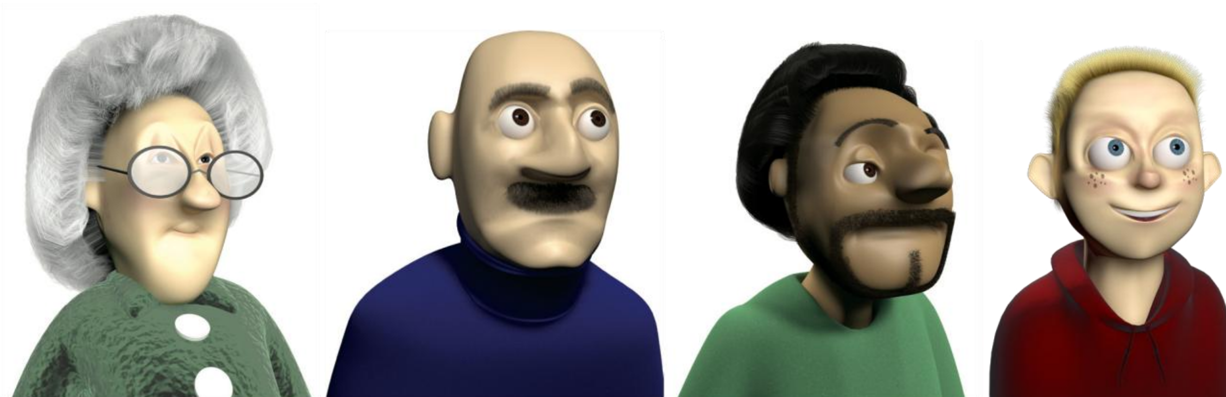
NHS

Southport and Formby
Clinical Commissioning Group

Everyone Counts

Planning for Patients in Southport and Formby
2013 - 2014



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1.0 Introduction

NHS Southport and Formby Clinical Commissioning Group (SFCCG) bring together 20 doctors surgeries covering an area stretching from Ince Blundell in the south to Churchtown in the north. From April 2013, we are fully responsible for planning and buying or 'commissioning' the majority of local health services for our 122,000 patients. Our Governing Body is made up of local doctors, nurses, practice staff and lay people, who are well placed to know the health needs and views of people living in the area, and will lead and be accountable for the work we carry out.

This plan sets out an ambitious programme to ensure that health and health services in Southport and Formby continue to improve in the future, amidst an increasingly complex and challenging social and economic environment. SFCCG has a budget of £160 million in 2013-2014, and we will need to work innovatively and even closer with our partners if we are to make improvements. This plan also reflects the progress we have made in developing working relationships with our partners since coming into being - with organisations and groups including Sefton Council, hospitals, local people and voluntary and community organisations.

Over the past 18 months, we have played an active role in local commissioning and we have operated in shadow form from April 2012 to being awarded statutory body status effective from April 2013, as part of the changes to the NHS. Our work during this period has informed the priorities detailed in this operational plan for 2013-2014.

Our plans for the year ahead build on what we already know about health and wellbeing in Southport and Formby – identified through mapping, analysis, research and evidence, Sefton's joint strategic needs assessment, called the Sefton Strategic Needs Assessment (SSNA) and involving and informing the people who live in the area. It also responds to the goals set out in the following:

- Everyone counts – planning for patients 2013-2014
- NHS Outcomes Framework
- NHS Constitution
- The Quality, Innovation, Productivity and Prevention (QIPP) programme

1.1 Our vision and values

Our vision and values clearly set out what we want to achieve for everyone who lives in Southport and Formby. They embody our commitment to our local and statutory duties, and most importantly, local people.

Our vision

Southport and Formby; a sustainable, healthy community.

We will therefore:

- Strive to ensure that no community is left behind or disadvantaged
- Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients
- Treat patients respectfully and put their interests first
- Transform NHS services to enable patients to take more control and make informed choices

1.2 How we have developed our plan

Our plans have been shaped around the effectiveness of current services, the views and experiences of the people living locally and the national standards that we aim to achieve. This section describes these considerations in more detail.

Health in Southport and Formby

Overall, life expectancy is similar to the national average 78.4 years for men and 82.5 years for women. However, men and women living in the most deprived areas of Southport and Formby can expect to live over seven years less than their neighbours in more affluent communities. This gap in life expectancy is mainly caused by lifestyle related factors, such as smoking and poor diet, which account for greater rates of circulatory disease, Chronic Obstructive Pulmonary Disease (COPD), obesity, diabetes, poor mental health and alcohol related illness.

Sefton has the highest proportion of residents aged over 65 of any metropolitan borough. In Southport and Formby there are over 26,000 residents over 65 years of age (21%) and this could increase by 10% in the next five years.

Southport and Formby also has growing migrant worker population. Sources indicate there could be as many as 2,000 migrant workers, 300 school age children and 600 partners or other family members. The main communities are from Poland, Portugal and Latvia. In 2009 there were over 200 births to non-British mothers (13% of all births).

All these factors contribute to deciding what health services Southport and Formby residents' need. Because of this, SFCCG has continued working with partners to develop primary care based strategies that can promote health improvement and reduce health inequalities.

There is a strong history of commissioning against the priorities set out in Sefton's first two joint strategic needs assessments (JSNAs). The latest refresh of the JSNA in 2012, called the Sefton Strategic Needs Assessment (SSNA) was carried out by SFCCG and Sefton Council and the results have formed the basis of the Health and Wellbeing Strategy (HWBS) – which is in turn shaping priorities for both organisations.

The strategic objectives of the HWBS are:

- Ensure all children have a positive start in life
- Support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- Support older people and those with long term conditions and disabilities to remain independent in their own homes
- Promote positive mental wellbeing
- Seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- Build capacity and resilience to empower and strengthen communities

Listening to local people

In all our discussions with Southport and Formby residents over the past few years, some clear and consistent themes have emerged about what they want for their health and from their health services. Our plans for 2013-2014 reflect these themes and priorities:

- For more services – like diabetes clinics, children's immunisations and physiotherapy - to be provided closer to home rather than in hospital, with better use made of existing community facilities like Ainsdale Centre for Health and Wellbeing
- Better integrated care – so, the many different health services to work better together, to make people's care and treatment easier
- More choice and involvement for people in their care and treatment
- Continued focus on programmes and services that prevent ill health, and that promote independent living
- Improve access to drug and mental health services
- Support for the most vulnerable and excluded people in our communities
- For people's views to be listened to, particularly those who find it difficult to voice their opinions

Priorities across the NHS

There is a clear mandate for NHS commissioners to achieve more. Our plans take account of this mandate and focus our work on the standards set out in the NHS Constitution and the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

In working towards achieving the goals set out in this plan, we will:

- Strive to ensure that no community is left behind or disadvantaged
- Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients
- Treat patients respectfully and put their interests first
- Transform NHS services to enable patients to take more control and make informed choices

In order for us to deliver our priorities within the resources we have available, we need to work with key partners to change the way in which care is delivered. One of the most significant programmes of work is delivering 'Care Closer to Home' which will shift the emphasis of care delivery from hospital based to community based services. Our main provider, Southport and Ormskirk Trust is an Integrated Care Organisation, which means they are ideally positioned to make such changes as part of the wider plans. Given the scale of these changes and in order to release the expected efficiencies the transformation plan is over a three year period and forms part of the CCG Strategic Plan. Our plans for 2013-14 reflect no growth, with some efficiencies released through the 'Care Closer to Home' implementation, however we are mindful of the demographic of our population and plans reflect that despite transformational change delivering a reduction in hospital based services, the requirements of the population will be increasing. The individual programmes of work to be delivered during 2013-14 that contribute to these plans can be found listed on page 12.

Appendix 2 sets out how we have involved and informed our partners in developing and setting this work plan for 2013-2014.

2.0 Improving Outcomes, Reducing Inequalities

2.1 Overview of our plans for 2013-2014 – Plan on a Page

Our ‘Plan on a page’ summarises key areas of delivery in 2013 – 2014 in the context of our vision, corporate aims, joint health and wellbeing strategic objectives and which shows the links to the achievement of progress against the NHS Outcomes Framework and delivery of the rights enshrined within the NHS Constitution.

Southport & Formby CCG – Plan on a page

Southport & Formby CCG — **Our Vision : A sustainable, healthy community** — **Our Values: Respectful, approachable, efficient, responsive**

Context

- Growing elderly population
- Inequalities of health care
- Improving quality of life
- Care closer to home
- Safe Care
- Financial Challenge
- Winter Pressures

Strategic

Corporate Objectives

- Consolidate robust CCG strategic plan within financial envelope
- Maintain systems to ensure quality and safety of patient care
- Deliver through establishment of PMO approach to CCG programmes
- Ensure C&M CSU deliver successful support to the CCG
- Sustain engagement of CCG members, partners and stakeholders
- Drive clinical leadership development through Governing body, locality and wider constituency

Health and Wellbeing Board Objectives

- Build capacity & resilience to empower & strengthen communities
- Promote positive mental health & wellbeing
- Support Older People & those with long term conditions & disabilities to remain independent in own homes
- Support people early to prevent and treat avoidable illnesses and reduce health inequalities
- Seek to address social & economic issues which contribute to poor H&WB
- Ensure all children have positive start in life

CCG / LA Joint Priorities

- Children & Young People
- Adults
- Public Health

System

- Optimising use of Secondary Care
- Driving Improvement in Health & Wellbeing
- Improving Quality of Primary Care and Delivery of Community Services
- Ensuring Cost Effectiveness in High Quality Tertiary Care

Enabling Themes, Programmes, Transformational Change and Improving Outcomes

Enabling Themes	Programmes	Transformational Change	Improving Outcomes
Patient & Public Engagement	Unplanned	• Evaluate Care Home Audit and select model of care to support care homes and reduce attendances at AE / EAU • Redesign Frail Elderly Pathway • Care Closer to Home to redesign 6 Integrated Care Pathways • Empower patients to take control of and responsibility for their own health through self management programmes • Evaluation of Out of Hours service and roll out of 111	• Non Elective admissions for Ambulatory Care Sensitive conditions • Non elective admissions • A&E attendances converted to non elective admission rates • Improved community services managing care in more effective setting
The Francis Report	Long Term Conditions	• Primary Care LES primary care to improve diagnosis /management of COPD/ Obesity/ Atrial Fibrillation • Vascular Health Checks • Alcohol Nurse in A&E • Peer support for cardiology service	• Reduced admissions with LTC as primary diagnosis • Person centred, integrated primary care provision • Reduction under 75 mortality rates
Any Qualified Provider	Diabetes	• Performance management of IGR diabetes prevention pathway with Public Health • Benchmark practices against treatment targets and offer additional support to those not achieving. • Review training of staff in primary care in relation to diabetes • Ensure patients receive foot care/screening • Review multi-professional input into care homes	• Decreased numbers of unnecessary emergency admissions • Increase numbers of nine processes being recorded • Increased numbers of people being referred to Healthy Lifestyle services
Programme Management Office CQUINs	Mental Health	• Achievement of Care Programme Approach (CPA) follow up target. • Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%. • Increase Dementia detection. including care home staff liaison (51% to 75% by 2015/16) • Refresh Sefton Dementia strategy • Locality approach via psycho-geriatrician service • Adoption of quality of life principles, safe models of care	• Improved integration across services • Appropriate, timely support received by patients • Improved early intervention, including increased access to Memory Assessment Services • Ensuring patients are safe and receive safe, effective care • Improved support services for carers • Improved diagnosis rates • Increased home based assessments
Information Management Technology Innovation	Children	• Review ADHD services • Review of Children's equipment services • Review pilot of Community Children's nursing team • Collaborative working with NCB/LA re: Health visitor and school health national implementation plans • Review the Health economy recommendations which result from the Youth offending service inspection	• Improved integration of services, including transition to Adult services • Reducing emergency admissions and EG Asthma & Epilepsy and length of stay • Early identification of families in need of support to promote the safeguarding of Children & Young People
Value for Money through Finance and Contracting	Planned	• Implement Community Ophthalmology Schemes • Better Care Better Value benchmark indicators to support improved performance • Any Qualified Provider procurements podiatry, audiology and MSK • Implement Alternative Quality Contract for local indicators with Southport & Ormskirk Trust	• Patients receive care in the most appropriate setting and to improve the quality and experience of care for patients.
Quality of Care Sustainable Change	Cancer	• Compliance with cancer waits 31 and 62 day targets • Peer review compliance • Cancer CQUIN incentivise 14 day key diagnostics pathway • Optimise performance- Cancer referral 14 days • Support to GPs via Cancer Network NAEDI project • Review CAB service for patients • Undertake needs assessment for psychological support services and physical activity programmes	• Ensure appropriate, timely Cancer treatment for our patients • Improved survival rates through early detection • Cancer Survivorship – improved support for people and families affected by cancer • Increase use of Macmillan Cancer Information Centre in Southport
Promotion of Self Care	End of Life	• Develop End of life strategy • Hospice at Home • End of Life facilitator	• To Increase the number of people at end of life dying in their normal place of residence. + 1%
Sefton Needs Assessment	Prevention	• Develop collaborative CQUIN to support improved breastfeeding rates • Develop an obesity strategy and clarify obesity treatment pathway. • Commission Alcohol Liaison Service at Southport & Ormskirk Hospital • Build capacity to facilitate the provision of Identification and Brief Advice(IBA) across ranges settings	• Better Maternal /early years health • Reduced Obesity levels • Reduce rate of alcohol related hospital admissions • Reduce length of stay linked to alcohol related hospital admissions • Increased skills/knowledge of Primary Care & key stakeholders to identify those at risk of alcohol /drug dependency
Clinical, Community, 3rd Sector collaboration	Primary Care Quality	• Develop Primary Care strategy • Support improvements using the Quality Premium	• Improved quality, capability and productivity, and capacity of Primary care services
	Medicine Management	• Role out Optimisation plan across GP • Patient education to reduce waste	• Improved assurance that medicines are safe, appropriate, clinically effective and value for money

NHS Outcome Framework

QUALITY PREMIUMS

- Reducing potential years of life lost through amenable mortality
- Reducing avoidable emergency admissions
- Improving patients experience of hospital services – Ensuring roll out Friends & Family Test
- Preventing healthcare associated infections

LOCAL PRIORITIES

- Reduction in hospital admissions for under 19s related to Asthma
- Reduction in the number of patients who have an emergency admission for dehydration
- Offer Interventions to Patients with Alcohol Related Admissions

Everyone Counts — **Fundamentals of Care** — **Patients' Rights: The NHS Constitution** — **Patient Centred, Customer Focused** — **Transformation of Health and Social Care at CCG Level** — **Financial Planning**

Key Programmes - Programme Management Approach

Our Plan on a Page also highlights key programmes of work. To enable us to achieve our longer term strategy, we have been able to identify actions to deliver required progress in 2013-14. We have developed an internal Programme Management capability, supported by a Programme Management Office function, which we commission from Cheshire and Merseyside Commissioning Support Unit (CMCSU) to drive this work forward.

We have identified a lead clinician / board member and a lead manager for each of our key programmes of work, who are developing detailed implementation plans. A list of leads can be found in Appendix 2. These leads have worked in conjunction with key stakeholders, across the NHS, local authority, the voluntary sector and with local people, as appropriate to develop their plans. This includes an increasing emphasis on clinician to clinician discussion around the key priority areas, both across primary and secondary care and also with the CCG localities, where discussions are led by Locality GP Chairs. We have recently increased our clinical leadership and capacity in relation to our key areas of work – our Unplanned Care strategy, Care Closer to Home - through the secondment of a local secondary care doctor, working with a lead manager to work across the whole system. Each programme has a clear link to the transformation change required across the wider health system and to achieving the outcomes required for our population. Some programmes are more fully developed than others. Where there are gaps, leads are working on completing the detail over the next few weeks and months as part of our longer term strategic planning process.

The following pages provide more detailed on each of the key programme areas:

- Unplanned Care
- Long Term Conditions including, Chronic Obstructive Pulmonary Disorder (COPD), Cardiovascular Disease (CVD)
- Diabetes
- Mental Health, Dementia and Learning Disabilities (LD)
- Children
- Planned Care
- Cancer
- End of Life
- Prevention – Obesity, Alcohol and Maternal Health
- Primary Care Development
- Medicines Management

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Programme: Unplanned Care **Lead Clinician: Dr Graeme Allen**

OBJECTIVE

To redesign community services to reduce hospital attendances and manage care more effectively in a community setting.
(Domain 1,3,4,5)

WHY CHANGE IS NEEDED?

Despite a decreasing trend, non elective admissions remain higher than the national average (120/1000 pop versus 114/ 1000 pop). A&E attendance to admission conversion rates is in the 4th quintile. By redesigning community services (Care Closer to Home) we aim to deliver more care in a community setting which given the demographic of the local population will offer improved care for patients.

DESCRIPTION

Evaluate Care Home Audit and select model of care to support care homes and reduce attendances at AE / EAU
Redesign Frail Elderly Pathway
Retender of Out of Hours contract and roll out of 111
Care Closer to Home to redesign 6 Integrated Care Pathways
Empower patients to take control of and responsibility for their own health through self management programmes
(improving quality in primary care and advanced care planning for patients in last year of life separate schemes)

KEY MILESTONES	Q1	Q2	Q3	Q4
New out of hours contract			■	
New model of care for care homes		■		
Redesigned Frail Elderly Pathway launched		■		
New pathways of care for diabetes, cardiology, respiratory, dementia, End of Life, Frail Elderly.		■		

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Non Elective admissions for Ambulatory Care Sensitive conditions				
Non elective admissions				
A&E attendances converted to non elective admission rates				

RISKS	MITIGATING ACTIONS
Care homes fail to adopt new model of care (financial risk as no reduction in admission rates)	Support and education during launch
Delay in implementing new pathways (financial risk as no reduction in admissions)	Recognise pace of change during 13/14 contract round and plan accordingly
Resistance to new ways of working	Project management, support to staff, regular briefings

WORKFORCE IMPLICATIONS

Training for staff in community settings to support new ways of working
Closer working with other agencies (Local Authority and third sector) to deliver effective care

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Programme: Long Term Conditions **Lead Clinician: Dr Liam Grant/Dr Niall Leonard**

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OBJECTIVE
To provide person centred integrated care for people with long term conditions through improvements in primary care. To put patients in charge and have ownership of their care through personalised care plans and budgets whilst ensuring co-ordination and continuity of care. (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?
The number of people diagnosed with long term conditions is higher than the England average and despite this there may be under diagnosis. Half of the population may be classed as overweight or obese. The Atlas of Variation indicates the following areas with potential for improvement: rates for bariatric surgery, closing the gap between the actual and expected prevalence of Coronary Heart Disease, reduce the number of admissions with COPD and the primary diagnosis.

DESCRIPTION
New integrated pathway for Respiratory disease, cardiology and frail elderly to be developed as part of the Care Closer to home scheme (*separate proforma)* Local Enhanced Service in primary care to improve diagnosis and management of COPD LES in primary care managing obesity LES primary care to diagnose and manage Atrial Fibrillation Vascular Health Checks Alcohol Nurse in A&E (See Priority Alcohol) Peer support for cardiology service in Southport and Ormskirk Trust

KEY MILESTONES	Q1	Q2	Q3	Q4
New integrated care pathways		■		
Peer Support for Cardiology	■			

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Under 75 mortality rates for CVD and respiratory disease (longer term)				
CHD actual v predicted data				

RISKS	MITIGATING ACTIONS
Poor take up on Local enhanced service resulting in no changes	Monitor uptake, focus within locality groups, feedback on schemes for future developments

WORKFORCE IMPLICATIONS
Impact on primary care with multiple LES schemes Peer support may identify changes with workforce implications

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

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Programme: Diabetes **Lead Clinician: Dr Doug Callow**

OBJECTIVE

Prevent or delay the onset of diabetes.
Improves the recording of the nine care processes for people with diabetes
Increase the number of people who access education for Type 1&2 diabetes
(Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?

There is now an increasingly aging population in Sefton. Compared to ten years ago (1998), Sefton's population now has fewer under 45s and more people aged 45+ (particularly 45-64). This is important in relation to diabetes prevalence as Type 2 Diabetes tends to present in middle-aged and older age groups (although it is becoming more common in younger overweight people). Sefton's population is estimated to plateau to around 272,500 in the next 20 years with the number and percentage of over 65s continuing to increase. Older people account for the majority of both hospital admissions and long term conditions.
The number of people in Sefton likely to have Diabetes is about is 13,783, or 4.94% of the total population. Sefton's prevalence of diabetes has risen over the last 4 years by around 500-600 patients each year. The number of people with diabetes in Sefton is predicted to rise by 42% to nearly 20,000 in the next twenty years. This equates to around 300 new patients per year. In Sefton, 42,102 people are estimated to have IGR (borderline diabetes). 70% of diabetes is thought to be preventable and obesity is thee key modifiable risk factor.
Between April 2008 to March 2009, there were 23 day case or elective Hospital admissions with Diabetes as a Primary Diagnosis across the four hospital trusts. Between April 2008 to March 2009, there were 125 emergency admissions with a primary diagnosis of Diabetes .
The average length of hospital stay (days) for day case, elective and non-elective admissions with a primary diagnosis of Diabetes = 493.
HbA1c is a marker of long-term control of diabetes. Better control leads to fewer complications in both insulin-dependent and non-insulin dependent patients with diabetes

DESCRIPTION

- Performance management of IGR diabetes prevention pathway (activity to include annual review, patient education and weight management) – work with public health
- Explore the benefits of commissioning education for patients with established diabetes
- Improve recording of all nine care processes using the diabetes dashboard
- Benchmark practices against treatment targets (HbA1c, blood pressure, cholesterol) and offer additional support to those not achieving.
- Review training needs of staff in primary care in relation to diabetes
- Ensure patients receive foot care/screening as agreed within Nice Guidance the foot care pathway as agreed by North Mersey Network Group
- Review multi-professional input into care homes for residents with diabetes
- Explore the potential working with intermediate care to increase care closer to home.
- Work with secondary care to understand diabetic patients flow through improved coding of data
- Ensure that patients are discharged as appropriate from secondary care to be managed in a primary/community setting
- Encourage healthy lifestyles in particular to reducing obesity levels

KEY MILESTONES	Q1	Q2	Q3	Q4
Increase recording of the nine processes				
Review training needs				
Launch Merseyside IGR pathway, managing overweight / obese patients with high blood sugar				
Develop an integrated pathway and monitor impact on emergency attendances/admission				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Decreased numbers of unnecessary emergency admissions				
Increase numbers of nine processes being recorded				
Increased numbers of people being referred to Healthy Lifestyle services				

RISKS	MITIGATING ACTIONS
Funding	Potential use of PC investment (£3/head)
Lack of capacity within GP practices	Primary Care Quality Strategy
Educational issues	Use of protected learning times

WORKFORCE IMPLICATIONS

None at this time

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

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Programme: Mental Health   Lead Clinician: Dr Hilal Mulla

OBJECTIVE

Achievement of Care Programme Approach (CPA) follow up target.
Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%.
Increase the proportion of people with depression/anxiety entering treatment (Domain 4)

WHY CHANGE IS NEEDED?

High incidence of mental health across the borough .

The challenge of matching the mental health needs of an ageing population with reducing resources.

DESCRIPTION

Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.

IAPT: The plan is to employ IAPT Wave 5 trainees, that are currently employed on temporary contracts as permanent staff post qualification, and to participate in Wave 6 of the roll out to achieve DH objectives of meeting 15% prevalence with recovery rates of 50% by 2014/15.

KEY MILESTONES	Q1	Q2	Q3	Q4
Increase in number of people who receive psychological therapies	418	424	438	440

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Mental Health Measure - CPA	95%			
Mental Health Measure - IAPT	11%	11%	15%	

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	181,431	
2014/15		
2015/16		
Total		

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Programme: Dementia **Lead Clinician: Dr Hilal Mulla**

OBJECTIVE
Refresh of the Sefton Dementia Strategy in line with recent policy changes including the targets in the Prime Ministers Dementia Challenge. Enhancing quality of life for people with dementia. (Domain 2)

WHY CHANGE IS NEEDED?
Increase in the numbers of people with dementia. Increase in Sefton's ageing population. Need to increase appropriate early referral to Memory Assessment Services. Need to improve access to support services for people with dementia and their carers / family.

DESCRIPTION
Case finding / diagnosis rates to increase from 51% to 75% by 2015/16 in line with GMS Contractual Changes 2013/14 – Enhanced service for Dementia Case Finding (6th December 2012). Facilitate further locality based approach of the psycho-geriatrician service. Improving public and professional awareness / understanding of dementia and impact on peoples lives. Facilitate appropriate support for patients, families and carers through co-ordination of VCF Sector.

KEY MILESTONES	Q1	Q2	Q3	Q4
Develop GP dementia screening tool				
Increased referrals to memory assessment service				
Increase in memory assessments in persons home				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Increase in diagnosis rates	75%	59%	67%	75%
Increase in prescribing of Cholinesterase Inhibitors				
Decrease in anti-psychotic prescriptions				

RISKS	MITIGATING ACTIONS
Lack of GP uptake in enhanced service for dementia case finding	Proactive clinical leadership and support
Capacity of psycho-geriatrician's may have resource implications	

WORKFORCE IMPLICATIONS
Enhance skill set of primary care workers in relation to dementia through appropriate training support.

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

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Programme: Learning Disabilities **Lead Clinician: Dr Hillal Mulla**

OBJECTIVE
Ensure effective and safe models of care for people with learning disabilities (Domain 2,4,5) Commission annual health checks Quality of Life principles should be adopted in all health and social care contracts to drive up standards. (Domain 1)

WHY CHANGE IS NEEDED?
Response to the Transforming Care: local response to Winterbourne View Hospital and Francis Report that ensures people with learning disabilities , autism, a mental health condition or challenging behaviour are safe and well looked after for NHS funded care.

DESCRIPTION
Joint working with Sefton Council to ensure any placements outside Sefton will be monitored to ensure good pathways for discharge. Contracts will be used to hold providers to account for the quality and safety of the services they provide. The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities .

KEY MILESTONES	Q1	Q2	Q3	Q4
Local register of people with challenging behaviour for NHS funded care.				
Contract monitoring and reviews to drive up standards of care.				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Learning Disability Health Self Assessment Framework	Yearly			
Winterbourne View local response	1st April 2013			
Annual Health Checks	Yearly			

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	£40,000 for Annual Health Checks	
2014/15	Possibly NCB investment	
2015/16		
Total		

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Programme: Children **Lead Clinician: Dr Robert Caudwell**

OBJECTIVE
Children's Community Nursing Team Admission avoidance and facilitating early discharge for children and young people within North Sefton. Improve care pathways through joint working between primary and secondary care providers. Improve access to acute care which can be provided closer to home (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?
Children's community nursing teams support the range of needs from complex needs, chronic ill health, long term conditions and also acute illness. This includes supporting discharge from hospital and early assessment and treatment of children to support families to stay at home where possible. Whilst North Sefton has a complex needs nursing team who support known children on a planned care basis, there is no equivalent service to support the acutely ill child within the community.

DESCRIPTION
Developing Children's Community Nursing Team for North Sefton with Southport & Ormskirk Paediatric Service. 18 month pilot to assess the benefits in increasing acute care available outside of hospital settings. Pilot will also • Review LCH complex needs (1 WTE Band 7) • Epilepsy development • EOL project • Secondment from LCH complex needs team to CCNT pilot (1 WTE Band 6) • Decommissioning LCH re Paediatric diabetes nursing service & commissioning S&O (TUPE transfer 1 WTE Band 7)

WORKFORCE IMPLICATIONS
Nursing team – 3.6 WTE – Funded via QIPP monies during pilot.

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduced emergency readmissions	No actual targets set for pilot, aim to see a reduction against expected activity levels CCNT activity aims to reduce PBR activity/income to meet service costs, therefore cost neutral			
Reduced A&E attendances at point of primary care				
Reduced length of stay				

RISKS	MITIGATING ACTIONS
CCG do not implement /fund service at end of pilot in 2013/14	Exit strategy agreed with providers.
No risk to diabetes specialist nurse	TUPE Transfer
On-going S&O service dependant on internal redesign of resources	Review of service redesign at S&O

KEY MILESTONES	Q1	Q2	Q3	Q4
Service fully established –Monthly activity review to support performance monitoring	X			
LCH complex needs review and LTC service redesigns completed.		X		
GP referral pathway developed with pilot practices			X	
Full service evaluation of S&O pilot in conjunction with LCH/Claire House work to inform model for future community nursing services.				X

YEAR	INVESTMENT £	SAVINGS £
2013/14	160k – QIPP funding	
2014/15		
2015/16		
Total		

NHS
Southport and Formby
Clinical Commissioning Group

Programme: Children **Lead Clinician: Dr Robert Caudwell**

OBJECTIVE
Improve outcomes for children through integrated commissioning and service delivery (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?
1. Children's community nursing teams do not deliver equitable service across the borough 2. Service restructured to improve access and outcomes on previous poor performance 3. ADHD has no agreed multi-disciplinary pathway – works on historic practice 4. Demand for children's equipment has significantly increased

DESCRIPTION
Review community nursing support for children with complex needs Implementation of new T3 CAMHS specification Performance monitoring of ADHD services Review children's equipment arrangements

KEY MILESTONES	Q1	Q2	Q3	Q4
Implementation of new T3 CAMHS specification				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
TBC				
KPIs in service spec				
Implementation of agreed pathway and KPIs				

RISKS	MITIGATING ACTIONS
2. LA could withdraw CAMHS funding	New steering group in place with performance framework that currently has robust clinical involvement and LA support

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby
Clinical Commissioning Group

Programme: Planned Care **Lead Clinician: Dr Martin Evans**

OBJECTIVE
To ensure that patients receive care in the most appropriate setting and to improve the quality and experience of care for patients. (Domain 1,3,4,5)

WHY CHANGE IS NEEDED?
We know there are opportunities to change the way care is delivered for a number of clinical services, some of which will see care delivered in a community setting. This will improve the patients experience through offering more timely access and convenient locations.

DESCRIPTION
Review the orthopaedic / MSK pathway in Southport & Ormskirk Trust Implement Community Ophthalmology Schemes Ensure that key Better Care Better Value benchmark indicators are implemented where performance has declined Implement Alternative Quality Contract for local indicators with Southport & Ormskirk Trust. Any Qualified Provider procurements podiatry, audiology and MSK Community anticoagulation service re-procurement

WORKFORCE IMPLICATIONS
Training requirements for Community Optometrists wishing to participate in scheme. If significant shifts between providers for AQP / MSK may have workforce implications for current main provider.

KEY MILESTONES	Q1	Q2	Q3	Q4
Community Ophthalmology Scheme				
Orthopaedic / MSK				
Alternative Quality Contract				
Anticoagulation procurement				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Orthopaedic first outpatient referrals (all providers inc Independent)				
Referrals to MSK by GP Practice				
Ophthalmology first outpatient referrals (all providers inc Independent) and follow up rate				

RISKS	MITIGATING ACTIONS
MSK services not fully utilised – patients access secondary care services (financial risk)	Ownership of any changes by local GPs New model must demonstrate improved quality and experience for patients
Community Ophthalmology Scheme not fully utilised (financial risk)	Ownership of any changes by local GPs New model must demonstrate improved quality and experience for patients
Failure to deliver BCBV indicators (referral rates, follow ups and consultant to consultant) (Financial risk)	Performance management of rates, early discussion if performance slips with plan to bring performance back to trajectory

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	Ophthalmology 34k	
2014/15		
2015/16		
Total		

Southport and Formby Clinical Commissioning Group

Programme: Cancer **Clinical Lead: Dr Graeme Allen**

OBJECTIVE
Early detection (1) Improve cancer survival (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Late detection is believed to be the key reason why cancer survival in the UK lags behind Europe. As a Cancer Network Merseyside and Cheshire needs to save 4000 lives a year to fall in line with European average survival rates. This equates to 1 life per GP practice. The ageing demographic will also result in higher rates of cancer diagnosis, so we cannot afford to stand still. Evidence shows that cancers detected via emergency presentations are likely to be later stage with correspondingly poorer prognosis than those detected via a managed ideally 2 week wait route

DESCRIPTION

- Ensure GPs receive timely information relating to their practice's cancer performance, eg 2week wait referral rates, diagnostic yield from 2 week wait referrals. presentation routes, staging data
- Provide support (Cancer Network NAEDI project) to encourage reflective practice in relation to the management of potential cancer symptoms by general practitioners
- Provide support (Cancer Network NAEDI project) to develop cancer early detection action plans at a practice level eg improving breast screening uptake or follow up of patients who decline bowel cancer screening

KEY MILESTONES	Q1	Q2	Q3	Q4
All practices have access to their cancer practice profiles	X			
Include cancer intelligence within Mersey intelligence portal				X
Present findings of 2012/13 QP8 cancer pathway audits at a CCG level		X		

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
NAEDI primary care project managers make contact with % of practices-	75%	75%	75%	75%

RISKS	MITIGATING ACTIONS
Lack of engagement by practices	Work through localities and educational opportunities
Delays in data provision	Work with the data provider
Sustainability of NAEDI project manager roles	Review workload on regular basis

WORKFORCE IMPLICATIONS
The Cancer Network's National Awareness and Early Detection Initiative (NAEDI) project team are instrumental in providing support to individual practices. The team are employed by CRUK and exclusivity to Cheshire and Merseyside cannot be guaranteed

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS Southport and Formby Clinical Commissioning Group

Programme: Cancer **Clinical Lead: Dr Graeme Allen**

OBJECTIVE
Early Detection (2) Improving cancer survival (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Late detection is believed to be the key reason why cancer survival in the UK lags behind Europe. As a Cancer Network Merseyside and Cheshire needs to save 4000 lives a year to fall in line with European average survival rates. This equates to 1 life per GP practice. The ageing demographic will also result in higher rates of cancer diagnosis, so we cannot afford to stand still. Evidence shows that cancers detected via emergency presentations are likely to be later stage with correspondingly poorer prognosis than those detected via a managed ideally 2 week wait route

DESCRIPTION

- Incentivise 14 day pathways to key diagnostics (rather than outpatient clinic) through CQUIN
- Ensure optimum performance against 14 day referral to first seen target for suspected cancer patients
- Consider introduction of direct access flexible sigmoidoscopy to improve early detection of colorectal cancers

KEY MILESTONES	Q1	Q2	Q3	Q4
Produce a leaflet to encourage attendance at 2 week wait clinics	■			
Introduce cancer waits CQUIN	■			
Make decision on implementation of direct access flexible sigmoidoscopy				■

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Cancer waits 2 week wait Southport & Ormskirk Hospital	93%	93%	93%	93%
Performance against cancer waits CQUIN requirements	Tbc			

RISKS	MITIGATING ACTIONS
Financial impact of direct access flexible sigmoidoscopy	

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Programme:Cancer **Clinical Lead: Dr Graeme Allen**

NHS
Southport and Formby
Clinical Commissioning Group

OBJECTIVE
Ensuring prompt access to high quality cancer treatments (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Ensuring that all cancer patients receive the appropriate treatment, promptly and delivered to a high standard, is critical to improving cancer outcomes. Cancer Peer review has identified some areas of concern in the quality of service provision locally. Performance for the 62 days referral to treatment standard has slipped during 2012/13, average performance 84.2% year to date (Commissioner based –December 2012) against a standard of 85%

DESCRIPTION
• Identify the need for service improvements using the annual cancer peer review cycle holding providers to account through remedial action plans. • Ensure compliance with cancer waits 31 and 62 day targets

KEY MILESTONES	Q1	Q2	Q3	Q4
Peer review reporting				
Introduction of cancer waits CQUIN				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Peer review compliance with measures		100%	100%	100%
Performance against requirements of cancer waits CQUIN	tbc			
Cancer waits 31 days target		95%	95%	95%
Cancer Waits 62 day target (aggregate measure)		86%	86%	86%

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby
Clinical Commissioning Group

Programme: Cancer **Clinical Lead: Dr Graeme Allen**

OBJECTIVE
Cancer Survivorship – supporting people and families affected by cancer (Domain 2,3,4)

WHY CHANGE IS NEEDED?
There are now about 1.8 million people living in England who have had a cancer diagnosis. By 2030 it is anticipated that there will be 3 million people in England living with and beyond cancer. People living with and beyond cancer often have specific support needs which, if left unmet, can damage their long-term prognosis and ability to lead an active and healthy life. These needs can include information about treatment and care options, psychological support, access to advice on financial assistance and support in self-managing their condition. Cancer patient experience surveys undertaken by Southport and Ormskirk Hospitals indicate that there are unmet information support needs especially in regard to financial and benefits advice.

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Monthly contacts at Southport Macmillan Cancer Information Centre	120	100	115	120

RISKS	MITIGATING ACTIONS

DESCRIPTION
Continue to promote and evaluate the services of the Macmillan Cancer Information Centre in Southport Review the service provided by CAB for cancer patients in Southport & Formby Undertake needs assessment for psychological support services for cancer patients in Southport & Formby Undertake needs assessment for physical activity programmes for cancer survivors

WORKFORCE IMPLICATIONS

KEY MILESTONES	Q1	Q2	Q3	Q4
2 year annual report Macmillan Cancer Information Centre				
Psychological support needs assessment				
Physical activity needs assessment				

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £'000
2013/14		
2014/15		
2015/16		
Total		

Programme: End of Life **Lead Clinician: Dr Karen Groves**

NHS Southport and Formby Clinical Commissioning Group

OBJECTIVE
To decrease the number of people at end of life dying in a hospital setting To Increase the number of people at end of life dying in their normal place of residence. (Domain 3,4,5)

WHY CHANGE IS NEEDED?
Population forecasts published in 2012 suggest Sefton's resident population is set to grow by around 5% by 2035. The largest percentage increase across the population will be amongst older residents, aged 65 and over, with this age group expected to rise by more than 40% from 59,000 in 2012 to 83,000 by 2035. With 21% of residents in area aged over 65, Sefton already has one of the highest proportions of older residents nationally. A survey commissioned by the National Audit Office and based on data from Sheffield in 2008 found that 40% of 200 patients who died in hospital were found to have had no medical need which required them to be in hospital at the point of admission, and could have been cared for and died elsewhere.

DESCRIPTION
Hospice at Home Consultant End of Life Care at Home Partnership, is an outreach service provided by a recognised Specialist Palliative Care Consultant led unit. It is able to provide a full range of hospice/specialist palliative care services and so give the patient and family the appropriate service at the appropriate time to meet their specialist needs. The aim of this service is to fill the gaps in the usual planned and currently funded community and sitting services, to ensure people can stay in their own homes. This is also in line with government policy to provide care to enable more patients to die at home. **End of Life Care Home Facilitator** This End of Life Care Home Facilitator's role involves working within the framework of the North West End of Life Care Model, in ensuring best practice end of life care for all conditions. The role plays a key part in enabling and empowering health and social care professionals to deliver best practice end of life care in their organisations.

KEY MILESTONES	Q1	Q2	Q3	Q4
Ensure staff capacity to deliver H@H service				
Increased number of care homes participating in education programme				
Encourage GP Practices to find their 1% of patients at end of life (QP Indicators)				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Increase of people dying in their normal place of residence				
Decrease in unnecessary hospital admissions				
GP Practices identifying and recording their 1% of patients at end of life				

RISKS	MITIGATING ACTIONS
Patients not being identified as being at end of life	Full review of pathway
Care homes not participating in education programmes	Engagement strategy

WORKFORCE IMPLICATIONS
None at this time

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	H@H = £160,000 Care Home facilitator = £45,000	Not known at this time
2014/15	H@H = £160,000 Care Home facilitator = £45,000	Not known at this time
2015/16	H@H = £160,000 Care Home facilitator = £45,000	Not known at this time
Total	£615,000	Not known at this time

NHS
Southport and Formby
Clinical Commissioning Group

Programme: Obesity **Lead Clinician: To be confirmed**

OBJECTIVE
Develop an obesity strategy and clarify obesity treatment pathway. (Domain 1,2,4,5)

WHY CHANGE IS NEEDED?
Nearly half of the adult population are overweight, obese or very obese (108,000 adults). A quarter of 5 year olds and more than a third of our 11 year olds are now overweight or obese.

DESCRIPTION
Develop an obesity strategy that links the current weight management programme with BMI screening, public health interventions and opportunities provided by Sefton Council and other voluntary sector organisations Work with public health to ensure that prevention based interventions/programmes are part of clinical interventions for patients (adults and children) who are overweight or obese Clarify the referral criteria and treatment pathway for bariatric surgery

KEY MILESTONES	Q1	Q2	Q3	Q4
Sefton wide obesity strategy agreed			■	
Every contact counts implemented			■	
Review bariatric surgery pathway				■

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16

RISKS	MITIGATING ACTIONS
Funding only ring fenced for 2 years	Value for money evidenced

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Southport and Formby Clinical Commissioning Group

Programme: Alcohol **Lead Clinician: To be confirmed**

OBJECTIVE
To slow down the current rate of alcohol related hospital admissions To reduce current levels of binge drinking To increase the capacity and skills of hospital staff at S&O Hospital to provide screening and brief intervention support to increasing and higher risk drinkers (Domain 1,2,3,4)

WHY CHANGE IS NEEDED?
Alcohol related admissions is in the upper quintile in wards within this CCG. Approximately 1 in 4 men and over 1 in 7 women drink at increasing or higher risk levels. This is similar to regional average. Higher risk drinking is more common amongst males.

DESCRIPTION
In partnership with West Lancs CCG jointly commission and performance manage the Hospital Alcohol Liaison Service at Southport & Ormskirk NHS Hospital Build capacity and skills to facilitate the provision of Identification and Brief Advice(IBA) across all Southport & Ormskirk Hospital Sefton council is currently commissioning an integrated substance misuse service. We will work with them to ensure the service is responsive to the needs of residents and is integrated via appropriate pathways with CCG commissioned services.

KEY MILESTONES	Q1	Q2	Q3	Q4
Ensure all practices read code all patient intervention offers				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Achieve reductions in the projected rate of increasing AF1 alcohol specific admissions at Southport & Ormskirk Hospital	-5%	-5%	-5%	-5%
Achieve reductions in the length of stay as a result of alcohol specific admissions	-5%	-5%	-5%	-5%

RISKS	MITIGATING ACTIONS
Inability to recruit Alcohol Specialist Nurses	Provide in house alcohol specialist nurse training for existing S&O staff
Committing to 1 year funding only will not return savings on investment	Commit to a 3 year funding programme for the Alcohol Specialist Nurse Service
Reliant on partnership investment with West Lancs CCG	Negotiate with W Lancs CCG re investment intentions Years 2/3

WORKFORCE IMPLICATIONS
Alcohol Nurse Specialists 1 WTE Band 7, 3 WTE Band 6

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	108,700	61,000
2014/15	111,000	400
2015/16	111,000	86,000
Total	330,700	147,400

NHS

Southport and Formby
Clinical Commissioning Group

Programme: Maternal Health **Lead Clinician: to be confirmed**

OBJECTIVE
Increase initiation and continuation rates for breastfeeding (Domain 1,2,3,4)

WHY CHANGE IS NEEDED?
Sefton rates, although the highest in North Mersey are below the regional and national average. Breastfeeding . Breastfeeding is the best form of nutrition for infants. Exclusive breastfeeding is recommended for the first 6 months of life. Available evidence suggests breastfeeding may have long term benefits such as reducing the risk of obesity and type 2 diabetes

DESCRIPTION
The CCG will work with partners to develop an environment that encourages and enables women to breastfeed. We will work to ensure that services provide individualised care and support, specifically we will Use commissioning levers to ensure maternity providers used by Sefton women are on target to achieve the UNICEF Baby Friendly Initiative Develop a CQUIN that rewards maternity and community providers who achieve improvements in initiation and continuation rates Work with public health to explore the possibility of a similar reward scheme for the community peer support scheme. Contribute to the Maternity Services Liaison Committee action plan objective of increasing breastfeeding, especially amongst younger women and those from the most socially and economically deprived areas. Support the Liverpool City Region Child Poverty and Life Chances Commission to implement their plan to increase Breastfeeding across Merseyside.

KEY MILESTONES	Q1	Q2	Q3	Q4
Liverpool Community Health to complete stage 3 BFI assessment				■
Southport & Ormskirk Trust to receive Breastfeeding initiative assessment	■			
Agree collaborative approach to commissioning with NCB and LA	■			

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
To be agreed				

RISKS	MITIGATING ACTIONS
Fragmented commissioning of key services which influence decisions to breastfeed and provision of breastfeeding support	CCG, NCB and LA to agree joint targets and performance monitoring, and service improvement systems.

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Programme: Primary Development **Clinical Lead: Dr Bal Duper**

NHS
Southport and Formby
Clinical Commissioning Group

OBJECTIVE

To devise a primary care medical strategy focusing on local priorities to support continuous primary care quality and development. The aim is to improve quality, capability and productivity further and to create capacity within primary care.
(Domain 1,2,3,4)

WHY CHANGE IS NEEDED?

From April 2013 a statutory duty of the CCG will be to assist and support the NCB in discharging its duty in relation to securing continuous improvement in the quality of primary medical services.

NHS restructures / changing policies especially in regard to NCB

Primary care capacity and development to reflect NHS and population

DESCRIPTION

The process of developing the strategy will include key stakeholders and engagement of people directly involved in delivering primary care services. The strategy will consider

- practice demographics
- Workforce development
- Clinical services particularly primary care through locality model
- Premises / estate management
- IT
- Health outcomes of primary care activity

KEY MILESTONES	Q1	Q2	Q3	Q4
Draft Primary Care (Medical) Strategy	■			
Board Approval		■		
Implementation strategy			■	
Investment of areas in primary care strategy				■

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Quality premium – primary care areas		■		
Primary care strategy in place		■		
Investment of primary care development			■	

RISKS	MITIGATING ACTIONS
Variable engagement from stakeholders	Involvement with partners eg: LMC, Locality clinicians
Involvement in primary care development reflecting patient needs	Strategy will reflect recommendations of recent Francis report
Resources within CCG for substantial piece of work	Consider investment

WORKFORCE IMPLICATIONS

To be determined via primary care strategy

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	To be determined	
2014/15	To be determined	
2015/16	To be determined	
Total		

Programme: Medicines Management Lead Clinician: Dr Hilal Mulla / Dr Janice Eldridge

OBJECTIVE

To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money. (Domain 1,2,3)

WHY CHANGE IS NEEDED?

Primary care prescribing accounts for one in every nine pounds spent in Southport and Formby CCG. The pressure on prescription item growth will continue at 6-7 % pa. There is a constant requirement to work towards the statutory duty of the CCG to remain in financial balance. There is a duty to ensure health outcomes for patients are improved by prescription of medicines rather than management of cost alone. This will require support in evidence based decision making, focussing on vulnerable patient groups and continued engagement with primary care prescribers.

DESCRIPTION

A clear and realistic medicines optimisation plan based upon a realistic prescribing budget will keep primary care prescribers engaged in safe and effective prescribing. A strong medicines management team support will support the delivery of the plan in addressing both therapeutic and disease areas in practice as well as supporting different systems of work in prescribing.
Engage with over providers to direct accountability and responsibility for supply of medicines/ appliances to the most appropriate service.
Medicines support to the older persons /long term conditions management project

KEY MILESTONES	Q1	Q2	Q3	Q4
Optimisation plan ratified				
Work stream plan developed				
All practices visited to ensure plan is actioned				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Evidence based decision making programme delivered				
Patient education campaign on medicines waste				

RISKS	MITIGATING ACTIONS
Financial balance is not achieved	Prescribing quality scheme to engage practice
Lack of capacity of medicines management team to deliver support at practice	Support of team members and investment in key area to ensure support is consistent

WORKFORCE IMPLICATIONS

Practice coverage plan in place. Locality leads for medicines management now in place.
Review of functions in practice to maximise benefits of support to prescribers.

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		900,000
2014/15		
2015/16		
Total		

2.3 Additional information relating to the NHS Framework domains

Ensuring people have a positive experience of care

Currently 92% of patients have a good experience of primary care and 79% have a good experience of Out of Hours (OOH.)

We will work with practices to improve the quality of primary care - this is one of our strategic objectives. The OOH service is currently out to tender and we will work with the successful bidder to improve patient satisfaction for OOH services

Patient Experience of hospital care: Southport and Ormskirk Hospital Trust is on the national average, the other providers are above the national average, the data for the Ramsey Group is not available.

We will work with each provider to understand the patient's experience and together will implement the friends and family test and ensure that the results are clearly published on the Trust's and CCG's web page. A large proportion of practices now have a Patient Reference Group and our Engagement and Patient Experience Group (EPEG) is co-ordinating a range of relevant activities to gain feedback (see p52).

Providers (ordered by number of admissions) for this CCG	Number of Admissions / spells (Acute 2010/11)	4b Inpatient Overall Experience	4.1 Outpatient Overall Experience	4.2 Inpatient Responsiveness to needs	4.3 A&E Overall Experience
Southport & Ormskirk Hospital NHS Trust	24,674	76	79	64	79
Aintree Hospitals NHS FT	2,054	77	79	69	83
Ramsay Healthcare UK Operations Ltd	1,260	NA	NA	NA	NA
Alder Hey Children's NHS FT	1,013	NA	NA	NA	NA
Royal Liverpool & Broadgreen Hospitals NHS Trust	984	77	81	70	82
CCG weighted average		76	79	64	79
England average		Tbc	Tbc	Tbc	Tbc

Treating and caring for people in a safe environment and protecting them from avoidable harm

Current Health Care Associated Infection (HCAI) rates:

- MRSA (rate per 1000) = 3.91 Bottom Quintile (worse)
- C Diff (rate per 1000) = 37.9 Bottom Quintile (worse)

During 2013-2014, we plan to:

- Significantly reduce C Difficile in all providers in the local health economy (Appendix 6)
- Use the National Quality Dashboard to identify potential safety failures in providers
- Deliver zero tolerance to MRSA infection and conduct Post Infection Review

We have support from CMCSU to ensure that the indicators relating to HCAI (MRSA and C Diff) are in the provider contracts for 2013-14. Our Chief Nurse supports the CCG Clinical Quality Leads in this area. HCAIs will continue to be a focus of discussion at the appropriate contract / quality meetings with remedial action planning being put in place as appropriate. We are working in partnership with Liverpool CCG and providers to set up a Strategic HCAI forum to address these issues that will be led and driven at a strategic level – CCG representation includes the GP Clinical Lead for Quality, Chief Nurse and the Head of Medicine's Management. Current status regarding HCAI will be a standard agenda item at the Quality Committee with reporting also to the Governing Body Board Meeting. We also plan to link to the Quality Premium, part of which covers HCAI.

3.0 The 3 local priorities – Quality Premium

Ownership of the local priorities

The following local priority areas have been agreed by:

- The CCG Governing Body during informal and formal Board meetings in February and March 2013
- The CCG Wider Constituent membership – through the Wider Group meeting in March 2013
- The Health and Wellbeing Board – formally presented at March meeting and supported
- The CCG Experience and Patient Engagement Group (membership including Sefton LINks, Sefton CVS, Sefton MBC and CCG Board Lay and Practice Manager members.) March session

The priorities have also been mapped to the Health and Wellbeing Strategic Objectives, the CCG Commissioning Intentions, and feedback from recent public consultation events to ensure that they fit strategically and respond to issues raised by local people.
These are shown in Appendix 2.

Our 3 local priorities are:

A reduction in the number of patients who have an emergency admission for dehydration.

Rationale - We are an outlier on the Better Care Better Value indicators for this and it reflects the age of our local population. We plan to take a more proactive approach with supporting our care homes and through this we expect to prevent admissions. We are also working with our local Acute Trust to develop an integrated care pathway for Frail Elderly patients and this will also contribute to reducing admissions.

Measures – Reducing emergency admissions (adults) for dehydration by 10 %.

1) **Reduction in hospital admissions for patients under 19 related to asthma**

Rationale - The NCB outcomes benchmarking pack and the Atlas of Variation shows that Southport and Formby has more admissions than the national average in this area.

A new children's community nursing team will be established and will work with general practice to support children and families to prevent admissions.

Measures- 20% admissions for asthma <19 years

Offer Interventions to Patients with Alcohol Related Admissions

Rationale - In Sefton one in five residents drink at increasing or higher risk levels and one third of all hospital admissions are in some way alcohol related. Across Sefton the costs to the health service of alcohol related harm is estimated to be £14,755,000 (Sefton Comprehensive Needs Assessment May 2012).

Measures – 20% of alcohol related admissions will receive an intervention.

Delivering and monitoring progress through localities

Our four localities will play a key role in the planning and implementation of these local quality premium priorities and monitoring progress towards the national measures. Locality Managerial leads will work with clinical leaders within the localities to drive this process, supported by the GP lead for Quality and the Head of CCG Development.

The proposed process is:

Quarter 1: Consider benchmarks and agree plan of action within each locality.

Quarter 2: On-going implementation of plan and data review

Quarter 3: Review progress against quality measures

Quarter 4: Final data capture to demonstrate improvements.

Progress against the measures will also be included in the CCG Board performance dashboard.

4.0 The Basics of Care

We will drive quality improvement in the delivery of care from all providers and will seek on going assurance that provider cost improvement programmes, and services, are safe for patients with no reduction in quality and do not contravene NICE guidance.

We have plans in place to utilise suggested tools - Quality Dashboards and the Safety Thermometer - together with intelligence from staff and patient surveys. A Quality Dashboard, that includes staff survey information, is presented to both the Quality Committee and to our Governing Body. Our main providers voluntarily participate in the North West Transparency in Care Audit, which reports on a monthly basis in the public domain information on staff views regarding the organisation as a place to be cared for at when harm (e.g. pressure ulcer or fall) has occurred on a particular ward or department.

We have agreed the local quality indicators and CQUINs relating to patient safety and patient experience that it wishes to be negotiated into the contracts for 2013-14 alongside the national mandated indicators and CQUINs. We will be supported in this by CMCSU in this.

Our GP Quality Leads, supported by our senior management team and CMCSU, lead the Quality Contract meetings with providers, where performance in relation to quality is monitored. Finance representation at the Quality Committee is provided by our Chief Finance Officer and Quality representation at the Finance and Resource Committee is provided by our Chief Nurse, as part of our risk management processes.

'How to Guides' – such as the Quality Impact Assessment of Provider CIPs and Rapid Response Review - will be used as appropriate under the Governance arrangements set out within the CCG constitution.

In addition we are commissioning a governance review by Merseyside Internal Audit Authority (MIAA) to test committee functions in order to add extra assurance.

5.0 Patients' Rights: The NHS Constitution

We are developing a framework to performance manage the requirements of the NHS Constitution. The CCG Experience and Patient Engagement Group (EPEG) will have the responsibility within the governance structure to review this framework in order to reassure our governing body and our wider members that the rights and pledges from the NHS are adhered to across the system.

5.1 Eliminating Long Waiting Times

We have plans to ensure:

Referral to Treatment for waiting times for non-urgent consultant-led treatment:

- 90% of admitted patients to start treatment within a max of 18 weeks from referral
- 95% of non-admitted patients to start treatment within a max of 18 weeks from referral
- 92% of patients on an incomplete non-emergency pathway (yet to start treatment) should have been waiting no more than 18 weeks from referral

We will ensure that patients have access to high quality treatment in a timely manner. This means patients will be seen and treated within the 18 week pathway. We will work with Southport and Ormskirk Hospital Trust to maintain performance and ensure that we have early warning of any potential problem and offer patient alternative pathways.

We will also work with the Trust to ensure that there are no patients waiting over 52 weeks and that the Trust moves to a maximum waiting time of 40 weeks. SFCCG will use contractual levers where appropriate.

Diagnostic test waiting times

We plan to ensure:

- 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral

In order to help Southport and Ormskirk deliver the 18 week pathway, we will work with the Trust to enable patients to access diagnostic tests within 6 weeks.

5.2 More Responsive Care: Urgent & Emergency Care

A&E waits

We plan to ensure:

- 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- No patient to wait on a trolley for longer than 12 hours

We are working with Southport and Ormskirk Hospital Trust to deliver the A&E standard. Whilst the Trust has struggled to deliver the standard over the past two years, the health economy has made improvements in urgent care pathways, many of which are based on prevention of attendance / admission by managing people in the community. As an Integrated Care Organisation, Southport and Ormskirk Hospital Trust is well placed to implement these new pathways. In addition, we will work with the Trust to improve patient flow from admission to discharge.

Category A ambulance calls

We aim to ensure:

- 75% Category A calls resulting in an emergency response arrive within 8 minutes (met for red 1 and red 2 calls separately)
- 95% Category A calls resulting in an ambulance arriving at the scene within 19 minutes

Urgent and Emergency Care

- All handovers between an ambulance and an A&E department to take place within 15 minutes and crews ready to accept new calls within further 15 minutes
- Implement contractual fine for all delays over 30 minutes, further fine for delays of over an hour

Sefton saw a surge in Category A calls in the latter half of 2012. The CCG is looking at several data sources to understand this surge, however this target has been met by NWAS in the past, and the CCG has confidence that NWAS will deliver the target. We will apply the contract levers and fine the Trust for breaches of the 30 minute handover time

Cancer waits – 2 week wait

We plan to ensure:

- 93% max 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP
- 93% max 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)

Actions to achieve this:

- Implement cancer waits CQUIN which incentivises delivery of first key diagnostic test (rather than outpatient appointment) by day 14 and reducing cancellations and DNAs of 2 week target appointments
- Modelling has shown that delivery of the first key diagnostic within 14 days has a strong positive impact on reducing 62 day breaches
- Produce a refreshed patient leaflet to be given by GP at the time of referral to help patients understand why they have been referred urgently and encourage attendance. DNAs and cancellations of 2 week wait target appointments have a significant impact on efficiency and performance, as well as delaying treatment

Cancer waits – 31 days

We plan to:

Maintain good Trust and CCG level performance against the standards set out below.

- 96% max one month (31-day) wait from diagnosis to treatment for all cancers
- 94% max 31 day wait for subsequent treatment where that treatment is surgery
- 98% 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen
- 94% max 31 day wait for subsequent treatment where that treatment is a course of radiotherapy

Surgical capacity is the most common issue accounting for breaches.

Cancer waits – 62 days

We aim to deliver:

- 85% max 2 month (62-day) wait from urgent GP referral for treatment for cancer
- 95% max 62 day wait from referral from an NHS Screening service for treatment for all cancers
- Max 62 day wait for FDT following a consultant's decision to upgrade the priority of the patient (all cancers) - no operational standard

We plan to:

- Implement cancer waits CQUIN which incentivises referral to treating trust by day 42 of the pathway
- Continue to monitor performance closely. A number of improvement areas have been identified – for example the use of timed diagnostic pathways for specified tumours especially those using specialist surgical centres where multiple trusts are likely to be involved
- Work with Southport and Ormskirk to use the Intensive Support Team to support this area of work

5.3 Keeping Our Promises: Eliminating mixed-sex accommodation

Mixed sex accommodation breaches

We will work in partnership with our commissioned providers to ensure there are minimal mixed sex accommodation breaches. This will be monitored through the appropriate contract and quality meetings supported by CMCSU and appropriate action taken – for example remedial action plan, or invoking of financial penalties. Performance and Quality Reports, which include mixed sex accommodation breaches, is a standing agenda item at our Quality Committee and the Governing Body meetings.

5.4 Keeping Our Promises: Reducing Cancellations

Cancelled Operations

- All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice
- No patient to tolerate an urgent operation being cancelled for the second time

We will work with Trusts to ensure that cancelled operations are kept to a minimum and where an operation is cancelled patients are offered an alternative date within the 18 week pathway where possible.

5.5 Mental health

We plan to ensure:

- 95% of the proportion of people under adult mental health specialities of Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric in-patient care during the period. (Currently 97.25% is achieved)
- The full roll-out of the access to psychological therapies programme by 2014-15 and reach a 50% recovery rate

5.6 Keeping Our Promises: Choice and the information to exercise it

We are committed to ensuring the delivery of the 18 week Referral To Treatment standard for our population and we will continue to rigorously performance manage providers to ensure contract compliance with this national standard.

As set out in the NHS Constitution, we will ensure that in the unlikely event that a patient breaches this target, and they have not chosen to wait longer or it is not clinically appropriate they do so, there is an effective working process in place to offer a range of alternative providers using the 'Right to Redress' process adopted by our local providers.

We will work with all our providers to ensure outpatient letters provide patients with information on their right to treatment within maximum wait times and have a process in place for patients who are concerned or will likely to wait longer to formally redress the situation.

During 2013-2014, we will explore the health market for service providers who have the capacity and capability to deliver the high quality, timely and cost effective services our population require and are able, within the competitive market, to demonstrate a willingness and ability to meet all national and local standards.

We will promote the use of Choose and Book with our GP colleagues, and will continue to work with our Local Hosted Trusts to reduce slot issues to the 'gold standard 0.04 slot issues per successful Choose and Book Booking'. This will be performance managed to ensure capacity is proactively managed and appointments made available to Choose and Book.

5.7 Keeping Our Promises: Dementia, IAPT, Military Veteran health, Offender health, Health visitors

Dementia

Aim to increase timely detection rates across Sefton to 75% by 2015-16:

Primary Care:

- Dementia: (NHS Outcome Framework Domain 1, Domain 2, Domain 4 and Domain5)
- Current rate of detection for dementia is: NHS Southport and Formby CCG - 49%
- ‘Care Closer to Home’ and ‘Virtual Ward’ approaches and via CQUIN’s with Liverpool Community Health Trust and Merseycare NHS Trust
- Improved access to GP and health screening for Sefton residents over age 65
- In the GMS – Contractual Changes 2013/14 (for consultation) the NHS Commissioning Board to develop a Dementia Case Finding Scheme with GP’s.
- Extra support for GPs on dementia, the Department of Health is working on a dementia toolkit for surgeries. This is to better equip them to spot and diagnose dementia, and to help people with dementia and their carers to manage the condition.
- GP support from Alzheimer’s’ Society (Sefton) for training and awareness raising
- Increase in ‘appropriate’ patient flow from GP practices to Memory Assessment Units in Waterloo and Southport
- Increase in locality based assessment of the psycho-geriatrician service e.g. in persons home, as appropriate
- Increase in appropriate prescribing of anti-dementia drugs which can help to delay progression of disease

Secondary Care:

- A National CQUIN has been developed that will have 3 main aims:
- Identify people with dementia – members of staff in hospitals will ask members of the family or friends of a person admitted to hospital if the patient has suffered any problems with their memory in the last 12 months
- Assess people with dementia – if there is evidence to suggest a problem with their memory, that person will be given a dementia risk assessment

Refer on for advice – a referral would be made for further support either to a liaison team, a memory clinic or a GP

Aim to enhance the quality of life for people with dementia:

Improve access to post diagnostic support through access to a full range of services including Alzheimer's Society Dementia Community Support Service, Peer Support Groups / Dementia Cafes following diagnosis

Working collaboratively with Sefton Council and other partners ensure each person has a personalised care plan post diagnosis

Ensure people with dementia have access to advocacy assistance if required through Sefton Pensioners Advocacy Centre, Sefton Carers Centre

Ensure people diagnosed with dementia and their carers have full benefits check post diagnosis

Increased carers assessments and individualised support for carers of people with a diagnosis of dementia

Improve access to appropriate community and social networks to maintain independence via voluntary community and faith sector support and sign up to Dementia Action Alliance

Aim: Achievement of the Care Programme Approach (CPA) follow up target: (NHS Outcome Framework Domain 2, Domain 3, Domain 4)

Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%

Increase the proportion of people with depression/anxiety entering treatment

NHS outcomes framework 2013-14 Domain 4 - Ensuring that people have a positive experience of care. Patient experience of community mental health services (4.7)

Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.

Aim: Improving Access to Psychological Therapies (IAPT): (NHS Outcome Framework Domain 2, Domain 3, Domain 4)

The plan is to employ IAPT Wave 5 trainees that are currently employed on temporary contracts as permanent staff post qualification. Funding for wave 5 investment been agreed by Financial Sub Committee of NHS Southport and Formby CCG and NHS South Sefton CCG to ensure success in achieving the 11% prevalence target for 2013-14

To participate in Wave 6 of the roll out to achieve DH objectives of meeting 15% prevalence with recovery rates of 50% by 2014-15. Three IAPT CQUIN's have been developed to achieve the overall outcome on improving access to psychological therapies:

CQUIN 1:

Inclusion Matters (IM) will increase the delivery of psychological therapies through on-line, telephone, text and remote video interactions.

1. IM to develop an e-clinic model to improve online access to psychological therapies.
2. In the first year to train 10 staff in each area to deliver online therapy
3. By Q4 trained staff to deliver 15% of therapy online
4. IM to produce Quarterly progress report

CQUIN 2:

Inclusion Matters will establish on-line relapse prevention facilities.

1. IM to develop an on-line relapse prevention facility.
2. In the first year to train 5 staff in each area to act as online facilitators
3. To develop online relapse prevention facilities in relation to at least three different conditions
4. By Q4 online relapse prevention will be offered to all clients who have finished a course of therapy in relation to the specific conditions
5. IM to produce Quarterly progress report

CQUIN 3:

In conjunction with Inclusion Matters Merseyside, Mayden Health, and Health Care Gateway, Inclusion Matters will develop a system for sending GP letters electronically.

IM in conjunction with partners to develop an electronic GP letter system

2. By Q4 all IM staff trained to in using electronic GP letters
3. IM to produce Quarterly progress report

Military Veteran health

The North West is the largest recruitment area for the British Armed Forces and accounts for 33% of the annual intake - in comparison to other regions. It is estimated that nearly 20% of all Military Veterans may suffer with anxiety and/or depression upon leaving the Services with a smaller percentage suffering from Post-Traumatic Stress Disorder and alcohol/substance misuse.

What is a Veteran?

The Ministry of Defence (MOD) defines a veteran as "anyone who has served in HM Armed Forces, at any time, irrespective of length of service (including National Servicemen and Reservists)".

In 2011 a number of legislative initiatives were proposed that ensured continued support for current and ex-service personnel. They included:

- Armed Forces Act 2011: Annual duty to report on progress against the Military Covenant to Parliament including health Health & Social Care Bill 2011: Includes duty of the NHS Commissioning Board to commission services on behalf of the Armed Forces.

- NHS Mental Health Strategy 2011: Includes a specific provision for veterans.

Under the new commissioning arrangements (see appendix 5) commissioning of services for Armed Forces Veterans, Reservists (when not mobilised) and Armed Forces Families (serving, reservist or veteran) are the responsibility of the CCG in each area. CCGs will also be responsible for the commissioning of emergency care services for veterans and family member in their area. It is also recommended that the hosting of the Armed Forces Network will be handed over to CCGs from the SHA.

Sefton Community Voluntary Services have led on the establishment and servicing or a Sefton Armed Forces Community Covenant Partnership to co-ordinate multi – agency activity. Sefton has now developed, and signed off, a Local Community Covenant which sets out commitments to supporting the Sefton armed forces community.

All CCGs across Merseyside were asked to consider continuation funding of the Military Veteran IAPT service for a further 12 months. The request is that each CCG allocates £32k (circa) for the service for 13/14. South Sefton and Southport & Formby CCGS (SS & S&F CCGs) have signed up to this for 2013-2014. The funding will be used for providing access to veterans to the MV IAPT Service which is Psychological therapies service based on the original IAPT model but adapted for ex and current Service Personnel and their families. This project is hosted by Pennine NHS Foundation Trust

The NHS is also supporting the Live at Ease Project – This project supports ex-service men/women to adapt to civilian life. The support includes help with housing, accommodation, employment, training, and debt advice and drug and alcohol dependency issues. The project will also support family members.

Liverpool Public Health Observatory is currently carrying out a health needs assessment for ex armed forces personnel and their families, on behalf of Merseyside and Cheshire Directors of Public Health. Initial findings have identified families:

- Have poor access to health and wellbeing advice
- Have depression, reliance on alcohol and anxiety as being common within service families
- Worry about a husband/wife/partner who is away on active service
- Struggle to cope alone and with children
- Live far away from their immediate family, lack of immediate support
- Have a limited social network, moving around prevents friendships and support networks forming
- Have financial insecurity, unable to work due to house moves and caring commitments.
- Suffer domestic abuse as both victims and perpetrators

There are no definitive figures on the total number of veterans in the UK at the present time. Estimates produced in 2007 by the Office of National Statistics in conjunction with the Royal British Legion (RBL). RBL extrapolated the findings of this survey to provide an estimate of 4.8

million veterans in the UK, with approximately 3.9 million in England. This equates to approximately 8% of the UK population aged over 16 years and over.

Local Authority	16-24yrs	25-34yrs	35-44yrs	45-54yrs	55-64yrs	65-74yrs	75+yrs	Total	Total Under 65yrs
*Sefton	516	797	1,996	2,282	2,400	6,569	9,567	24,128	7992
*Please note information currently not available at CCG level									

Currently all service personnel and families do not have an NHS number making it difficult to establish the level of spend on these groups. A project is on-going to map across Defence medical Service (DMS) number to the NHS number.

Further work will need to be undertaken to understand exact numbers, patient flows, and service uptake as current data suggest fluctuation in referral levels. Once this work has been completed CCGs will be better placed to understand future commitments, Consideration will need to be made for the recent military veterans redundancy scheme that will increase veterans returning to Sefton.

The Northwest armed forces Network held a commissioning handover event in March 2013, including handover arrangement for Clinical Commissioning Groups (CCGs). Each CCG identified a lead person to support and develop their local Military Health agenda.

SS & S&F CCGs will continue to work with Sefton CVS to undertake a mapping exercise of local services offering support to military veterans and their families to support and encourage partnership working.

6.0 Patient Centred, Customer Focussed

6.1 NHS services, 7 days a week

We plan to respond to the Medical Director's report to ensure primary and community services deliver high quality, responsive service in out of hours and ensure better access to routine services 7 days a week in urgent and emergency care and diagnostic services.

We have dedicated project management support to the area of unplanned care. The demographics of our CCG are indicating a predicted use of our over 75 population from 11.4% in 2011 to 13.5% by 2020. It is the intention in 2013-14 to review and transfer this element of care through work with all our partners and to this end we have established a 'care close to home' (CCH) network. The network involves the following membership:

- Mental Health Services
- Social Services
- Hospital Services
- Ambulance Services
- Community Services
- Other CCGs

Our strategic planning refresh and business plan for 2013-14 will focus on the four CCG key strategic elements - namely driving improvement in the public health and wellbeing of Sefton residents, improving quality of primary care and delivery of community services, reducing the demand on secondary care and ensuring cost effectiveness of high quality tertiary care - which are intrinsically linked to the true use of NHS services through 7 days a week. As commissioners we will work through the CCH network to specifically shape primary, community and secondary care services and focus on integration, with social care, support from the Ambulance Trust and the third sector. This work will help to drive out service transformation.

Work needs to be undertaken with our main secondary care provider to scope and understand the diagnostic requirements of our population and the capacity needs. This will not only support unplanned care delivery but also our planned care delivery. This work should support the findings of the review launched on the 18th January 2013 by Sir Bruce Keogh – NCB Medical Director. We work closely with West Lancashire CCG and South Sefton CCG around the Southport and Ormskirk ICO footprint. However, work across all six Merseyside CCGs with the NCB's Local Area Team to firm up future arrangements to 'share and spread' learning, is currently underway. There is a specific focus on the impact of the major strategic service changes, such as the reconfiguration of trauma, vascular, cancer and rehabilitation services at this more regional as well as local level for each individual CCG Commissioner. The work plan of the Merseyside CCG network will be prioritised during 2013-14 to focus on and be cognisant of the Keogh review.

6.2 More transparency, more choice

In summer 2013, the Healthcare Quality Improvement Partnership (HQIP) will develop methodologies for case-mix comparison and publish activity, quality measures and national survival rates for every consultant in:

- Adult cardiac surgery
- Interventional cardiology
- Vascular surgery
- Upper gastro-intestinal surgery
- Colorectal surgery
- Orthopaedic surgery
- Bariatric surgery
- Urological surgery
- Head and neck surgery
- Thyroid and endocrine surgery

We expect each of our providers for the services they commission to publish their own information on these specialities on their website in the HQIP format in preparation for inclusion in the standard contract 2014-15.

We are currently developing a plan to detail how we intend to increase Choice in 2013-14 at all points of the pathway and how, where and in what services / pathways choice and competition will make the most difference.

6.3 Listening to Patients and Increasing Their Participation

We are working with providers to gather public insight into local health services and our Quality Lead GP is working to develop a CQUIN on patient experience. We have systems to ensure patient experience and insight is reported to our Quality Committee for scrutiny and action, as this section describes:

Acting on feedback

We are exploring a number of options presently and working with providers in the development of a patient feedback framework (via the CQUIN) which places the patient at the centre of the service. However, taking into account the national policy direction, we are considering utilising the Patient Access to Health Records programme as a key mechanism by which patients can leave feedback in real time. We will be working with CMCSU to fully realise the potential of developing technology and utilisation of social media tools and other programmes via an expanding digital eco system. We recognises the opportunity for developing ICT based solutions and models that support the development of a participative society in which patients, their families and carers respond and interact collaboratively for their own benefit and for the benefit of the wider community as a collective movement (Social Return on Investment).

We recognises that the Friends and Family Test is still in developmental form and understand that each provider will have chosen to develop its own systems and processes (as independent businesses) by which they capture and report patient feedback. With the potential for diverse fragmentation of systems across providers and possible manipulation of data, we are focussed on the development of technological based systems - supported by a communication strategy and enhanced patient and public participation programme - which encourage Southport and Formby residents to become active citizens in their own health. Implementation of this programme fully supports the DH publications ‘The

Power of Information' (May 2012), articulating the NCB's commitment to improved customer service, through systematic patient and public involvement, intelligence based insight and positive patient outcomes.

We are of the opinion that the introduction of capturing real time feedback via Patient Access to Records (PATR) would generate significant savings (and supports the QIPP agenda) for providers who currently employ capacity and invest in systems and processes to support their own patient experience agenda and the newly introduced Friends and Family Test (FFT). In collaboration with our provider partners, we will seek to fully understand the potential for cost savings through development and implementation of comprehensive technological systems, which focus on patient experience and not based upon the commissioner/provider relationship. There is potential to capture all patient feedback in real-time via one source (PATR) linked to the NHS Information Centre for Health and Social Care (such a system could also be utilised by Social Care partners) providing a comprehensive data-set for patient consumption. The implementation of this process fits with the ideology and vision of the NCB National Director for Patients and Information, Tim Kelsey and supports the further role out of FFT into primary care by 2014-15.

We would welcome the opportunity to be a pathfinder in demonstrating how we would utilise the Patient Access to Health Records as a functional mechanism in reporting the consequences of feedback from the FFT.

Informing patients

We will continue to:

- Work with our local Health and Wellbeing Board to assess population need
- Work with Health Watch to ensure public involvement plans match local expectations for engagement at individual and collective level
- Develop metrics to evaluate socio economic return on investment and other impacts of patient and public involvement activities

We have played an integral role in the development of the Sefton Health and Wellbeing Board (HWBB). Our Chair has been a member of the shadow Board since its inception and has more recently been joined by our Accountable Officer. The HWBB, building on previous close working relationships in Sefton, has led an approach to assessing the population needs through a refresh of the JSNA. The results of this JSNA have

formed the basis of the Joint Health Strategy, which is currently out for consultation and has been the subject of a very extensive consultation process and (along with our CCG commissioning intentions for 2013-14) the focus of five large public events across Sefton during December 2012 and January 2013 (see Appendix 2 for details).

We have established a joint working group for both CCGs in Sefton called the EPEG (Engagement and Patient Experience Group), which feeds directly into the Quality Committee of each CCG. This group has a broad membership is Chaired by the CCG Lay Board members and comprises of CCG Board Practice Manager members, CCG senior managers, Sefton Council engagement leads, Sefton CVS and Sefton LINk and in future, it is hoped, members and officers of Health watch. This group acts by co-ordinating engagement activities and considers patient information from all parts of the system including GP Practice Patient Reference Groups, LINk Community Champions (who work in local community settings and feed into CCG localities), and LINk patient experience reports of our local providers and CCG wide systems, such as trends from complaints. Once in place, we will work with Sefton Health Watch to ensure that public involvement plans match local expectations for engagement at all levels.

We are seeking to work with CMCSU in developing metrics to evaluate the socio economic return on investments (SEROI) and other impacts of our patient and public involvement activities. We are alerted to the work of the NHS Institute of Innovation and Improvement in collaboration with David Gilbert of InHealth Associates and Sally Williams of Frontline. We are seeking to utilise the learning from the number of case studies referenced in 'The economic case for patient and public involvement in commissioning', co-authored by David Gilbert and Sally Williams. In addition, we will underpin the development of metrics to evaluate the SEROI by utilising learning from implementing our programme supporting shared decision making and fully utilising the recently published 'Smart Guides to Engagement'. We are awaiting the soon to be published 'individual' and 'collective' involvement guidance from the NCB.

6.4 Better data, informed commissioning, driving improved outcomes

Key areas include:

- Universal adoption of the NHS number as the primary identifier by all providers in 2013-14
- We will use the contract to ensure that our local Trust uses the NHS number as the primary identifier. GP practices will have to use the NHS number as part of the implementation of 111
- By the end of December 2013, over 95% of GP practices in Sefton CCG's will be on the EMIS Web clinical system. EMIS Web will provide the opportunity to utilise its searches and reports module to collect clinical data. A Risk Stratification facility is already in place and currently being utilised to present analysed data back to GP practices for clinical care
- A dedicated team of Information Facilitators within Informatics Merseyside will support GP practices and Sefton CCG's to extract and report on clinical data as required
- We will use NHS Standard Contract sanctions in 2013-14 if not satisfied with completeness and quality of provider data on Secondary Uses Service (SUS)
- We will ensure that secondary care providers will account for patient outcomes and they will ensure the adoption of safe, modern standards of electronic record keeping by 2014-15
- Based on our agreed Informatics Strategy of developing a local Electronic Patient Record (EPR) we are working with all partner Trusts to enable economy wide joined up patient care through systems integration, interoperability and information sharing, encouraging and developing integrated and electronic clinical pathways and communications across health care sectors
- We will ensure secondary care providers comply with data collections based on Information Standards Board and NCB advice by 30 September 2013
- We aim to move to a paperless referral system by 2015 to enable easy access to appointments in primary and secondary care
- We will work with GP practices to pro-actively increase uptake and utilisation of Choose and Book and support practices with training on the Advice and Guidance module to ensure paperless referral systems are utilised wherever possible
- Work is currently on going to utilise EMIS Web's internal referral system to enable electronic referrals across primary and community care. This will be rolled out to all EMIS users as the functionality becomes available

- Direct Commissioners will be responsible for the development of the primary care medical care record by Spring 2015
- An Informatics Strategy has been developed in conjunction with Informatics Merseyside. One of the key components of the strategy is patient empowerment. A key element of this component is the Patient Access to Medical Records project which is currently in progression with two pilot sites. The pilot will establish correct processes and protocols around Patient Access. The results of the pilot will be discussed by our Governing Body and the Local Medical Committee and from this point, future activity will be planned accordingly in response to the findings of the pilot
- The NCB is accountable for ensuring delivery of IT services is devolved to CCGs to manage GP IT services
- We have a Service Level Agreement in place with the CMCSU (and its strategic partnership with Informatics Merseyside) to commission appropriate GP information services to provide clinical assurance and safety

6.5 Higher standards, safer care

Along with the Health and Wellbeing Board, we will work with providers to ensure the recommendations in Transforming Care: A National response to Winterbourne View Hospital and Francis report are implemented, and ensure a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care that have a mental health condition or challenging behaviour.

Our Joint Commissioning Manager for adult services is leading across health and social care on the local response and planning to Winterbourne. We are receiving commissioning support from CMCSU regarding individual packages of care and complex cases but – with Sefton Council – we have retained a specific joint post that has a portfolio around Learning Disability and the commissioning of individual packages of care. Once the Francis Report is published, plans are in place to present the recommendations to the HWBB, Quality Committee and Governing Body.

Chief Nurses across Mersey are working collaboratively to ensure that Nursing Quality Indicators and necessary CQUINs are negotiated into the contracts for 2013-14 as appropriate.

We aim to ensure the Compassion in Practice standards and application of the 6 C's are implemented across all the services provided for our population. We are involved in the regional work regarding informing the implementation of the strategy. Chief Nurses across Merseyside are working in collaboration with the support of CMCSU to develop quality indicators and CQUINs for negotiation into the contract with providers from 2013-14. In particular, we will work in partnership with the NCB Local Area Team as part of their quality improvement role.

We have a lead for Primary Care Quality and Primary Care Quality is a standing agenda item at the Quality Committee.

Comply or Explain Procurement Rule:

CCGs will encourage trusts to (comply) purchase though framework agreements unless they can (explain) articulate a clear reason to take a different approach. This will be discussed with Trusts during contract negotiations and specified in the NHS Standard Contract.

The NHS will have to "Comply" with NICE guidance on new drugs and treatments or "Explain" why there is a delay. We will ensure that the latest NICE approved treatments are available in our area, and if not we will be responsible for explaining to patients why not. Through the NHS Constitution, patients have a right to NICE drugs and NHS organisations have a statutory duty to fund them. We will discuss with trusts during contract negotiations and specified in the NHS Standard Contract.

Innovation

We are committed to innovation and driving up standards across the system. All positive NICE Technology Appraisals (TAs) are considered for formal adoption via the Pan Mersey Area Prescribing Committee (APC). Recommendations on adoption of NICE TAs at this forum are passed to the respective Governing Bodies across Merseyside. We have representation at the APC. Both Formulary and Guidelines and New Medicines Subgroups are sub committees of the APC and we are represented at the sub committees. Sub committees provide the agenda to the APC on adoption of NICE TAs. APC recommendations are accepted at CCG Medicines Operational Groups and formally ratified at board.

Local formularies will cover all Merseyside CCGs. The local formulary will be published via the CCG website linking to the Pan Mersey formulary. This will obviously incorporate NICE TA adoption and will be tracked by medicines management support from CMCSU.

We are a member of the North West Cost Academic Health Science Network. By agreement with the Merseyside CCG Network, Dr Andy Davies Chair of Warrington CCG is our representative on the group. We will use a number of methodologies to ensure the adoption of innovation, including improving methodologies and spread.

We are working with the health economy to deliver 'Care Closer to Home' and will embrace technology with our providers to ensure patient get the best possible outcomes. For example community nurses using "iPads" to access patient's records in the patient's home, thus delivering real time record keeping and reducing duplicate inputting. We will also look at the use of telemedicine in order that patients can make better informed decisions about accessing health services - an example might be when a COPD patient exacerbates they have a better understanding of the type and severity of the exacerbation.

7.0 Transforming health and social care at CCG level

7.1 Joined up Local Planning

Organisations in the local health economy have worked together to identify the parents of children with special educational needs or disabilities who could benefit from a personal budget based on a single assessment across health, social care and education.

Our plans:

Following the draft legislation on ‘Reform of Provision for Children and Young people with Special Educational Needs (SEN)’ published in September 2012 it is expected that this will be followed up in 2014 with the new SEN Code of Practice.

Sefton Council is already working towards its implementation of the National Funding Proposals (Schools funding reform: Next steps towards a fairer system) and its joint funding arrangements with health.

It is subsequently expected that the outcomes from this will be followed up in 2014 to comply with legislation around personal budgets in the new SEN Code of Practice.

Workforce Plans

We will work closely with providers to ensure they have robust workforce plans and there will be no compromising on quality improvements or any reduction in safety as a result of these plans.

7.2 Quality Innovation Productivity and Prevention (QIPP) 2013-14

CCGs' outline QIPP plans for 2013-14 should include the key milestones and outcomes to be delivered and detail on:

- Learning from 2012-13
- How they will ensure the delivery of wider service and financial sustainability
- Outline plans to ensure triangulation of activity, quality and cost data to drive QIPP planning and assurance
- Confirm that clinically led quality impact assessment of all cost improvement programmes (CIP) and detail how CIP will have medical director and nursing director sign off
- Activity plans and forecasts for the next 2 years
- Confirm that local metrics (such as staff and patient views and the Safety Thermometer) have been used to reflect needs of health economy in the planning

We remain on course to deliver our QIPP schemes in 2012-13, mainly drawn from three key areas - prescribing, efficiency delivered by local providers and transformational schemes - working in conjunction with local commissioning and public sector bodies to develop new ways of working through productivity and innovation.

QIPP PLANS 2013/14	Description	£'000	Total £'000
Transformational Schemes			**2,400**
Prescribing	ARB	14	
	Statins	74	
	ED	46	
	Other	764	
			898
Provider Contracts	Tariff efficiency - 4%		**4,564**
Total			**7,862**

We have reviewed plans from 2012-13 and provisionally identified areas where existing schemes will make a contribution to the delivery of QIPP in 2013-14. These plans will be worked up over the next few weeks and details will be included within our final submission. We are looking to work with the NCB Local Area Team to ensure that existing PCT QIPP targets are allocated to successor bodies and would be grateful for advice on how this will be achieved.

We have sought assurance from provider executive teams that known CIPs have been rigorously assessed in terms of from a service quality and patient safety perspective, and although progress is being made, we are not yet in a position where we have full assurance for the year.

We have assumed steady state activity plans over the next 2 years based on a view that increased demand for services will be offset by productivity gains elsewhere in the system. CCG plans developing Primary and Community based services will support this change. As a contingency reserve we have made provision for 1% contingency reserve within our financial plans to deal with the costs of any unexpected growth in activity. We will work with public health colleagues to review these assumptions over the next few weeks and more details of specific assumptions will be provided in the final plans.

It should be noted that the CCG is continuing to work to conclude contract negotiations with our providers, which have been complicated this year in light of changes to commissioning responsibilities, as a result of the Health and Social Care Act.

We continually review local metrics and are using key tools, such as ‘Right Care’, to help shape and influence our plans in respect of the needs of the local health economy.

8.0 Financial Planning

8.1 Financial Control

Surplus policy

We have planned to make a surplus of 1% of our revenue resource

Managing risk

We have set aside 2% of our recurrent resource allocation for investment on a non-recurrent basis in 2013-14. We will focus this investment in local schemes aimed at transforming pathways to deliver savings in later years and to redesign services to meet changing needs of our local population. There are some residual schemes left over from the PCT legacy which we have made provision for within our plans. We will work with other commissioners including the local area team to agree these schemes between now and final plan submission. We have established risk share arrangements with South Sefton CCG, which will include the review of the 2% non-recurrent investment and adjustments to baselines where additional analysis proves incorrect. We are also exploring wider risk-share agreements with other CCGs in Merseyside, particularly in respect of high cost Mental Health package of care. We have included contingency of 0.5% specifically to deal with growth areas in 2013-14 in our plans.

Planning assumptions

We have assessed growth in demand and included this in our plans, however assumed a steady state overall.

Tariff

Our plans have been constructed in line with tariff assumptions.

Integrated care plans

We will be working with local partners, notably Sefton Council, providers and the voluntary, community and faith sector, to identify how the recurrent reablement funding (c. £1.8m across the Sefton area) can be best invested to deliver maximum benefit in terms of health outcomes and improving effectiveness of the local healthcare system. It is envisaged that this will be managed through a sub-group of the Strategic Integrated Commissioning Group established with Sefton Council.

8.2 Contracting for Quality

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CQUIN

CQUIN applies to 2.5% of the value of all services commissioned through the NHS Standard Contract. One-fifth is to be linked to national CQUIN goals and CCGs and direct commissioners should outline to plans to apply this to ensure delivery of improvements in:

- Friends and Family Test
- Improvement against the NHS safety Thermometer (excluding VTE)
- Improving dementia care (FAIR)
- Venous Thromboembolism – 95% patients being risk assessed and achieve locally agreed goal for no. of VTE admissions that are reviewed through RCA.

CQUINs will only be paid where providers meet the minimum requirements of high impact innovations. We are working collaboratively across Merseyside with the support of CMCSU to deliver a co-ordinated approach to CQUIN across the health economy. CCGs have identified CQUIN schemes for negotiation into the 2013-14 contract and where possible have come to an agreement regarding common CQUINs – the Chief Nurses are leading on the development of specific portfolio related areas. CQUINs have been identified in commissioner workshops that have taken place in November 2012 and January 2013. Providers were also asked, via CMCSU, to put some suggested CQUINs forward for commissioners to consider. A further meeting has been arranged whereby commissioners and providers will meet in order to start the negotiation process. CMCSU are liaising with Specialist Commissioning regarding any local CQUINs that have been developed that may be applicable for tertiary units in the area.

Local and Regional CQUIN plans

We will work with neighbouring CCGs and CMCSU to monitor the national CQUINs with our providers. We will also work collaboratively to develop and monitor the implementation of the Alternative quality contract which is being developed with local clinicians and in collaboration with West Lancashire CCG.

Our plans include CQUIN within applicable provider contracts at 2.5%. Alongside national measures, it is anticipated that a number of local measures will be applied consistently across Merseyside and will be agreed and reported within the final draft of commissioning plans.

Key Performance Indicators (KPIs)

We have a clinical lead for quality that, in conjunction with our lead Nurse, will develop Key Performance Indicators with our providers and engage in performance management. In collaboration with the contract management team, this will also provide a direct link to our Governing Body. We will include appropriate penalty clauses in standard contracts and will apply them accordingly.

Continuity of Care

We will designate A&E as a commissioner required service in addition (as part of the designation), and we will require the following services to support A&E:

- Anaesthetics
- ICU/HDU
- Diagnostics
- Path labs

Appendix 1 - What the data shows us about morbidity and mortality in Southport and Formby

The information below compares Southport and Formby CCG against its neighbouring CCG and national figures. Consideration of the Sefton wide picture is relevant when working with the Health and Wellbeing Board and Local Authority colleagues, but increasingly we are able to look at much more local data, relevant to our four localities. As our plans develop we will increasingly work at a more local level, supported by member practices interrogating and acting on intelligence from the Merseyside Intelligence Portal.

Potential Years of Life Lost and Premature Mortality Rates

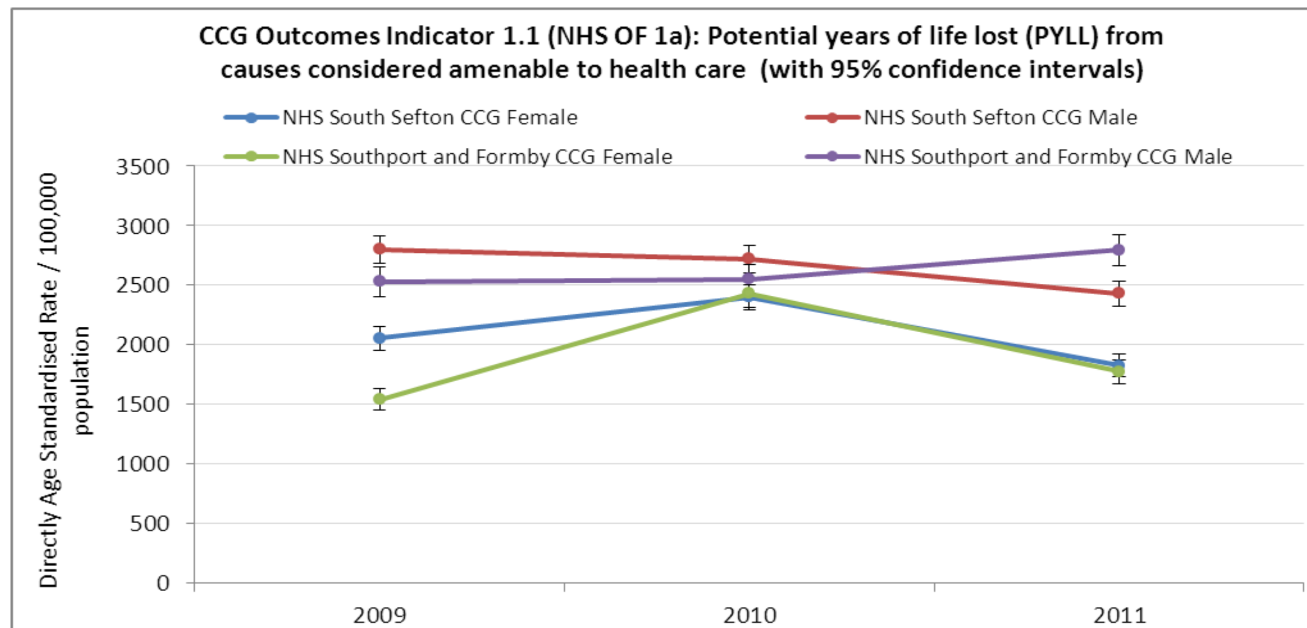
Deaths from causes considered 'amenable' to health care are premature deaths that should not occur in the presence of timely and effective health care. Potential years of life lost (PYLL) from causes considered amenable to health care in 2011 was significantly lower for females than males in Southport & Formby CCG. Rates were significantly higher among males in Southport & Formby CCG than males in South Sefton, and females in both CCGs. However, this has not been the case in previous years there were no significant differences between the CCGs, or between genders in 2010.

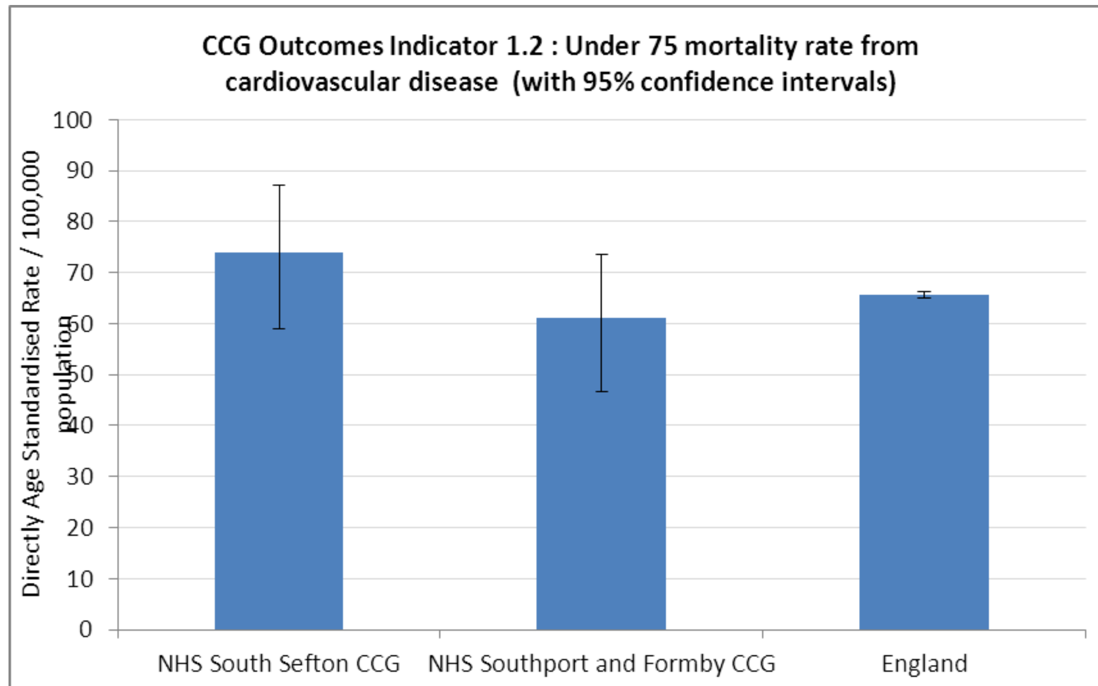
For premature mortality from cardiovascular disease there are no significant differences between the two Sefton CCGs or the England rate. Rates for CVD are higher than for premature mortality from respiratory diseases but lower than premature cancer mortality (also monitored in this indicator set).

Rates of premature mortality from respiratory disease are lower than those for CVD and cancer. Neither CCG differs significantly from the other, nor from the England rate.

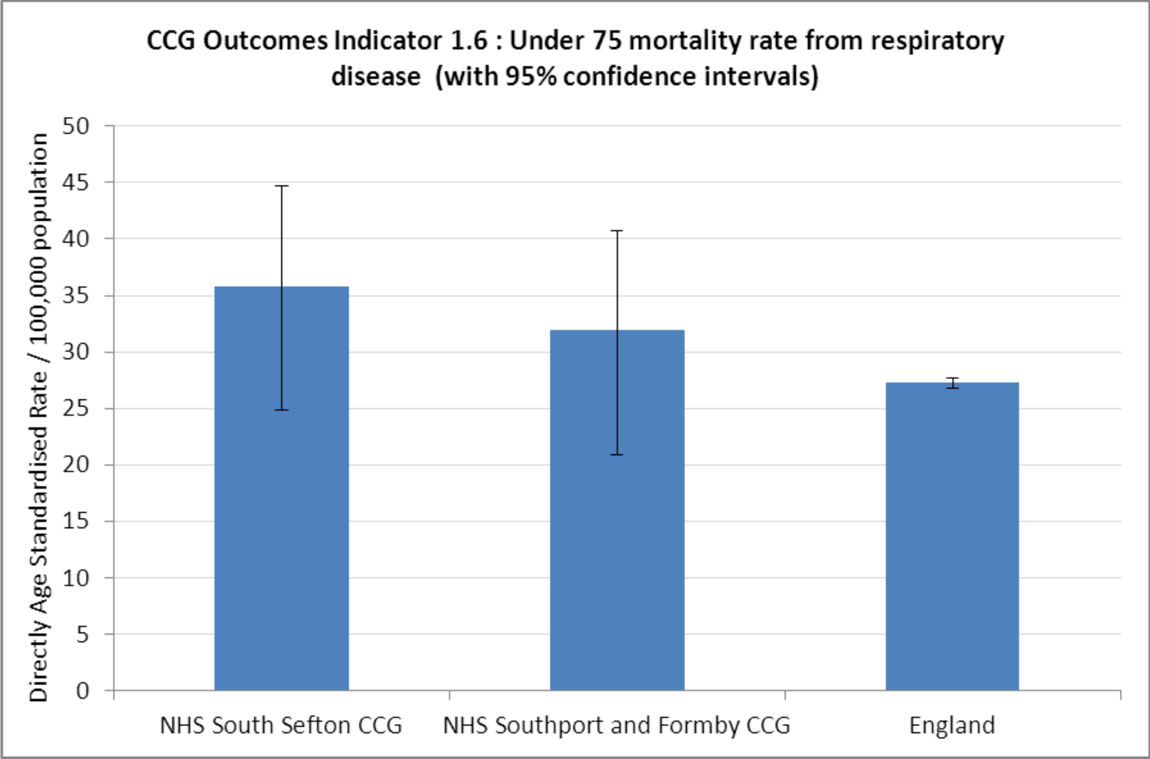
Premature mortality rates for cancer are higher than for premature mortality from respiratory diseases and cardiovascular mortality. There are no significant differences between the two Sefton CCGs and the England rate.

These indicators require careful interpretation and should not be viewed in isolation, but instead be considered alongside information from other indicators and alternative source such as patient feedback, staff surveys and similar material. Changes in the PYLL must be interpreted with care and may be due to changes in the number of lives lost, changes in life expectancy or a combination of these and other factors. Projected life expectancies have increased year on year so a downward trend in PYLL would reflect sustained improvement in healthcare and better outcomes for patients whereas a static PYLL figure should not be interpreted as showing no improvement. Other contributory factors outside of the control of the NHS, such as socio-economic factors also affect these outcomes. Direct comparison with previous year's mortality, prior to 2011, is not advisable. Differences in case-mix (beyond that accounted for by standardisation), comorbidities and other potential risk factors also contribute to any perceived variation. There may be variation in the prevalence of particular conditions due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages.

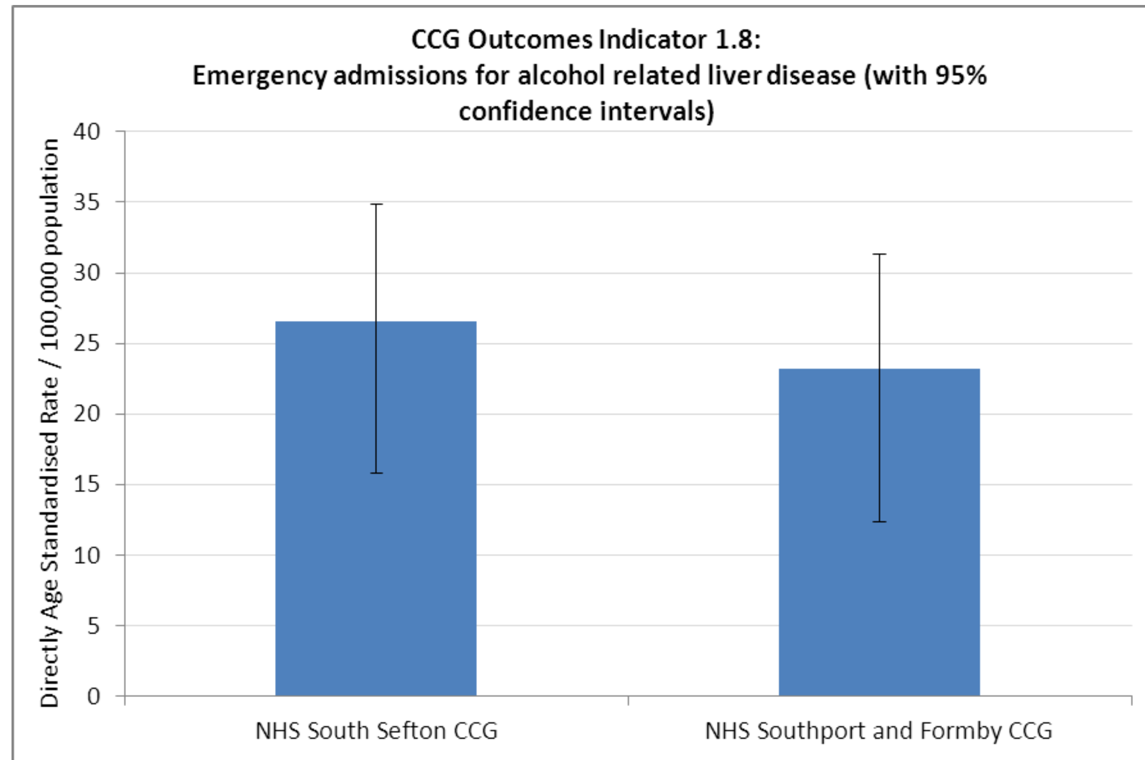




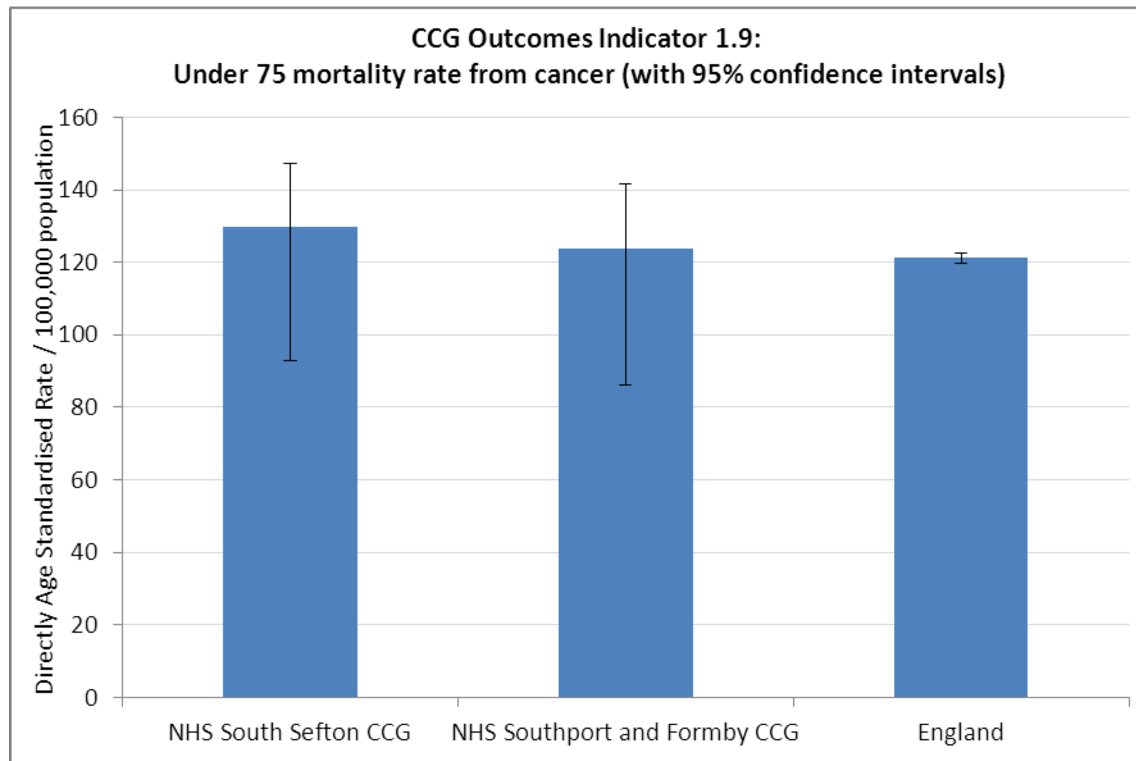
There are no significant differences between the two Sefton CCGs and the England rate. Rates for CVD are higher than for premature mortality from respiratory diseases but lower than premature cancer mortality (also monitored in this indicator set).



Rates of premature mortality from respiratory disease are lower than those for CVD and cancer. Neither CCG differs significantly from the other, nor from the England rate.



Rates between the two CCGs are not significantly different. A national average for this indicator was not available. This indicator forms part of domain 2: Enhancing Quality of Life for People with Long-Term Conditions and is intended to act as a proxy for the overall management of alcohol related liver disease. Some, but not all admissions for liver disease, may be potentially avoidable by high quality management in primary care. Excessive consumption of alcohol may be amenable to influence, and could result in a reduction in avoidable hospital admissions which are costly and expose patients to otherwise avoidable clinical risks such as health care acquired infections. The patterns of providing care may vary between organisations in terms of: extent of treatment in primary care settings; referral policies and practices; hospital outpatient facilities/walk-in clinics; and hospital inpatient admission policies and practices.



There are no significant differences between the two Sefton CCGs and the England rate. Premature mortality rates for cancer are higher than for premature mortality from respiratory diseases and cardiovascular mortality (also monitored in this indicator set). The desirable outcomes of this domain, specifically the prevention of premature deaths, are supported not only by the provision of health care, but also by public health and social care initiatives. Other contributory factors outside of the control of the NHS, such as socio-economic factors also affect these outcomes.

This indicator requires careful interpretation and should not be used in isolation. It should be taken in conjunction with other indicators and information from other sources (patient feedback, staff surveys and other such material) that together form a holistic view of CCG outcomes and a fuller overview of how CCG processes are impacting on outcomes. Direct comparison with previous year’s mortality, prior to 2011, is not

advisable. There was a decrease in the number of deaths with an underlying cause coded to ‘Cardiovascular Disease’. However, a large proportion of this decrease is caused by a correction to the coding of vascular dementia, which was coded as underlying cause CVD (I67.9) until 2010 and is now coded as underlying cause in ‘Mental Health’ deaths (F01). Differences in case-mix (beyond that accounted for by standardisation), comorbidities and other potential risk factors also contribute to any perceived variation. There may be variation in the prevalence of particular conditions due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages.

Appendix 2 - How we have involved people in developing our plans

We have worked with and consulted a wide range of partners to develop our plans for 2013-2014. Below are some of the ways we have done this:

Big Chat

We held our first public event in summer 2012, inviting local residents to give their views about how health and health services should develop in the future. Sefton Council and Sefton LINk (the forerunner to Sefton Health Watch, the patient's champion) joined forces with us at the event to gain feedback on the priorities identified in our joint strategic needs assessment, the Sefton Strategic Needs Assessment (SSNA).

SSNA involvement events

Nearly 50 public and partner events were held during 2012 by us and Sefton Council to gain wide ranging feedback on the priorities set out in the SSNA. These were organised to ensure as many people as possible could comment on the findings of the SSNA, from hard to reach communities to partners in different parts of the health and social care system.

Talking Health and Wellbeing in Sefton

All the feedback gained from the Big Chat and SSNA involvement events have been used to inform the overarching draft Health and Wellbeing Strategy for Sefton (HWBS). Our plans for 2013-2014, outlined in this document, also reflect these locally developed priorities and goals. In December 2012 and January 2013 we again worked with Sefton Council to hold five public Talking Health and Wellbeing sessions across Sefton to test out our specific CCG plans and the themes contained in the HWBS. There were also over 40 other events where people were invited to comment on the objectives and priorities in the draft HWBS.

Appendix 3 – Clinical and Managerial Leads for each programme

Area	Southport & Formby CCG Lead	CCG Team Lead
Alcohol	To be confirmed	Tina Ewart
Cancer	Dr Graeme Allen	Sarah Reynolds
Children	Dr Robert Caudwell	Jane Uglow
Contracting	Dr Martin Evans	Stephen Astles / Jan Leonard
COPD	Dr Liam Grant	Sandra Boner / Jenny Kristiansen
CVD	Dr Niall Leonard	Stephen Astles / Sandra Boner
Communication	Karen Leverett	Lyn Cooke / Tina Ewart
Dementia / Mental Health / Learning Disabilities	Dr Hilal Mulla	Geraldine O'Carroll / Kevin Thorne
Dermatology	To be confirmed	Billie Dodd
Diabetes	*Doug Callow*	Moira McGuiness
End of Life	*Karen Groves*	Moira McGuiness
Integrated Care	Dr Niall Leonard	Stephen Astles / Billie Dodd
IT	Dr Robert Caudwell	Alison Johnson
Medicines Management/Prescribing	Dr Hilal Mulla / *Dr Janice Eldridge*	Brendan Prescott
Quality	Doug Callow	Debbie Fagan /Steve Astles / Billie Dodd
Patient and Public Involvement	Karen Leverett	Jackie Robinson / Tracy Jeffes
Prevention and Public Health	To be confirmed	Margaret Jones
Primary Care Quality	*Bal Duper*	Angela Parkinson / Debbie Fagan
Unplanned Care / 111 Care	Dr Graeme Allen	Jane Uglow
Governance	Helen Nichols	Tracy Jeffes

**Italics* – not a Board member

Appendix 4 – Southport and Formby Local Priorities Mapping

Southport and Formby Local Priorities Mapping

Reduction in hospital admissions for patients under 19 related to asthma

Health and Wellbeing Strategy Priorities 2013 – 2018	Southport and Formby CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Ensure all children have a positive start in life.** **Ensuring that children and young people including those with complex needs and disabilities have the best opportunities in life to enable them to become healthy adults and make the best of their life chances**	**Long Term Conditions** Better identification of patients with long term conditions and support for them to better manage their conditions and avoid hospitalisation Reducing higher than average number of children with asthma admitted to hospital	It was identified that the flow of patients and treatment between primary and secondary care needs to be reviewed, with particular emphasis on the patient journey and level of care received. Services nearer to home were identified as being important Longer term, better treatment for young people was seen as preventing admissions, being preventative rather than reactive. However there were seen to be issues in retracting from acute providers in order to switch the investment to prevention. The identification of and support for carers was identified as key in preventing hospital admissions Using technology, such as telehealth, could improve timely access to services and reduce admissions.	It was agreed that there needs to be a focus on young people when commissioning services. Encouraging self-management, lifestyle changes and the education of patients with long term conditions was seen as important along with the need to commission a range of different services

Southport and Formby Local Priorities Mapping

Offer Interventions to Patients with Alcohol Related Admissions

Health and Wellbeing Strategy Priorities 2013 – 2018	Southport and Formby CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support people early to prevent and treat avoidable illnesses and reduce inequalities of health** **Needs assessment identified:** **Whilst Sefton's rate of admissions is lower than other Merseyside Local Authorities, alcohol related admissions continue to rise.** **Consultation and engagement identified:** **Need to find different ways to support people early to avoid those needing acute services and surgical procedures.**	Prevention Primary care programme to identify and support those with alcohol dependencies	During the Big Chat discussions it was identified that alcohol issues need to be addressed at a community level. The cost of alcohol and mental health services was raised . There were questions as to whether services at A&E for alcohol related visits should be charged and if not, should the tax charged on alcohol be used to fund these services. The link between investing in alcohol services and falls reductions were seen as measurable outcomes	Drugs and Alcohol programmes were seen as being very important services by those attending the consultation on the Sefton strategic needs assessment

Reduction in the number of patients who have an emergency admission for dehydration

Health and Wellbeing Strategy Priorities 2013 – 2018	Southport and Formby CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective – **Support Older people and those with long term conditions and disabilities to remain independent in their own homes** **Needs assessment identified:** **By 2015 over 2,300 people are forecast to be living in a care or nursing home**	Long term Conditions Better identification of patients with long term conditions and support for them to better manage their conditions and avoid hospitalisation	The big Chat consultation identified the need to improve the link between G.P.'s and nursing and residential care settings. Concern was expressed that there has been no increase in financial support for care homes through fees from Adult Social care in Sefton for three years. A review of the patient journey between primary and secondary care and the level of care received was seen to be necessary if the patient experience was to be improved. Using services nearer to home and the use of assistive technology and telemedicine were seen as being able to keep people independent and out of care or hospital	Formby residents during the consultation on the Sefton Strategic needs assessment identified the need to provide a good medical service to people regardless of age

Appendix 5 – Armed Forces commissioning responsibilities: April 2013

	Serving Armed Forces in England	Serving Armed Forces overseas	Armed Forces Families registered with DMS med centres in England	Armed Forces Families registered with DMS med centres overseas	Armed Forces Families registered with NHS GP Practices	Reservists while mobilised [i]	Veterans (inc. reservists when not mobilised)
Primary Care	DMS [ii]	DMS	DMS	DMS	NHS CB	DMS & NHS CB [iv]	NHS CB
Community Mental Health	DMS	DMS	NHS CB	DMS	**CCG**	DMS	**CCG**
Secondary acute & community care	NHS CB	DMS & NHS CB [iv]	NHS CB	DMS & NHS CB [iv]	**CCG**	DMS & NHS CB [iv]	**CCG** [iii]
MOD Enhanced pathways	DMS	DMS	N/A	N/A	N/A	DMS	N/A

i - Reservists have access to DMS care whilst mobilised
ii - Serving personnel can access local GPs on an emergency basis if needing to access care whilst away from the military address
iii - The NHS CB will commission specialised services for veterans, e.g. limb prostheses
iv - While overseas, serving personnel and families can access DMS-commissioned healthcare where such provision exists, or may be provided with non-DMS healthcare by local Host Nation or other contracted arrangements, or have right of return for NHS CB-commissioned NHS care in England

*Source - Securing excellence in commissioning for the Armed Forces and their families – 2013

Table Key :
DMS - Defence Medical Services
NHS CB – Commissioning Board
CCG – Southport & Formby Clinical Commissioning Group

Appendix 6 – Proposed C. difficile Plan Trajectories 2013-14

DRAFT - Proposed C. difficile Plan Trajectories 2013-14

CCG's have been asked to self-certify that they will deliver equal to or better than their clostridium difficile objective for the Everyone Counts 2013-14 planning. Plans are based on last year's plan and the objectives set by the NHS Commissioning Board.

Monthly target [1]

Infection	Trust		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Total / Forecast
C-Difficile	Trust-Acquired	12/13 Plan (44% split)	4	2	2	2	2	2	2	2	2	2	2	2		26
		12/13 Actual [2]	-	1	2	4	3	2	1	1	4	3			21	25
		13/14 Plan [3]	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*1.42*	*17*	*17*
	Community-Acquired	12/13 Plan (44% split)	3	2	2	4	2	2	2	2	3	3	2	2		29
		12/13 Actual [2]	1	1	3	5	3	3	1	1	4	4			26	31
		13/14 Plan [3]	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*1.75*	*21*	*21*
	Total	12/13 Plan	7	4	4	6	4	4	4	4	5	5	4	4		55
		12/13 Actual	1	2	5	9	6	5	2	2	8	7	-	-	47	56
		13/14 Plan [4]	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*38*	*38*

[1] **Please note that these targets apply only to Southport & Formby CCG-responsible patients.**

[2] **Activity from HPA website.**

[3] **Target divided between trust- and community-acquired.**

[4] **Target set by NHS Commissiong Board (Objectives)**

Cumulative target [1]

Infection	Trust		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
C-Difficile	Trust-Acquired	12/13 Plan	4	6	8	10	12	14	16	18	20	22	24	26	26
		13/14 Plan [3]	1	3	4	6	7	9	10	11	13	14	16	17	17
	Community-Acquired	12/13 Plan	3	5	7	11	13	15	17	19	22	25	27	29	29
		13/14 Plan [3]	2	4	5	7	9	11	12	14	16	18	19	21	21
	Total	12/13 Plan	7	11	15	21	25	29	33	37	42	47	51	55	55
		13/14 Plan [4]	3	6	10	13	16	19	22	25	29	32	35	38	38

25% at 3 months = 9.51

[1] **Please note that these targets apply only to Southport & Formby CCG -responsible patients.**

[3] **SHA target divided between trust- and community-acquired.**

[4] **Target set by NHS Commissiong Board (Objectives)**

Note: Sefton PCT split - South Sefton CCG 56%, Southport & Formby CCG 44%)

PLEASE NOTE THESE ARE DRAFT - Data provided by Commissioning Support Unit, requires final review and sign off.