acute Kidney Injury.

The systematic and transparent approach to commissioning is underpinned by adhering to a systematic rules based approach. We have adopted a coordinated and constant approach to assessing services against the service specification by ensuring that we have external validation of the process by using members of the regional team, strategic clinical networks and senate as part of this process. Being proactive in ensuring we have a team approach to all aspects of commissioning ensures that maximum use is made of everyone's skills and experience to deliver services which are both clinically and financially sustainable.

All of our commissioning intentions and ambitions are considered within the context of the local healthcare environment. This includes any sustainability reviews being undertaken that are exploring the long-term provision of healthcare over a wide geographical area (Lincolnshire). Well established and programmed peer reviews of cohorts of specialist services (cancer) or service inspections (Keogh or CQC). The impact of changes in the demographics and the dispersal of populations are factors that will need to be considered in implementing nationally set policies and guidance. Local intelligence will come from engagement with the strategic clinical networks and senates, health related charities and user groups. Close cooperation with public health colleagues and the integration of the commissioning function of Public Health England into the organisation will ensure the wider aspects of health care are considered when planning changes to how we commission healthcare. We support Strategic Clinical Networks and Academic Health Science Networks to develop work plans which focus on strategic care models and pathway development for key health needs. This enables integration of care and a shift toward earlier intervention and treatment. The benefit from this work will manifest where there is a direct link to access to specialised care pathways such as in obesity, kidney care and cancer services. Although we will not lose sight of the importance of access, egress, quality and availability of specialised services the team must also be mindful of the financial sustainability of any specialised service that we commission.

A key area for the Area Team is managing its financial risks and for developing the value for money and quality it delivers through its service providers. In order to do this we have an established team of supplier managers and service leads who work together in a matrix to underpin a formal approach to the way that we manage our suppliers. This includes:

- Contract management, negotiation, & where required dispute resolution.
- Co-ordinating the delivery of outcomes and quality including the management of Significant Incidents & commissioning Quality Innovation (CQUIN) schemes.
- Forecasting Demand and Planning Capacity of services
- Production of monthly reporting of performance indicators for service providers
- Financial performance – including carrying out monthly financial review and forecasts, assuring co-ordination with service providers cost base and being accountable to the Head of Finance for accurate financial reporting.
- Maintaining detailed Trust specific business knowledge, including maintaining awareness of providers' service risks.
- Raising and resolving performance issues (e.g. readmission levels, mortality).
- Identifying and managing efficiency programs and targets.
- Supporting the adoption of "best practice" to ensure value for money care processes
- Maintaining high visibility with senior management and clinicians in providers.
- Business Case Review for service developments.
- Benchmarking costs/performance with service specialists

Direct Commissioning of Primary Care: Context

From 1st April 2013, NHS England became the sole commissioner of primary medical, ophthalmic and pharmaceutical services, and all dental services with an associated budget

of £12.6bn. This also included contractor payments, patient registration and primary care support services (Family Health Services).

All 27 Area Teams have direct commissioning responsibility for these services and this is summarised in the table below along with the responsibilities of other commissioners where there is a joint commissioning role.

NHS England Area Team	Related Commissioning
Primary Medical Services Essential and additional primary medical services through GP contracts and nationally commissioned enhanced services. Out of hours primary medical services (where practices have retained the responsibility for providing out-of-hours services. Improving the quality of primary care, access and patient experience.	**CCGs** - Community-based services that go beyond the scope of the GP contract (akin to the current Local Enhanced Services). **CCGs** - Out-of-hours primary medical services (where practices have opted out of providing out-of-hours services under the GP contract). **CCGs** - A duty to support the Area Team to improve the quality of primary medical care.
Pharmaceutical Services Pharmaceutical services provided by community pharmacy contractors (not though a contract but the contractors' terms of service are included in Regulation), dispensing doctors and appliance contractors.	**CCGs** – meeting the costs of prescriptions written by member practices (but not the associated dispensing costs). **Local Authority** – production of the Pharmaceutical Needs Assessment.
General Ophthalmic Services Primary ophthalmic services, NHS sight tests and optical vouchers.	**CCGs** – any other community-based eye care services and secondary care services.
Dental Services All dental services, including primary, community, and secondary care services, plus urgent and emergency dental care.	**Local Authority** – Dental Public Health.

The strategic direction of NHS England is to enable primary care to play a greater role in the move to more integrated out-of-hospital services that deliver better health outcomes and deliver more personalised and proactive care, an excellent patient experience, high standards of quality, and the best possible value for money.

The main challenges for primary care are:

- How can primary care support prevention, care navigation, and case management through an increasingly multidisciplinary approach to service delivery?
- How can primary care reduce expensive unplanned admissions to secondary care and build capacity in the community to deliver integrated out-of-hospital services?
- How can primary care resolve its capacity issues to raise standards and improve consistency?

The Leicestershire and Lincolnshire Area Team's five year strategy aims to address these 'big issues' and deliver our vision for primary care. This includes:

- supporting innovative sustainable models of service delivery, workforce capacity solutions, improved access,
- working through contractual limitations,
- valuing the role of the primary care generalist in providing continuity, coordination and a personal approach, and
- involving patients in our commissioning of services.

The operational plan outlines the first two years of that journey.

Direct Commissioning of Public Health Services: Context

The public health function is responsible for commissioning the 30 services defined in section 7a of the agreement between the Department of Health and NHS England. Twenty six of these relate to national screening programmes and to immunisation programmes. The Public Health England embedded team lead on the commissioning of these services. The remaining four services include health visiting services for those under 5 years, child health records departments, public health services for detained offenders and sexual health referral centres.

Commissioning of all these services requires close working links with other commissioners including:

- CCGs and specialised services commissioners as they commissioning many of the treatment pathways that follow on from screening programmes
- primary care commissioners as much of immunisation is commissioned from primary care as part of the GMS/PMS contract
- local authority commissioners due to the links with school nursing and immunisation services and the transfer of responsibility for commissioning health visiting services that will take place in October 2015.

Whilst the financial value of these services is relatively modest the reach is great with several hundred thousand contacts per year from these services within the population of Leicestershire, Lincolnshire & Rutland

SECTION TWO: OUR CURRENT STATE

Demand for Healthcare - The Health Needs of our Population

Leicester, Leicestershire & Rutland and Lincolnshire

Leicestershire, Lincolnshire and Rutland are the areas whose population is served by our Primary care and Public Health services, geographically amongst the largest footprint served by NHS England's area teams at over 9,500 square km, almost 60% of the east midlands.

The population is diverse with a 40 fold difference in rurality between the 4 local authority areas. The main centres of population are the cities of Leicester and Lincoln with smaller market towns serving the county areas of Leicestershire, Lincolnshire and Rutland in otherwise predominantly rural areas, as well as coastal East Lincolnshire, with a seasonal migrant population. The BME community is under 3% in Lincolnshire and Rutland, 15% in Leicestershire and 49% in Leicester city, with a large South Asian population.

Geographically, Lincolnshire is the third largest county in England and covers an area of 2350 square miles. Leicestershire covers an area of 800 square miles and Rutland is the smallest county in England and covers an area of 152 square miles.

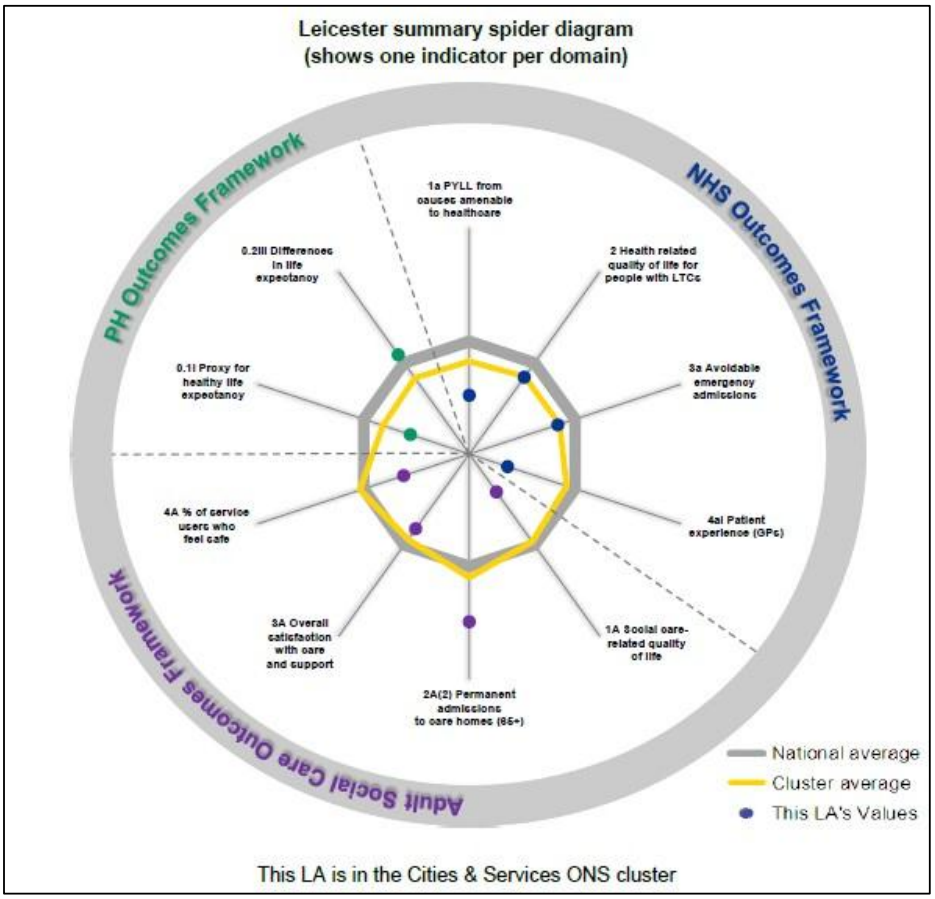
By road, it is approximately 125 miles to travel from the north to south of the area and 140 miles west to east.

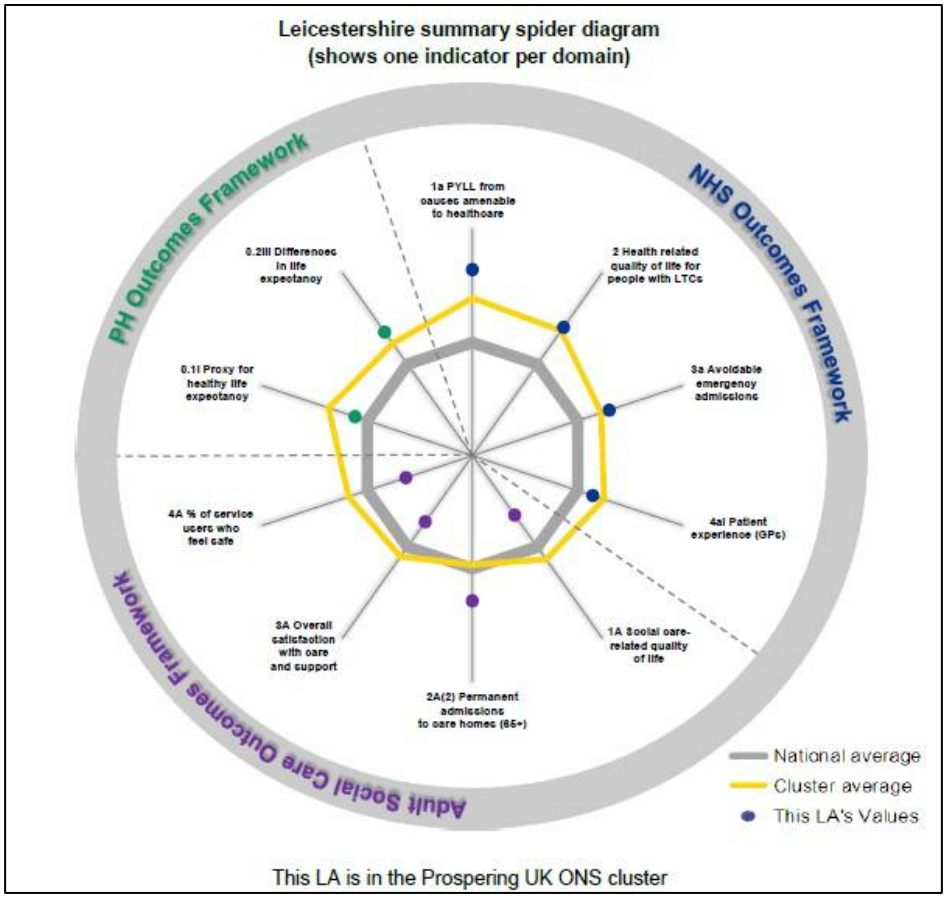
The Leicestershire and Lincolnshire area has a registered population of 1,792,400 with a higher proportion of 0-9 year olds in its population than the England average, a lower proportion of 25-39 year olds in its population than the England average, and a higher proportion of residents aged 60+.

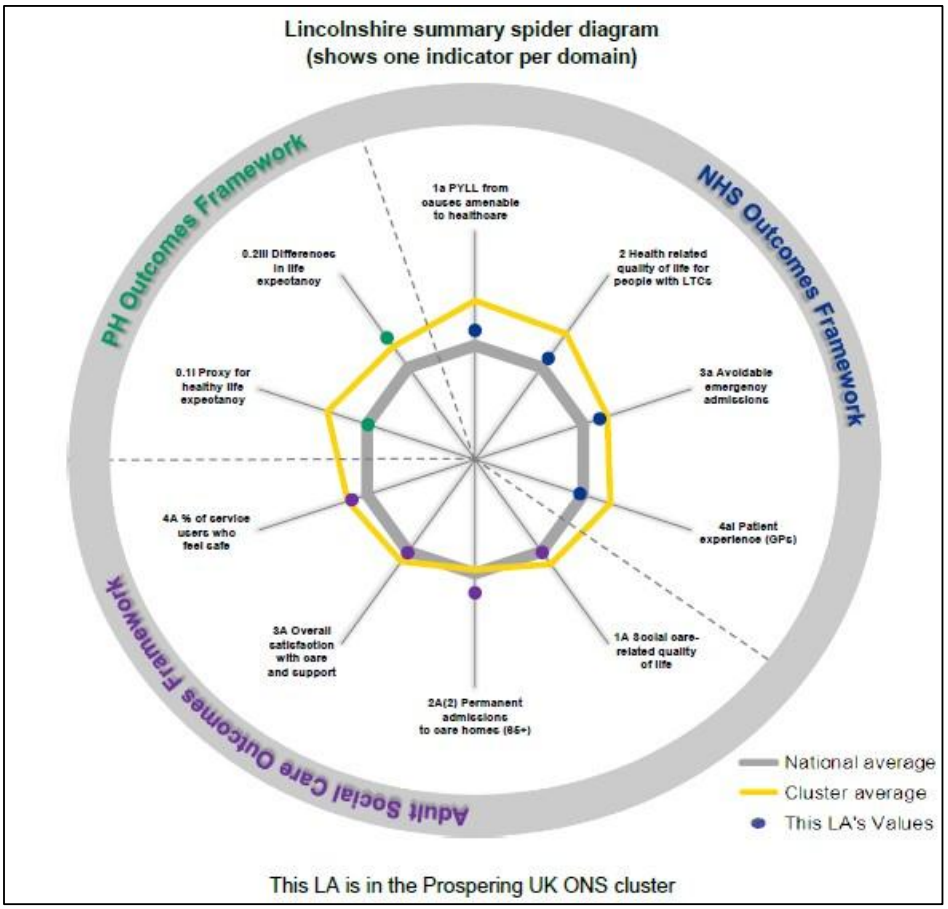
Summary of Health in Leicestershire, Lincolnshire & Rutland

Outcomes benchmarking support packs published by NHS England, Public Health England, The Information Centre and Local Government association identify the existing health and care system performance in Leicestershire, Lincolnshire and Rutland compared to England averages and to similar comparable populations for the outcomes indicators defined by government for health, public health, and social care. The overview of these comparators is shown overleaf. The key health issues identified are:

Leic City	Lincs	Leics	Rutland
Poor Patient surveyed GP Experience	More years of life lost from causes amenable to healthcare than peers	Average Life expectancy below peers	More years of life lost from causes amenable to healthcare than peers
High Years of life lost from causes amendable to healthcare	Health related Quality of life for people with LTC below peers	Patient surveyed GP experience below peers	
Low Average Health Life Expectancy	Patient surveyed GP experience below peers		
	Average Life expectancy below peers		




Leicestershire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4al Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Lincolnshire summary spider diagram
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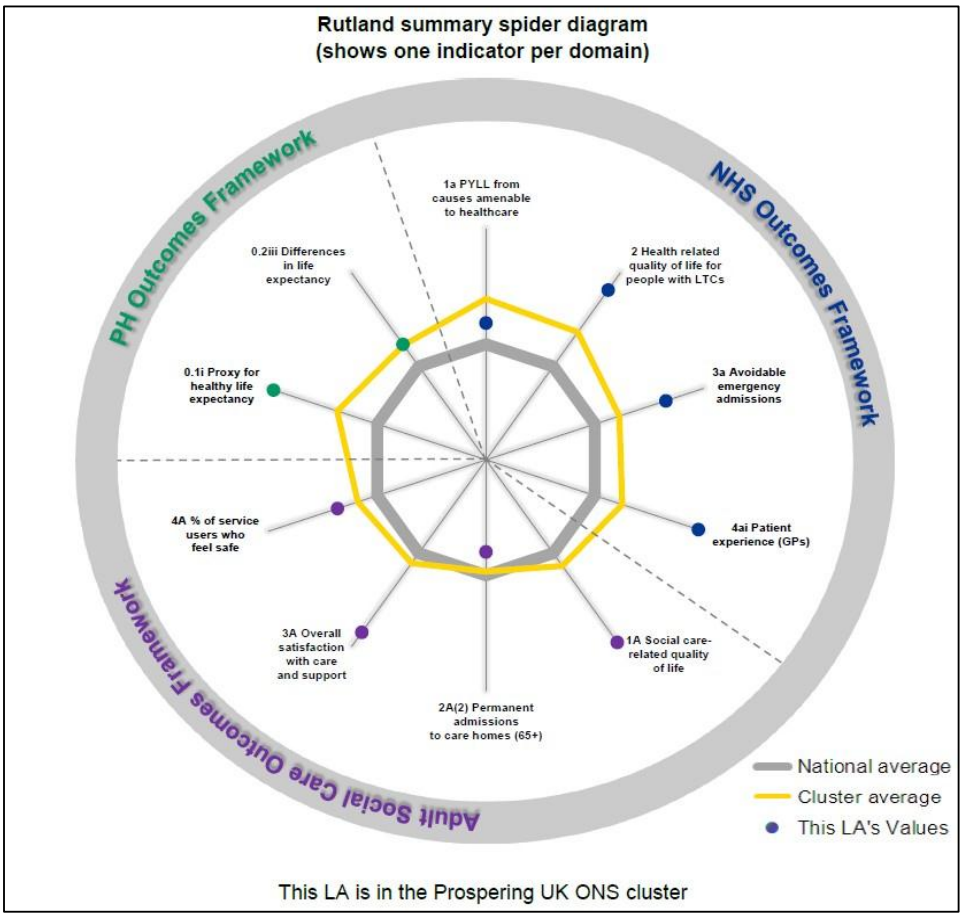
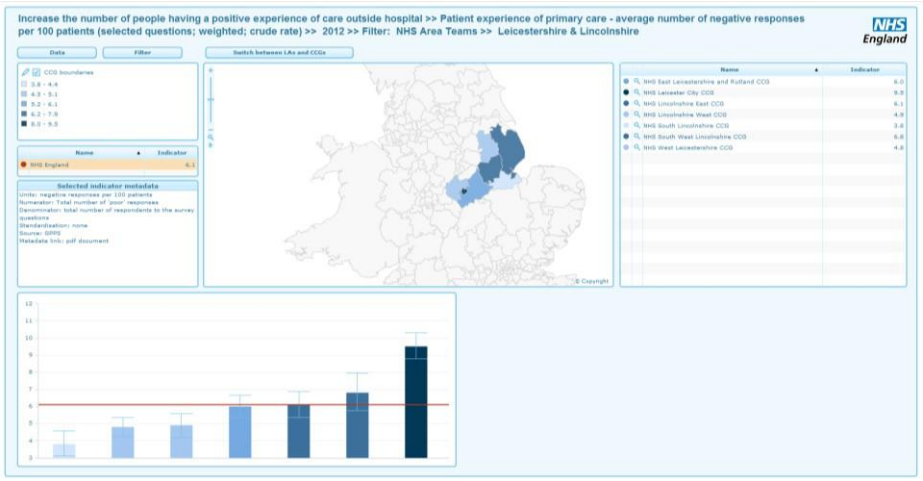


Insights from the Atlas of Variation

The range of issues to be addressed in partnership with the seven CCGs serving Leicestershire and Lincolnshire includes significant variation in the outcomes and experience affected by primary care and public health:

There is significant variation in patients experience of primary care



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

As well as the significant difference in primary care in Leicester city, Lincolnshire South West and Lincolnshire East Appendix 1 highlights greater potential years of life lost in Leicester city and East Lincolnshire, poorer reported quality of life for people with long term conditions in Leicester city, East and west Lincolnshire, and higher levels of avoidable emergency admission in East Lincolnshire. These variances in outcomes help to define the joint agenda between NHS England and CCGs for improving the quality and contribution of primary care services to the wider health and care system.

The East Midlands

Other than national chains of healthcare providers, our commissioned specialised services providers are based in the East Midlands. Our responsibilities are for all patients nationally who use these services; including patients from other regions who choose to use services in the East Midlands. Our providers provide a range of specialised services which address the health needs of the populations they serve. The majority of which will come from the East Midlands catchment. Some specialised services used by the population in the region are not delivered by East Midlands providers; patients from the East Midlands will travel to other providers elsewhere in the UK for those services.

The East Midlands is geographically the fourth largest region in England in terms of area (15,607 sq km) and has a resident population of approximately 4.9 million. The provider landscape includes; two large teaching hospitals for acute care are situated in the region, Nottingham University Hospitals and University Hospitals of Leicester, both of which provide specialised tertiary care. There are seven district general hospitals and five NHS mental health providers which also provide elements of specialised care. Rampton Hospital, which is part of Nottinghamshire Healthcare NHS Trust, the largest Mental Health Trust in the country, is one of three providers of High Secure Psychiatric Services.

The East Midlands has a diverse population with the main centres of population in the cities of Derby, Leicester, Lincoln & Nottingham, & the large town of Northampton. The county areas of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire & Rutland are predominantly rural. Overall, the East Midlands region has the second lowest population density in England. In the cities a substantial proportion of the population is drawn from black & minority ethnic groups & there are high levels of deprivation, as there are in particular areas such as the old mining villages & steel towns. There are particularly low levels of deprivation in some county areas & the average deprivation for the East Midlands is similar to that of England. Increases in births, decreases in deaths, changes in migration & the pattern of UK immigration have all contributed to population growth since 2001.

Summary of Health in the East Midlands

The East Midlands Health Profile 2010, produced by the Association of Public Health Observatories and Department of Health, provides a snapshot of health in the region. It compares East Midlands with other regions and the England average for a range of indicators.

The health of people in the East Midlands is generally close to the England average. However, levels of physical activity in adults, children in Reception year classified as obese and hospital stays for alcohol related harm are all better than the average for England, whilst levels of smoking in pregnancy, breast feeding initiation and infant deaths are all worse.

There are inequalities in health within the East Midlands which are closely associated with deprivation. For example, the health of people in Harborough, Rushcliffe and South Northamptonshire is generally better than both the England average and the East Midlands average, while the health of people in Nottingham, Mansfield and Derby is generally worse.

Death rates from all causes for both males and females have reduced over recent years; however life expectancy for both men and women living in the East Midlands is lower than the England average.

In the East Midlands, levels of people diagnosed with diabetes have increased over the last five years, and are higher than the average for England.

The priorities for the East Midlands are to address health inequalities, tobacco and alcohol use, obesity, physical activity, avoidable injury and death, affordable warmth and the health of children and young people.

The Outcomes benchmarking support packs published by NHS England, Public Health England, The Information Centre and Local Government association identify the existing health and care system performance in the other 6 local authority areas across the east midlands in addition to Leicestershire, Lincolnshire and Rutland. The packs compare to England averages and to similar comparable populations for the outcomes indicators defined by government for health, public health, and social care. The overview of these comparators is shown overleaf. The key health issues identified are:

Notts	Derbyshire	Nottm City	Derby City	Leic City	Lincs	Leics	Rutland	Northants	MK
Differences in life expectancy better than peers but larger than average	Average life expectancy better than peers but below average	Low Average Life expectancy	Low Average Life expectancy	Poor Patient surveyed GP Experience	More years of life lost from causes amenable to healthcare than peers	Average Life expectancy below peers	More years of life lost from causes amenable to healthcare than peers	Differences in life expectancy average, but larger than peers	More years of life lost from causes amenable to healthcare than
Quality of Life for LTC patients better than peers but below average	Quality of Life for LTC patients better than peers but below average	Large differences in life expectancy	Large differences in life expectancy	High Years of life lost from causes amendable to healthcare	Health related Quality of life for people with LTC below peers	Patient surveyed GP experience below peers		More years of life lost from causes amenable to healthcare than peers	Health related Quality of life for people with LTC below peers
		High years of life lost from causes amenable to healthcare		Low Average Health Life Expectancy	Patient surveyed GP experience below peers			More avoidable emergency admissions than peers	Poor Patient surveyed GP Experience
		Poor health related quality of life for people with LTC			Average Life expectancy below peers				

Health Profile Summaries for other East Midlands Authorities are shown in the appendix.

Demographic factors which particularly influence need for services are the age structure, gender, levels of deprivation and ethnicity. Changes in regional demographics will impact on the health care needs and in turn directly influence the type and volume of health services required by a population.

Population Trends

Area Team CCG Breakdown Year on Year ONS Estimates Growth All Ages	2013	2014	2015	2016	2017	2018	2019	2020	2021	9 Year Total
NHS Lincolnshire East CCG	1.4%	1.3%	1.3%	1.3%	1.2%	1.2%	1.2%	1.1%	1.1%	11.7%
NHS Lincolnshire West CCG	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	0.7%	0.7%	0.7%	7.4%
NHS South West Lincolnshire CCG	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%	10.0%
NHS South Lincolnshire CCG	1.3%	1.3%	1.3%	1.3%	1.3%	1.2%	1.2%	1.2%	1.2%	12.0%
NHS Leicester City CCG	0.5%	0.5%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	0.4%	4.2%
NHS East Leicestershire And Rutland CCG	1.0%	0.9%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	8.1%
NHS West Leicestershire CCG	1.1%	1.0%	1.0%	0.9%	0.8%	0.8%	0.8%	0.7%	0.7%	8.2%
Leics Year on year	0.9%	0.8%	0.8%	0.8%	0.7%	0.7%	0.7%	0.7%	0.6%	6.9%
Lincs Year on year	1.2%	1.2%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%	10.1%
L&L Year on Year	1.0%	1.0%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	8.2%
Derbyshire And Nottinghamshire Area Team Year on Year	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	0.6%	0.6%	6.3%
Hertfordshire And The South Midlands (E Mids) Year on Year	1.3%	1.3%	1.3%	1.2%	1.2%	1.2%	1.1%	1.1%	1.1%	11.4%
EAST MIDLANDS TOTAL YEAR ON YEAR	1.0%	0.9%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	8.0%
England Total Year on Year	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	7.7%

For primary care and public health services, the area team's population served will grow at slightly above the national and east midlands rate. This masks an underlying significant difference between Leicester city which will grow at a significantly lower rate, just over half the regional and national rates of growth, but Lincolnshire as a whole, particularly the east and south of Lincolnshire is forecast to grow at rates significantly above regional and national levels.

For specialised services, the East Midlands population will grow 0.3 percentage points above the national rate over the next 7 years with the South Midlands population growing 50% faster than England as a whole offset by lower growth in Derbyshire & Nottinghamshire with implications for the balance of provider capacity over time, to be factored into the future strategy for specialised services.

Supply of Healthcare – Our Healthcare Providers

Provider Profile – Specialised Services

The Area team hold Acute contracts to the value of circa - £600m (nine providers) and Mental Health contracts to the value of - circa £285m (nine providers):

ACUTE SPECIALISED SERVICES	TYPE	CQC Risk Rating	2013/14 Annual Budget	% of Acute Specialised Budget	Provider Annual Turnover	Specialised Budget as % of Provider Turnover 2012/13
Provider			£m	%	£m	%
Nottingham University Hospitals	NHS Trust	2	228	38%	631	36%
University Hospitals of Leicester	NHS Trust	1	198	33%	649	31%
Derby Hospitals NHS	Foundation Trust	3	55	9%	411	13%
United Lincolnshire Hospitals	NHS Trust	1	42	7%	383	11%
Northampton General Hospital	NHS Trust	1	32	5%	236	13%
Kettering General Hospital T	Foundation Trust	2	19	3%	165	11%
Milton Keynes Hospital	Foundation Trust	3	15	2%	163	9%
Sherwood Forest Hospitals	Foundation Trust	1	10	2%	258	4%
Chesterfield Royal Hospital	Foundation Trust	5	8	1%	178	5%
TOTAL			**607**	**100%**		
SPECIALISED MENTAL HEALTH	**TYPE**		**2013/14 Annual Budget**	**% of Mental Health Specialised budget**	**Provider Annual Turnover**	**Specialised budget as % of Provider Turnover 2012/13**
			£m	%	£m	%
Nottinghamshire Healthcare	Partnership Trust		139	49%	385	36%
St Andrew's Healthcare	Charity		100	35%	169	59%
Northamptonshire Healthcare	Foundation Trust		10	4%	171	6%
Leicestershire Partnership	Partnership Trust		8	3%	235	3%
Raphael Healthcare	Independent		8	3%		
Derbyshire Healthcare	Foundation Trust		5	2%	125	4%
Lincolnshire Partnership	Foundation Trust		4	1%	94	4%
Severe Personality Disorder			6	2%		
The Ansel Group	Independent		4	1%		
Meadow View Hospital (Curate)	Independent		3	1%		
TOTAL			**285**	**100%**		

Within the acute services sector:

- Over 70% of Commissioned spend is with the 2 main tertiary teaching trusts in the region, where NHS England is the largest single commissioner of services at between 30-40% of Total Trust Income

- For the other providers NHS England is only 5-13% of Trust income reflecting a much narrower range of services
- Over 83% of spend is with providers yet to achieve foundation trust status
- Over 85% of spend is at providers in the two highest CQC quality risk ratings
- Financially the 2 NHS Trusts in Leicestershire and Lincolnshire are operating with a large financial deficit (over £70m combined) and three of the five foundation trusts are rated in the highest financial risk rating by Monitor.

This wider context reflects the major priority, working in partnership with CCGs, to achieve financial sustainability and improvements in quality at the whole system level across the majority of acute providers in the East Midlands. The strategy for specialised services will take account of this context

Within the Mental Health Sector, although the spend shows similarly high levels of concentration at the top 2 providers, the drivers are very different:

- More than a third of total spend in this sector, is on one of three national High secure services, which represents 60% of the spend with Nottinghamshire healthcare
- The second largest spend reflects the East Midlands lead for an independent provider with services across 3 regions for which this area team takes a lead role
- The remaining contracts are below £10m in value, with individual case management, rather than high volume treatment, the predominant characteristic of mental health services commissioned.

A key dimension of the profile of providers of specialised healthcare is their current service levels compliance to nationally developed clinical service specifications and policies.

There are currently 359 services identified in the acute services that are currently under consideration for compliance against the service specification. The table below is a summary of the current status with services described in three main categories; **compliant** with the service specification, services not compliant but they have applied for **derogation**[2] and services where only part of the pathway is provided and the service is **provided in partnership**.

Table: Summary of current position of the acute services in the East Midlands current delivery specialist services in accordance with the service specifications

Hospital	Compliant	Derogation	In partnership	TOTAL
Chesterfield Royal Hospital	4		10	**14**
Derby Hospitals	27	3	4	**34**
Kettering General Hospital Milton	6	4	52	**62**
Keynes Foundation Trust	4	4	9	**17**
Northampton General Hospital	23	6	7	**36**
Sherwood Forest Hospitals	4		2	**6**
University Hospitals of Leicester	75	10	2	**87**
United Lincolnshire Hospitals	2	7	5	**14**
Nottingham University Hospitals	68	21	0	**89**
Total	**213**	**55**	**91**	**359**

[2] Derogation is a time-limited conditional agreement to operate at variance to the national specification

Our operational plans set out later in this document outline the intentions for addressing areas of non-compliance with service specifications in line with the emerging strategy for specialised services.

NHS England commissions according to agreed policies and service specifications, which identify where treatments, devices and services are routinely commissioned. Commissioning policies that specify treatment thresholds and criteria act within the NHS contract as 'group prior-approvals' for treatment. In some cases, additional audit may be required with to give prior approval for individual patients by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned, or where treatment thresholds and criteria have not been adhered to providers will not receive funding if they initiate these treatments. This ensures, so the money provided to us by the government is available for treatments our population need that do have clear evidence of benefit, in line with NHS England's ethical framework for prioritisation.

Providers are also required to comply with national audit requirements as part of the service specifications. Resulting audit data will be reviewed and used to inform service and quality improvement initiatives as part of on-going contractual monitoring arrangements.

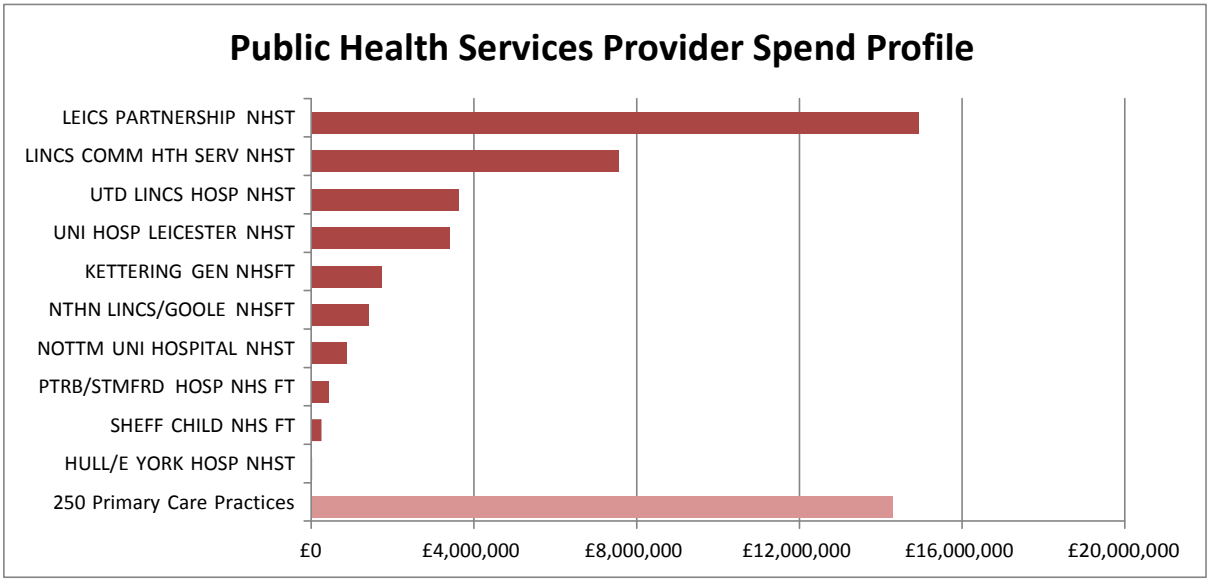
Provider Profile – Public Health Services

PUBLIC HEALTH SERVICES	TYPE	2013/14 Annual Spend	% of Public Health Services Budget	Provider Annual Turnover	L&L Public Health Spend as % of Provider Turnover 2012/13
Provider		£m	%	£m	%
Leicester Partnership Trust	Partnership Trust	14.9	31%	235	6%
Lincolnshire Community Health Services	NHS Trust	7.5	16%	109	7%
United Lincolnshire Hospitals	NHS Trust	3.6	7%	383	1%
University Hospitals of Leicester	NHS Trust	3.4	7%	649	0.5%
Kettering General Hospital	Foundation Trust	1.7	4%	165	1%
North Lincs and Goole Hospitals	Foundation Trust	1.4	3%	285	0.5%
Nottingham University Hospitals	NHS Trust	0.9	2%	631	0.1%
Peterborough & Stamford	Foundation	0.4	1%	219	0.2%
Other Acute		0.3	1%	N/A	N/A
Primary Care Practices	Independent Contractors	14.3	29%	Varies	Varies

Public health services across Leicestershire and Lincolnshire are shown below. The provider base falls into three categories:

- One large provider of community services in each county with spend on child health services though health visitors and family nurse partnerships. These services also provide some immunisation services where not delivered in general practice, and account for just under half (45%) public health services commissioning spend. These services form a relatively small but significant share of provider income.

- Acute services contracts in the area team's geography and neighbouring geographies predominantly screening services. These services comprise a quarter of public health spend but typically represent below 1% of provider turnover.
- Primary care providers, predominantly for immunisation, where the proportion of turnover is higher but overall spend is much less concentrated and geographically decentralised into local communities, spread across over 250 contractors.



The focus for provider development for public health services is at the service level ensuring development in line with national standards and responding to audit visits of national clinical teams.

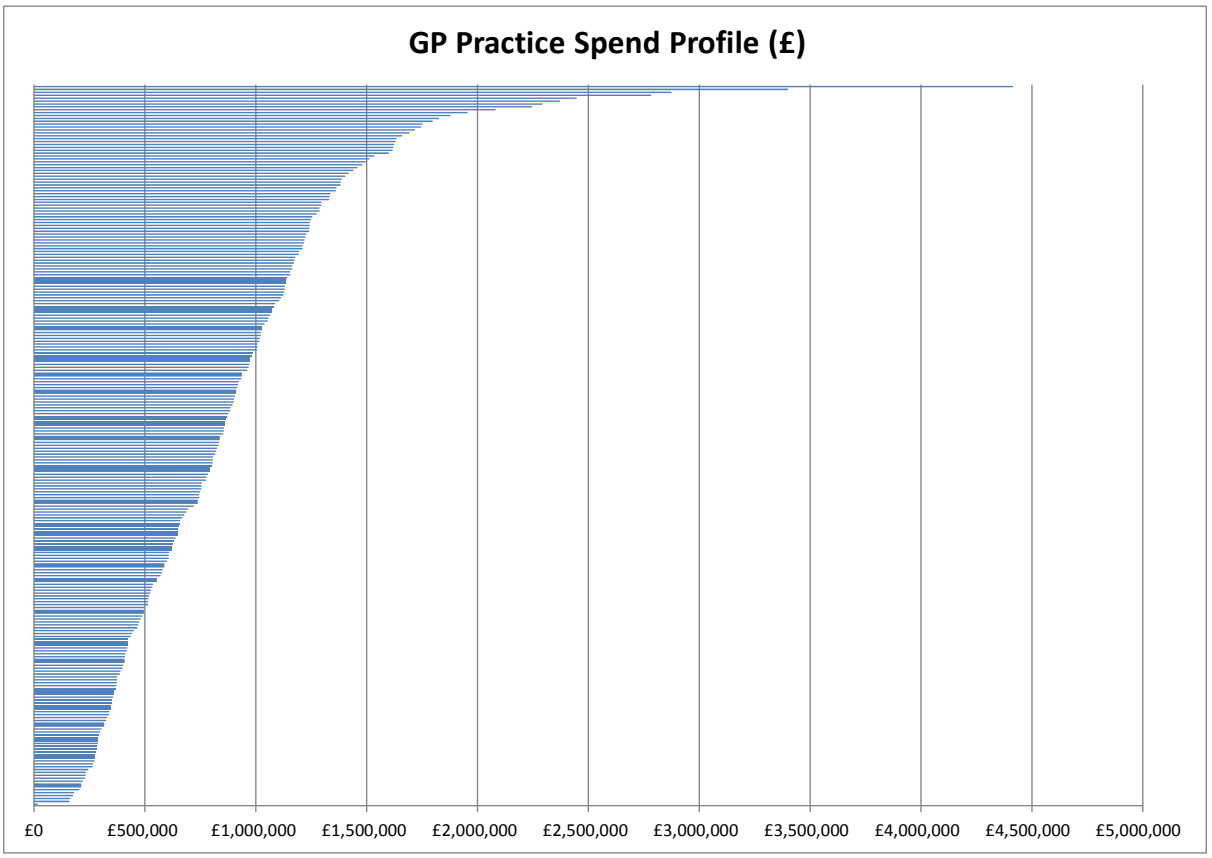
Provider Profile – General Practice

Across Leicestershire and Lincolnshire Primary care services are provided through over 1,100 independent contractors, of which 250 are general practitioner medical services contracts, the balance being primary care dentistry, optometry and pharmacy.

More than nine in ten encounters with the NHS are with Primary healthcare providers. For GP services NHS England represents a single national contracting body, and although practices may be funded by clinical commissioning groups and local authorities for other services, typically well over 95% of practice income will come from NHS England's commissioning of primary care [3]

Commissioning spend with general practice has low levels of concentration with the largest primary care contract accounting for only 2% of NHS England's spend. Within this however, there is considerable variation in the scale of primary care:

[3] Enhanced services vs core services spend set out in the HSCIC report 'Investment in General Practice' 2013



The spread of spend is illustrated below:

Practice Contract	Annual Spend
Upper Decile	£1.60m
Upper Quartile	£1.16m
Median Spend	£0.83m
Lower Quartile	£0.47m
Lower Decile	£0.30m

Strategic plans for primary care acknowledge and respond to the diversity in the scale and size of existing primary care providers, with contracts up to £4.4m per annum from significantly sized organisations, down to small business holders.

Patient Experience of General Practice

GP Patient Survey Results – General Practice

Satisfaction with Accessing Primary Care	NHS EAST LEICESTERSHIRE AND RUTLAND CCG		NHS LEICESTER CITY CCG		NHS LINCOLNSHIRE EAST CCG		NHS LINCOLNSHIRE WEST CCG		NHS SOUTH LINCOLNSHIRE CCG		NHS SOUTH WEST LINCOLNSHIRE CCG		NHS WEST LEICESTERSHIRE CCG	
	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers
Accessing GP Services	75	45	72	70	74	38	76	39	78	8	77	16	76	61
Making an Appointment	85	26	84	41	85	19	87	17	89	3	90	8	88	14
Opening Hours	80	18	82	15	82	11	83	6	85	1	82	5	82	15
Average of All Three/sum of outliers	80	89	79	126	80	68	82	62	84	12	83	29	82	90

Satisfaction with the Quality of Consultation at the GP Practice	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers
Seeing a Doctor	89	27	83	118	86	44	89	25	90	7	90	15	88	49
Seeing a Nurse	90	9	87	29	91	4	92	3	92	2	92	0	89	40
Average of both/sum of outliers	90	36	85	147	89	48	91	28	91	9	91	15	89	89

Satisfaction with the overall care received at the surgery	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers
Overall Experience	84	19	77	42	81	16	84	10	88	3	86	7	85	18

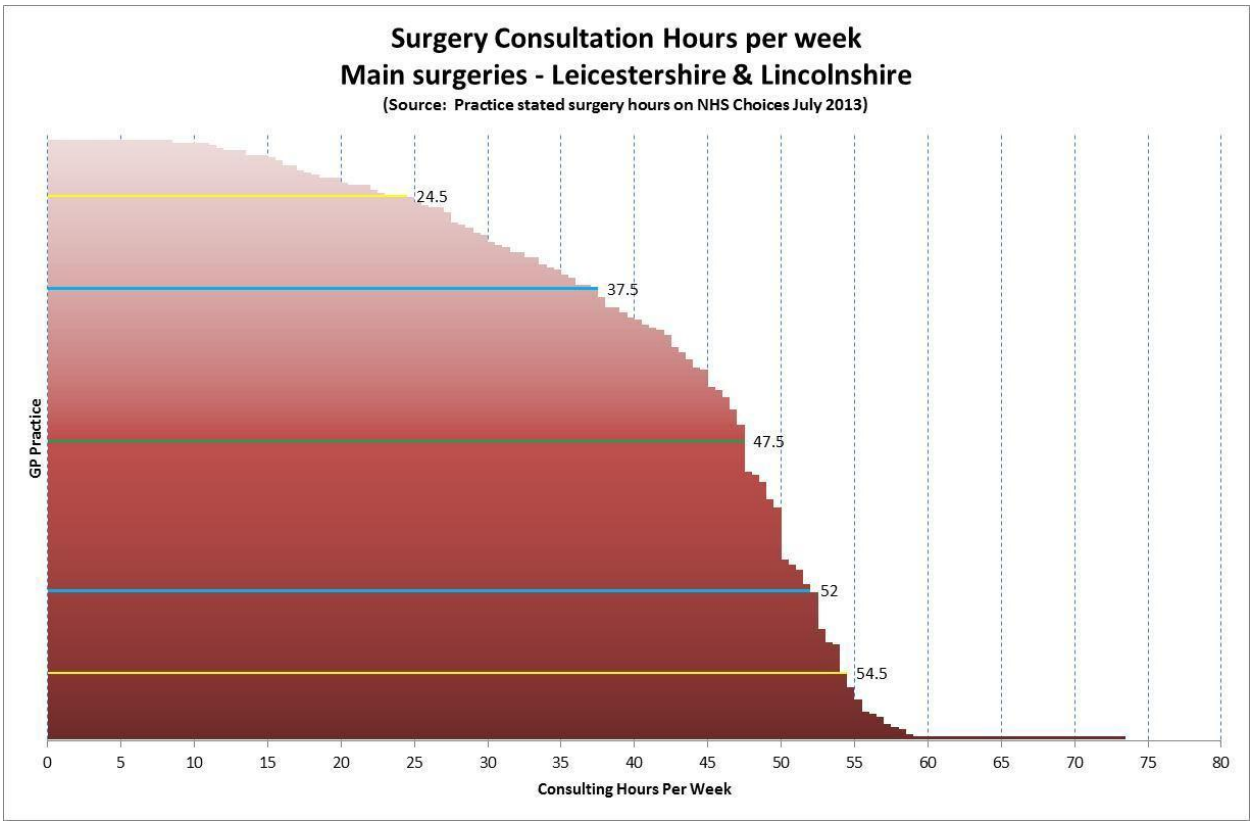
Work to improve quality is a joint responsibility of NHS England and Clinical commissioning groups. The table above illustrates that even where overall satisfaction rates are good across an area there are practices who are adverse outliers. This informs our priorities set out later in this plan taken forward with the relevant CCG.

Analysis of number of outliers						
CCG	**Practices with no outliers**	**1<5**	**6<10**	**11<15**	**16<21**	**Total no of practices**
NHS EAST LEICESTERSHIRE & RUTLAND CCG	11	10	6	4	3	34
NHS LEICESTER CITY CCG	13	27	7	10	7	64
NHS LINCOLNSHIRE EAST CCG	6	11	10	2	1	30
NHS LINCOLNSHIRE WEST CCG	11	18	8	1	0	38
NHS SOUTH LINCOLNSHIRE CCG	6	7	2	0	0	15
NHS SOUTH WEST LINCOLNSHIRE CCG	8	8	0	2	1	19
NHS WEST LEICESTERSHIRE CCG	13	19	16	2	0	50

Red Outliers - indicate where the practice score for a particular question is significantly worse compared to the national average (i.e. where confidence intervals for the practice and the national average do not overlap).

Ease of Access to GP practices

In addition to patient surveyed perception of the opening hours and ease of making an appointment, local analysis has been undertaken highlighting the significant differences in the degree to which a GP consultation is available at times that are convenient to all:



Whilst a quarter of practices provide more than 52 hours per week in which to book appointments, a quarter of our practices offer fewer than 37.5 hours, and one in ten less than 25 hours per week.

The distribution of opening hours illustrates times when our population are less likely to be able to secure a routine GP appointment, depending on the practice they are registered with.

Specific opening hours are not a condition of national GMS contracts held by GPs although meeting the reasonable needs of patients is required. As general practice is supported to make a greater contribution to the health and care system, the availability of services at times convenient to all, together with the cost effective use of premises and workforce in primary care, is a key consideration.

We will continue to work with our CCG colleagues to drive improvement in patient experience of general practice. This will be informed further by the results from the Friends & Family Test, which states in general practice in December 2014.

Leicestershire and Lincolnshire Area

% Area Open for GP-Routine Appointments (Main & Branches)

Commencing	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
06:00	0%	0%	0%	0%	0%	0%	0%
06:30	0%	0%	0%	0%	0%	0%	0%
07:00	2%	1%	1%	2%	0%	1%	0%
07:30	5%	6%	4%	6%	3%	1%	0%
08:00	31%	31%	33%	30%	30%	4%	0%
08:30	78%	76%	77%	77%	77%	7%	1%
09:00	98%	97%	97%	98%	97%	9%	1%
09:30	100%	99%	99%	100%	99%	8%	1%
10:00	100%	99%	99%	100%	99%	9%	1%
10:30	97%	96%	96%	96%	96%	7%	1%
11:00	89%	89%	89%	89%	89%	5%	0%
11:30	77%	78%	76%	75%	75%	3%	0%
12:00	63%	65%	61%	61%	62%	2%	0%
12:30	49%	50%	47%	47%	49%	2%	0%
13:00	43%	42%	40%	39%	41%	1%	0%
13:30	43%	42%	39%	38%	41%	1%	0%
14:00	58%	55%	53%	49%	57%	1%	0%
14:30	65%	61%	59%	54%	63%	1%	0%
15:00	73%	69%	65%	59%	71%	1%	0%
15:30	85%	78%	73%	65%	80%	0%	0%
16:00	96%	92%	84%	75%	93%	0%	0%
16:30	97%	93%	85%	76%	95%	0%	0%
17:00	94%	93%	84%	73%	93%	0%	0%
17:30	86%	84%	78%	68%	84%	0%	0%
18:00	64%	62%	59%	52%	62%	0%	0%
18:30	36%	32%	33%	27%	28%	0%	0%
19:00	18%	12%	10%	5%	5%	0%	0%
19:30	15%	9%	9%	3%	2%	0%	0%
20:00	11%	5%	7%	2%	1%	0%	0%
20:30	3%	2%	2%	1%	1%	0%	0%
21:00	2%	0%	1%	1%	0%	0%	0%
21:30	0%	0%	0%	0%	0%	0%	0%
22:00	0%	0%	0%	0%	0%	0%	0%

% of Practice sites offering routine GP appointments

Key:

Darker Green = High number of practices
Yellow = Medium number of practices
Orange = Low number of practices
Darker Red = Minimum number of practices

(Source: Practice Declared Surgery Hours. NHS Choices July 2013)

i. Effectiveness

General Practice - Primary Care Web Tool

The Assurance Management Framework for Primary Medical Services introduces high level indicators supported by outcome standards which are a set of measurable indicators for general practice. The aim is to inform practices and commissioners on a range of measures that are evidence based, outcome focused and are appropriate measures to use for any practice.

Clinical effectiveness and patient experience is assured through a nationally consistent approach using 2 tools: The General Practice Outcome Standards (GPOS) and the General Practice High Level Indicators (GPHLI).

The General Practice High Level Indicators (GPHLI) form part of the assurance management framework for primary medical services and the indicators present a minimum level of service and outcomes that patients can expect from general practice. Indicators have been grouped across the NHS Outcomes Framework domains and will change and evolve over time. The purpose of the tool is to generate the start of a discussion between Area Teams and practices so that they can understand the reasons behind variation, be that warranted or unwarranted, and where necessary to support practices to make improvements

or changes. Examples of the indicators are emergency asthma admissions per 100 patients on the disease register and emergency diabetes admissions per 100 patients on the disease register both of which sit under Domain 2 of the NHS Outcomes Framework.
Across the Leicestershire and Lincolnshire area we have 26 outliers against the GPHLI.

The General Practice Outcome Standards (GPOS) have been provided to support quality improvement; they can be used for peer review and benchmarking and also to provide a consistent platform for Area Teams and CCGs to identify areas for quality improvement. The outcome standards are not process based indicators and therefore represent a good measure of practice achievement; they represent the basics patients should expect to receive from general practice. The outcome standards also represent a benchmark for how a practice is doing over time compared to other practices in a similar context. The benchmarked data will help us to understand whether variation is fair or unwarranted. However, individual outcome standards should not be viewed in isolation, these need to be triangulated with other information, such as GPHLIs, hospital activity data, and patient complaints, in order to identify areas of unwarranted variation and monitor improvement. Examples of the outcome standards are satisfaction with the quality of consultation at the
GP practice and satisfaction with accessing primary care both of which sit under Domain 4 of the NHS Outcomes Framework.
Across the Leicestershire and Lincolnshire area we have 41 outliers against the GPOS.

Provider Profile – Dentistry

Provider Profile – Dentistry

Dental Service Provider	Type	Total Number	Total Contract Value	Average (£Thousand)
General Dental Services (GDS) Providers	Independent Contractor (Sole/Partnership)	140	£33.2m	£237
General Dental Services (GDS) Providers	Body Corporate	60	£22.7m	£378
Personal Dental Services (PDS) Providers	Independent Contractor (Sole/Partnership)	36	£7.4 m	£205
Personal Dental Services (PDS) Providers	Body Corporate	15	£4.0 m	£267
Personal Dental Services Plus (PDS Plus) Providers	Independent Contractor (Sole/Partnership)	4	£0.6 m	£141
Personal Dental Services Plus (PDS Plus) Providers	Body Corporate	10	£4.9 m	£490
General Dental Services Provider GDS (Pilot contract)	Body Corporate	1	£0.8 m	£774
General Dental Services Provider GDS (Pilot contract)	Independent Contractor (Sole/Partnership)	1	£0.5 m	£529
Total		**267**	**£74.2 m**	**£278**

Primary Dental Services Commissioning
Since April 2006, the following contracting routes have been available to enable the commissioning of primary dental services:
• General Dental Services contracts (GDS)
• Personal Dental Service contracts (PDS) which includes non -mandatory services such as orthodontic services and sedation services.
PDS Plus Contracts area variation of the PDS contract and include KP's (quality metrics) that reward the delivery of good oral health and care pathway and improved access.

GDS contracts and PDS agreements
GDS contracts are nationally negotiated contracts and PDS agreements are negotiated locally but are underpinned by national regulations. The main differences between GDS and PDS are that GDS contracts are not time limited (PDS agreements are) and that PDS can apply to non-mandatory services (eg orthodontic only practices).
Community or Salaried Dental Services are directly commissioned using the PDS contract framework and generally provide services for vulnerable and hard to reach groups.

Primary dental services comprise:
Essential services
Every GDS practice is required to provide a full range of general dental services (mandatory services) plus any agreed non -mandatory services. PDS may also include mandatory services and a mix of additional locally negotiated services, but can also be agreed for solely non-mandatory services (i.e. with no general dental services).
Community or Salaried Dental Services are as defined locally.
All GDS providers and PDS contractors with a mandatory service agreement are expected to provide a full range of primary care dental services to all their NHS patients based on clinical need (limited only by their ability to clinically provide the intervention).

Additional services
All GDS and PDS practices can contract or agree to provide additional services with the commissioner.

General Dental Services Provider GDS (Pilot contract)
Dental Pilots have been established to test new ways of working in order to inform a new national contract.

Locally our primary care dental contracts are split as follows:
GDS contracts = 76%
PDS agreements = 18%
PDS Plus agreements = 5%
Dental Pilots = 1%

NHS England will be the sole NHS commissioner with dental practices, but the key characteristic of this contractor group is that under 60% of primary care dentistry is commissioned and funded through the NHS with private healthcare (self-funded, and insurance and corporate benefit based) comprising over 40%.

GP Patient Survey Results – General Dental Practice

March 2013 data from the GPPS results show 83% Positive Experience for Leicestershire & Lincolnshire, which when benchmarked to other Area Teams in the region, puts us at the lowest level of positive experience but we are not statistically significantly different to the national position.
From the most recent data available from e-reporting (Sept 2013), the % of patients satisfied with the treatment received was 92.3% (national % = 92.5%, regional % = 92.7%).
When looking at the number of unique patients seen in the last 24 months, there is a slight improvement compared to the previous year (ranked 4th in the region). However there has been a drop in the activity commissioned when compared to last year.

Quality and Access - General Dental Practice

The drivers for NHS dental services for us are high quality dental services, improved access, patient centred services, appropriate referrals into secondary care and prevention focus through 'Delivery Better Oral Health' and our operational plan.

Community and Acute Dental Services

Whilst Local Authorities have a central role to play in oral health promotion, NHS England area team commissions all steps in dental pathways, with contracts with community and acute services for more complex care. The provider profile for spend on these services is:

COMMUNITY AND ACUTE ORAL HEALTHCARE SERVICES	TYPE	2013/14 Annual Spend	% of Secondary Dental Services Budget	Provider Annual Turnover	L&L Public Health Spend as % of Provider Turnover 2012/13
Provider		£m	%	£m	%
University Hospitals of Leicester	NHS Trust	5.6	32%	649	0.9%
United Lincolnshire Hospitals	NHS Trust	5.4	31%	383	1.4%
Derbyshire Community Health Services (in Leicestershire)	NHS Trust	3.3	19%	198	2%
Lincolnshire Community Health Services	NHS Trust	1.7	10%	109	2%
Peterborough & Stamford	Foundation	0.9	5%	219	0.2%
Kettering General Hospital T	Foundation Trust	0.2	1%	165	0.1%
Derby Hospitals	Foundation Trust	0.2	1%	285	<0.1%
Nottingham University Hospitals	NHS Trust	0.2	1%	631	<0.1%

For all providers, these services constitute a very small share of turnover. The supply base segments into three groups:

- Two Acute Dentistry in-area contracts, 63% of spend
- Two Community Dental services (DCHS serves Leicestershire), 29% of spend
- Small contracts for out of county acute dentistry flows 8% of spend

Acute contracts are predominantly funded through nationally set prices (Payment by Results) with demand and capacity management to maintain NHS constitution rights to treatment within 18 weeks a key focus. Community provider dentistry contracts are more varied reflecting models to improve access for populations with specific needs.

Provider Profile - General Ophthalmic Services

Provider Profile – General Ophthalmic Services

Ophthalmic Service Provider	Type	Number	13/14 Contract Value
Mandatory Services Contracts	Independent Contractor (Sole/Partnership)	67	
Mandatory Services Contracts	Body Corporate	129	
Total Mandatory Contracts		196	
Additional Services Contracts	Independent Contractor (Sole/Partnership)	38	
Additional Services Contracts	Body Corporate	67	
Total Additional Services Contracts		105	
Total Optometry Contracts		**301**	**£18m**

The primary characteristic of provider profiles for Ophthalmic services is a mature retail market with an even split between larger chain and independent outlets. NHS commissioned spend is based on nationally negotiated services and prices, and represents less than £1 in every £5 of provider income, the vast majority being private spending on eye care.

Provider Profile - Community Pharmacy

Provider Profile – Pharmaceutical Services

Pharmaceutical Service Provider	Type	Number	13/14 Spend (Forecast)
Community Pharmacy	Independent Contractor (Sole/Partnership)	151	£52.6m
Community Pharmacy	Multiple/Chain	195	
Dispensing Practices	Independent Contractor (Sole/Partnership)	84	£13.2m [4]
Total Providers		**430**	**£65.8m**

The Community Pharmacy Contractual Framework was introduced in April 2005.

[4] Professional fees associated with dispensing costs

The contractual framework for community pharmacies has three different elements:

1. **Essential Services** – the following list of services must be provided by all contractors:

    - The dispensing of medicines
    - The dispensing of appliances
    - Repeat dispensing
    - Clinical governance
    - Public health (promotion of healthy lifestyles)
    - Signposting and
    - Support for self –care

2. **Advanced Services** – these services can be provided by all contractors if they have met the accreditation requirements and are providing ALL essential services. There are two advanced services:

    - Medicine Use Reviews
    - New Medicines Service

Both essential and advanced services are commissioned by NHS England.

3. **Locally commissioned services** (previously known as enhanced services) – these are commissioned to meet local health care needs and are commissioned by CCGs or Local Authorities. They can include services such as smoking cessation, provision of emergency hormonal contraception, and minor ailment services.

Dispensing doctors provide the following services to patients:

- The dispensing of medicines
- The dispensing of appliances.

These services are funded by NHS England.

Community Pharmacy can make an important contribution to the provision and delivery of integrated services for patients. For example, the hospitals discharge process. There is a risk that commissioners do not see the potential of community pharmacy and this valuable resource may be overlooked. Our plans are designed to ensure that the risk of community pharmacy is optimised. Generally hours of availability of community pharmacies extend into the evenings and weekends. In addition, across the area, there are 36 pharmacies that open for 100 hours per week.

Like ophthalmic services NHS commissioned spend on community pharmacy is a relatively small part (£1 in every £6) of the large £14.5bn industry, the main dynamics being the competition between the supermarket, national chain and independent providers, with over the counter medicines and diversified retail playing a large role. The services commissioned by NHS England fund prescription medicine dispensing, medicines use reviews with potential for a wider range of primary healthcare services to be delivered by pharmacists as an alternative primary care local facility with wide opening hours.

Summary

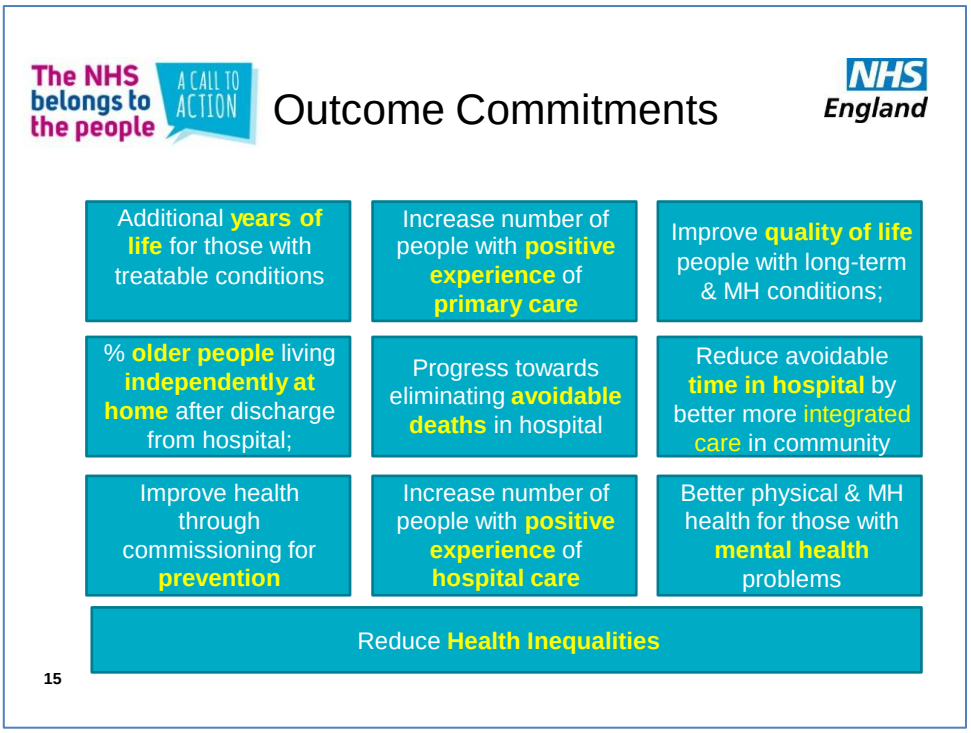
Our plans and future strategy for the three commissioning responsibilities reflect the health needs and priorities of the communities we serve, but the key issues, and the nature of healthcare provider services varies greatly between primary care, public health service and specialised commissioning. A ‘one size fits all’ approach would not be effective. The next section sets out our Ambitions and plans in light of these different challenges.

SECTION THREE: OUR AMBITIONS AND PLANS

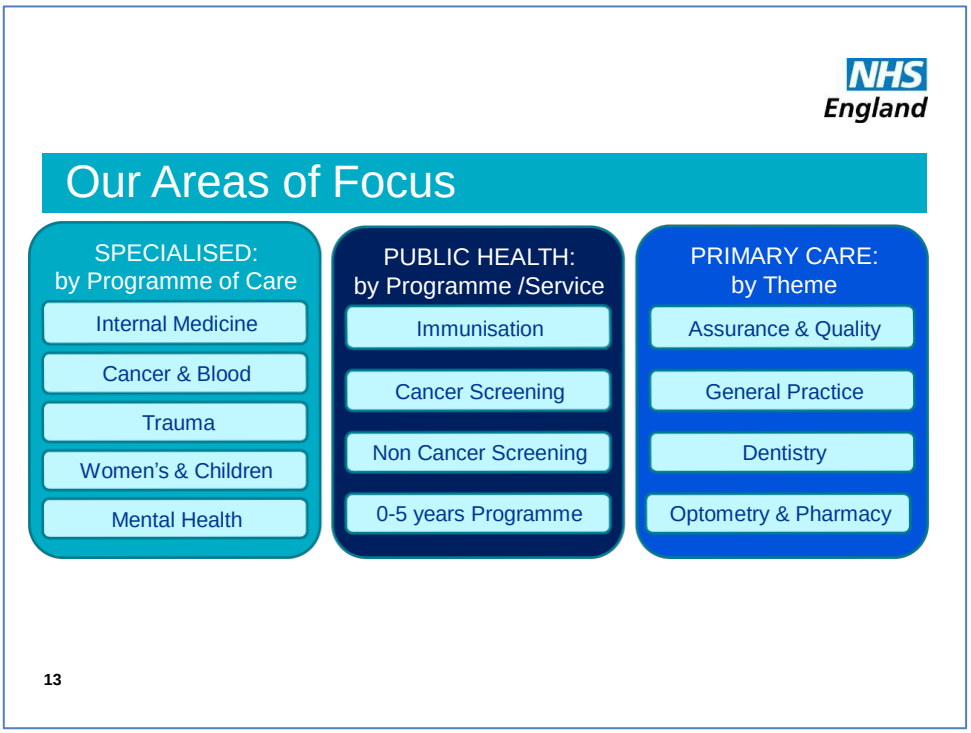
Values and Principles:

- Services Patient Centred and Outcome Based
- Improved outcomes in each of the 5 domains
- Fairness and Consistency of Access
- Productivity and Efficiency Improves

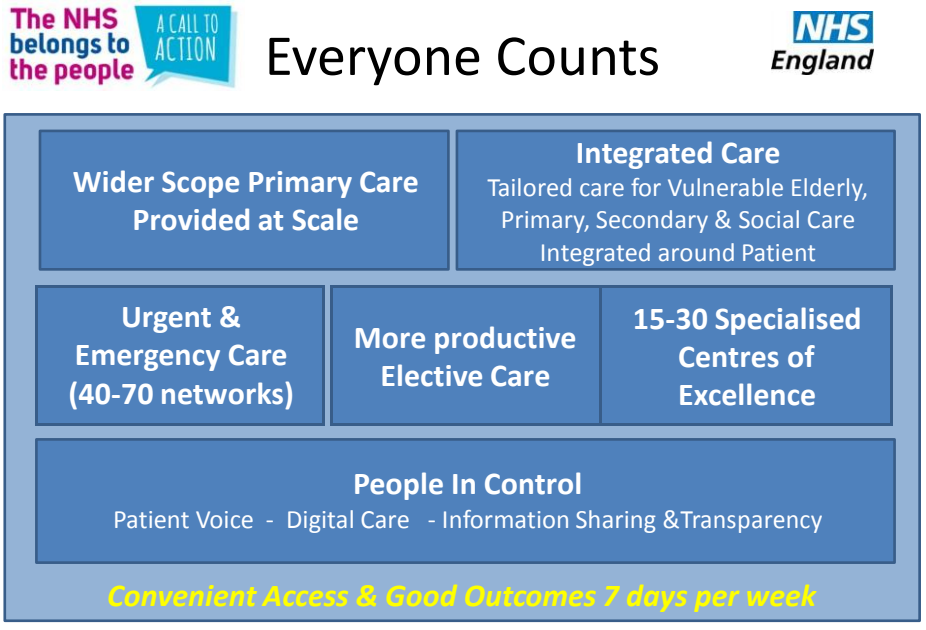
These will be underpinned by the delivery of the goals set out within Everyone Counts. Published in December 2013, Everyone counts: Planning for patients 2014/15 to 2018/19 sets out proposals to make the NHS England vision and purpose "High quality care for all, now and for future generations" a reality. The ten goals set out in the guidance include:



Our ambition and actions to address these ten goals and ensure delivery across the five domains and seven outcome measures of the NHS Outcomes Framework are set out in summary below, for each of our three commissioning responsibilities.



Within this section below, for each of our commissioning responsibilities we also set out the direction for service development, in particular how our strategy responds to the emerging national direction for services set out in 'everyone counts' and the national review of Emergency and Urgent Care:



In some cases initiatives are managed as projects with the aim of a measurable improvement in Quality, in Innovation, in Productivity, or in Prevention. These projects are referred to as QIPP and help free up financial resources to commit to strategic priorities and to remain within allocated budgets.

Specialised Services – Our Ambitions and Plans

Our ambition and actions to address these ten goals and ensure delivery across the five domains and seven outcome measures of the NHS Outcomes Framework are set out in summary within the following tables split between the mental health programme of care, and the 4 programmes of care delivered through acute services:

Table: Delivering Everyone Counts - Specialised Mental Health Services Objectives

Goals	Key actions/features
Secure **additional years of life** for people with treatable mental & physical health conditions	"**Plans to reduce 20yr gap in life expectancy for people with severe mental illness"** For our services this is most applicable to people with psychotic illness and the long term effects of psychotropic medication and poor access to physical healthcare. • Specialised commissioners introduced a CQUIN in 2011 in high secure and 2013 for all other specialised mental health services targeted at improving physical healthcare. This will be built on in 2014/15 and in future years. • We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to poor access to physical healthcare and will build on this and any lessons learnt going forward. • Contracted requirements are to ensure continued improvement of healthy lifestyles for staff and patients.
Improve **health-related quality of life** for 15 million people with MH & Long Term conditions	• Ensuring services are effective and of high quality through service user feedback and service visits provides assurance that health related quality of life is maximised for service users. • Ensuring that the CQUIN for 13/14 physical health care is rolled into the quality schedule of the contract and will built upon in future years. • Patients have access to education and training opportunities whilst an inpatient to improve the options available to them on discharge.
Reduce **avoidable time in hospital** through better, more integrated care in community	"**Identification and support for young people with mental health problems"** • NHS England took on responsibility for commissioning Tier 4 CAMHS in April 2013. There is currently a national review of CAMHS tier 4 taking place which will report March/April. We will need to build in to the plan implementing the findings of the review. • Locally we need to commit to continued funding of the 2 CAMHS case managers who are ensuring appropriate, efficient and effective care pathways into and out of Tier 4 services and are starting to work with East Midlands providers to improve the quality of services and patient experience. • Case managers actively engage with patients and clinical teams to ensure patients are in the right place at the right time for treatment and that delayed discharges are avoided. • CAMHS patients are reviewed regularly and case managers actively work with partner agencies to ensure that care pathways and discharge plans are effective to reduce length of stays and avoidable delays.

Goals	Key actions/features
	• Introduction of shared pathway into specialised services, providers asked to implement a recovery approach which includes identifying the most appropriate recovery tools for their populations, drawing upon a range of recovery resources and which supports service users to engage directly in identifying outcomes, care planning and the CPA process, E.g. Recovery Star, My Shared Pathway Resource Books, Care Index, and Wrap.
Increasing number of people having a **positive experience** of **Hospital** care	• We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to poor access to physical healthcare and will build on this and any lessons learnt going forward. • Service visits and interviews with service users to gain direct service user feedback and take actions with the provider to improve positive experiences in hospital. • CQUIN for innovation introduced into specialised services to enhance patient choice and experience for example CPA for CAMHS and Adults, which in future years will be established as common practice. • Case managers actively engage with patients and clinical teams to ensure patients are in the right place at the right time for treatment and that delayed discharges are avoided.

Goals	Key actions/features
Increasing number of people having a **positive experience** of **GP & community** care	• All patients in secure hospitals will have an annual health check, this is a contractual requirement and was measured as part of the 'My Shared pathway' CQUIN • In addition all patients with a learning disability will be offered an annual health check that meets the criteria of the Cardiff health check tool • That patients in secure hospitals will have access to healthcare equal to that which they would receive via a GP and commissioned by CCGs • The area team will continue to implement a comprehensive response to the winterbourne view findings: ✓ Quarterly data collection process will provide detail to the Leicestershire and Lincolnshire Area on the number of adults and young people with Learning Disabilities and/or Autism in secure hospitals hosted in the Leicestershire and Lincolnshire Area. ✓ Our case managers will continue to work with providers to ensure all patients who are detained and in secure services in the East Midlands have robust care plans in place and that discharge planning commences as possible; ensuring patients with a learning disabilities and/or autism do not remain in secure hospital care any longer than is clinically appropriate. ✓ Our case managers monitor the CPA process to ensure each patient identified as being fit for discharge are proceeding though their treatment and discharge pathway in a timely and appropriate way. ✓ Our case managers regularly meet and liaise with our area CCG colleagues and the patient care co-ordinators to monitor the patient's discharge pathway. ✓ As a net importer of patients from other areas into our large services providers, such as St Andrews Healthcare, we work closely with the other Area Teams. A number of these patients will be identified as needing to transition to lower security or to community settings by the local Area Teams and CCGs and we will continue to work with our partners to move patients on to appropriate services. ✓ Area Team will link in with CCG and Local Authority strategic planning and reporting on Winterbourne View Review, Autism Strategy, Learning Disability Self-Assessment Framework (LD SAF) and Joint Strategic Assessment Needs(JSNA)
Make progress in eliminating **avoidable deaths in hospital** caused by problems in care	• Serious incident investigation and quality management via Area Team Quality and Nursing Directorate. • Suicide prevention is a contract requirement and hospitals are required to not using non-collapsible rails in patient areas. • Annual ligature audit is required in all services. • Specialised commissioners introduced a CQUIN in 2011 in high secure and 2013 for all other specialised mental health services targeted at improving physical healthcare. This will be built on in 2014/15 and in future years.

Goals	Key actions/features
Reducing health **inequalities**	• All commissioned services are required to have Equity of Access, Equality and Non-Discrimination policies. • Access to services it through a nationally agreed access assessment process to ensure patients access the right services at the right time for the right treatment. • Guidance for the transfer of prisoners to hospital for treatment. • Case managers and quality reviews in hospitals will check that 'reasonable measures' are taken by providers to ensure a patient's needs are met across the all elements covered by the Equality Act. • The CAMHS Tier 4 review will look at location and access of provision, which will then inform commissioners future location planning. • Commissioners will also work with Clinical Reference Groups to look at specialised service provision such a perinatal inpatient services to ensure that location of future commissioned services takes into account location and access.
Parity of Esteem: Equal focus on **improvements in Mental Health** & on physical outcomes for people with MH problems	The approach to achieving parity of esteem for mental health includes: • Review the % of the specialised budget this year that is mental health and commit to at least maintaining it, if not increasing which is probably warranted across some of the new services we have taken on recently. • Patient length of stay is being monitored to compare parity in services and outcomes. • Working with providers to ensure that not only are mental health services are compliant with minimum services specification requirements but that they meet high quality standards. This may require additional investment as East Midlands prices are at the lower end of national provision. • We have among the most price efficient MH services in the country which has been confirmed during the 10 Area Team benchmarking exercises. • The Area Team will contribute and support to national procurement exercises being planned for mental health services to ensure that the services commissioned represent high quality and value for money. Our parity of esteem is reflected by: • A small number of services that are lower than the national average and where this has a negative impact on the ability for the provider to deliver the national service specifications, the Area Team will work with the provider to address this, providing parity of esteem for patients closer to home and supporting the stabilisation of high quality service delivery. • Size of provider, capacity, quality of service and outcomes are considered when negotiating contracts to ensure there is local and national parity. • Provider stabilisation, capacity and demand at local and national levels are also incorporated into contract negotiations. • The 10 Area Teams managing mental health services work closely to ensure that providers across the country are treated and managed consistently.

Table 2 Delivering Everyone Counts - Specialised Acute Services Objectives

Goals	Key actions/features
Secure **additional years of life** for people with treatable mental & physical health conditions Preventing people from dying prematurely	A comprehensive review of all specialised services against the service specification will ensure that care is centred around centres of excellence and this should increase the efficacy of health care in the EM. Given that 2 major providers deliver 70% of the specialist services in the region it is likely that there will be a concentration of expertise in these areas. Effective use of a Major Trauma system with a coordinated approach between MTC, trauma units and the ambulance service should prevent unnecessary deaths, increase both life years in real terms and in quality terms. The use of a coordinated approach to rehabilitation across the EM will also assist with the above. The development of a rehabilitation network is in its infancy but work associated with increasing wellbeing, early return to work and achieving better measurable rehabilitation outcomes will see improvements in this area. A coordinated approach which includes assessing all formally designated services delivering specialised rehabilitation, a review of the activity using the UKROC data and support for the development of a clinical network charged with developing rehabilitation across the East Midlands will add quality years to the lives of patients. Implementation of Specialised Services Policies, CQUINS and QIPP schemes aim to achieve increased services quality and improved patient experience and better outcomes.
Improve **health-related quality of life** for 15 million people with MH & Long Term conditions	Use of the medical intelligence from the review of all services providing specialist services using the service specification coupled with a complete assessment against the activity in these centres and the population distribution in the EM we will be able to develop a long term strategy to ensure access to specialist care is available for all. This is particular important for patients with long-term conditions when access to care spans the spectrum from intensive inpatient care and also specialist care in the home or close to their home. Cooperation with clinical networks, CCGs, relevant charities and local authorities will ensure there is a comprehensive “network” of care for patients with long-term conditions. Support for the principle of providing specialist care throughout the whole pathway (in patient and the community) by making effective use of support workers and specialist nurses / therapists will provide a supportive platform for this cohort of patients and their families. Examples of this are the current support for support workers / nurses / therapists to span both the inpatient aspect of specialist care an care in the community can be found in a number of specialist areas including: HIV, burns and plastics, cancer, Teenager and Young Adults services, Long Term Ventilation and neurological conditions. There are plans to work with acute providers to expand this mode of care across more specialist areas. This initiative will be supported on the basis that it can reduce hospital admissions, promote early discharge and improve patient care. Ensuring that appropriate the CQUINs for 14/15 accurately reflect improvements in this area also acts as a stimulus to promoting quality. The intention is to ensure the quality schedule of the contract is managed robustly.

Goals	Key actions/features
Reduce **avoidable time in hospital** through better, more integrated care in community	"**Identification and support for initiatives that ensure that the whole pathway for specialised services is provided for by adopting an integrated approach to the delivery of specialised services that spans both the acute care and primary care environment"** Identifying specialist services that are commissioned to provide or it is beneficial to provide services using a model that reaches out into the community will both reduce hospital admissions and provide a more integrated service. The intention is where appropriate to support providers to provide specialist posts that bridge the gap between the acute and community environment. Examples of this are the current support for support workers / nurses / therapists to span both the inpatient aspect of specialist care and care in the community can be found in a number of specialist areas including: HIV, burns and plastics, cancer, Teenager and Young Adults services, Long Term Ventilation and neurological conditions. There are plans to work with acute providers to expand this mode of care across more specialist areas. This initiative will be supported on the basis that it can reduce hospital admissions, promote early discharge and improve patient care.
Increase % **older people living independently** following hospital **discharge**	Better rehabilitation services, specialist community support and case management will address this issue (as above). This is all covered by the philosophy of providing an integrated model of working for specialised services.
Increasing number of people having a **positive experience** of **Hospital** care	We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to the timely access to specialised services. Some qualitative data is available regarding the enhanced patient experience of operating a specialist outreach service (burns service outreach team). The intention is to continue to evaluate this form of initiative. There is work underway to do a joint evaluation of specialist nursing teams delivering burns care in the community. This will be undertaken jointly by members of the service specialist team and the burns outreach team. Providers of specialised services will be compliant with the requirement to seek patient feedback using the Friends and Family test and provide feedback to commissioners on progress.
Make progress in eliminating **avoidable deaths in hospital** caused by problems in care	Serious incident investigation and quality management via Area Team Quality and Nursing Directorate. Audit of major trauma data, increased numbers of unexpected survivors as a result of implementation of major trauma system. Region wide peer review / mortality and morbidity meetings to peer review clinical outcomes (Burns Audit, Major Trauma, Cancer

Goals	Key actions/features
Improve health through **commissioning for prevention** and every contact counts	• Support for the implementation of a rehabilitation network and endorsing initiatives that promote wellbeing may have a positive effect on prevention. • Support for enhanced Long Term Ventilation team and Long Term Conditions (such as neurological conditions) will help to prevent avoidable events that require hospital admission or episodes of sub optimal health. E.g. Neuromuscular Dystrophy
Reducing health **inequalities**	• The use of the service specifications and a comprehensive review of all services will provide the medical intelligence to undertake a review of all specialised services against the population served. This will ensure there is a matrix of specialised services that is accessible to all. This work will take 2 to 5 years to complete but is part of a long term strategy to ensure that the right specialists services are in the right place to ensure there is equality of access for all patients in the EM. This will help address any issues associated with health inequality.
Parity of Esteem	For acute services parity of esteem relates both to the delivery of improvements in mental health services, and focusing with providers of physical health care, on differences in relative outcomes for those in receipt of mental health services. • As the availability of data improves through national developments such as care.data we will explore with CCG and CSU partners the opportunities to provide improved insights for our providers of acute care to target services where outcome differentials are significant and not attributable to presenting differences in health status.

Specialised Services - Service Development

Commissioning for prevention

The partnership challenge to achieve financial sustainability of services is well illustrated in specialised healthcare. Research indicates that year on year growth in spend for specialised services has been on average 4% higher than for other sectors of care over the last ten years, partly due to the availability of new technologies and drugs but also due to growth in underlying health needs. The key levers to address this rise relate to wider prevention and early intervention commissioned through local authorities and clinical commissioning groups – for example interventions to address alcohol use, exercise, smoking, and diet through local authority led public sector partnerships, and the effective management of chronic kidney disease in primary care will both have an impact on rates of growth for renal dialysis and transplant. By the time patients present with a need for high cost specialist interventions the opportunity to intervene at lower cost has been lost.

We will work with our partners within the ten Health and Wellbeing Boards, utilising the 5 steps recommended in the 'Commissioning for prevention' report to address key service risks and improve health outcomes in our region:

1. Analyse key health problems
2. Prioritise & set common goals
3. Identify high-impact programmes

4. Plan resources
5. Measure & experiment

National Issues being addressed by all Specialised Commissioners:

- Continued variation in access
- Sustainability of some services
- Achieving compliance with full service specifications and supporting reconfiguration where this is not a realistic prospect
- Financial affordability
- Supporting new models for commissioning to promote integrated care
- National reviews of capacity and service models including radiotherapy, cardiac surgery, Tier 4 CAMHS and liver transplant services
- Development of remaining service specifications and clinical policies
- Development of national procurement arrangements and key priority areas
- Financial benchmarking and development of standardised prices

Key issues for East Midlands services by programme of care

Programme of Care: Internal Medicine

Obesity/ Bariatric surgery

Implementation of the Clinical Commissioning Policy for Complex and Specialised Obesity Surgery

The Area Team is working with CCGs and Local Authorities to develop a co-ordinated plan to achieve a safe managed transition to the new national commissioning policy. This aims to keep the capacity of services at each stage of the pathway in balance. Including benchmarking and a flow model that will help identify required inputs at each level of service. Pathways will be agreed across commissioners and patients will receive a seamless service so that patients who may benefit from potentially lifesaving surgery are be identified after they have completed Tier-3 weight management and referred in a timely manner for specialised surgery. The pathway should include long term Public Health initiatives which impact on behaviour and reduce demand for specialised surgery.

Programme of Care: Blood and Cancer

Radiotherapy Review

From 1 April 2013 NHS England became the commissioners of radiotherapy services for England as a prescribed service, enabling strategic decisions about service needs and clinical pathways across geographical boundaries to be made. Locally, decisions in relation to radiotherapy delivery partner at Milton Keynes and relationships with NGH and OUH on cancer pathways require the involvement of the Area Team and network in advising on

appropriate options for consideration in the light of the sustainability of services. An option appraisal has been completed and recommendations are being developed pending further activity and outcomes modelling and national guidance.

HIV Services

There are risks to the sustainability of HIV/GUM services in some East Midlands Providers due to the re procurement of Sexual Health Services by Local Authorities- Risk of segregation of services and introduction of private sector providers. In addition emerging cost pressure of the introduction of new service tariffs for HIV services (year of care).

Programme of Care: Mental Health

Perinatal Mental Health

A provider - Leicestershire Partnership Trust (LPT) has given notice to NHS England that it cannot comply with the service specification, necessary quality standards or invest the finances required to bring the current service up to standard. NHS England has been liaising with LPT and the CCG's regarding the way forward and the need to ensure that the pathway to Inpatient Perinatal beds is clear and widely known by all stakeholders to ensure that women receiving effective treatment and admission when identified as appropriate by the Community Perinatal Service.

Since NHS England has developed a national service specification to ensure that all Perinatal Inpatient Units across the country are of the same standard and deliver the same quality and standard of care, the East Midlands CCG's and Perinatal Quality Network are working together to write a regional service specification for Community Perinatal Services. This will also ensure that all areas of the East Midlands are working towards a Gold Standard service for pregnant women and mothers with mental health problems. And no matter where a woman may become ill the quality and standard of support she receives will not depend upon the area, county or postcode where she resides or receives her treatment.

Programme of Care: Women and Children's Services

Paediatric congenital cardiac Services

A new national review has been established to consider the whole lifetime pathway of care for people with congenital heart disease (CHD). This aims to:

- Secure best outcomes for patients
- Tackle variation
- Deliver great patient experience

University Hospitals Leicester is one of the providers currently providing paediatric congenital cardiac surgery. They are currently providing monthly returns on the transition dashboard which is being implemented nationally. CRGs are developing national commissioning products including service specifications incorporating new standards of care. Upon the outcome of the review the Area Team will be required to support

implementation of an action plan to deliver the recommendations. This may involve the decommissioning /reconfiguration of current service models in the region.

Strategic Ambition to build a sustainable coordinated approach to the provision of specialised services in the East Midlands

Addressing Services not yet at national service specification standards

The assessment of all specialised services against the service specifications developed by the Clinical Reference Groups will inform this strategic direction of travel and ensure that there is a robust platform on which we can develop a plan to deliver commission specialised services in a manner that improves quality, access and efficiency. Throughout the process of reviewing all specialised services in the East Midlands there has been good engagement with the providers and both the strategic and operational delivery networks. This has ensured that historic knowledge and current medical intelligence from a variety of sources has been taken into consideration when measuring compliance of the services against the specification.

There are currently 359 services identified in the acute services that are currently under consideration for compliance against the service specification. The table in section two provides a summary of the current status with services described in three main categories; **compliant** with the service specification, services not compliant but they have applied for **derogation** and services where only part of the pathway is provided and the service is **provided in partnership**.

The two major hospitals providing specialised services in the region Leicester and Nottingham have 87 and 89 specialised services respectively. This supports the intention, set out below, to concentrate specialised services in centres of excellence with some 15 to 30 such centres being viable in England (NHS England, 2013a). This process will become part of the current contract round and form the basis of planning of service provision in the future. NUH have the most services undergoing the derogation process (21). The principle deficits identified are associated with gaps in resources (staffing or infrastructure) to meet all of the service specification. The level of clinical risk associated with the derogation plans have been reviewed with regards to the providers continuing to provide these services.

Specialised services concentrated in centres of excellence

NHS England now develops specialised service policies and service specifications nationally. These specify the services patients can expect to receive and where they will be provided, they also set out what high cost treatments NHS England will or won't routinely fund.

Strategic Direction of travel outlined in 'Everyone counts' is for Specialised services to be consolidated in fewer providers**,** linked to Academic Health Science Networks, utilising service specifications, policy and national procurement where required.

For the purpose of planning it is understood that consolidation of specialised services is expected and that this will be to the most capable provider where issues of quality or affordability are unresolvable. Approximately 60% of specialised services are already provided in fewer than 30 centres. We would therefore expect that most specialised services, which are by their nature often rare and complex, should be provided in relatively

few centres, although there are of course, exceptions. As part of NHS England's work on the 5-year strategy they will be looking at the evidence base for greater consolidation of services at both service and provider level.

Our Aspirations for partnering East Midlands commissioners & providers to deliver this change:

- The provider landscape is redesigned in partnership with providers and CCGs in line with local whole system change programmes. The new provider landscape is:
    - Best for patients overall health and outcomes (CCG population and commissioned provider population) - Reducing the no of years of life lost for treatable conditions
    - Local citizens will be included in all aspects of service change resulting from the consolidation of services
    - Best for the economic climate – model ensures Value for money and better use of resources
    - There is oversight and assurance of CCG plans to ensure overlap and integration is managed – we have agreed future mechanisms for engagement and partnership working.
    - Prime contracting models are in place for networked care delivering in partnership with tight clinical governance across providers (80% of services within programmes of care).

In order to ensure that NHS funded care is appropriately placed, we will agree plans and work together with providers and CCG commissioners, to ensure that all elements of the care pathway are aligned and reflect local strategic reviews (e.g. Better Care Together programme for Leicestershire & Rutland, and Lincolnshire Sustainable Services Review).

The on-going work across the East Midlands will secure consistent levels of quality and efficiency, as the team works with regional providers to ensure compliance to national service specifications. This, together with a programme of redesign to ensure our providers can deliver services in line with the most efficient peers has the potential to identify further services that are not clinically sustainable to national standards at efficient levels of spend

These services, together with services which cannot meet national standards for structural reasons (e.g. undertaking insufficient cases per year, or serving a population catchment insufficient to maintain standalone services) or services unable to make the transition to seven day consistent outcomes on a standalone basis will be the focus of strategic change.

Subject to the approval of regulators we will look favourably on clinical joint ventures between the 2 main tertiary providers to create the opportunity for clinicians to drive the consolidation and collaboration agenda, respecting patient's opportunities to exercise choice in neighbouring services at the point of tertiary referral and publishing outcomes relative to others to ensure such choices are well informed and lead to greater volumes of treatment at services achieving better outcomes.

Where there are benefits significant economies of scale which achieve better clinical outcomes or financial sustainability we will encourage providers to consider consolidation of

sites and more centralised access to services, whilst preserving access locally where these gains are not significant.

Principal Deliverables that underpin the strategy for improving the provision of specialised care

Deliverable	Description
Seven day services	We will engage with NHS IQ to model and plan the potential for 7 day working across our provider footprint ensuring that this reflects clinical quality requirements within national service specifications and the available affordability envelope. This will link with ambitions to consolidate specialised services within a reduced provider footprint which will require the redesign and modernisation of services and associated patient pathways.
Highest Quality Urgent and Emergency Care	In the East Midlands the major trauma network will be completed by April 14 which will cover the whole of the region and be centred on the Major Trauma Centre (MTC) located within Nottingham University Hospital NHS Trust. Development of a comprehensive major trauma network and system has involved the MTC working with other providers of emergency care in local Accident and Emergency Departments, the East Midlands Ambulance Service and the Major Trauma Network. Because trauma and urgent care spans the commissioning responsibilities of both CCGs and specialised commissioners a number of the services will have to be commissioned in a manner that involves working in partnership. Major trauma is commissioned by NHS England and falls under the remit of those responsible for specialised services with other Emergency Medicine services being the responsibility of CCGs. One of the challenges is the traditional boundaries of the clinical networks which are not aligned with all of the services commissioned in the East Midlands. To develop a truly integrated system for urgent and emergency care commissioners (specialised and non- specialised), clinicians (primary and secondary care), clinical networks and the ambulance services will have to work in partnership.
Research and Innovation	As part of the redesign of the specialised provider landscape we will actively encourage providers to seek research opportunities. This will be supported through local commissioning decisions where possible and linked to Academic Health Science networks.
Access and utilisation of reliable and robust medical intelligence	Joint working between commissioners and providers to implement system wide processes to monitor bed utilisation will help all those involved in health care to develop a strategic plan which is robust, defensible and delivers quality care. The use of Utilisation Reviews has been incorporated into the CQUIN process to incentivise healthcare providers to embrace this technology. In addition to influencing lasting organisational change associated with bed utilisation there are also plans to influence clinical practice by encouraging the use of new technologies to reduce hospital acquired infection. This is seen as a priority across all clinical areas.

Supporting Delivery of Specialised Commissioning

The number of staff involved in specialised commissioning has significantly reduced since 2012/13, whilst the range of services included within the specialised commissioning portfolio has increased by almost two-fold. The task of moving from between 10 and 152 different ways of commissioning services, to a single consistent national model, has been immense. It is recognised that there needs to be some immediate improvements to the way in which specialised services are commissioned in order to put specialised commissioning on a stronger footing for the future.

NHS England's Executive Team is committed to supporting specialised commissioning at this challenging time and is putting additional resources in place to support the existing teams, drawing on the wealth of skills and expertise from across the organisation. This will involve around 50 additional individuals, identified for the unique contribution they will be able to make, temporarily taking up posts within the team.

There will be seven distinct workstreams with a particular focus on financial control in 2014-15 and planning for the 2015-16 commissioning round. This workstream will be headed up by Dr Paul Watson, Regional Director (Midlands and East), and Chair of the Specialsied Commissioning Oversight Group (SCOG).

The team is working to a three-month timetable. The seven workstreams are:

Workstream 1 – **Strategic Projects**, headed up by Ann Sutton, Director of Commissioning (Corporate). This team will ensure continuation of the most complex and highly specialised programmes such as Proton Beam Therapy, and ensure delivery of a prioritisation framework for 2015/16.

Workstream 2 – **Strategy**, headed up by Michael Macdonnell, Head of Strategy. This team will develop a financial sustainability strategy for specialised commissioning, and make recommendations about how the range of specialised services and commissioning models should change.

Workstream 3 - **Clinically Driven Change**, headed up by James Palmer, Clinical Director, Specialised Services. This team will ensure that our programmes continue to be clinically led, driving forward programmes that deliver clinical benefit alongside efficiency improvements. They will also be responsible for ensuring a sustainable approach to the commissioning of cancer drugs.

Workstream 4 - **Operational Leadership**, headed up by Cathy Edwards, Director of Commissioning in South Yorkshire & Bassetlaw Area Team. This team will be the engine room of specialised commissioning, ensuring all programmes are properly led, working collaboratively with our area teams and stakeholders. They will have overall responsibility for our QIPP programme, and will develop recommendations on the future shape of the specialised commissioning infrastructure. This team will also include a communications and engagement function, dedicated to ensuring that all stakeholders, including NHS England staff, are well informed; and will also support the work of the Specialised Commissioning Oversight Group (SCOG) and the Patient and Public Voice Assurance Group (PPV AG).

Workstream 5 - **Commercial and Technical Delivery**, headed up by Peter Huskinson, Director of Commissioning in Leicestershire & Lincolnshire Area Team. This team will ensure specialised commissioning manages its provider market in a highly effective, mature way, through well planned and rigorous procurement and contracting programmes, supported by building capacity and embedding best practice across area teams.

Workstream 6 - **Strong Financial Control**, headed up by Rachel Hardy, Regional Director of Finance in Midlands & East. This team will ensure specialised commissioning has strong financial leadership and focus across all of its programmes. It will also carry out specific technical pieces of work on area teams' financial baselines, and will provide support to the Clinical Priorities Advisory Group (CPAG).

Workstream 7 – **Analytics**, headed up by Ming Tang, Director, Data and Information Management Systems. This team will ensure specialised commissioning is supported by good data and intelligence, building capacity and capability across area teams and commissioning support units (CSUs), as well as moving towards much greater standardisation of informatics processes.

A communications and engagement plan to is being developed to support this important programme and stakeholders will be fully informed of the progress of this work.

Public Health Services – Our Ambitions and Plans

The function of the public health team within the Area Team is to implement the content of the section 7a agreement. Currently this contains 30 specifications; 14 immunisation programmes, 12 screening programmes and four other programmes the largest of which is the public health services for under 5s, predominantly health visiting and family nurse partnerships.

Aligning priorities to anticipated changes to section 7a agreement

The content of the section 7a will change over time. The three major changes that are already known are:

1. Roll out of the Fluenz programme (intranasal flu vaccine) to all 2-16 year olds
2. The transfer of the commissioning responsibility for public health services for the under 5s to local authorities. This is likely to take place in October 2015.
3. The introduction of bowel scoping as part of the bowel cancer screening programme. This will see sigmoidoscopy offered to everyone at the age of 55 years.

Other potential changes to the section 7a agreement the possible introduction of a meningococcal B vaccine in to the childhood immunisation schedule, additions to the new born screening programme with tests for other rare conditions using the blood spot sample at 3 days, and possibly a move to using HPV testing as the primary test in cervical screening. The introduction of other new immunisation or screening programmes within a 5 year timescale is quite conceivable.

Changes to provider landscape for public health services

There are two main drivers that might affect the provider landscape over a five year period:

1. Decisions at national level as to the ideal size of a provider of screening services. For example there is a desire to see larger grading units for diabetic eye screening services. This may see work being brought together at an East Midlands or even larger level. Conversely, the current arrangement that sees Kettering as the lead bowel cancer screening provider for Leicestershire and Northamptonshire is currently being split up as the national team has decreed that the unit is too large for efficient operation.

2. Any requirement to go out to tender may significantly change the provider landscape for screening services. If independent providers become involved in the screening services the processes for referring in to the programmes and for the onward referral to treatment services are likely to become more complicated, as will the necessary fail safe systems.

The Fluenz programme is sufficiently large that it may change the way that immunisation services are provided. Currently in Leicestershire and Lincolnshire only HPV vaccine is given through schools. The move to providing Fluenz through schools may dictate the need to establish a robust immunisation service for schools in both areas. It may then make sense to move the teenage booster for Td/IPV and the new teenage booster for meningitis C from general practice in to schools. This would require investment.

Demography / prevalence

Both screening and immunisation services are population based services and are therefore sensitive to demographic changes. The Knowledge and Information Team (KIT) in the PHE Centre have been asked to take on the work for the East Midlands of modelling the impact of demographic changes for all screening and immunisation services. This will include taking account of the predicted changes in prevalence of diabetes in different geographical areas. There will also be the option to look at sensitivity analyses around uptake of services as this is the other principal driver of resource use.

Core business over the next five years

The core business for the next five years will be to ensure efficient, effective and equitable service provision informed by patient experience. This will be include targeted actions in support of the following themes:

Quality	• To ensure that screening programmes meet the minimum acceptable targets at the earliest opportunity and to strive to meet the achievable targets over this time. • To comply with the recommendations following regional QA visits • To meet new recommendations from national programmes including amendments to section 7a service specifications • To ensure childhood immunisation programmes move towards 95% uptake for all programmes.
Productive Efficiency	• To ensure that services are provided at costs that are at least not higher than the median price for the service nationally
Allocative efficiency	• To ensure that resources within the public health ring fence are allocated to services in the most appropriate way resulting in all services being fairly resourced and able to generate maximal health benefit.
Equity	• To undertake equity audits and act on the outcomes to ensure that services are accessed by, and provide benefit to, all parts of society according to need.
Patient experience	• To find innovative and effective ways to gather patient views about service provision and to involve patients in the design and evaluation of services.
Governance	• To ensure a managed process for the transfer of commissioning responsibility for public health services for children under 5 years from the Area Team to upper tier local authorities • To ensure that all programmes are subject to good governance procedures and processes.

Public Health Services - Two Year Plan Priorities

The Development programme over the next 2 years is outlined below:

The services that are commissioned by the AT under the section 7a agreement are specific and clearly defined. This plan therefore focusses on each service rather than looking at overarching themes such as the ten goals or six themes.

Immunisation services

Routine childhood immunisation

In Leicestershire we will strive to maintain existing good performance with a focus on the practices that are performing least well.

In Lincolnshire performance compares unfavourably with peer "PCT" areas (the only unit of comparison available). A work stream is in place to improve all aspects of the patient pathway, including the child health information service involvement, to ensure that accurate and timely information is available that will be used to drive up performance.

Meningitis C teenage booster

For 2014 this will be given in general practice. During 2014/15 work will be undertaken to establish a new commissioning arrangement from April 2015 in line with national guidance. This links to work around the Fluenz programme as there may be benefit in concentrating all teenage immunisations through a school based service.

New Meningitis C catch up for university entrants

The detail of this catch-up has yet to be announced. It is assumed that this will be a GP provided service but the contractual mechanism for this is not yet clear. It is assumed that new money will be available for this catch-up programme.

HPV vaccination

In Leicestershire and in Leicester City the target of 90% has been achieved in 2012/13. For the City this was the first time the target has been achieved so the aim is to maintain this excellent performance.

In Lincolnshire the performance was slightly below the target at 88%. Work is in hand to improve this rate with an expectation that 90% will be achieved for dose three in 2014 and beyond.

Seasonal flu

Performance across the Area Team for those over 65 is likely to be slightly under the 75% target for 2013/14. It is difficult to know what else to put in place to try to improve uptake further. For those at risk under 65 the aim is to immunise more individuals each year. The target of 75% for this group is unattainable due to the methodology of data collection, hence the focus on numbers of individuals immunised.

In addition to the normal cohorts general practices have immunised >40% of all 2 and 3 year olds with Fluenz in 2013/14. The aim will be to increase this percentage on an annual basis and to add in the 4 year old cohort from 2014.

Pneumococcal vaccine

There is reference to a change to the adult pneumococcal programme. The details of this are not known but we are confident that we can implement any change.

Fluenz programme in schools

Leicestershire ran the largest pilot of Fluenz in primary schools in 2013. In 2014 the aspiration is to extend the primary school pilot to cover the whole of the LLR primary school population as well as offering the vaccine to years 7 and 8 in secondary schools. This is dependent on national funding being available. In 2015 we will at least match whatever the national plan is for this programme which has yet to be announced.

Lincolnshire in 2014 will offer the vaccine to all years 7 and 8 in secondary schools. In 2015 we will follow whatever the national plan is for this programme which has yet to be announced.

Neonatal hepatitis B

We will establish revised pathways of care to ensure that all at risk babies receive hep B vaccination in line with national policy and that an appropriate failsafe process is in place involving CHIS to ensure that no children fall through the net. We will also initiate the blood spot test at one year.

Screening Services

Bench marking

For screening services that are not based on a national funding formula we will continue with our benchmarking work to ensure that we are achieving value for money from the services that we commission.

Breast cancer screening

Leicestershire:

We will implement the pathway for high risk women in line with NICE guidance. We will maintain the good level of uptake that this service has traditionally secured.

Lincolnshire

We will implement the pathway for high risk women in line with NICE guidance. We will ensure that the service becomes fully digital at the earliest opportunity. We will work with the trust to ensure that they can deliver a robust and effective service based on effective team working.

Cervical cancer screening

We will commission HPV testing as part of the cervical screening programme. We will look to stop the decline in uptake of cervical screening particularly in younger women.

Bowel cancer screening

We will establish University Hospitals of Leicester NHS Trust as an independent bowel cancer screening unit. We will support the trust to participate in wave two of implementation of the bowel scope extension of the bowel screening programme.

We will ensure that United Lincolnshire Hospitals NHS Trust can provide this service in fully accredited facilities. We will support their aspiration to be in phase two of implementing the bowel scope programme.

Diabetic eye screening programme

We will implement the new pathway for surveillance. We will work with both providers to look at better ways of contracting for this service, potentially building on the local tariff developed in Nottingham and Derbyshire Area Team.

Abdominal aortic aneurysm screening

We will take on the commissioning and contracting responsibility from the national team for the site in Lincolnshire and will continue to support the site in Leicestershire.

Antenatal and Newborn screening

We will implement the fail safe programme for the new born blood spot programme.

We will support trusts to implement the SMART system for managing the NIPE programme.

Child health information system

We will ensure that the local Child Health Information Systems are in accordance with the national service specification by the end of March 2015 and will work with our providers to address any issue they may have in attaining the required standards.

Child & Family Health Services

Health visiting for under 5s

We will commission such that in each area they will reach the nationally required trajectory for health visiting numbers. We will also ensure that the rest of the skill mix of the teams is appropriNGHate given the rapid expansion in qualified health visitor numbers.

We will work jointly with colleagues from local authorities to manage the transfer of commissioning from NHS England to local authorities to take effect whenever that transfer is confirmed.

Family nurse partnership

We will commission the required expansion of the nationally agreed increase in the number of FNP places which include the introduction of a new site in Lincolnshire and the continued support of the existing site in Leicester City.

We will work jointly with colleagues from local authorities to manage the transfer of commissioning from NHS England to local authorities to take effect whenever that transfer is confirmed.

Primary Care Services – Our Ambitions and Plans

Local Ambition One (Quality)

To **reduce unjustified variation in the quality** of the services received by patients.
Key outcomes:

- a high quality workforce, optimising the skill mix across all primary care service providers to ensure the right people, with the right skills, are in the right place at the right time ;
- modern models of integrated working designed around the patient, recognising the expanded role of general practice in co-ordinating and delivering personalised care and the potential role of others such as community pharmacy.;
- Optimising the new GMS contract changes, in partnership with CCGs, to deliver more proactive care for people with more complex needs and promoting consistently high standards of quality;
- Improved patient experience.

Improvement interventions

We will establish more robust mechanisms for triangulating data and information to improve our understanding of the quality of the service provided by primary care. We will develop robust quality and performance assurance frameworks for primary care to ensure that there is a consistent approach to managing unwarranted variation in quality.

Implementing the GMS Contract changes for 14/15 – the range of changes to the GMS contract seek to enable integration, new ways of working, and proactive care that is 'wrapped around' patients, particularly those with complex needs; this supports local CCG plans for managing multi morbidity through integrated neighbourhood teams.

The new enhanced service for reducing unplanned hospital admissions will again support CCG plans and by working together and giving consistent messages we can ensure that there is no duplication of effort or confusion for general practice and we can improve patient experience and outcomes.

Working with CCGs to address capacity issues in Primary Care and secure a high quality workforce. As a starting point we need to understand our GP workforce and identify the gaps. During the next 12 months we are planning to undertake a GP recruitment initiative in partnership with CCG's.

For dental service providers we are looking to better use of resources, IMOS pathway (awaited) and Orthodontic Framework.

Local Ambition Two (Outcomes)

To reduce **unjustifiable inequalities** in health outcomes and access to services
Key outcomes:

- commissioning across pathways (e.g. LD, homeless etc)
- federated models of delivery across independent contractors
- modern models of integrated working designed around the patient

Improvement interventions

GMS contract changes 14/15

Implementing other nationally negotiated changes which include:

- A review of the enhanced service for Diagnosis and Care for People with Dementia;
- A review of the enhanced service for Annual Health Checks for People with Learning Disabilities
- A review of the enhanced service for Alcohol Abuse, to incorporate additional assessment for depression and anxiety.

Improving oral health
Partnership working with Leicester City Council to deliver the Oral Health Promotion Strategy (2014-2017) for pre-school children. Five year old children in Leicester have the highest experience of dental decay observed in England. The aim of the strategy is to support co-ordinated activity across Leicester City to improve oral health, reduce oral health inequalities and lay solid foundations for good oral health throughout life. The ambition is for a 10% increase in the proportion of 5 year olds in Leicester with no signs of dental disease by 2019. We will jointly explore different models of service provision, direct access to dental therapists etc, and ensure access is equitable.

The Leicestershire, Leicester City and Lincolnshire Oral Health Needs Assessment is being produced and this is expected to be completed by June 2014.

Eye health
The Eye Health Needs Assessment (gap analysis) is being produced for our area and will be overseen by the Eye Health LPN.

Improve access to and uptake of GOS sight testing for vulnerable groups and at risks groups, for example the homeless. This proposal will be implemented through the Eye Health LPN task and finish group in 2014/15.

Local Ambition Three (Patient Services): To increase citizen participation and empowerment and ensure that they are at the centre of our planning.

Key outcomes:

- Improved access to the right services in a timely manner through better information
- Greater access to NHS Choices
- Choice of GP practice
- Greater involvement of patients in service design and commissioning.
- Friends and family test implemented

Improvement Intervention

GMS contract changes 14/15
The Friends and family test will be a contractual requirement for GP practices from December 2014. Practices will be able to develop a second question and we are encouraging practice to discuss this with their CCG and the Area Team. The Friends and family test has already been piloted in Lincolnshire. This is expected to be introduced for other primary care providers by March 2015.

From October 2014, all GP practices will be able to register patients from outside their boundary area without a duty to provide home visits.

From April 2014 it will be a contractual requirement for GP practices to promote and offer patients the opportunity to book appointments, order repeat prescriptions and gain access to medical records on line.

The patient participation enhanced service will be reviewed so that this is greater innovation in how practices seek and act on patient feedback, including the views of patients with mental health needs.

Patient Engagement and Empowerment
Introduction of patient stories which engage patients, relatives, and carers in ways that use their knowledge and experience to directly influence future service provision. This has commenced in January 2014 within the Lincolnshire Salaried Dental Service. It is the intention to develop this approach and roll it out.

Establish a 'People Bank' where citizens and organisations can register an interest in participation opportunities. Commissioners can also use it to identify interested people for engagement activities.

Hold a local 'listening event' to understand how patients want to participate in the management of their care and how they wish to participate in the commissioning process itself.

Good links with Healthwatch have already been established and we want to strengthen this further in 2014/15 through the primary care meeting structure and the development and implementation of the primary care strategy.

Patient involvement in the planned procurements for 2014/15.
Review Area Team structures and processes to ensure that the local need, local voice and shared decision making with patient representatives are incorporated at every stage of the commissioning cycle from design to delivery to contract monitoring.

Local Ambition Four (Patient Services): To improve the quality of life for older patients and those patients with one or more Long Term Condition.

Key outcomes:

- Commissioning for outcomes
- Wider primary care, provided at scale
- Modern models of integrated working designed around the patient

Improvement Intervention

GMS contract changes 14/15
Implementing nationally negotiated changes for general practice that support more personalised care for older people and those with complex needs.

There will be a new enhanced service to improve services for patients with complex health and care needs and reduce avoidable emergency admissions. The resources released from the QOF quality and productivity domain (100 points) and the risk stratification DES (which will cease with effect from 31st March 2104) will fund the new enhanced service. Given the level of funding associated with the new enhanced service, the expectation is that the majority of practices will sign up to provide this service.
The key elements of the scheme are intended to reduce unplanned admissions, for example proactive care management of at least 2% of patients with complex needs and at the high risk of emergency admissions.

As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care. This will be a contractual duty from 01 April 2014 and any new patients will be notified within 21 days and existing patients notified by June 2014.

These changes will be reflected in PMS contracts once underpinning legislative changes and guidance are in place. These changes will also be reflected in all our local newly procured APMS contracts as a minimum.

We are working with CCGs to ensure that the funding available to support practice plans that improve the quality of care for older people, complement the above core contract changes.

The Eye Health LPN will establish a task and finish group in 2014/15 to take forward Falls Prevention with the aim to reduce avoidable emergency admissions.

Now that the Pharmacy LPN and Eye Health LPN have been established we will be strengthening links with CCGs to improve patient pathways.

Implementing the GMS Contract changes for 14/15 – the range of changes to the GMS contract seek to enable integration, new ways of working, and proactive care that is 'wrapped around' patients, particularly those with complex needs; this supports local CCG plans for managing multi morbidity through integrated neighbourhood teams.

The new enhanced service for reducing unplanned hospital admissions will again support CCG plans and by working together and giving consistent messages we can ensure that there is no duplication of effort or confusion for general practice and we can improve patient experience and outcomes.

Local Ambition Five (Access):To improve access to primary care services & secondary care dental services.

Key outcomes:

- Annual improvement in patient experience of access to services
- Pilot(s) in place for testing new ways of working for general practice

Improvement Intervention

PM Challenge Fund: Improving Access to General Practice

This national scheme is seeking bids for a 2 year pilot to test out innovative models of service delivery, such as federated models, new ways of working that improve access, and make better use of email and phone consultations.

Local Service Reviews

Align the local primary care strategy with the Lincolnshire Sustainable Services Review and the LLR Better Care Together Programme to ensure that there is a 'fit' with local approaches to new models of service delivery and integrated patient care packages.

Access to dental services
The Leicestershire, Leicester City and Lincolnshire Oral Health Needs Assessment is being produced and this is expected to be completed by June 2014. This will provide
Access to dental services – dental look at the % of patients seen

Secondary care pathway development across primary, community, and secondary care dental services. Currently prioritising minor oral surgery and orthodontics (awaiting national pathways) and restorative dentistry, which requires a local review due to differences in the referral criteria applied across the area.

Service reconfiguration project for the Leicestershire Salaried Dental Service, including a review of dental out of hours services and Dental Access Centres. The project was established late in 13/14 and will be taken forward in 2014/15

Access to sight testing
Improve access to and uptake of GOS sight testing for vulnerable groups and at risks groups, for example the homeless. This proposal will be implemented through the Eye Health LPN task and finish group in 2014/15.

Local Ambition 6 (Delivering Value): To reduce unjustified variation in funding levels received by providers and secure the highest quality of care and the best outcomes for every pound invested.

Key outcomes:

- better use of estate from which primary care services are delivered (quality of premises and value for money)
- Delivery of financial plan and associated QIPP schemes
- Redirection of resources to primary care services aligned to strategic direction for scale, scope and integrated care.

Improvement Interventions

Encouraging the adoption of new models of primary and integrated care
A key priority for NHS England is to implement the new arrangements for GP practices to deliver tailored and co-ordinated care for older people and those with complex needs, in partnership with CCGs.

We will support wider primary care delivered in conjunction with social care, community services and formerly acute services where CCG plans support this. This may mean embedding NHS England GP practice contracts in wider arrangements, and jointly commissioning providers of a wider range of integrated care, as a practical way to support tangible delivery aligned to the purpose of the Better Care Fund.

We will support, enabled by a regional and national programme of Primary Care Development, 6 potential care delivery models relevant to local needs and aspirations:

1. Integration around related services for a specific medical condition or group of conditions, in line with the intentions of Leicestershire CCGs.

2. Integration across a wide range of conditions around a specific geography, as reflected in Lincolnshire sustainable services review priority for neighbourhood teams

3. Colocation & merger of practices where it allows improvements in premises in a more cost effective way than standalone development, whilst preserving a level of choice.

4. Creative use of primary care with other public sector and community services in more rural locations

5. Support for practices to bring core services and functions together and manage them jointly on a shared basis such as through federation agreements, whilst preserving individual contractual arrangements for patients.

6. Exploration of the use and expansion of specialist GP services for targeted populations, where evidence suggests clustering patients with specific conditions or needs with others achieves better outcomes than dispersed in small numbers within general contracts.

Except where there are no other alternatives, it is expected these arrangements will take priority in any resource allocation decisions over standalone developments. Further dialogue with commissioning partners and local representative committees will take place to more fully articulate the range of models we will provide support to, as part of the implementation plans for the primary care strategy currently under development

GMS Contract changes 14/15
All area teams in NHS England are implementing the nationally agreed phase out of Minimum practice income guarantee (MPIG) funding for GP practices from 01 April 2014 with a pace of change of 7 years. Funding will be recycled into global sum payments so that funding is more fairly matched to number of patients and key determinants of practice workload.

Local impact for practices – we have 6 ‘outlier’ practices (nationally there are 98) which will lose the largest amount of funding per patient. We will need to discuss possible options with those practices: this could include federation or networking, merging with another practice, other cost-efficiency improvements within the practice, or other commissioning/contracting solutions.

PMS reviews
Impact for practices (assessed on the same basis as GMS) – we have 8 ‘outlier’ practices . We will review all practices, starting with the 8 ‘outlier’ practices, and the resources released will support QIPP delivery. Where possible these resources will be targeted towards our strategic aims for primary care, such as wider primary care provided at scale, supporting new models of care (federation, networks, and neighbourhood teams) and better more convenient access. This will involve joint working with our CCGs, particularly in supporting local urgent and emergency care networks and reducing avoidable emergency admissions. Implement equitable funding mechanisms with an agreed pace of change; with a part year effect in Year 1 to accommodate a reasonable notice period of change.

Local 'premium' for Leicestershire practices (from PCT fairer funding exercise).
We will Implement equitable funding mechanisms with an agreed pace of change in consultation with Local Medical Committees (LMCs), practices and CCGs recognising a managed process is needed. Again released resources will be targeted to strategic aims.

Premises utilisation/Rent abatement policy
We will implement the rent abatement policy for GP practices (which means where practices host wider services they attract a share of the premises rent). This will ensure that the true costs of wider primary and community services are reflected. We will implement this in a staged way for existing services, ensuring finances are aligned between commissioners, and there are no unintended consequences. All new services delivered in practice will be costed taking account of rent costs due.

Time limited contracts
We will review the time limited contracts and where appropriate re-procure services, which is already underway. Design and commission services in partnership with local communities, so that we secure value for money, improve health outcomes and offer new models of care.

Sustainability
Delivery of financial plan and associated QIPP schemes to address the local financial gap for primary care and secondary care dental services. Detailed QIPP plans will be made available as they are further developed.

We need to address workforce capacity and resilience in order to sustain the large-scale shift to community-based patient care and new models of integrated working. In partnership with CCGs and Local Education and Training Boards we aim to have a workforce that can deliver personalised and cost effective care; two key elements are

- An expanded, skilled, resilient and flexible workforce working within integrated teams.
- Academic and quality-improvement activity plus a positive learning climate embedded in primary care.

Governance Overview
Within NHS England, the AT Change Programme Board and Primary Care Strategy Group will oversee the delivery of the improvement interventions reporting to the Area Team executive, and with national line of sight through Primary Care Oversight Group as required.

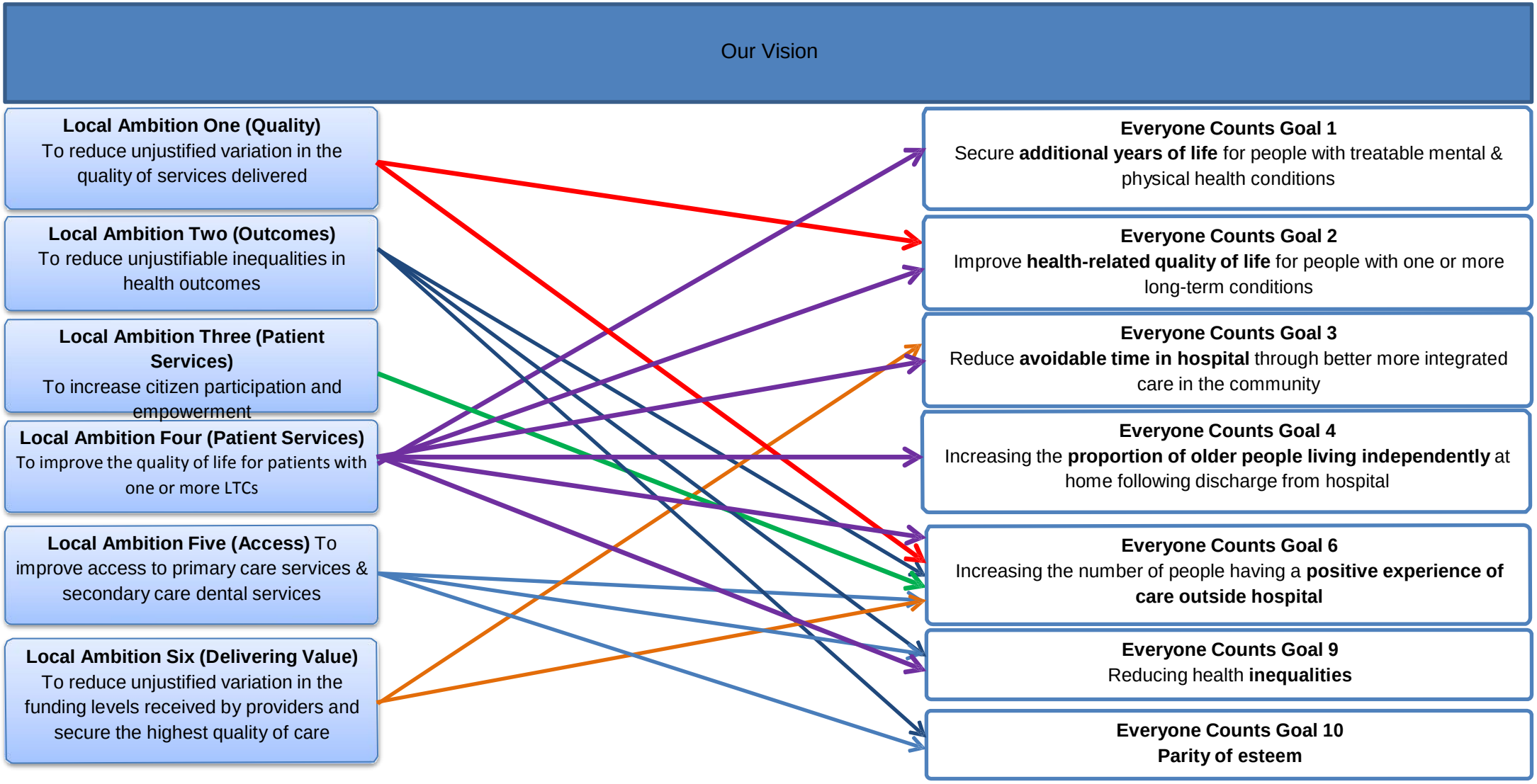
- On-going dialogue with CCGs on progress, recognising our shared agenda
- Membership of the Lincolnshire Sustainable Services Review Steering Board and LLR Better Care Together Programme Board and relevant delivery groups to ensure alignment
- Quarterly updates to the 4 health and wellbeing boards

Key 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
- Maximise value by securing the highest quality of care and the best outcomes for every pound invested

The diagram (overleaf) maps primary care operational plans to ‘everyone counts’ guidance:

Primary Care Services – Everyone Counts

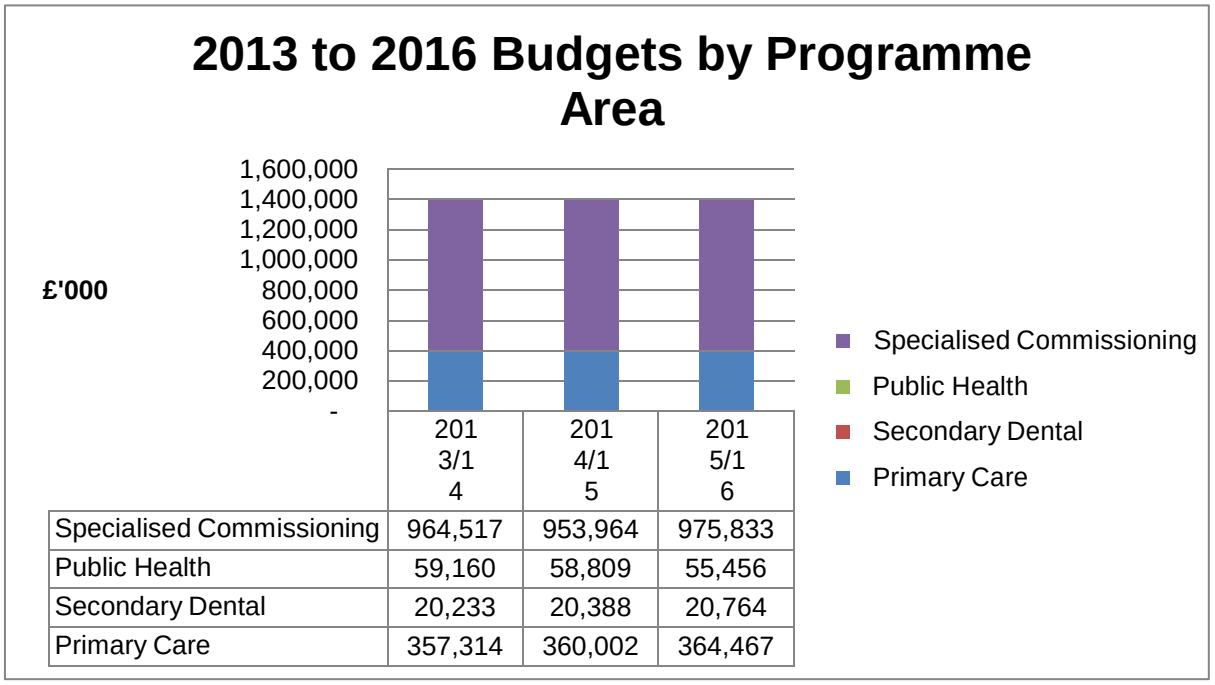


SECTION FOUR: FINANCE, PERFORMANCE, AND DELIVERY

Draft Financial Plans – Financial Commentary

Introduction

Leicestershire & Lincolnshire Area Team has a budget of £1.4bn, as shown in the graph below. This financial commentary is intended to highlight the changes assumed with the budgets below from 2013/14 to 2015/16, and the outcomes as a result of those changes.



	2013/14	2014/15	2015/16
Specialised Commissioning	964,517	953,964	975,833
Public Health	59,160	58,809	55,456
Secondary Dental	20,233	20,388	20,764
Primary Care	357,314	360,002	364,467

Plans have been developed in detail for 2014/15 and 2015/16. Financial plans have been populated for 2016/17 to 2018/19 however these reflect continuation of basic assumptions for allocations and costs in line with 2014 to 2016. Strategic plans are to be developed for the plan submission required in March.

The plans have been developed in line with commissioning plans, and reflect the current development of operational planning, and currently available information.

Requirements

Table 1 shows a list of the key business rules for Direct Commissioning. In summary these are in line with 2013/14 apart from the requirement of specialised commissioning to deliver a 1% surplus, and ensure a headroom reserve is placed aside, where in 13/14 this was used in lieu of growth.

The other major change is the increase of the headroom from 2% to 2.5% in 2014/15. This then returns to 2% in 2015/16 onwards. A minimum of 1% of the headroom should be used for transformation.

All areas are expected to maintain a 0.5% contingency for in year pressures.

Although the requirement is for a 1% surplus, the requirement for 2014/15 is that the current agreed forecast surplus in 2013/14 is the required surplus for 2014/15. Reductions to surplus can be made in 2015/16 to meet the

'financial cliff edge'.

The 1% surplus from 2013/14 has been confirmed will be carried forward from 2013/14 in Primary Care, and secondary Dental. The forms currently allow all surplus/deficits to impact on 2014/15, which has an impact for Specialised Commissioning as it is currently forecasting to be £4.6m overspent. In line with national discussions on specialist commissioning it has been assumed that this pressure will be met centrally.

Table 1. Business rules for 2014/15 and 2015/16

	2014/15			2015/16		
Commissioned Area	Surplus	Contingency	Headroom	Surplus	Contingency	Headroom
Specialised Commissioning	1.0%	0.5%	2.5%	1.0%	0.5%	2.0%
Primary care	1.0%	0.5%	2.5%	1.0%	0.5%	2.0%
Public Health	0.0%	0.5%	0.0%	0.0%	0.5%	0.0%
Secondary Dental	1.0%	0.5%	2.5%	1.0%	0.5%	2.0%

Allocations

Allocation changes are summarised in table 2. Specialised commissioning received an uplift of 4.3%. This was designed to allow specialised commissioners to meet in year pressures from 2013/14 and reflecting the evidence about relative pace of growth in healthcare need for complex services such as new high cost drugs being made available.

Primary care increases for the Leicestershire and Lincolnshire Area are 2.2% in 2014/15. This is weighted taking into account forecast population changes, and unmet need. This increase is also applied to Secondary Dental, which nationally is considered as part of the primary care allocation.

The public health growth in allocation is being retained nationally. The intention is to allocate the growth based upon the outcome of the plans. As a result it's expected with the investment requirements in public health that the financial plans will be overspent pending agreed transfers.

For technical reasons financial plans templates in 2014/15 and onwards allow for no anticipated allocations. This means where recurrent allocations haven't been included with the national allocation notified for the plans the position this causes a pressure in the position. These have been notified to the central team and amount to £1.831m within Primary care. £1.41m of this relates to agreed infrastructure allocation corrections with

Leicestershire CCGs.

Table 2. 2014/15 to 2015/16 Recurrent Allocations

	Specialised Commissioning		Public Health		Secondary Dental		Primary Care	
	2014/15 £000	**2015/16 £000**	**2014/15 £000**	**2015/16 £000**	**2014/15 £000**	**2015/16 £000**	**2014/15 £000**	**2015/16 £000**
Total Recurrent Notified Allocation	953,964	1,011,679	58,809	58,693	20,190	20,560	356,130	362,680

Key Assumptions

Below is a list of the key assumptions made within the financial plans.

Specialised

4% Tariff efficiency will be applied in full to health care providers, apart from primary care providers.

2.8% Tariff Increase – Different from national at 2.7%, which reflects local view that the impact will not reflect in the same proportions as anticipated nationally.

Demographic growth at 0.82% - determined by projections on local ONS data.

Non-demographic growth of 4.6% - This relates to drugs and device increases and other service growth.

Coding and Counting issues expected to cost around £6m (where providers can increase charges for care delivered according to national rules where improved coding results in extra activity being billed).

Convergence costs over 13/14 of £12.4m reflecting additional eligibility for treatment under new national clinical policies

A separate ring fenced fund for demand management and prevention for specialised services as a result of the national tariff for emergency care, with £4m planned in line with
2013/14.

Cancer Drugs Fund allocations and costs are removed for 14/15 onwards as funding held centrally by NHS England.

Public Health

Contracts change in line with national assumptions i.e. 4% tariff efficiency 2.7% price increase

Demographic Growth at 0.82%

Secondary Dental

Contracts change in line with national assumptions i.e. 4% tariff efficiency 2.7% price increase

Demographic Growth at 0.82%

Primary care

Inflation applied in line with previous year's impact at 1.25% on GPs.

Demographic Growth at 0.82% or GP demographics are in line with national assumptions, 1.3% and 1.2% for 14/15 and 15/16 respectively.

GP IT allocation and costs are excluded from the position.

Where not population based, no increase has been assumed, in line with previous experience on Primary care.

Investments

Increases to costs over the assumptions already highlighted are listed within recurrent investments sheets (those which are required from the baseline), and non-recurrent investments (those that utilise the 'headroom'). A summary of those investments are contained within table 3.

Table 3. 2014/15 Recurrent and Non-Recurrent Investments

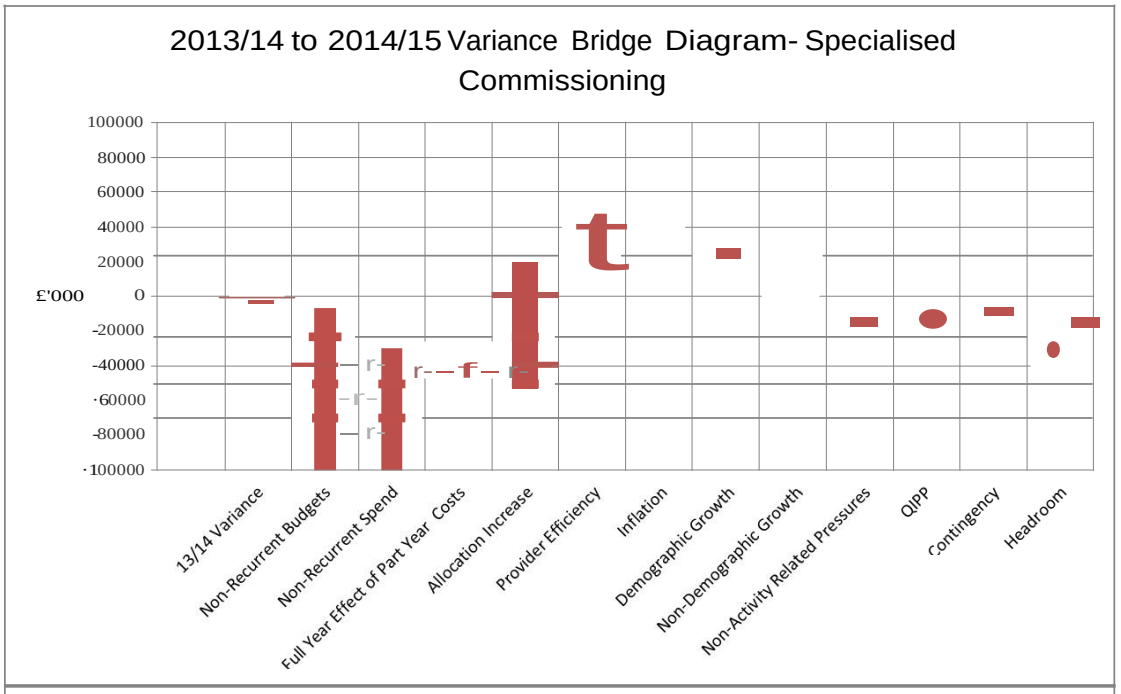
Programme Area	Recurrent £'000	Non-Recurrent £'000
Specialised Commissioning	0	23849
Public Health	5992	0
Secondary Dental	0	506
Primary Care	11887	4591
Total	**17879**	**28946**

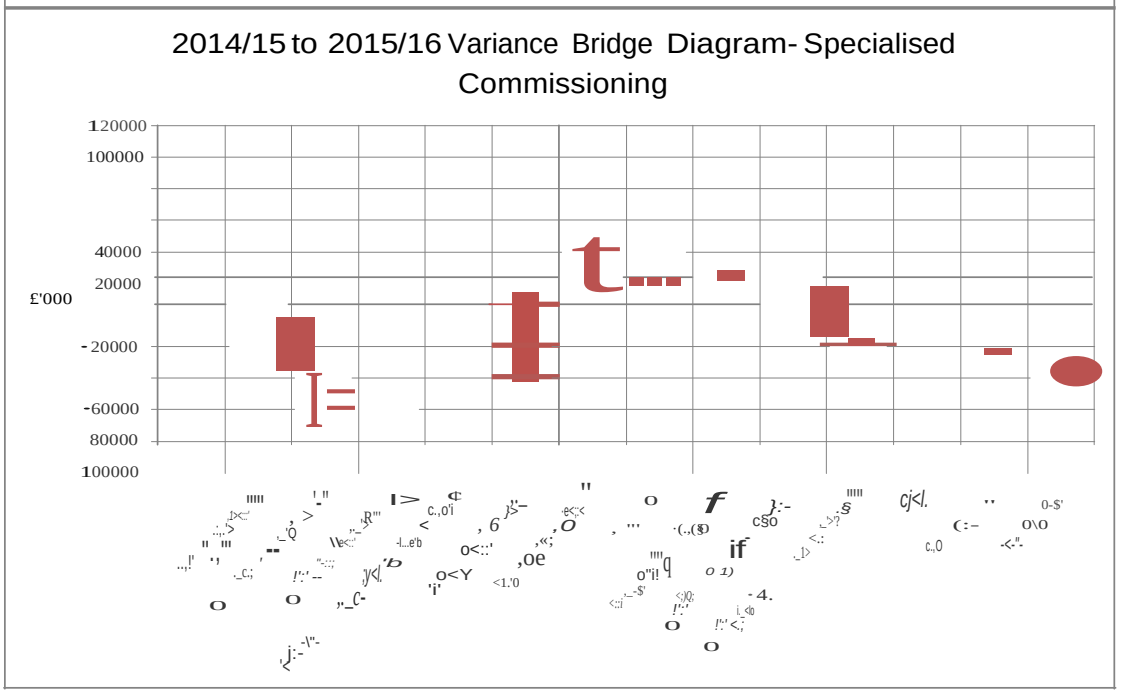
GP IT is excluded from resource and expenditure from 2014/15 onwards as it is being transferred to CCGs.

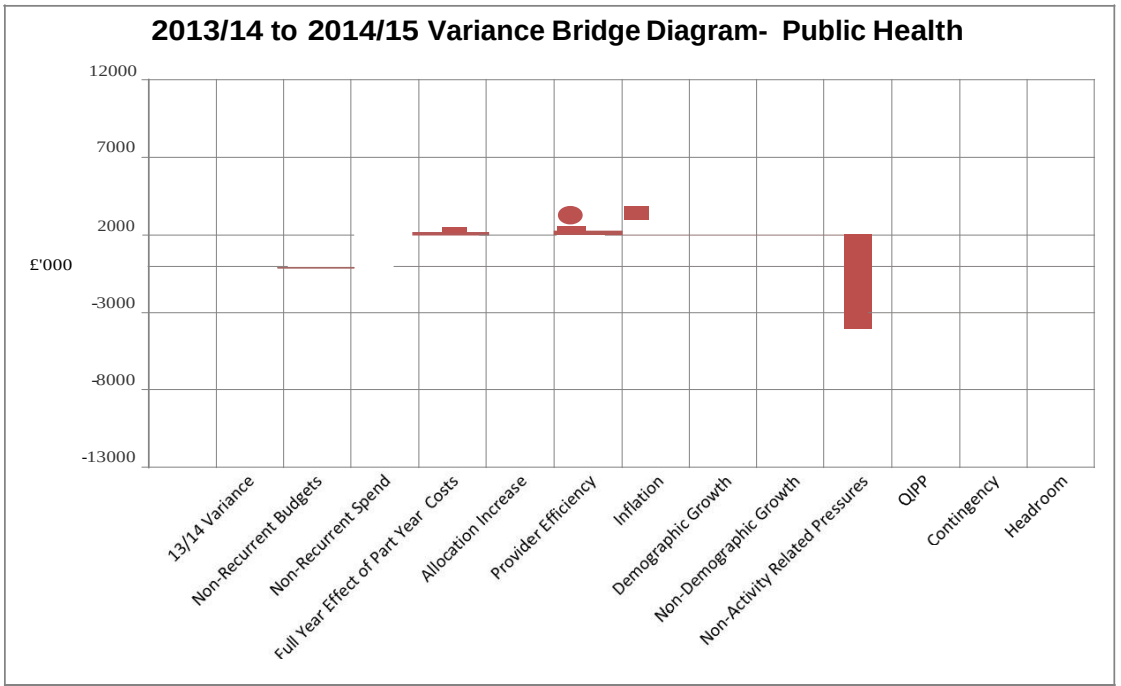
Detailed financial plans are assured through the NHS England regional office, a summary of which will be made available following finalisation.

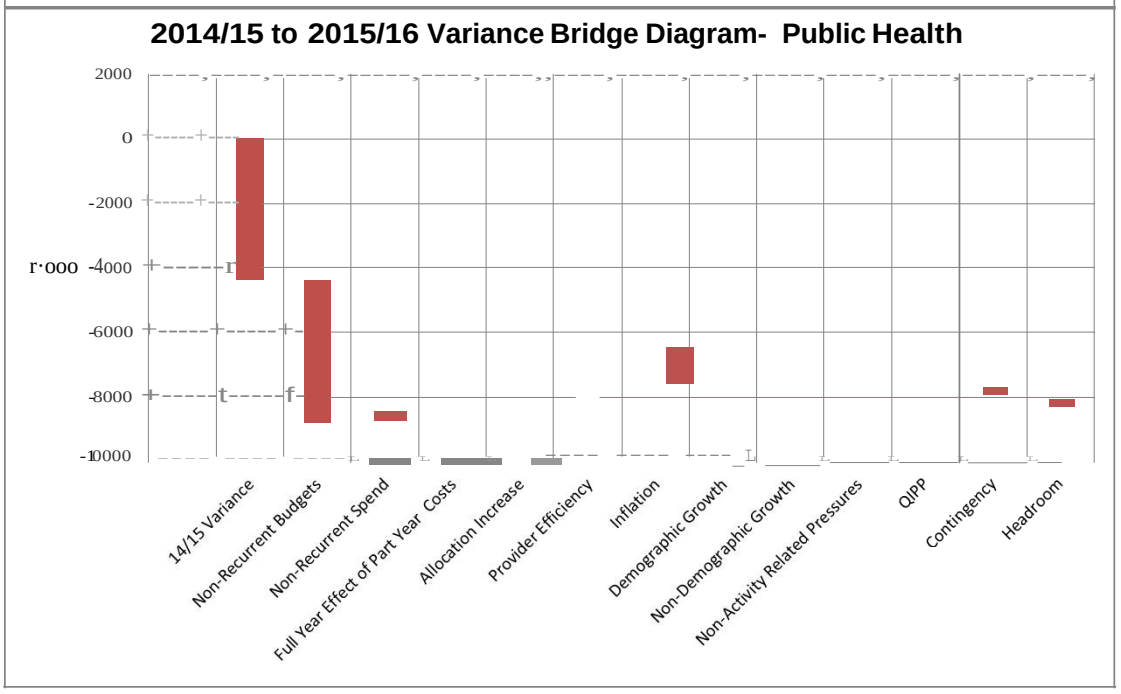
Bridge Diagrams

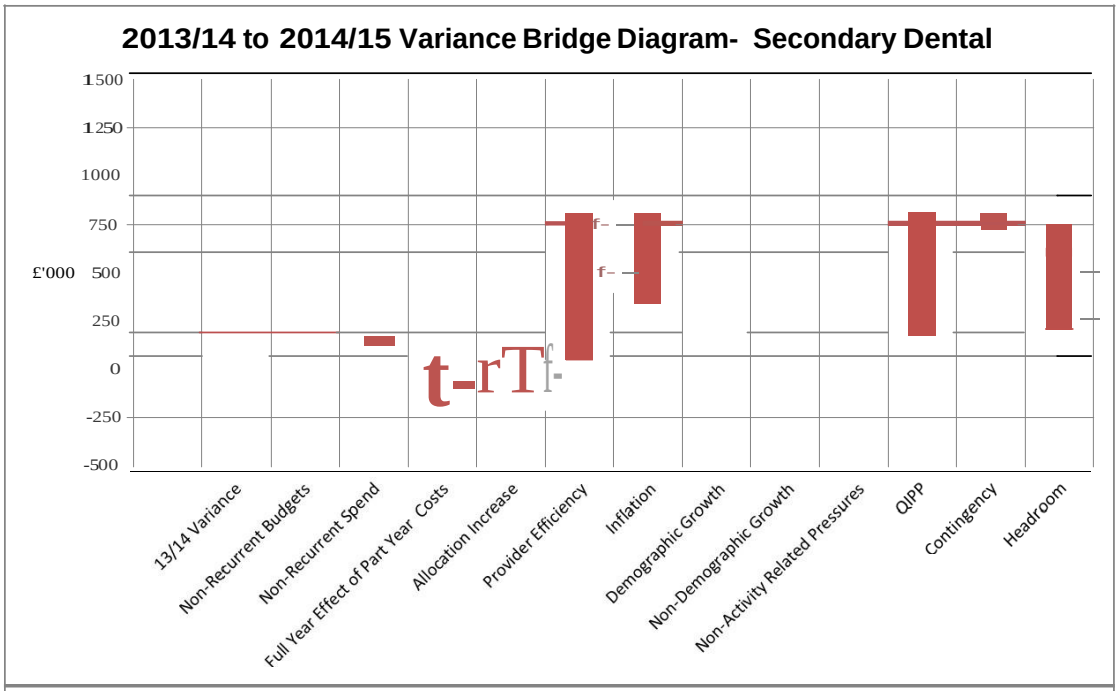
Below are bridge diagrams highlighting key movements within the financial plans from 2013/14 forecast outturn to 2015/16.

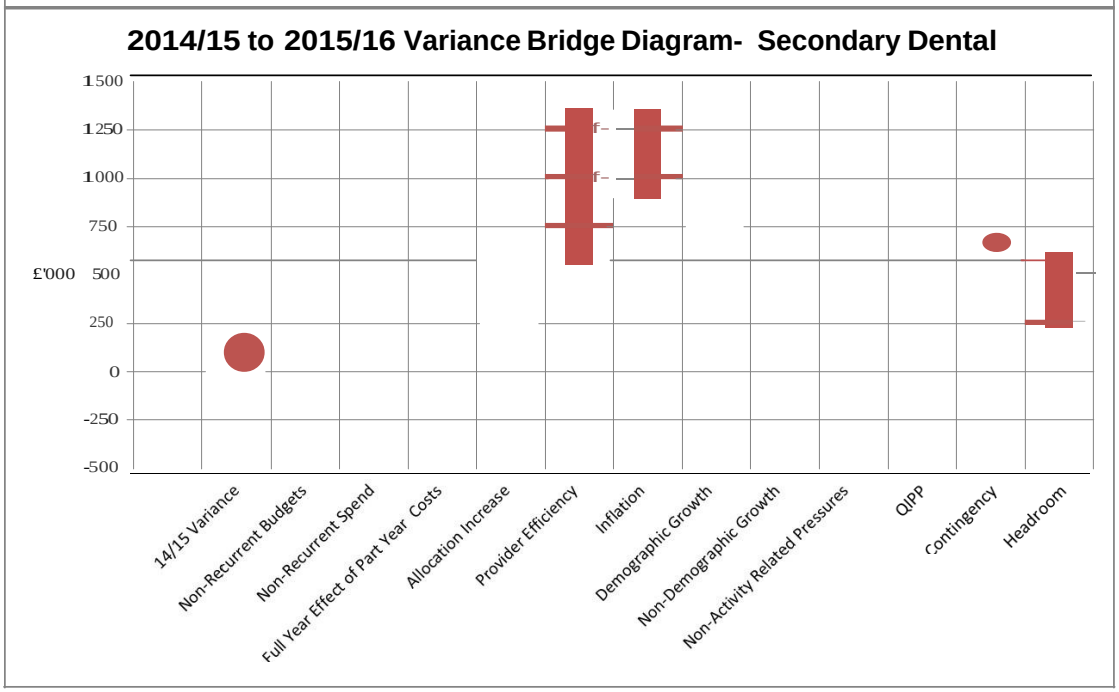


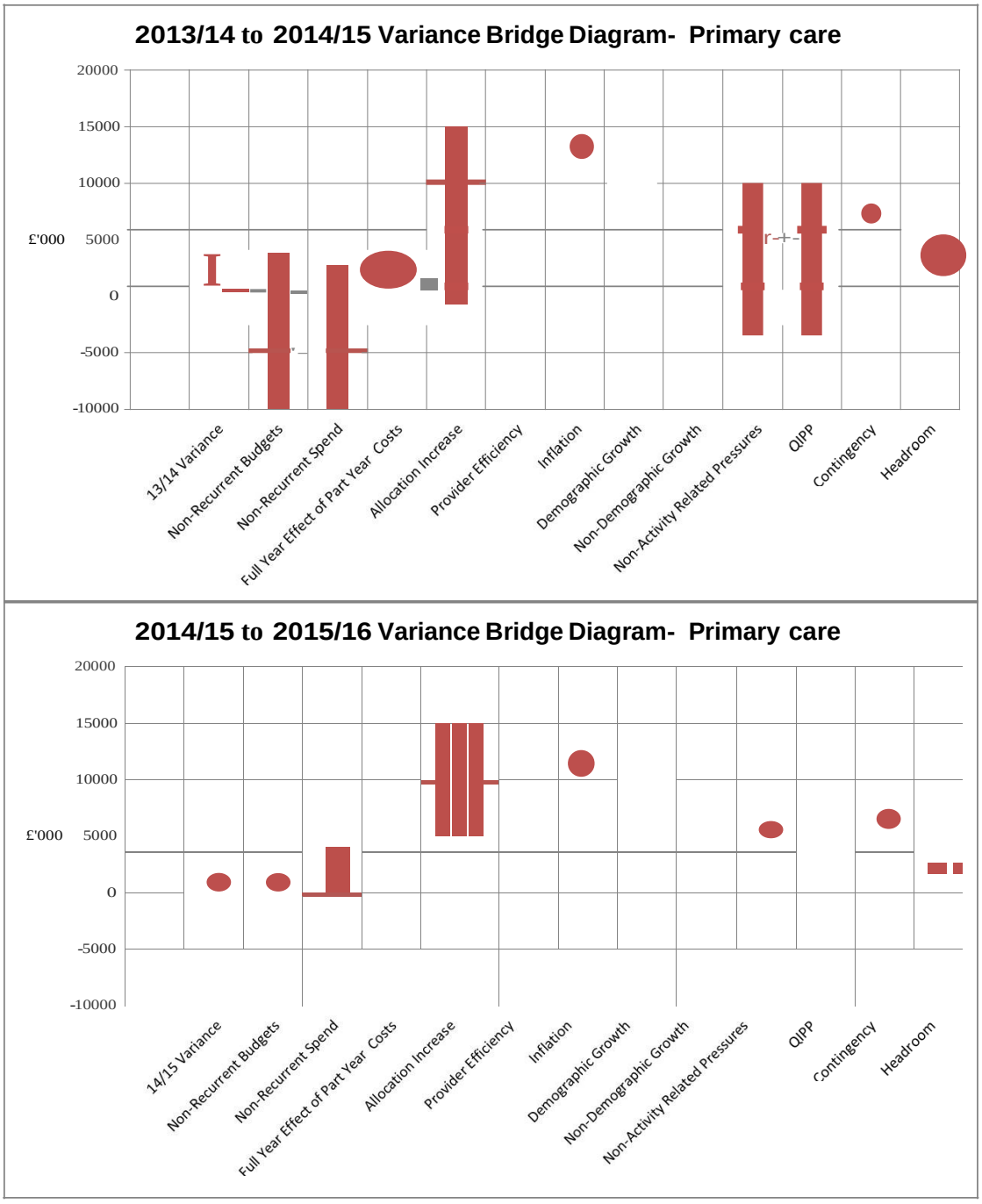



2013/14 to 2014/15 Variance Bridge Diagram- Public Health
12000
7000
2000
£'000
-3000
-8000
-13000
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2014/15 to 2015/16 Variance Bridge Diagram- Public Health
2000
0
-2000
-4000
-6000
-8000
-10000
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2013/14 to 2014/15 Variance Bridge Diagram- Secondary Dental
1500
1250
1000
750
£'000 500
250
0
-250
-500
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom

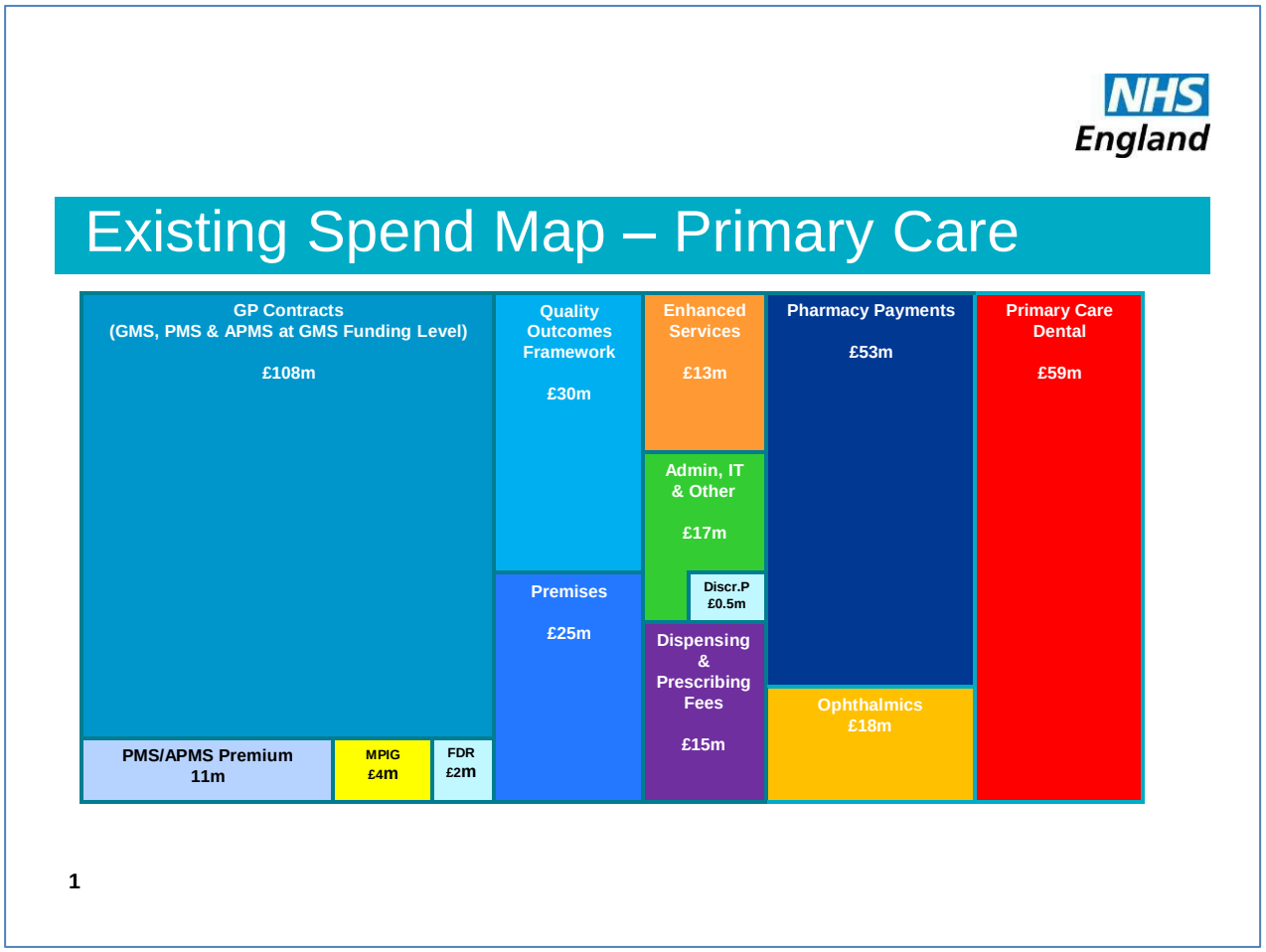

2014/15 to 2015/16 Variance Bridge Diagram- Secondary Dental
1500
1250
1000
750
£'000 500
250
0
-250
-500
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2013/14 to 2014/15 Variance Bridge Diagram- Primary care
20000
15000
10000
£'000 5000
0
-5000
-10000
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom
2014/15 to 2015/16 Variance Bridge Diagram- Primary care
20000
15000
10000
£'000 5000
0
-5000
-10000
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom

Financial Mapping for Direct Commissioning to inform QIPP Goals

The Charts below show the relative sizes of areas of spend within each direct commissioning budget, grouping together areas of spend in relation to the potential levers for change. In some cases there is scope for local action, and other areas are set by national policy.

Primary Care Financial Mapping



For each area of spend it is potentially possible, at national for some services or at local level for others to address the quantity of service commissioned, or the price/ level of payment for that service. Each spend area has specific contstraints:

GP contracts are funded to the level within GMS on a per registered patient basis at £108m. It is possible to reduce the number of registered patients through cleansing the GP registered list to ensure those who have left the area have been removed, but once this is being done annually and is reflected in the baseline spend levels, the spend in this area is not subject to local determination as the GMS spend per patient is nationally negotiated, and local population demographics will drive the level of patients registered.

PMS/APMS contract premiums are an example of funding per patient above GMS funded levels either to provide enhanced service levels to target groups with specific health needs (e.g. homeless people) or for more stretching quality KPIs. This is an area in which local action e.g. through a contract review may impact the number of practices receiving such payments, the conditions for payment, or the level of payment.

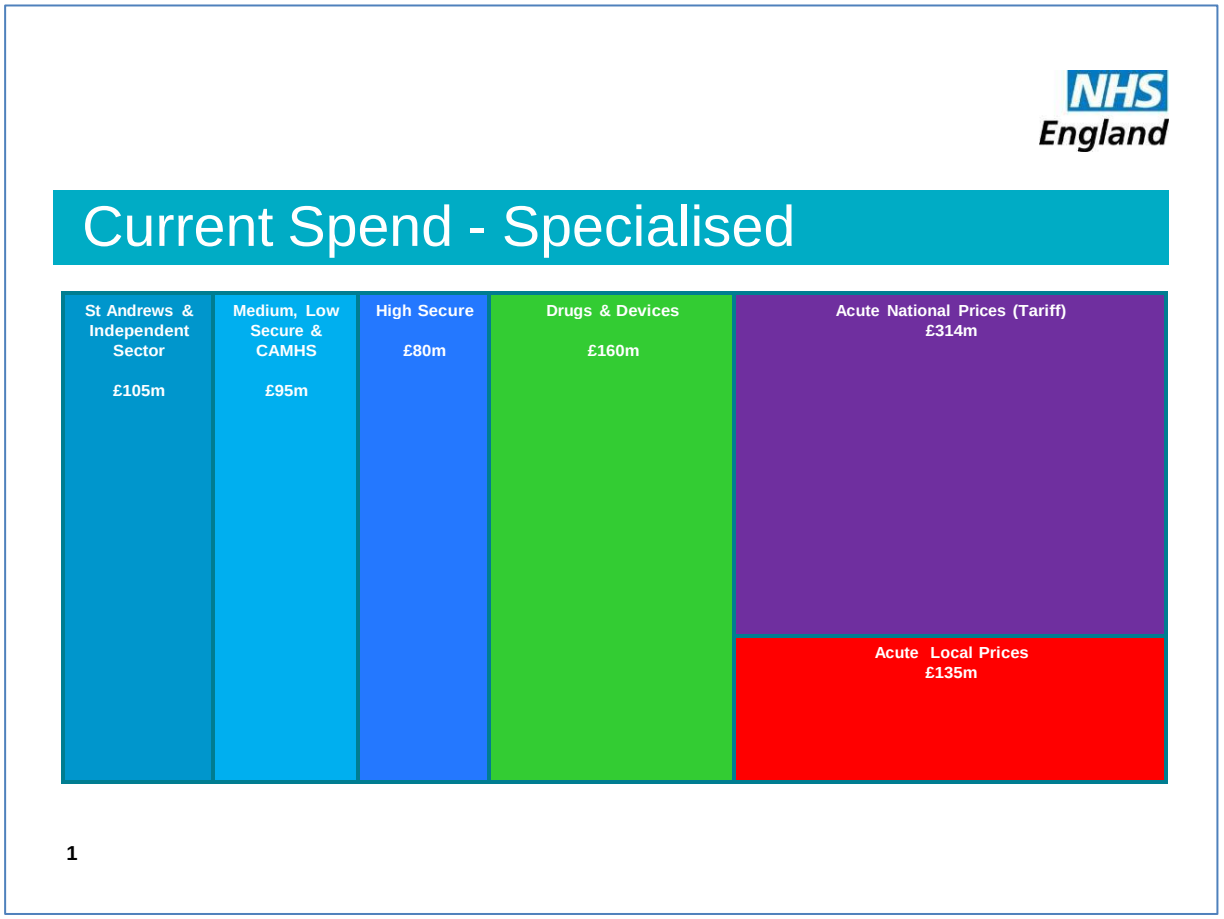
National and Directed Enhanced Services are areas where, once on-going payment verification is in place, uptake of services is determined by the choices of practices, with payment at nationally negotiated levels.

The benefit of financial mapping is to ensure informed dialogue in the setting of financial improvement plans. For primary care services this is particularly challenging, as the areas with local levers and discretion.

Setting a top down 3% Improvement target across the full £357m primary care budget requires year on year recurrent savings of £10.7m.

Our QIPP plans will be reviewed to address the gap against nationally set requirements based on setting bottom up % change for each area of spend and holding dialogue with regional and national teams to be assured goals are stretching but realistic and achievable without destabilising provider viability, or undermining strategic aims for the future role of primary care.

Specialised Commissioning Financial Mapping



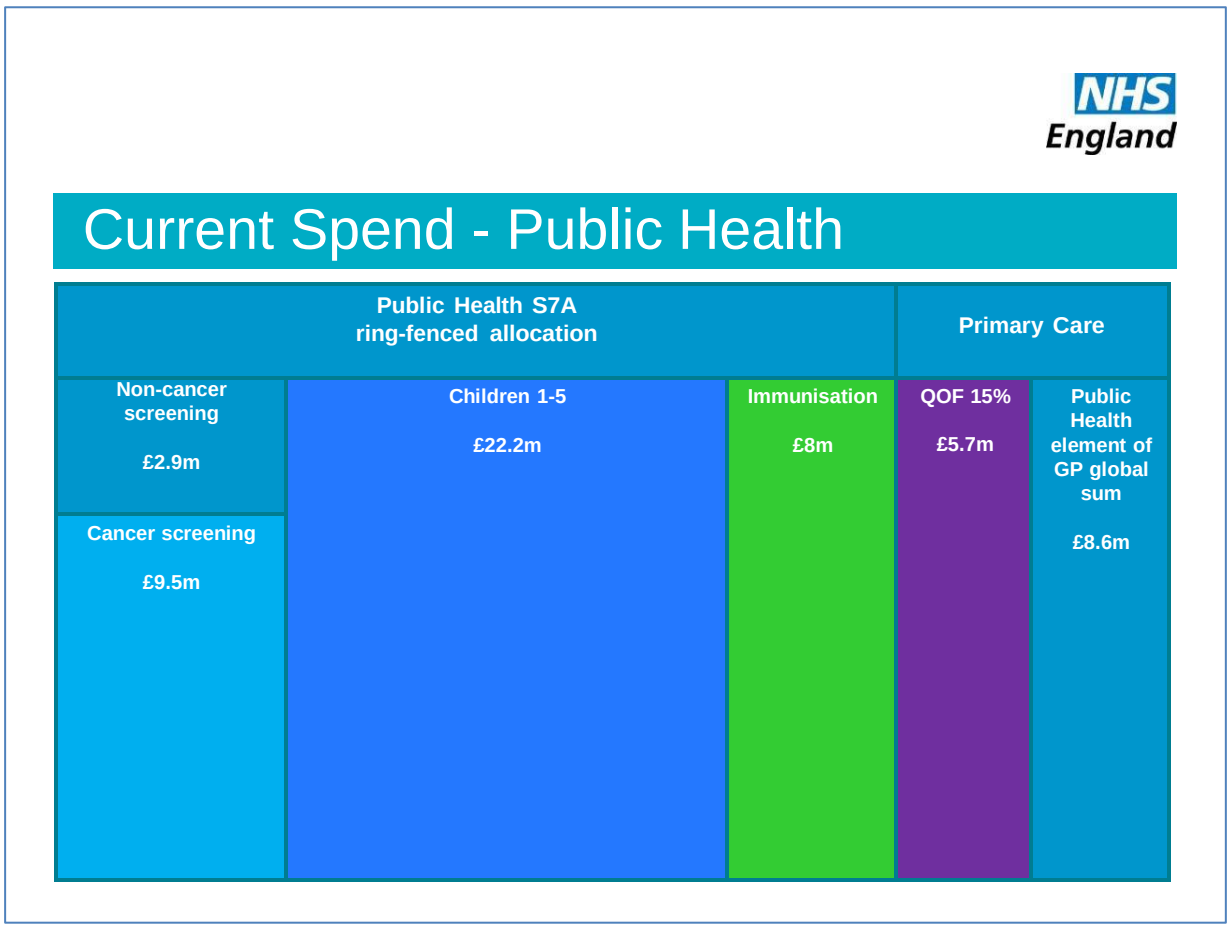
For specialised services the mental health spend profile is heavily influenced by High secure and national independent sector mental health responsibilities where placement levels are not in the control of the area team. The QIPP initiatives planned for medium, low secure, and CAMHS amount to around 2% of baseline spend in those areas.

For the 4 acute programmes of care, there are three distinct areas with different levers. A stretching cost improvement for high cost drugs and devices, on top of cost growth avoidance initiatives, of almost 7% of baseline spend, has robust local plans in place.

For the acute services paid at national tariff it is not possible to negotiate prices so areas of focus relate to reducing treatment volumes through clinical threshold auditing. Previous national benchmarks suggest levels of use by the east midlands population are low so the impact of clinical policies in aligning historic practice to current evidence will be less significant. Areas of bed day based spend through clinical utilisation review is an additional area where improvements are expected over a 1-3 year period of sustained change.

For acute services at local prices some price negotiation is possible. Many east midlands services are already at or below best quartile cost based prices, which reduces the scope to negotiate further reductions without impact on quality but there are exceptions to this, which inform contracting goals.

Public Health Financial Mapping

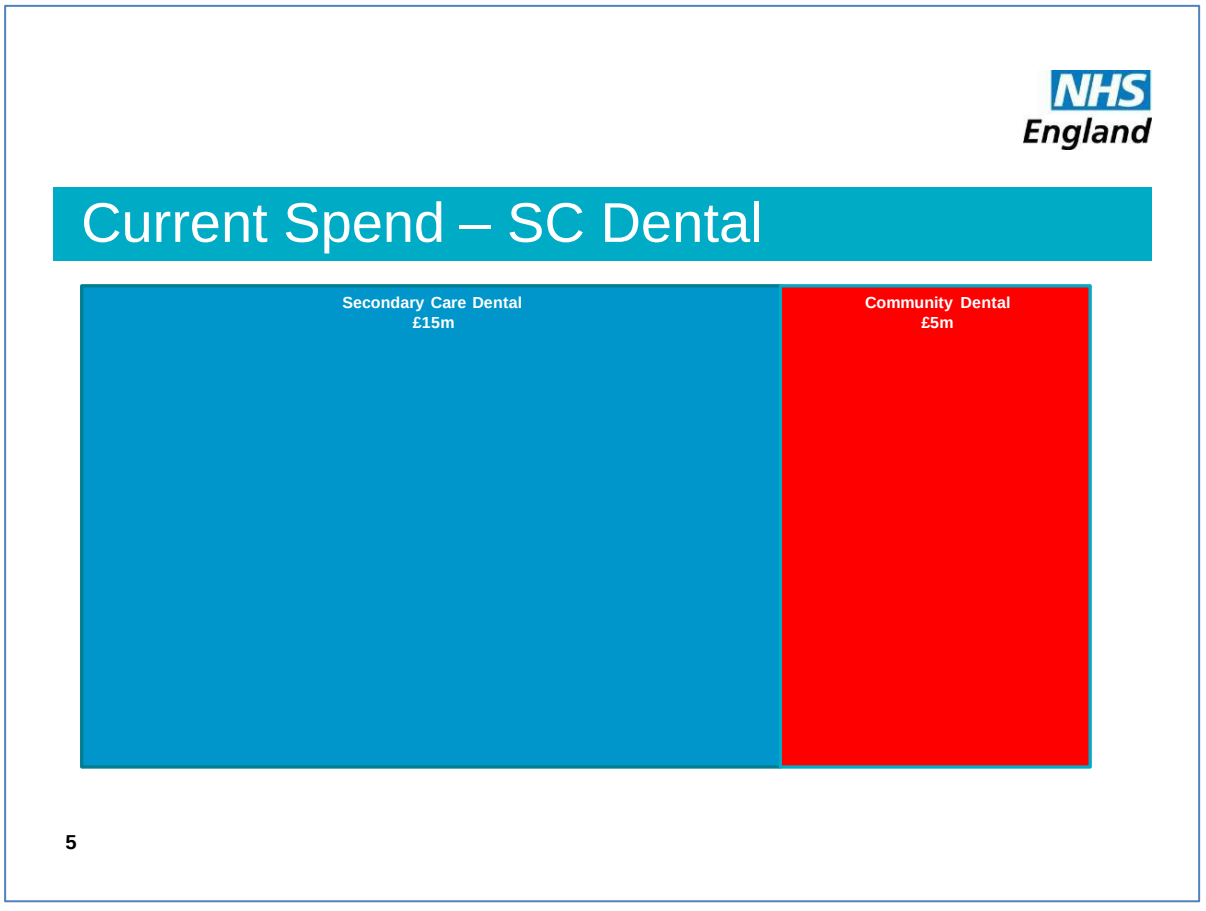


The three distinct areas (screening, child health, and immunisation) are subject to different dynamics. For QOF and global sum prices are nationally set, and constraining the level of achievement would be counter to the health outcome aims of commissioners. Immunisations are similarly paid at a 'going' rate to GP practices with links to patient registered list to maintain records a significant benefit of retaining a GP model where possible.

The major area of spend is on child health. This is subject to mandated targets for resource inputs (national targeted number of health visitors and family nurse partners employed) and agenda for change national pay scales. Efficiency can, in this area of spend, only come from reductions in the corporate overhead on services or in limited cases by changes to skill mix, although the nature of national targets allow limited flexibility.

The QIPP programme for public health is necessarily most focussed on screening services. Again whilst it is neither possible nor desirable to reduce quantity of screening activity (greater reach to populations is a positive health gain) there is opportunity to work with providers whose unit costs are not yet at the levels of the most efficient services, and to ensure service economies of scale are realised to support the commissioning of the national developments planned.

Secondary Dental Financial Mapping



Acute dental spend uses nationally set prices, with opportunities for productivity (reduced follow ups) and reductions in referrals through better primary care management, but beyond

this treatment volumes need to keep pace with referrals in order to meet NHS constitution rights of patients to be treated within 18 weeks of referral. The more significant area is community dental services where locally negotiated prices and service models are informing the work of the commissioning team to improve value.

Performance and Delivery - Specialised Services

All specialised services treatment must meet the standards in the NHS constitution, but the key performance measures are at trust wide levels, rather than split between specialised and non-specialised services, so no performance trajectories have been requested for operational plans.

Key areas of delivery, alongside the service development agenda are the management and effective governance of contracts, and the managed uptake of drugs and devices in line with best evidence and value.

Individual Funding Request and Cancer Drugs Fund (IFR/CDF)

The Area Team is also responsible for the establishment of a region-wide Individual Funding Request and Cancer Drugs Fund process hosted in the Leicestershire & Lincolnshire Area Team. Effective systems and processes have been established to administer the CDF and the IFR process and the team is working well. Cancer Drugs Fund budget is £50,248

PbR Excluded Drugs

During 14/15 we plan to achieve the following:

- Work with Provider Trusts and CCGs to repatriate post-transplant prescribing of renal immunosuppressant medication
- Work with Providers and CCGs to repatriate prescribing of inhaled antibacterials prescribed for Cystic Fibrosis
- Ensure there is a consistent understanding and application across East Midlands Provider Trusts of chemotherapy associated costs (procurement costs and supplementary medicines)
- Agree schemes with Providers so that the benefits associated with more efficient use of medicines not reimbursed through national prices are shared. We aim to agree 5 new schemes in 14/15 and 5 new schemes in 15/16

Effective procurement of high cost drugs
The Area Team is an active member of the national procurement framework for excluded drugs and devices and will continue to be an active contributor to the work plans of the Regional Pharmacy collaborative. Both of these mechanisms will ensure consistent pricing of high cost drugs and best value to the NHS.

NICE appraisal
Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and NICE Technology Appraisals (TA). NICE approved drugs recommended within a NICE Technology Appraisal that are excluded from tariff will be automatically funded from day 90 of its publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England.

Sharing the benefits associated with more efficient use of medicines not reimbursed through national prices

Because acquisition costs of medicines not reimbursed through national prices are reimbursed by commissioners, there may be little incentive for a provider to maximise the cost-effectiveness of these treatments, particularly where providers have to make decisions on prioritisation of their resources or if improvements in cost-effectiveness require the commitment of additional resources. The AT will incentivise provider trusts to ensure maximum value for money from medicines excluded from the national tariff. This will be done through clear, up-front agreements on the share of financial savings with both commissioners and providers and according to the principles described in national NHS England guidance.

Budget setting and reporting
Budgets for excluded drugs will be set on an annual basis. This will be based on the provider's assessment of need through horizon scanning, and agreed through a 'confirm and challenge' meeting with the provider. Analysis of monthly reports of Trust activity against budget will be undertaken, and questions on performance will be raised when necessary.

Post- transplant immunosuppressants and inhaled antibiotics for cystic fibrosis
All post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will be commissioned directly from Trusts by April 2016. The AT will work with Trusts and CCGs to ensure that prescribing of these drugs are safely repatriated from primary care to secondary care.

Homecare
The AT will work with Trusts to ensure that the recommendations identified in the Hackett Report are implemented effectively. The AT will work with Providers to ensure that Homecare services are safe and effective and make best use of NHS resources.

Chemotherapy
NHS England commissioning intentions states that only those drugs which are defined as a priority within a recognised chemotherapy regimen will be funded as part of the pass through arrangements. It does not include drugs which are provided for symptoms that arise post chemotherapy (e.g. antiemetics, unless given to all patients as part of the standard regimen) and it does not include longer-term use of non-chemotherapeutic agents such as bisphosphonates. In addition, hormone therapies, unless specifically identified as excluded by the national Payment by Results team or by agreement with NHS England, are considered in tariff.

The AT will work with Trusts to ensure that supportive medicines for chemotherapy are dealt with in a consistent manner across the East Midlands and will work towards a consistent national mechanism of payment.

Procurement costs related to chemotherapy will be agreed in line with national principles and the AT will work with colleagues nationally to develop a consistent mechanism of payment.

Performance and Delivery – Public Health Services

Public health measures performance trajectories based on the outlined plans are stated overleaf. These are subject to further refinement.

			UJNIFY Target	Current Achievement				
				Q1	Q2			
				Unless alt. period specified		14-15	15-16	2018/19
E.F.1	Population Vaccination Coverage – Dtap / IPV / Hib (1 year old)		>=94.7%	97.1	96.9	97.5	97.5	97.5
E.F.2	Population Vaccination Coverage – MenC (1 year old)		93.9%	96.7%	95.6	97.5	97.5	97.5
E.F.3	Population Vaccination Coverage – PCV (1 year old)		94.2%	97.0%	96.9	97.5	97.5	97.5
E.F.4	Population Vaccination Coverage – Dtap / IPV / Hib (2 years old)		96.1%	98.1%	98	98	98	98
E.F.5	Population Vaccination Coverage – PCV Booster (2 years old)		91.5%	95.6%	95.8	96	96	96
E.F.6	Population Vaccination Coverage – Hib / MenC Booster (2 years old)		92.3%	95.8%	95.9	96	96	96
E.F.7	Population Vaccination Coverage – MMR for One Dose (2 years old)		91.2%	95.2%	95.4	96	96	96
E.F.8	Population Vaccination Coverage – MMR for One Dose (5 years old)		92.9%	96.2%	96.3	97	97	97
E.F.9	Population Vaccination Coverage – MMR for Two Doses (5 years old)		86.0%	92.0%	91.3	93	94	95
E.F.10	Population vaccination coverage - Hib / MenC booster (5 years old)		88.6%	94.6%	94	95	95	96
E.F.11	Population Vaccination Coverage - Hepatitis B (1 year old)		tbc					
E.F.12	Population Vaccination Coverage - Hepatitis B (2 years old)		tbc					
E.F.13	Population Vaccination Coverage - HPV		86.8%			90	90	90
E.F.14	Population Vaccination Coverage - PPV		68.3%	69%		69	70	71
E.F.15	Population Vaccination Coverage - Flu (aged 65+)		73.4%	72.0%		74	75	75
E.F.16	Population Vaccination Coverage - Flu (at risk individuals)		51.3%	47.4%		51	55	60
E.F.17	Percentage of Pregnant Women eligible for Infectious Disease Screening who are tested for HIV, leading to a Conclusive Result		98.1%	99.0%	99.23%	99	99	99
E.F.18	Percentage of Women Booked for Antenatal Care, as reported by Maternity Services, who have a Screening Test for Syphilis, Hepatitis B and Susceptibility to Rubella leading to a Conclusive Result		tbc	not available	not available			
E.F.19	Percentage of Pregnant Women eligible for Antenatal Sickle Cell and Thalassaemia Screening for whom a Conclusive Screening Result is available at the Day of Report		98.0%	99.3%	99.1%	99	99	99
E.F.20	Percentage of Babies Registered within the Local Authority area both at Birth and at the Time of Report who are Eligible for Newborn Blood Spot Screening and have a Conclusive Result Recorded on the Child Health Information System within an Effective Timeframe		92.3%	87.1%	71.2%			
E.F.21	Percentage of Babies Eligible for Newborn Hearing Screening for whom the Screening Process is Complete within 4 Weeks Corrected Age (hospital programmes – well babies, all programmes – NICU babies) or 5 Weeks Corrected Age (community programmes – well babies)		97.5%	99.3%	99.1%	99	99	99
E.F.22	Percentage of Babies Eligible for the Newborn Physical Examination who were Tested within 72 hours of Birth		tbc		98.27%	98	99	99
E.F.23	Percentage of those offered Screening for Diabetic Eye Screening who attend a Digital Screening Event		80.2%		To Dec across AT =62%	82	83	84
E.F.24	Abdominal Aortic Aneurysm (AAA) KPI		-					
E.F.25	Breast Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 3 Years on 31st March		76.9%		82%	82	82	83
E.F.26	Cervical Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 3.5 or 5.5 Years (according to age) on 31st March		75.3%		80% 2012-13	80	80	80
E.F.27	Bowel Cancer Screening - Uptake and Coverage over 2.5 Years		55.8%			57	58	60
E.F.28	Number of FTE Health Visitors		tbc-improvement					

Performance and Delivery – Primary Care Services

Primary Care performance trajectories based on the outlined plans are stated overleaf. These are subject to further refinement and subject to a degree of inherent uncertainty due to the nature of the measures.

ANNEX D: PRIMARY CARE MEASURE	Reference number	Area team to complete	Target / trajectory guidance	2013/14	2014/15	2015/16	Comment (1 line Rationale for how change will be achieved)
Medical							
Patient satisfaction							
Satisfaction with the quality of consultation at the GP practice	ED1	YES	Annual improvement	611	615	619	Year on year reduction in the number of practices with red outliers (25% reduction).Review the practices that have more than 10 red outliers, triangulate with other measures in GPOS and GPHLI and in partnership with CCGs and their local balanced scorecard,as part of the assurance framework process. Agree action plan and timeframes for improvement.
Satisfaction with the overall care received at the surgery	ED2	YES	Annual improvement	166	168	170	Year on year reduction in the number of practices with red outliers (25% reduction).Review the practices that have more than 10 red outliers, triangulate with other measures in GPOS and GPHLI and in partnership with CCGs and their local balanced scorecard,as part of the assurance framework process.Agree action plan and timeframes for improvement.
Satisfaction with accessing primary care	ED3	YES	Annual improvement	252	254	256	Year on year reduction in the number of practices with red outliers (25% reduction).When looking at the availability of routine appointments, we intend to address the lack of availability during core hours and aim to ensure that access to extended hours is offered and available to patients. Improvement in the number of consultation hours available per week. This should improve patient satisfaction with GP opening hours and the convenience of opening times.
Referrals							
Proportion of new cancer cases referred using 2 week wait pathway	ED4	NO	None as area team not to complete				
Vaccinations							
Flu vaccinations – at risk coverage	ED5	YES	At or above 51.3%				
Mental health							
Identifying the prevalence of depression compared to estimated model	ED6	YES	The guidance quoted on GPOS gives an aim to reduce the outliers from level 1 and level 2 outliers - so I'd suggest reducing the number of outliers in the area and plans to tackle the level 2 outlieing practices	Trigger level 2 = 5 practices Trigger level 1 = 10	Reduce trigger level 2 practices from 5 to 3	Reduce trigger level 1 practices from 10 to 5	Target those that are at trigger level 2 in 14/15 (triangulating with other measures) and agree action plans with timescales for improvement. Review those practices that are at trigger level 1 in 15/16 and target those practices that have are 'approaching review ' under GPOS. Again agree action plans with timescale for improvement.
Dental							
Access							
% Patients seen – 24 month measure	ED7	YES	Exceeding the % of patients seen in 2012/13	55%	54%	54%	We have remained at the 55% level throughout 13/14. In 13/14 we clawedback under performance, we did not commission any additional activity (either recurrently or non recurrently), and we renegotiated contracts to reduce the level of recurrent under performance, hence in 14/15 we are likely to see the % level drop. There may be some positive impact from the monitoring of recall intervals but this is difficult to quantify. We are not planning to commission additional UDAs in 14/15 hence the % is likely to remain at 54%.
Activity							
Number of course of treatments per 100,000 population	ED8	YES	None in guidance - assume planning numbers rather than an improvement	2,779,098 UDAs contracted	2,779,098 UDAs contracted	2,779,098 UDAs contracted	This is based on the number of UDAs commissioned (Dec 2013 positio) rather than courses of treatment. This will remain the same for 14/15 & 15/16 because we are not planning to commission additional activity at this time.
Patient experience							
GPPS % Positive experience	ED9	YES	None given but based on Medical patient satisfaction assume an annual improvement	83%	83%	83%	If positive experience is based on questions relating to access improvement above 83% is unlikely; on the basis that patients may not wish to travel to where dental access is available and we are not planning to commissioned additional activity. Initiatives to impeove access relate more to the shift from secondary care to community based services.
General Ophthalmic Services							
Activity							
Total number of sight tests/per 100,000 population	ED10	YES	None - assume planning numbers rather than an increase	28096	28808	29520	waiting for guidance
Quality and Innovation							
%of tints per voucher	ED11	YES	None - assume planning numbers rather than an increase	not available	not available	not available	waiting for guidance
% of repairs per voucher and % of replacements per voucher	ED12	YES	None - assume planning numbers rather than an increase	not available	not available	not available	waiting for guidance
% of prisms per voucher	ED13	YES	None - assume planning numbers rather than an increase	not available	not available	not available	waiting for guidance

APPENDICES

Appendix 1: Primary Care Summary – Regional Plan on a Page Format

Appendix 2: Public Health Summary – Regional Plan on a Page Format

See following pages

Note: Specialised Operating Plan – National format

The Specialised Operating Plan contains key elements of this document and is available as a separate standalone publication. The Operating plan contains further detail of the financial element of QIPP plans assessed against national opportunities.

Leicestershire & Lincolnshire

Primary Care 5 year Strategic Plan on a Page

Our Vision

To have in place a **strong and effective primary care** that delivers high **quality and responsive services** to patients, that fulfils its pivotal role in improving the **health outcomes** of our population whilst **containing costs**, and hence makes a vital contribution to a **high-performing** and **sustainable well integrated** healthcare system.

Local Ambition One (Quality)
To reduce unjustified variation in the quality of services delivered

Local Ambition Two (Outcomes)
To reduce unjustifiable inequalities in health outcomes

Delivered through intervention

- Working with CCGs to address capacity issues in Primary Care and secure a high quality workforce
- Developing robust quality and performance assurance frameworks for primary care to ensure that there is a consistent approach to managing unwarranted variation in quality
- Supporting wider primary care in conjunction with social care, community services and acute services where this is supported by CCG plans

Local Ambition Three (Patient Services)
To increase citizen participation and empowerment

Local Ambition Four (Patient Services) To improve the quality of life for patients with one or more LTCs

Delivered through intervention

- Review Area Team structures and processes to ensure that the local need, local voice and shared decision making with patient representatives are incorporated at every stage of the commissioning cycle from design to delivery to contract monitoring
- Implementing nationally negotiated changes for general practice that support more personalised care for older people and those with complex needs in partnership with CCGs.

Local Ambition Five (Access)
To improve access to primary care services & secondary care dental services

Local Ambition Six (Delivering Value)
To replace unjustified variation in the funding levels received by providers with strategic investment in new models of primary care

Delivered through intervention

- Provide support to PM's Challenge Fund pilot bids to improve access
- Align the local primary care strategy with the Lincolnshire Sustainable Services Review and the LLR Better Care Together Programme to ensure that there is a 'fit' with local approaches to new models of service delivery and integrated patient care packages
- Implement equitable funding mechanisms with an appropriate pace of change
- Implement QIPP schemes

Overseen through the following governance arrangements

- The AT Change Programme Board and Primary Care Strategy Group will oversee delivery
- On-going dialogue with CCGs & Health and Wellbeing boards on progress, recognising our shared agenda
- Better care Together & LSSR Partnership boards

Sustainability Goals

- Delivery of financial plan & QIPP schemes
- Delivery of the local ambitions
- Academic and quality-improvement activity and a positive learning climate embedded in primary care
- An expanded, skilled, resilient and flexible workforce working within integrated teams

Key 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
- Maximise value by securing the highest quality of care and the best outcomes for every pound invested

Leicestershire & Lincolnshire **Area** Team, Public Health Commissioning

VISION: High Quality Care for all, now and future generations.

The Dept. of Health, NHS England share the vision of working in partnership to achieve the benefits of the Section 7A agreement for the people of England.
We maintain a shared commitment to protect and improve the public's health. (from S7Agreement)

System Objective One
Ensure the effective commissioning of Section 7A Agreement public health services, utilising innovative and extended service models to deliver best quality, highly skilled provision

****

System Objective Two
Seek to increase the pace of change for full implementation of the national S7A specifications, leading to a standardised offer for service users

****

System Objective Three
Reduce the range of variation in local performance seeking to consistently achieve highest practicable performance across all programmes

****

System Objective Four
Drive continuous improvement through on going service review/design and outcome monitoring, to ensure highest quality, best value public health S7A services for our population

****

System Objective Five
Work with key partners and HWB to optimise opportunities to reduce health inequalities, improve health and achieve better outcomes through best use of resources including development of integrated service

****

System Objective Six
Ensure that the views of service users, parents, cares etc. are sought and taken into account when planning and improving services

****

2014/15

- Work with providers to further develop processes regarding listening to the patient voice, client involvement in service evaluation and future commissioning of S7A services
- Increase HV workforce to meet trajectory of 363 WTE by 31/03/15
- Through joint working with providers & LETB ensure access to training modules to support full delivery of HCP
- Maximise capacity of FNP places available in Leicester City and introduce a new site in Lincolnshire
- Develop safe & robust co-produced transition plans, 0-5 years services working collaboratively with Local Authority
- Work with GPs and child health records department in Lincolnshire to improve routine childhood vaccination uptake
- Implement the meningitis C catch up programme for university entrants
- Establish revised pathways for newborm children requiring hepatitis B vaccination
- Bench mark all screening service providers to ensure good value for money is being achieved
- Commission high risk breast screening in line with Breast Screening Programme (BSP) guidance across the Area Team
- Monitor the safety and effectiveness of the new in-house and EMPATH for UHL laboratory provision of the IDSP programme following repatriation from NGHT to local maternity providers
- Support UHL and ULHT to be part of phase two of the bowel scope implmentation
- Review models of the delivery of all teenage vaccines in line with national guidance & parallel to childhood flu
- Identification and Implementation of PH related QIPP programmes
- Ensure implementation of the national fail safe programme for new born blood spot screening
- Support trusts to implement the SMART system for managing the NIPE programme

2015/16

- Review revised Section 7A Agreement and implement any national changes as required
- Work with providers to maintain and further develop patient & public involvement
- Progress and complete robust transfer to Local Authority responsibility commissioning of 0-5 years services (Oct 2015)
- Review, refinement and continuation of screening and immunisation 2014-15 intentions
- Continue roll out of childhood flu vaccination programme
- Identification and implementation of PH related QIPP programmes

2016/19

- Review Section 7 A Agreement and implement any national changes as required
- Maintain and improve against all PH S7A outcome measures in line with national requirements
- Ensure safe on going provision of high quality CHIS/CHRD services, and implement any nationally identified reporting mechanisms following any national changes to S7A
- Review and further align provider based patient experience and involvement processes

Overseen through the following governance arrangements

- Area Team Direct Commissioning Team Meeting
- Area Team Executive Meeting
- Change Programme Board
- Programme Board arrangements (all programmes)
- DPH led Health Protection Boards
- FNP Advisory group & National Unit
- Integrated childrens commissioning Groups/Childrens board (Joint LA/CCG/AT)
- Trust

Measured using the following success criteria

- Number of FTE Health Visitors, achievement of roll out HCP
- Population vaccination coverage programme specific (S7A)
- Breast cancer coverage % screened adequately previous 3 yrs
- Cervical cancer coverage % screened adequately previous 3.5 or 5.5 yrs (age dependent)
- Bowel cancer uptake & coverage
- AAA screening, KPI
- % offered Diabetic eye screening who attend
- Ante natal & new-born screening, specific measure in line with each programme requirement (S7A)

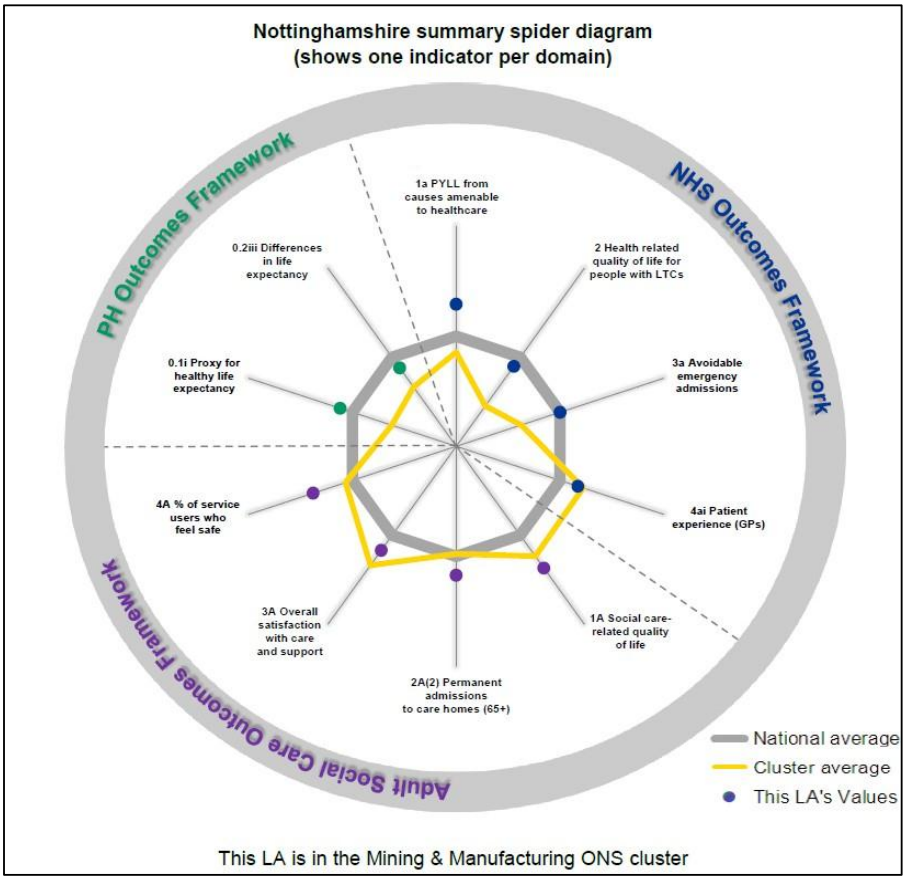
System values and principles (DN: Taken from NHS Constitution)

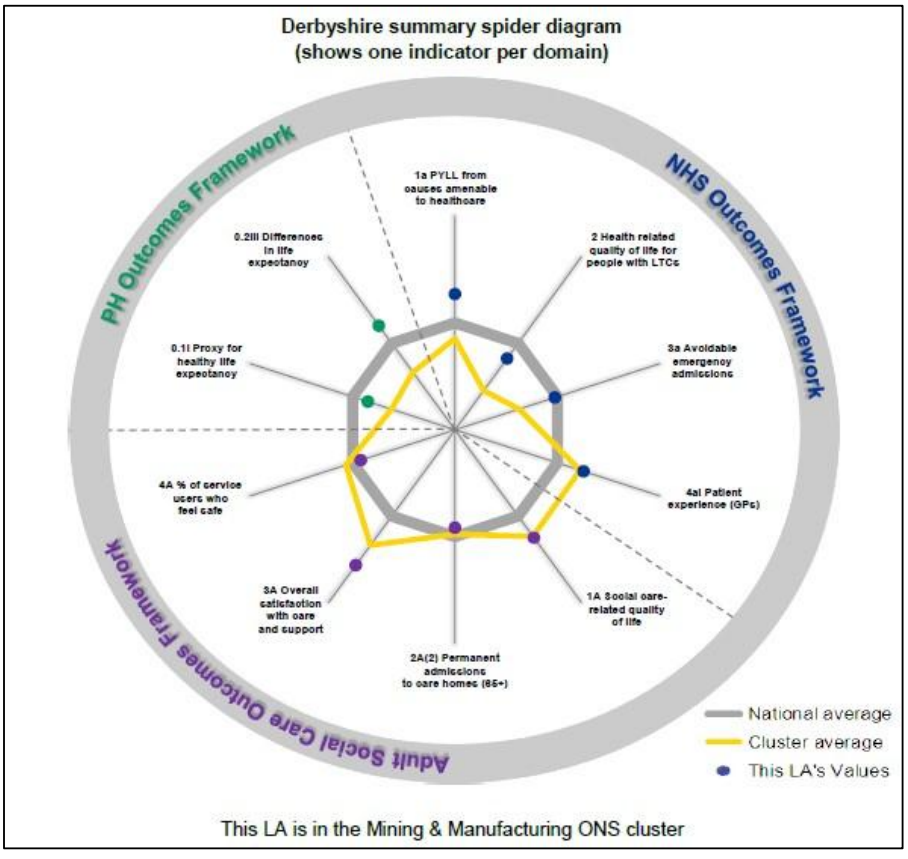
- Respect, consent, dignity, confidentiality
- Working together for patients
- Quality of Care and Environment
- The right to receive immunisation under the National Immunisation programmes
- The NHS will provide screening programmes as recommended by the National Screening Committee

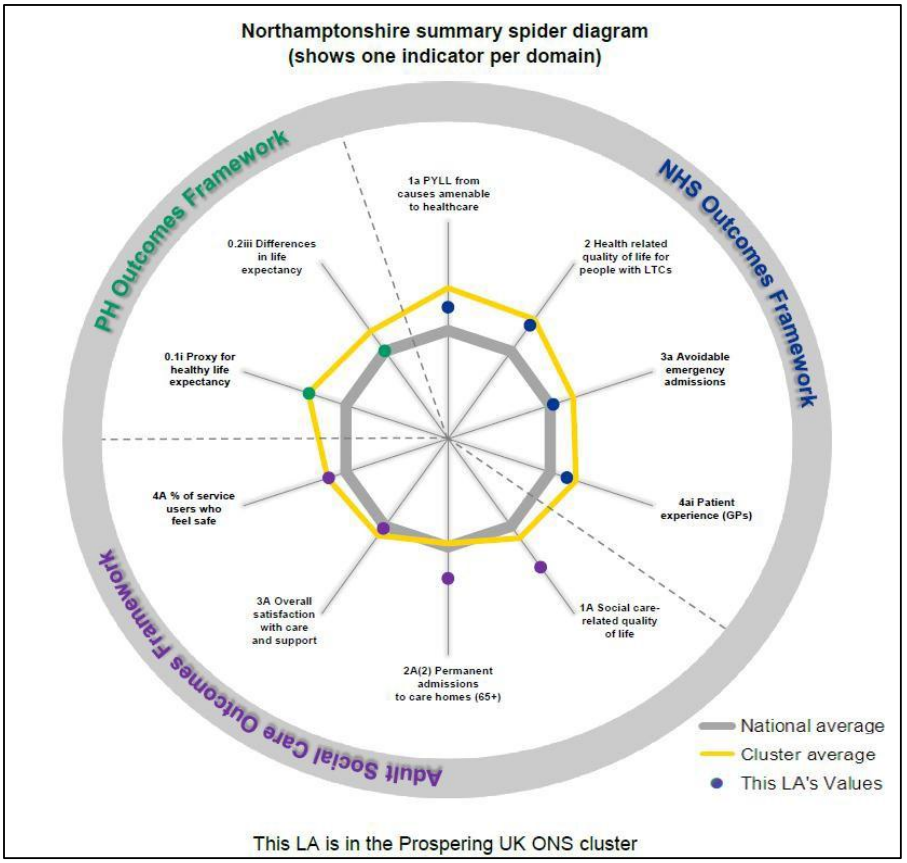
ADDITIONAL

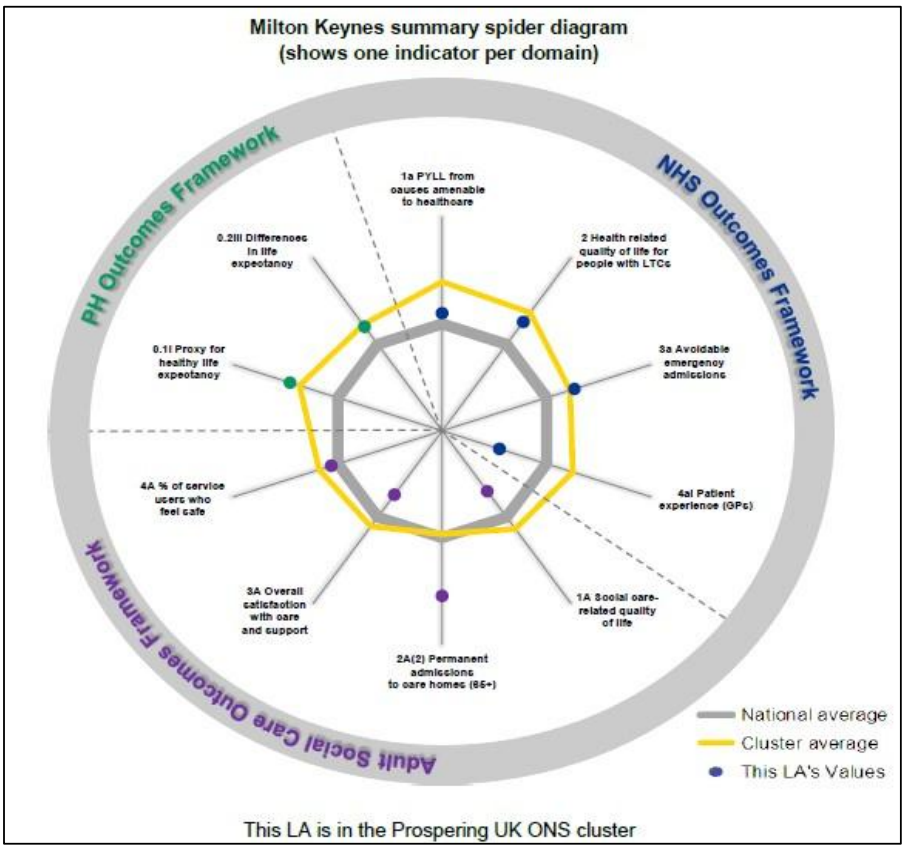
- PHE Code of Conduct and Values and Behaviours https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206902/Read-the-code-of-conduct-for-PHE-staff.pdf

Appendix 3: Health Profile Summaries for East Midlands Authorities






Northamptonshire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4ai Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Milton Keynes summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
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Cluster average
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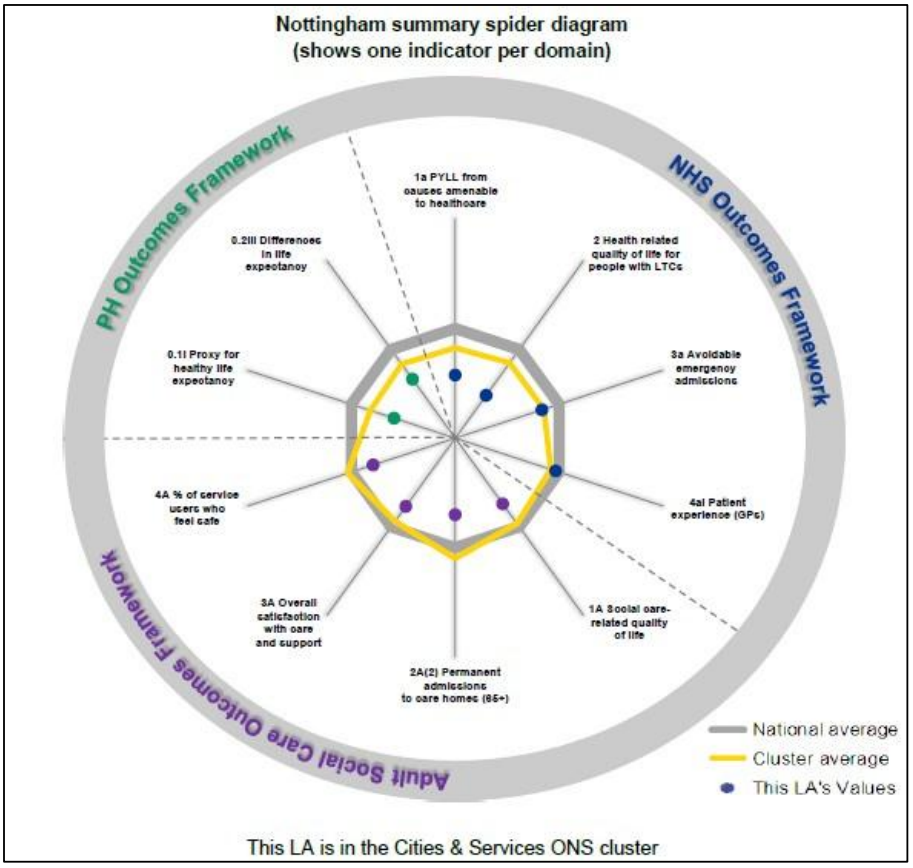
This LA is in the Prospering UK ONS cluster


Nottingham summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
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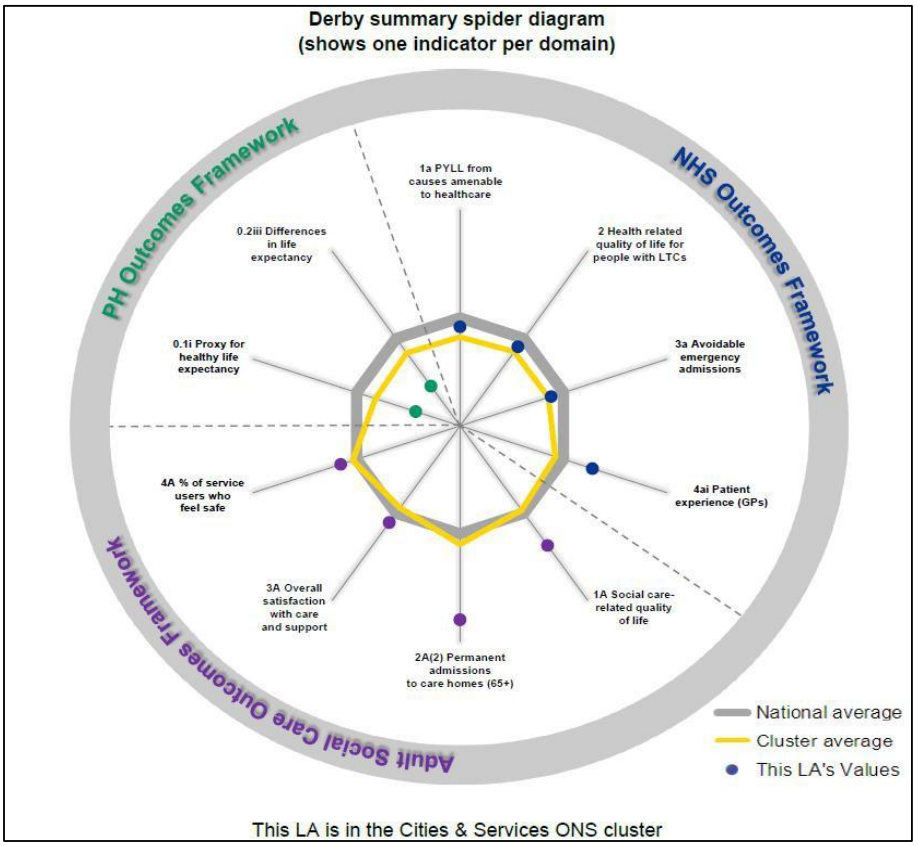
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Cities & Services ONS cluster


Derby summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
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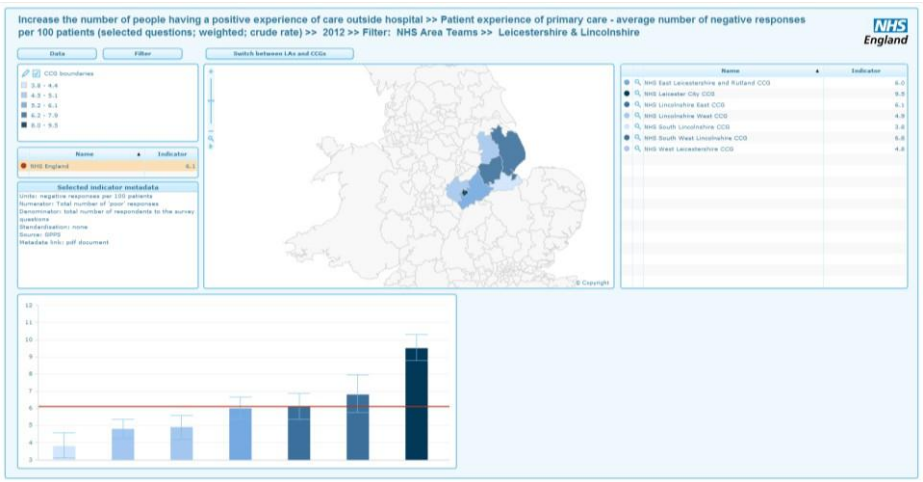
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Cities & Services ONS cluster

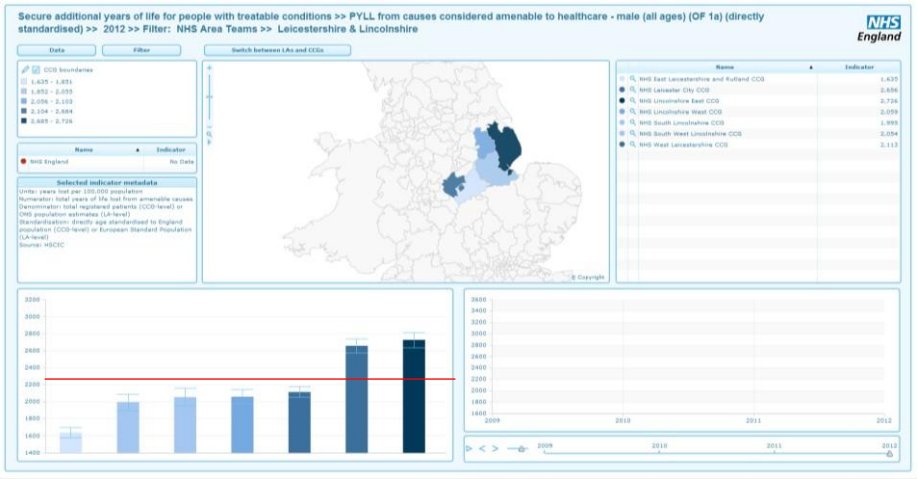
Appendix 4: Levels of Ambition Atlas Extracts

There is significant variation in patients experience of primary care



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

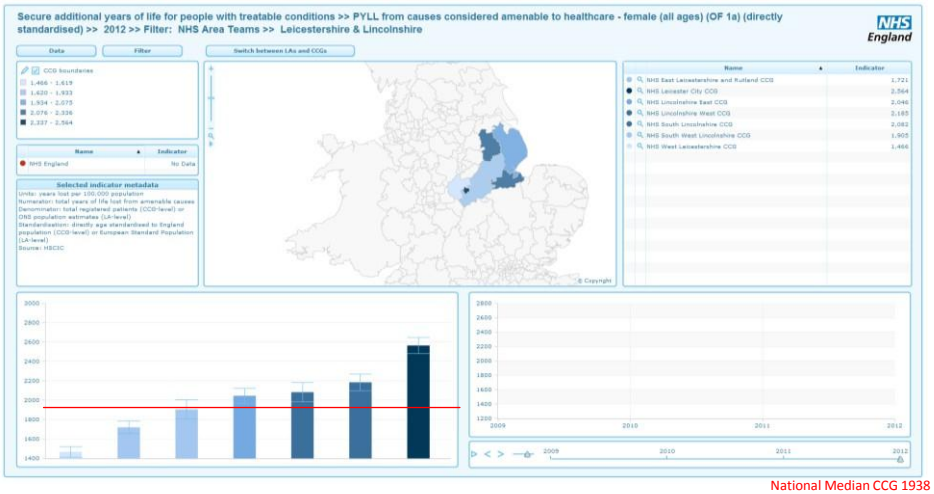
East Lincolnshire & Leicester City Potential Years of Life Lost: Males



National Median CCG 2251

Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

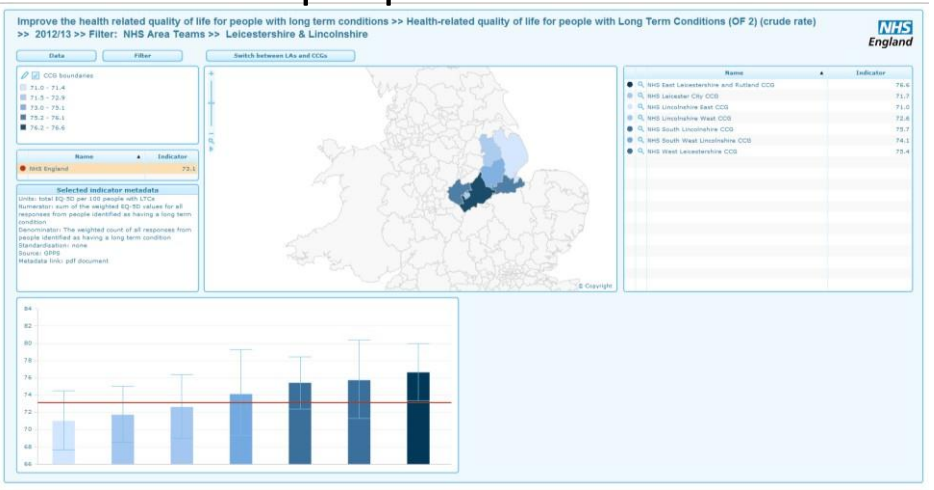
Leicester City, South & West Lincolnshire: Potential Years of Life Lost: Females



National Median CCG 1938

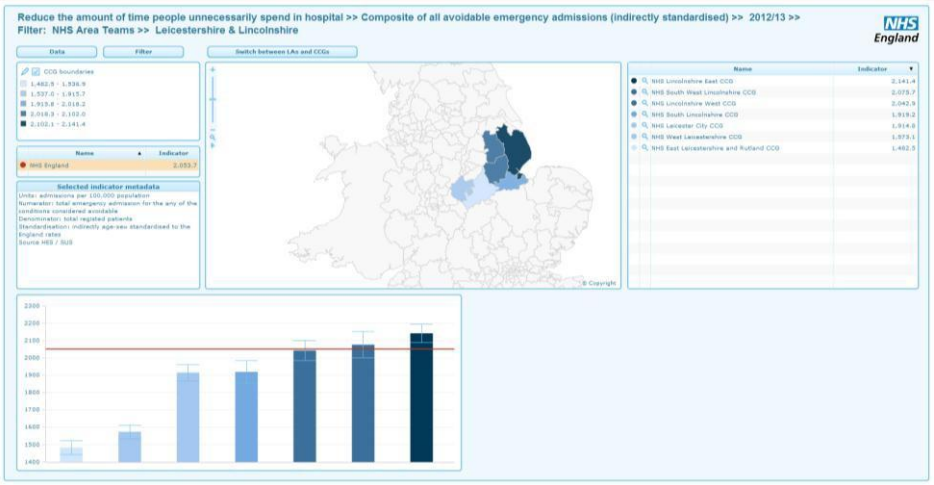
Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

Variable Quality of Life for people with LTC



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

Avoidable Emergency Admissions



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012/13 data

Appendix 5: Quality and Safety Plans

Introduction

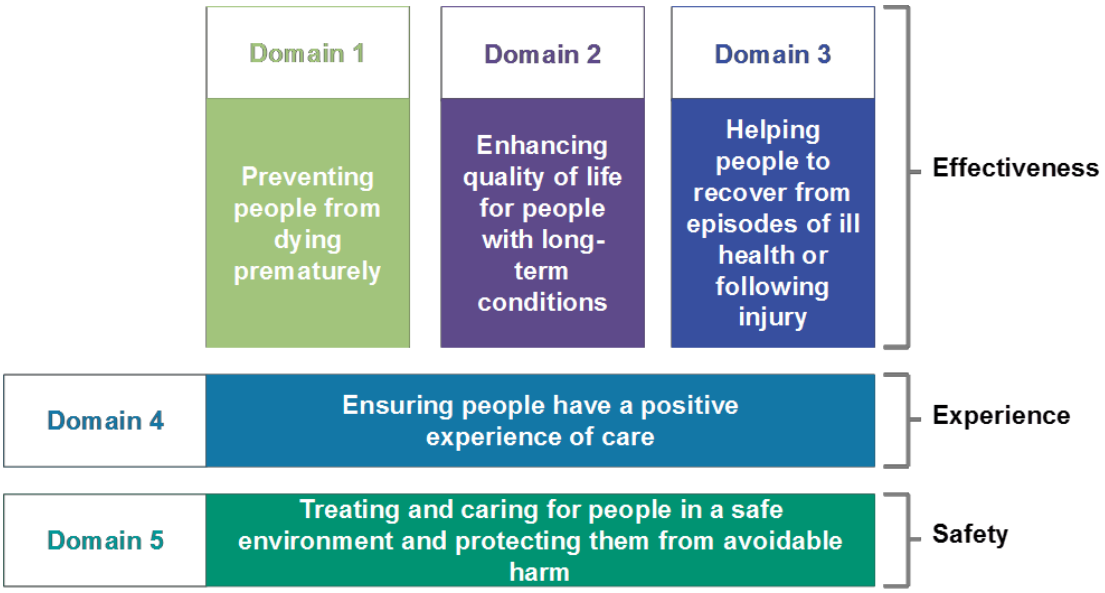
NHS England's mission is to secure **high quality care for all – now and for future generations.**

The NHS should support everyone to have greater control of their health and wellbeing, and to live longer, healthier lives by offering high quality health and care services that are compassionate, inclusive and constantly improving

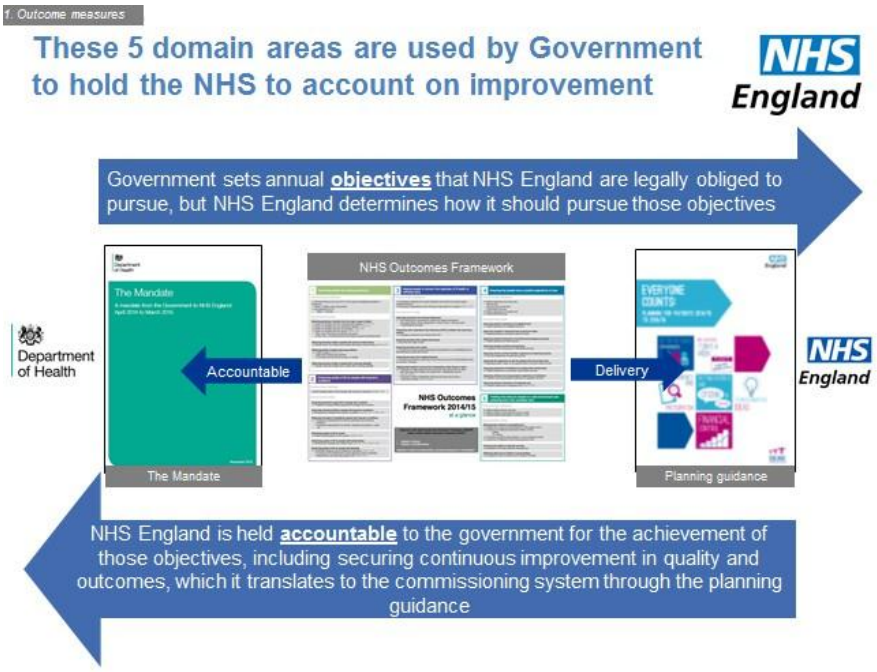
The single common definition of quality encompasses three equally important parts:

- Care that is **clinically effective**- not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is **safe**; and,
- Care that provides as positive an **experience** for patients as possible

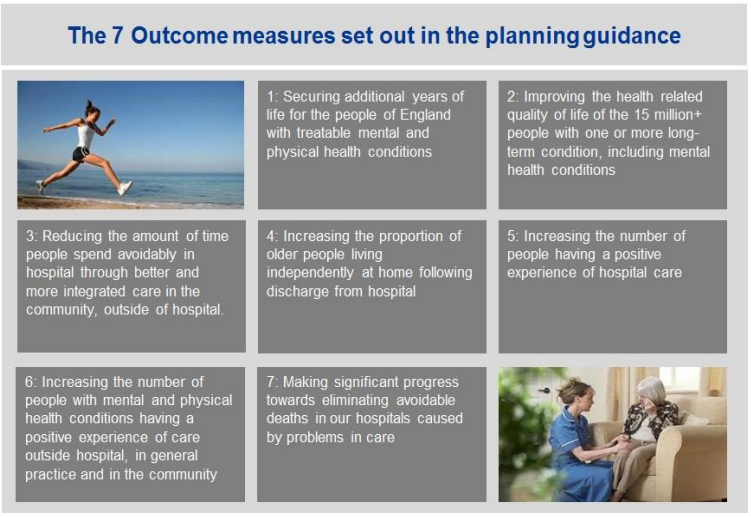
At a national level, the **NHS Outcomes Framework** has been developed. This framework provides us with a way of measuring the actual outcomes we are achieving for the population of England.



Further information on High Quality Care for all and the NHS Outcomes Framework: http://www.england.nhs.uk/about/imp-our-mission

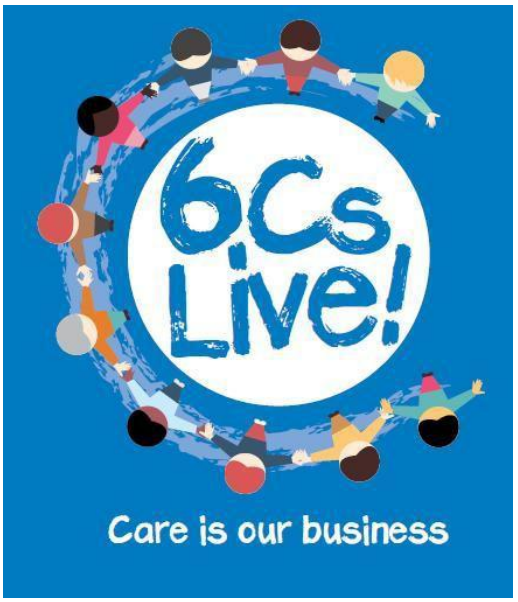


NHS England's planning guidance 'Everyone Counts: Planning for patients 2014/15 to 2018/19' sets out NHS England's clear commitment to an outcomes based approach and CCG's together with NHS England Area Teams are expected to jointly set levels of ambition against seven overarching outcomes.



A full version of our planning guide can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

2. Compassion in practice



The CNO strategy describes the **6 C's**

- ***C**are*;
- ***C**ompassion*;
- ***C**ompetence*;
- ***C**ommunication*;
- ***C**ourage*; and,
- ***C**ommitment*,

The 6C's have been developed to support a culture where patients and service users will have the best possible care.

These 6C's are not just for nurses and midwives but should underpin values and behaviours of all our staff. As such the CNO strategy underpins a significant proportion of the elements of our quality work with CCGs, and directly commissioned services.

- During the next two years we will establish a baseline to better understand how the ethos of the Nursing and midwifery strategy can be embedded into Primary Care and Specialised Services.

- We will ensure local provider plans are delivering against the six action areas associated with the 6 C's:

  - **Action area one:** Helping people to stay independent, maximise well-being and improving health outcomes
  - **Action area two:** Working with people to provide a positive experience of care
  - **Action area three:** Delivering high quality care and measuring the impact
  - **Action area four:** Building and strengthening leadership
  - **Action area five:** Ensuring we have the right staff, with the right skills, in the right place
  - **Action area six:** Supporting positive staff experience

We will work closely with our CCG colleagues to monitor the impact of compassion in practice across our local health service providers.

For more information about Compassion in Practice please visit: http://www.england.nhs.uk/nursingvision/

2. Learning from national reports

A number of recent high profile reports (Report of the Mid Staffordshire NHS Public Enquiry, by Robert Francis QC [2013]; Winterbourne View [DH, 2012]; Review into the quality of care and treatment provided by 14 hospital trust in England, by Professor Sir Bruce Keogh KBE [2013]; and Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England [2013]), have identified that vulnerable people were not provided with basic standards of care and that their fundamental rights to dignity were not respected.

- We will utilise the messages from these, and subsequent national reports and investigations, to identify and set key deliverable targets for quality and patient safety. In particular we will ensure we commission services to deliver the requirements of the Winterbourne Concordat.

- A key target will be to develop 'listening events' with vulnerable group's e.g. patients with a Learning Difficulty and Carers.

- Further to this we will engage with local healthwatch organisations and NHS partners to promote a culture of learning from complaints and PALs services, and encourage our local population to use the complaints route without fear of retribution, to help identify areas for improvement.

- We will endeavour to better understand the public satisfaction levels with our complaints service. The benefits of this will provide us with the opportunity to include thematic analysis into our quality reviews of directly commissioned services.

3. Patient Experience

Patient Experience is a key priority area for NHS England and has been outlined in:

- Domain 4 of the NHS Outcomes Framework: Ensuring that patients have a positive experience of care;
- Action area two of the Compassion in Practice strategy: Working with people to provide a positive experience of care; and,
- NHS England's 5 year planning guidance[5] under ambitions 5 & 6

Patient Experience

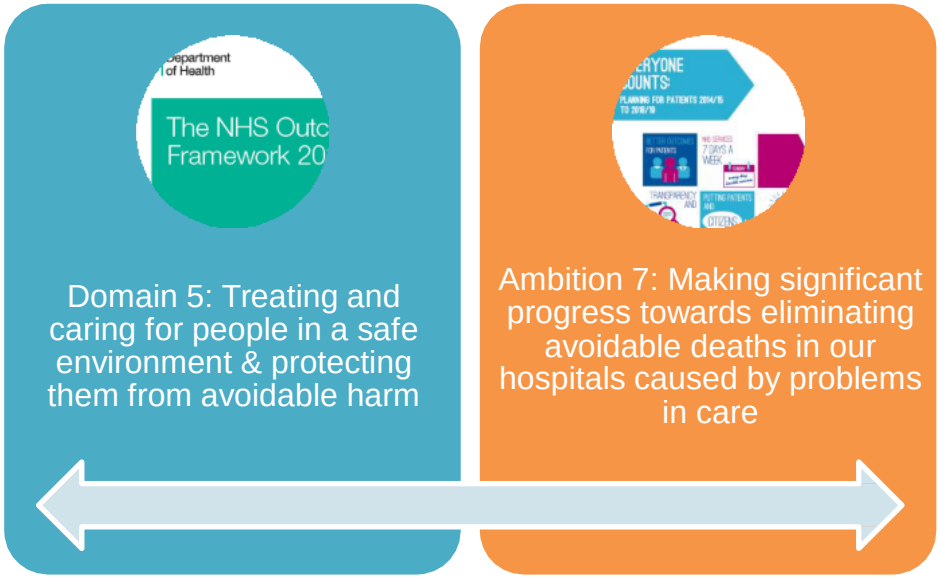
[5] Everyone Counts: Planning for patients 2014/15 to 2018/19, available at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

- We will continue to work with our CCG commissioning colleagues to drive improvement in patient experience of hospital care.
- We will support the roll-out of the Friends & Family Test across Primary Care starting in General Practice.
- We will collaboratively develop local systems to drive improved patient empowerment, linking to the national drivers 'Patients in control' and 'Personal health budgets'.
- We will improve partnership working with our local healthwatch establishments to enable lessons to be shared and provide scrutiny to our complaints process
- We will establish more robust mechanisms of triangulating data and information in order to improve our understanding of the available information. This improved data set and understanding will then be used to support our local delivery plans.

4. Patient Safety

Domain 5 of the NHS Outcomes Framework has been developed to measure a reduction in avoidable harm. Ambition 7 of NHS England's 5 year planning guide also focusses on patient safety.

Patient Safety



Healthcare Acquired Infections:

- We will take a whole health community approach to reducing healthcare acquired infections (HCAI) and continue to support our CCG colleagues to deliver improvements.

- We will ensure that CCGs and provider organisations are supported to analyse the underlying causes of HCAI and utilise this information to develop robust action plans to meet stringent targets for reducing Clostridium Difficile infections and MRSA bacteraemias.

Incident Reporting: Nationally and locally we recognise incident reporting from primary care is low. Across the Leicestershire & Lincolnshire area the rate of incidents reported from Primary Care per 100,000 population is 3.05 compared to 646 across all NHS sectors nationally.

- We will actively promote incident reporting across primary care through a structured education and training programme to increase incident reporting from Primary Care.

Harm Free Care: The NHS Safety Thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free' care.

'Harmfree'care
A new mindset in patient safety improvement

- Through systematic monitoring and analysis of the NHS safety thermometer data, and continuous work with our CCG colleagues, we aim to reduce avoidable harm from pressure ulcers; falls; urinary tract infections (UTI) and venous thromboembolism.

Local analysis suggests the priority for our community health service providers should be in relation to a reduction in pressure ulcers. For our acute providers focus should be on a reduction in pressure ulcers and, patients with a catheter and a UTI.

- Through collaboration with our CCG partners we will ensure the relevant priority areas are included within the local Commissioning for Quality and Innovation (CQUIN) schemes for 2014/15, as described in the NHS England CQUIN guidance 2014/15 document, published in December 2013.

The full CQUIN guidance can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/12/cquin-guid-1415.pdf

Serious Incident Management: We will work with our CCG and provider colleagues to ensure the NHS Commissioning Board Serious Incident Framework (2013) is adhered to.

- We will undertake systematic analysis of themes and trends of all serious incidents reported to NHS England Leicestershire & Lincolnshire Area Team to ensure to ensure robust investigations have been undertaken and that appropriate lessons have been learnt.

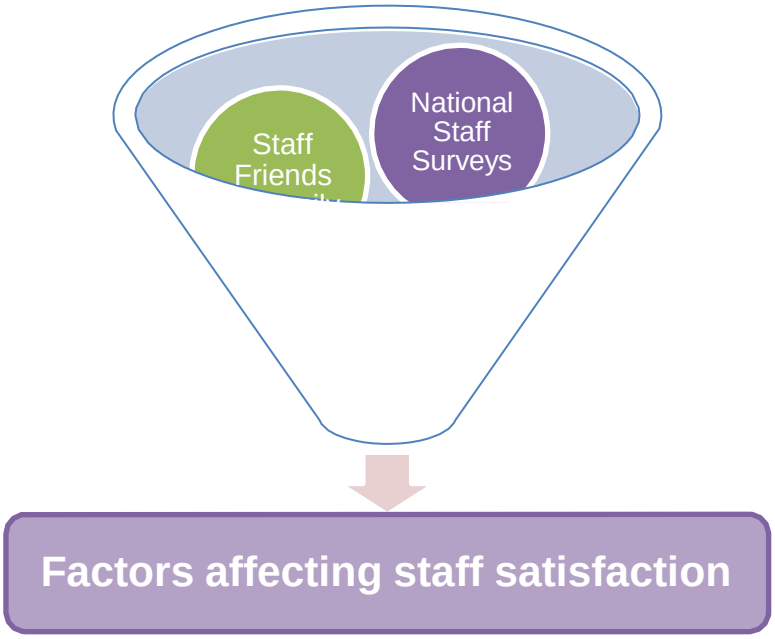
  This analysis will also be used to identify areas of patient safety for further scrutiny or improvement and will be used to support our local delivery plans.

- We will introduce a regular mechanism for disseminating lessons learnt across the health community, as appropriate, to ensure that others can learn the lessons and prevent a recurrence of the same event happening elsewhere.

5. Staff satisfaction

Action area six from the 6C's relates to supporting positive staff experience. Staff opinions, about their place of work, will continue to be collected via the annual staff surveys.

- We will undertake to analyse the outputs from these surveys to understand the factors affecting staff satisfaction in the local health economy and how staff satisfaction benchmarks against others.



- We will work with our CCG colleagues to ensure the new Staff Friends & Family Test is rolled out as per the NHS England CQUIN guidance 2014/15 document, published in December 2013.

- We will continue to promote the uptake of the NHS England staff barometer and co-ordinate the information to improve our local staff satisfaction.

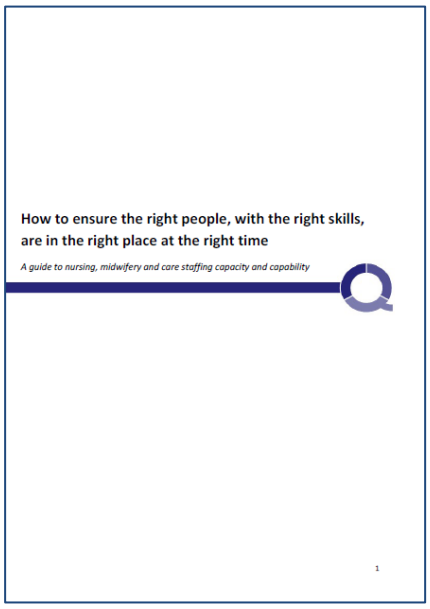
6. Safeguarding

- We will continue to support the strategic vision and direction of safeguarding across Leicestershire & Lincolnshire through pro-active engagement and attendance at all of the local safeguarding boards.
- We will ensure that all our staff undertakes safeguarding training, which is commensurate with their roles and responsibilities.

- We will develop the role of the 'Named GP' locally to support primary care professionals in the operational delivery of safeguarding the local population.

- We will work with the CCG's to utilise messages from Serious Case Reviews and Domestic Homicide reviews, as well as the wider learning sourced from the safeguarding boards learning and development frameworks, to improve practice standards.

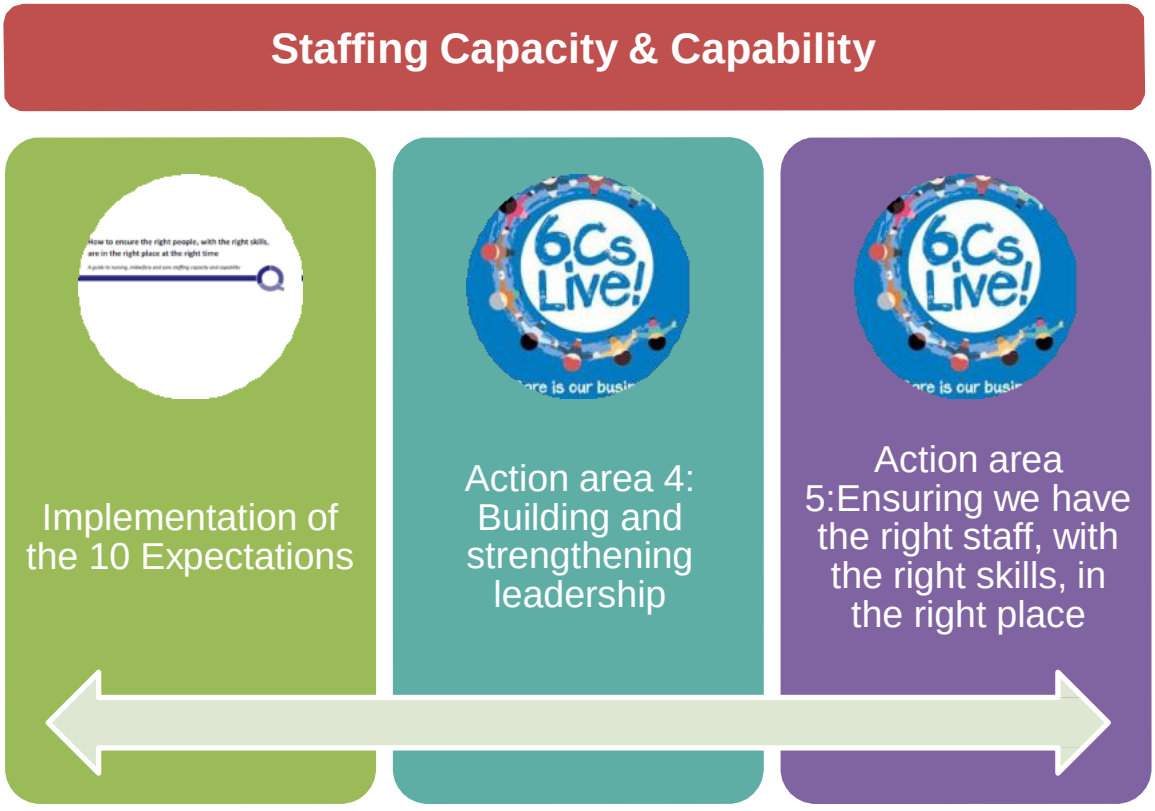
7. Staffing Capacity & Capability



The National Quality Board report: How to ensure the right people, with the right skills, are in the right place at the right time, *A guide to nursing, midwifery and care staffing capacity and capability* [2013] identified 10 expectations. The expectation is that all organisations are meeting these requirements currently, or taking active steps to ensure they do in the very near future.

- We will work with our internal, CCG and provider colleagues to ensure that the 10 expectations identified in the report have been implemented appropriately.

- We will link this work to Action areas 4 and 5 of the 6C's to ensure strong leadership and ensuring we have the right staff, with the right skills, in the right place.



- We will proactively support the development and implementation of a robust revalidation and appraisal system that is congruent with the NMC guidance for nurse revalidation.

- Individual practitioner concerns will be managed in a fair and open system that promotes learning and improvement and NHS England Clinical Teams will continue to actively contribute to the local governance arrangements relating to individual practitioners.

8. Quality Assurance Framework

- We will develop robust Quality Assurance Frameworks for all services directly commissioned by the Area Team, ensuring they offer the best possible outcomes for patients.

- We will set clear specifications for monitoring and assuring quality in the service contract and ensure patient and other stakeholder views are considered.

- We will maintain and improve the existing partnership relationships with local and regional Quality Surveillance Group members.

- We will ensure the local Quality Surveillance Group continues to provide constructive challenge and scrutiny of our local providers by systematically bringing together different parts of the health and care economy to routinely and methodically share information and intelligence about quality. The QSG will continue to:

  - Present information, including soft intelligence gathered through a variety of methods
  - Provide a forum, supported and facilitated by NHS England, for local health and care economies to work openly and honestly together to ensure quality across the system
  - Ensure a shared view of risks to quality through sharing intelligence
  - Acting as an early warning mechanism of risk about poor quality, and
  - Provide opportunities to coordinate actions to drive improvement whilst respecting statutory responsibilities of and on-going operational liaison between organisations

Document Version History

File	Notes
140210 Strategic & Operational plans LL Draft v1	Initial draft
140210 Strategic & Operational plans LL Draft v2i	Incorporating changes from initial regional NHS England review
140303 Strategic & Operational plans LL Draft v2j	Section completion primary care provider profiles. Explanatory notes for some technical terms. Truncation of technical financial commentary. Separation of draft QIPP projects to supplementary document for further development. Addition of Executive Summary and Document version history.
140305 Strategic & Operational plans LL Draft v2k	Amended to remove abbreviations for specific healthcare provider