NHS

South Sefton Clinical Commissioning Group

Everyone Counts

Planning for Patients in South Sefton
2013-2014

staying local & together

Contents

	Page
1.0 Introduction	**4**
1.1 Our vision and values	5
1.2 How we developed our plan	6
2.0 Improving Outcomes, Reducing Inequalities	**9**
2.1 Overview of our Plans for 2013-14 - Plan on a Page	10
2.2 Priority Programmes	11
• Unplanned care	12
• Virtual Ward	13
• Long Term Conditions	14
• Diabetes	15
• Mental Health	16
• Dementia	17
• Learning Disabilities	18
• Children's	19-20
• Planned	21
• Alcohol	22
• Obesity	23
• Maternal Health	24
• Cancer	25-28
• End of Life	29
• Primary Care Quality	30
• Medicines Management	31
2.3 Additional information relating to the NHS Framework domains	32

3.0 The 3 local priorities for the Quality Premium 41
4.0 The Basics of Care 44
5.0 Patients' Rights: The NHS Constitution 45
5.1 Eliminating Long Waiting Times 46
5.2 More Responsive Care: Urgent & Emergency Care 46
5.3 Keeping Our Promises: Eliminating mixed-sex accommodation 49
5.4 Keeping Our Promises: Reducing Cancellations 50
5.5 Mental health 50
5.6 Keeping Our Promises: Choice and the information to exercise it 51
5.7 Keeping Our Promises: Military Veteran health / Offender health / Health visitors / Dementia / IAPT 52
6.0 Patient Centred, Customer Focussed 58
6.1 NHS services, 7 days a week 58
6.2 More transparency, more choice 59
6.3 Listening to Patients and Increasing Their Participation 60
6.4 Better data, informed commissioning, driving improved outcomes 63
6.5 Higher standards, safer care 64
7.0 Transforming health and social care at CCG level 67
7.1 Joined up Local Planning 67
7.2 QIPP 2013/14 68
8.0 Financial Planning 70
8.1 Financial Control 70
8.2 Contracting for Quality 71

Appendix 1 How we involved people in our plans 74
Appendix 2 Clinical and Managerial Leads for each programme 75
Appendix 3 South Sefton Local Priorities Mapping 76-77
Appendix 4 Armed Forces commissioning responsibilities: NHS & DMS post-April 2013 78
Appendix 5 Proposed C. difficile Plan Trajectories 2013-14 79

1.0 Introduction

NHS South Sefton Clinical Commissioning Group (SSCCG) brings together 34 doctors surgeries. It has four distinct geographical localities - Crosby up to Hightown in the north, Bootle in the south, Seaforth and Litherland in the centre and Maghull to the east. From April 2013, it is fully responsible for planning and buying or 'commissioning' the majority of local health services for its 155,500 patients. Its 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 who will lead and be accountable for the work SSCCG carries out.

This plan sets out an ambitious programme to ensure that health and health services in south Sefton continue to improve in the future, amidst an increasingly complex and challenging social and economic environment. SSCCG has a budget of £240m in 2013-2014 and will need to work innovatively and even closer with its partners if it is to make improvements. So, this plan also reflects the progress SSCCG has made in developing working relationships with its partners since coming into being - with organisations and groups including Sefton Council, hospitals, local people and voluntary, community and faith organisations.

Over the past 18 months, SSCCG has played an active role in local commissioning and 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. Its work during this period has informed the priorities detailed in this operational plan for 2013-2014.

SSCCG's plans for the year ahead build on what we already know about health and wellbeing in south Sefton – 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 – and which also responds to the goals set out in the following:

- Everyone counts – planning for patients 2013-2014
- NHS Outcomes Framework
- NHS Constitution
- Strong financial management and good progress against our local plans as part of the national 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 south Sefton. They embody our commitment to our local and statutory duties, and most importantly, our local people.

Our vision

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

Our values

- Stay local and work in partnership
- Be transparent, open and honest
- Be approachable and accessible
- Show integrity – say what we mean and do what we say
- Be focused on what we want to achieve – prioritise what we do

Our aims

To work collaboratively to:

- Reduce health inequalities
- Improve quality of care
- Be patient - centred and put communities at the heart of what we do – support them and their wider needs
- Deliver value for money – ensure efficiency
- Ensure sound governance
- Make a difference, do things differently - do good

1.2 How we developed our plan

We shaped our plans 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. Appendix 1 sets out how we have involved and informed our partners about our strategy for delivery in 2013-2014.

Health in south Sefton

Significant inequalities in health remain between different parts of south Sefton. Life expectancy for men is 76 years and for women it is nearly 82 years – this is almost 2.5 years less than the national average for men and almost 1 year less for women. Overall, the difference in life expectancy between the most and least deprived wards of south Sefton is over 10 years. This 'gap' in life expectancy and high levels of ill health amongst some south Sefton residents is strongly linked to lifestyle choices such as smoking, alcohol, obesity and mental wellbeing.

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 was carried out by SSCCG 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 south Sefton 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:

- More care closer to home rather than in hospital
- 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

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 our key areas of delivery in 2013 – 2014 in the context of our vision, our corporate aims, the joint health and wellbeing strategic objectives and linked to the achievement of progress against the NHS Outcomes framework and delivery of the rights enshrined within the NHS Constitution.

South Sefton CCG – Plan on a page

South Sefton CCG Our vision: We want to work with the local community & other partners, to improve the health and healthcare of everyone living in south Sefton, spending money wisely, & supporting clinicians to do the best job they can

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

- Promote positive mental health & wellbeing
- Build capacity & resilience to empower & strengthen communities
- 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 Effective ness in High Quality Tertiary Care

Enabling Themes

- Patient & Public Engagement
- The Francis Report
- Any Qualified Provider
- Programme Management Office
- CQUINs
- Information Management Technology Innovation
- Value for Money through Finance and Contracting
- Quality of Care
- Sustainable Change
- Promotion of Self Care
- Sefton Needs Assessment
- Clinical, Community, 3rd Sector collaboration

Programmes, Transformational Change and Improving Outcomes

Programmes	Transformational Change	Improving Outcomes
Unplanned Virtual Ward	• Pro active case management • Reviewing patient pathways with Aintree for emergency patients • Support of the Community Geriatrician • Supporting Nursing and Care homes • Evaluation of Out of Hours service and 111 • Risk stratification / Pro active case management • Investment in Community services • Health care acquired infections • Roll out of Virtual Ward	• Reduce emergency admissions to secondary care • Reduce Follow Up Appointments • Reduce Readmissions • Redesigned community services to reduce hospital attendances and manage care more effectively in a community setting • Increased independence of the frail & old • Reduction in avoidable admissions • Increased integration • Reduce non elective admissions over 65's – 5% '13/14, 20% by '16/17
Long Term Conditions	• Primary Care LES primary care to improve diagnosis management of Atrial Fibrillation • Vascular Health Checks • Further investment in community respiratory services • Primary care risk stratification	• Reduced admissions with LTC as primary diagnosis • Person centred, integrated primary care provision • Reduction under 75 mortality rates • Earlier diagnosis of respiratory illness
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
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
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 • Reduced length of stay • Early identification of families in need of support to promote the safeguarding of Children & Young People
Planned	• Implement Community Ophthalmology Schemes • Better Care Better Value benchmark indicators to support improved performance • Any Qualified Provider procurements podiatry, audiology and MSK • Promote use of dyspepsia pathway • Commission Gynaecology community service pilot	• Patients receive care in the most appropriate setting and to improve the quality and experience of care for patients. • Reduced referrals to Secondary care
Prevention	• Develop CQUIN increase breastfeeding rates • Develop an obesity strategy and clarify obesity treatment pathway. • Commission Alcohol Liaison Service at Aintree University Hospital • Build capacity to facilitate the provision of Identification and Brief Advice(IBA) across ranges settings	• Better Maternal Health / Early years health • 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 or drug dependency • Reduced Obesity levels
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 /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
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%
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 of Friends & Family test
- Preventing healthcare associated infections

LOCAL PRIORITIES

- Reduce Respiratory Disease admissions through A&E at Aintree Hospital
- Reduction in prescribing for three high risk antibiotics 1.Quinolones 2.Co-amoxiclav 3. Cephalosproins
- Reduce the number of GP referred patients (during normal working hours) who receive an AED assessment before being admitted into Aintree Hospital care

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

2.2 Priority Programmes - Programme Management Approach

Our Plan on a Page also highlights key programmes of work. To achieve our longer term strategy, we have identified actions that will enable us to secure the required progress we need to make 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, Sefton Council, and 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, but also with the four SSCCG localities, where discussions are led by Locality GP Chairs. 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
- Virtual Ward
- Long Term Conditions including, Chronic Obstructive Pulmonary Disease (COPD), Cardiovascular Disease (CVD)
- Diabetes
- Mental Health, Dementia and Learning Disabilities (LD)
- Children
- Planned Care
- Prevention – Obesity, Alcohol and Maternal Health
- Cancer
- End of Life
- Primary Care Development
- Medicines Management

South Sefton Clinical Commissioning Group

Programme: Unplanned Care **Clinical Lead: Dr Andy Mimnagh**

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?
There is an increase in pressure on emergency services due to the increasing elderly population. The CCG need to develop measures to support patients in their homes and the community to manage their condition. The current community and primary care services do not have adequate capacity to support the needs of these patients

DESCRIPTION
The Virtual Ward development. (see Priority area) Reviewing patient pathways with Aintree for emergency patients Support of the Community Geriatrician Supporting Nursing and Care homes Pro active case management Risk stratification Investment in Community services

KEY MILESTONES	Q1	Q2	Q3	Q4
Liaising with Aintree to review emergency pathway				
Geriatrician to support nursing homes				
Virtual ward implementation				

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
Primary care not engaging in virtual ward	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		

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Programme: Virtual Ward   Clinical Lead: Dr Peter Chamberlain

OBJECTIVE

The goal of the Virtual Wards is to maintain happy independence for frail and old people. This will be achieved through a strategic and operational vision via the development of a community based comprehensive admission avoidance system. (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?

The Challenge:
Our health care system is facing the challenge of an increasingly frail, elderly and complex population. We work within a fragmented health and social care system and spend the vast majority of health care on high acute care costs. The current financial environment means that any solution must be innovative, efficient and effective.

DESCRIPTION

There are key aspects which will need to be in place to enable this vision:

- Integration - Holistic integrated health and social care system at the community level.
- Long Term Conditions - Improve secondary disease prevention
- Information Technology - Empowering clinicians, facilitating communication & rapid patient flow.
- Self-Care Approach - Empowering patients, families and carers.

A patient can be referred by the General Practitioner (GP), intermediate care and acute trust via a Single Point of Access. Patients may also be referred following identification after risk stratification and acute trust in-reach.

KEY MILESTONES	Q1	Q2	Q3	Q4
Evaluation of primary implementation site - March 2013				
Roll out of reablement & urgent care team across patch June 2013				
Roll out of full-integrated IT system January 2014				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduce trust non-elective admissions for over 65s (*On Full roll out 2016/17)	20%	5%	10%	15%
Reduce trust medical outpatients for over 65s (*On Full roll out 2016/17)	3%	0%	1%	2%
Reduce A&E attendances for over 65s (*On Full roll out 2016/17)	15%	2%	5%	10%
Patient satisfaction EQ5D (e.g. ability to self-care, activities of daily living)				

RISKS	MITIGATING ACTIONS
Engagement of multiple stakeholders – including external bodies.	Virtual Ward Steering group and programme management
Lack of numbers of patients to make project financially viable	GP engagement, Information sharing, risk stratification.

WORKFORCE IMPLICATIONS

A shift from 'silo' working to bringing the primary health care team back in a form relevant to the 21st century we are establishing once again that 'team' is the best way to provide care. Working collaboratively as a unit, the professionals will be joined by a common referral pathway, weekly multi-disciplinary team meeting or 'virtual ward round' and a common case record.

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		21% of investment
2014/15		21% of investment
2015/16		21% of investment
Total		£2.7 million (64% of investment)

Programme: Long Term Conditions **Lead Clinician: Dr Craig Gillespie**

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OBJECTIVE
South Sefton's population is growing increasingly older, this creates pressures on Health and Social care. The CCG's objective is to manage long term conditions in as cost effective way as possible using integrated care methodologies to include self care and care closer to home to reduce the reliance on secondary care (Domain 1,2,4)

WHY CHANGE IS NEEDED?
Increasing numbers of frail elderly patients with one or more co-morbidities will place increasing pressures on health and social services. This needs to be planned for now by reviewing services to ensure that patients have access to services that ensure early support to prevent acute episodes related to their chronic condition and they are educated to manage their condition.

DESCRIPTION
Local enhanced service in primary care to diagnose and manage Atrial Fibrillation Vascular Health Checks Alcohol Nurse in A&E Increased investment in community respiratory services Development of the virtual ward and case management Primary care risk stratification

KEY MILESTONES	Q1	Q2	Q3	Q4
Virtual Ward implementation		■		
Alcohol nurse in A&E	■			
Community Respiratory service	■			

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduce under 75 mortality rates for CVD and respiratory disease	1%	0%	0.5	1%
CHD actual v predicted data	2%	0.5%	1%	2%
Reduce alcohol related admissions	2%	0.5%	1%	2%

RISKS	MITIGATING ACTIONS
Poor take up of vascular health checks	Monitor uptake, focus within locality groups, feedback on schemes for future developments
Poor provider performance in reducing admissions for respiratory conditions	Contract monitoring and clinical performance discussions

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		

NHS

South Sefton Clinical Commissioning Group

Programme: Diabetes   Lead Clinician: Dr Nigel Taylor

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 Ricky Sinha**

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	532	541	557	560

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

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	235,364	
2014/15		
2015/16		
Total		

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Programme: Dementia **Lead Clinician: Dr Ricky Sinha**

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%	64%	69%	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		

South Sefton Clinical Commissioning Group

Programme: Learning Disabilities **Lead Clinician: Dr Ricky Sinha**

OBJECTIVE

Ensure effective and safe models of care for people with learning disabilities (Domain 5, 2 ,4)
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	Action plan		
Annual Health Checks	Yearly			

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	£60,000 for Annual Health Checks	
2014/15	Possibly NCB investment	
2015/16		
Total		

Programme: Children **Lead Clinician: Dr Wendy Hewitt**

NHS
South Sefton Clinical Commissioning Group

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

WHY CHANGE IS NEEDED?
1. Alder Hey are not providing the same support in South Sefton as exists in North Sefton from LCH 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 in South Sefton Implementation of new T3 CAMHS specification Review 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
1. tbc				
2. KPIs in service spec				
3. Implementation of agreed pathway and KPIs				

RISKS	MITIGATING ACTIONS
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		

Programme: Children **Lead Clinician: Dr Wendy Hewitt**

NHS
South Sefton Clinical Commissioning Group

OBJECTIVE
Children's Community Nursing Team Admission avoidance and facilitating early discharge for children and young people within South 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)

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduced emergency readmissions	N/a	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	N/a			
Reduced length of stay	N/a			

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 South Sefton has a complex needs nursing team who support known children on a planned care basis, there is limited capacity within the Alder Hey service to support the acutely ill child within the community.

RISKS	MITIGATING ACTIONS
CCG do not implement /fund service at end of pilot in 2013/14	Exit strategy agreed with providers.

DESCRIPTION
Developing Children's Community Nursing Team for South Sefton with Alder Hey Paediatric Service. 18 month pilot to assess the benefits in increasing acute care available outside of hospital settings. Also working in conjunction with Clare House on the End of Life project. Alder Hey pilot commenced April 2012 with extended funding from QIPP for 6 months 2013/14

WORKFORCE IMPLICATIONS
Nursing team funded via QIPP monies during pilot – 3.5 WTE to cover the Alder Hey patient flow footprint. South Sefton constitutes approx. 20% of this activity. The pilot is part of the Alder Hey Transformation Programme with an expectation from commissioners of reconfiguration of staff resources from inpatient to community team using QIPP principles.

KEY MILESTONES	Q1	Q2	Q3	Q4
Service review 12mth report to CCG	X			
Full service evaluation including evaluation of pathway redesign		X		
Service reviews to ensure readiness for winter pressures			X	
Full service evaluation of Clare House EOL project working in conjunction with local CCNTs				X

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	PYE 85k – QIPP funding	
2014/15		
2015/16		
Total		

NHS
South Sefton Clinical Commissioning Group

Programme: Planned Care **Lead Clinician: Dr Peter Chamberlain**

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
Implement Community Ophthalmology Schemes Ensure that key Better Care Better Value benchmark indicators are implemented where performance has declined Any Qualified Provider procurements podiatry, audiology and MSK Promote use of dyspepsia pathway Ensure the pilot Gynaecology community service is commissioned to reduce demand on secondary care

KEY MILESTONES	Q1	Q2	Q3	Q4
Community Ophthalmology Scheme launch				
Dyspepsia Pathway Promotion				
Make the community Gynaecology service recurrent				

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.

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Ophthalmology first outpatient referrals (all providers inc Independent) and follow up rates				
Number of gastroscopies performed at UHA				
BCBV indicators, new to follow up, referrals				
Number of referrals to the Women's hospital				

RISKS	MITIGATING ACTIONS
Community Ophthalmology Scheme not fully utilised (financial risk) / Dyspepsia pathway not adhered to	Ownership of any changes by local GPs New model must demonstrate improved quality and experience for patients
Practices do not refer to the community services	Communication and monitoring referrals
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		
2014/15		
2015/16		
Total		

South Sefton Clinical Commissioning Group

Programme: Alcohol **Lead Clinician: Dr Sunil Sapre**

OBJECTIVE

To slow down the current rate of south Sefton resident alcohol related hospital admissions
To increase the capacity and skills of AUHFT staff 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 this CCG. In Sefton, 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 Liverpool CCG and Knowsley CCG jointly commission and performance manage the Hospital Alcohol Liaison Service at Aintree University Hospital
Build capacity and skills to facilitate the provision of Identification and Brief Advice(IBA) across all staff at AUHFT
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 South Sefton residents and is integrated (via appropriate pathways) with CCG commissioned services.

KEY MILESTONES	Q1	Q2	Q3	Q4
To be agreed				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Achieve reductions in the projected rate of increasing AF1 alcohol specific admissions at AUH through increased nurse discharges	5%	5%	5%	5%
Achieve increases in bed days saved as a result of AF1 admissions, reducing length of stay	- 5% LOS	-5%	-5%	-5%

RISKS	MITIGATING ACTIONS
The funding of this service is reliant on 3 separate CCGs	Negotiate with Knowsley & Liverpool CCGs re continued investment in the service
Sefton MBC is tendering for a new integrated substance misuse provider - possible implications for current pathways	Ensure through performance meetings ongoing clarity re pathways and service functions

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	36,000	263,000
2014/15	38,000	276,000
2015/16	40,000	290,000
Total	114,000	829,000

NHS
South Sefton Clinical Commissioning Group

Programme: Obesity **Lead Clinician: Dr Paul Thomas**

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		

NHS
South Sefton Clinical Commissioning Group

Programme: Maternal Health **Lead Clinician: Dr Wendy Hewitt**

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				■
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		

South Sefton Clinical Commissioning Group

Programme: Cancer **Clinical Lead : Dr Debbie Harvey**

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.2 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 2 week 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	■			
Include cancer intelligence within Mersey intelligence portal				■

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 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
South Sefton Clinical Commissioning Group

Programme: Cancer **Clinical Lead: Dr Debbie Harvey**

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

KEY MILESTONES	Q1	Q2	Q3	Q4
Produce a leaflet to encourage attendance at 2 week wait clinics				
Introduce cancer waits CQUIN				

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

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

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

Programme: Cancer **Clinical Lead: Dr Debbie Harvey**

NHS
South Sefton 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%	100%
Performance against requirements of cancer waits CQUIN	tbc			
Cancer waits 31 days target	95%	95%	95%	95%
Cancer Waits 62 day target (aggregate measure)	86%	86%	86%	86%

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

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

Programme: Cancer **Clinical Lead: Dr Debbie Harvey**

NHS
South Sefton Clinical Commissioning Group

OBJECTIVE

Improving the quality of Cancer Survivorship – supporting people and families living with and beyond 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 Aintree Hospital indicate that there are unmet information support needs especially in regard to financial and benefits advice.

DESCRIPTION

Review the service provided by CAB for cancer patients in Sefton
Undertake needs assessment for psychological support services for cancer patients in Sefton
Review access to cancer information and support services outside the hospital setting in south Sefton
Undertake needs assessment for physical activity programmes for cancer survivors

KEY MILESTONES	Q1	Q2	Q3	Q4
Psychological support needs assessment				
Physical activity needs assessment				
Review community information provision				

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

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	Physical activity – 25k	
2014/15		
2015/16		
Total		

South Sefton Clinical Commissioning Group

Programme: End of Life   Lead Clinician: Dr Debbie Harvey

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.

WORKFORCE IMPLICATIONS

No End of Life Care Home Facilitator

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

RISKS	MITIGATING ACTIONS
Care homes not participating in education programmes	Engagement strategy
Funding for EOL Care Home Facilitator not available after October 2013	Business case to Finance & Resource committee
Patients not being identified as being at end of life	Full review of pathway

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				

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	H@H = £240,000 Care Home Facilitator = £18,750 (approx)	Not known at this time
2014/15	H@H = £240,000 Care Home Facilitator = £45,000	Not known at this time
2015/16	H@H = £240,000 Care Home Facilitator = £45,000	Not known at this time
Total	£828,750	Not known at this time

Programme: Primary Care Quality **Clinical Lead: Dr Bal Duper**

NHS South Sefton 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 Steve Fraser / Jill Thomas**

NHS
South Sefton Clinical Commissioning Group

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 South Sefton 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. Strong medicines management team support will facilitate the delivery of the plan in addressing both therapeutic and disease areas in practice as well as supporting different ways of working along the prescribing process.
Medicines management support provided to the 4 proposed virtual wards.
Focus medicines reviews with care home patients as a vulnerable cohort of patients

KEY MILESTONES	Q1	Q2	Q3	Q4
Optimisation plan ratified				
Work stream plan developed				
Planned visits to practices with performance / engagement issues				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
All care home patients reviewed	800	800		
Virtual ward support initiated				
Evidence based decision making programme delivered				

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		1,100,000
2014/15		
2015/16		
Total		

2.3 Additional information relating to the NHS Outcomes Framework domains

Enhancing the quality of life for people with long term conditions

We will work with direct commissioners through the Health and Wellbeing Board to ensure we:

- Provide person centred integrated care for people with long-term conditions through improvements in primary care
- Put patients in charge and having ownership of their care through personalised care plans and budgets and ensure coordination and continuity of their care

South Sefton's population is growing increasingly older. The over 65 age group is set to increase by 32% from 56,400 in 2010 to 82,900 in 2035, meaning that this age group in Sefton will rise from accounting for 20% of the population to almost 30% of the population. The challenge for us to ensure that healthcare matches the needs of the elderly population and reduces the pressure and high cost delivery in acute trusts.

Sefton generally displays slightly higher levels than average of diagnosed long term conditions. Data were first collected in 2004-05 and disease register numbers have changed slightly since then. Note that these figures do not take into account the different age structures of areas.

Diagnosed long term condition	Sefton 2009/10	Sefton 2010/11	NW 2010/11	England 2010/11
Asthma	6.0%	6.1%	6.3%	5.9%
Cancer	1.8%	2.1%	1.6%	1.6%
Coronary heart disease (CHD)	4.5%	4.5%	4.0%	3.4%
Chronic obstructive pulmonary disease (COPD)	2.3%	2.4%	2.1%	1.6%
Diabetes	5.6%	5.7%	5.8%	5.5%
Epilepsy	0.9%	0.9%	0.9%	0.8%
Hypertension	15.7%	15.9%	14.0%	13.5%
Hypothyroidism	3.4%	3.5%	3.0%	3.0%
Mental Health	1.0%	1.0%	0.9%	0.8%
Stroke	2.2%	2.2%	1.9%	1.7%
Learning Disability	0.5%	0.4%	0.5%	0.4%
Obesity	11.0%	10.2%	11.5%	10.5%
Heart Failure	1.1%	1.1%	0.8%	0.7%
Atrial Fibrillation	1.9%	1.9%	1.5%	1.4%
Chronic kidney disease (CKD)	5.1%	5.0%	4.6%	4.3%

Source: www.ic.nhs.uk

When benchmarked against local and comparable, previous primary care trust (PCT) areas, Sefton has:

- Similar levels of Coronary Heart Disease (CHD) and COPD to local PCTs but higher than comparable PCTs
- Higher levels of hypertension than local and comparable PCTs
- Lower levels of diabetes than local PCTs
- Lower levels of dementia than both local and comparable PCTs and the national and regional averages

EQ5D scores (0.67) for south Sefton show that SSCCG is in the bottom quintile. Unfortunately as the data is presented as a composite score for EQ5D it is difficult to determine the specificity of the data e.g. which specific part of ill health are they reporting (mobility, usual activities,

anxiety, self-care, or pain and discomfort) however 52% feel supported to manage their own condition. The plans set out below aim to improve people's overall quality of life.

Plans for long term Conditions

- Support and refine use of risk stratification for people with long term conditions
- Develop use of personalised care plans for diabetes / COPD/ heart failure / Chronic Kidney Disease (CKD) across primary care, specialist community teams and secondary care
- Increase screening of dementia, COPD, Diabetes and CKD through:
- Virtual ward dementia screening protocol
- Increasing access to Spirometry
- Promotion of healthy living checks
- Increase patient understanding of their condition through:
- Roll out of our 12 week pro-active care education and behavioural change programme
- Tailored education programmes
- Increasing patient access to records
- Linking patients to online education

Intermediate care (Bedded units - Ward 35 / CCAU)

- Continue to review utilisation following improved urgent care GP cover and advocate a step-up approach from the community.
- Improve utilisation of the service towards a robust primary care supportive mode

Respiratory

Admissions with COPD are still above average despite a 30% reduction in COPD admissions in the last 5 years.

- Commissioning of an acute COPD community service and integration of current respiratory services. We expect a minimum 5% reduction in admissions for respiratory conditions.
- Increase the capacity and local access to the Community Spirometry service
- Ensure all patients with COPD and a Medical Research Council Dyspnoea >3 are referred to a pulmonary rehabilitation programme

Diabetes

- Ensure patients receive foot care / screening as specified
- Undertake review of the community service with a view to enhancing service offered

Community intravenous (IV) therapy

- Improved access to the community IV team following review of the forms, pathway and single point of access.
- Development opportunities for other IV treatments in the community including fluids, blood transfusion and picc line maintenance.
- Alignment of cellulitis pathway between community and acute trusts
- Increase access to microbiology consultant review through ward 35 attendance

Gynaecology

- Review impact of community service on acute trust demand

Palliative care / end of Life

- Continue to support the 'Hospice at Home' service delivered by Jospice
- Increased number of patients being cared for and dying at home (if this is their choice)
- Support nursing homes to complete education programmes including the six steps to success and gold standard framework
- Increase the use of and monitoring of End of Life (EOL) Care Tools in the community, care / nursing homes and acute settings. These will include:
    - Gold Standard Framework
    - Liverpool Care Pathway
    - Advance Care Planning for patients in the last year of life
    - Preferred Place of Care
    - Increased usage of the End of Life Care Register

Virtual Ward

This programme supports the following two NHS Outcomes Framework domains:

Helping people to recover from episodes of ill health or following injury

We have developed a 'Virtual Ward' strategy (the pilot in Maghull is currently operational) in liaison with Aintree University Hospital (AUH), Liverpool Community Trust (LCH) , Sefton Council, neighbouring CCGs and other key stakeholders. This strategy will:

- Reduce avoidable admissions to hospitals
- Keep people out of hospitals if better care can be delivered in a different setting
- Ensure effective joined-up working between primary and secondary care
- Deliver high quality and efficient hospital care and coordinate care and support post discharge
- Work with providers to invest savings in better reablement and post discharge support

We have employed a part time GP lead supported by a lead manager to develop and implement this strategy across the whole of south Sefton.

We will seek to improve and invest in the generalist aspect of community care through the South Sefton Virtual Ward model. Principles to this include integration, pro-active care of long term conditions, IT and self-care. This includes development and changes to:

- Domiciliary Urgent Care
- Pro-active nursing
- Reablement
- Information management and technology and single point of access
- Linking of community specialist teams

Admission rates for over 74 year olds from nursing and residential homes in are the upper quintile.

As part of the Virtual Ward system we will seek to institute advanced care planning for nursing home, palliative and dementia patients in their last year of life.

Relevant supporting data

PROMS for Hip replacement 0.35 Bottom Quintile

Knee replacement 0.27 Bottom Quintile

Groin Hernia 0.04 Bottom Quintile

Emergency Admissions 388 mid quintile

The CCG will work with Aintree and other providers to improve the outcome of patients. Aintree participate in the North West's Advancing Quality Programme, which looks at specific measures to improve the clinical outcomes for patients. We will improve pathways to reduce the number of emergency admissions for children with lower respiratory tract infections.

Unplanned admissions for ACS:

- South Sefton: 1052 (second worse quintile)

Unplanned admissions for diabetes, asthma and epilepsy in U19s:

- South Sefton: 345 (second worse quintile)

Emergency admissions that shouldn't usually require an admission:

- South Sefton: 1145 (second worse quintile)

Emergency re-admissions within 30 days:

- South Sefton: 12.4% (second worse quintile)

To reduce avoidable admissions to hospital we will:

- Implement the 'Virtual Ward' model
- Institute advanced care plans for all nursing home, dementia and palliative patients in their last year of life
- Identify patients who are high users through risk stratification and pro-actively improving long term condition management
- Increase both specialist and generalist community urgent care cover
- Work with the acute trust in streamlining the urgent care pathways through the emergency area and facilitate coordination between the acute and community urgent care services.
- Support < 24h of stay for patients with specified ambulatory emergency conditions
- Support development of cross sector pathways and to increase awareness of alternatives to admission for A&E staff
- Facilitating a service level agreement between A&E and urgent care aspects of the community
- Increase appropriate use of NHS services through the pro-active care behavioural change
- Institute a 7 day urgent care team to investigate, monitor and support patients at risk of deterioration via our 'Virtual Ward' model.
- Review total health gain for patients following elective surgery and collaborate with our acute Trust to evaluate proactive choice of surgery with patients

Ensuring people have a positive experience of care

Currently 89% 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 winner of the tender to improve patient satisfaction for OOH services

South Sefton patients 'Experience of Hospital Care' rating is above the national average.

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 and SSCCG websites.

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 5)
- 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 3

Our 3 local priorities are:

1) To bring about a reduction in Respiratory Disease admissions through A&E at Aintree Hospital

Rationale - there is a high mortality rate from respiratory diseases in south Sefton and there are a high number of admissions to hospital related to COPD. The CCG will build on a scheme piloted in south Sefton within the last year which is part of our overall Virtual Ward strategy, to bring about the changes across the whole CCG area.

Measures - to achieve a 5% reduction in the number of admissions to Aintree Hospital, through A&E between the current baseline available compared to 12 months' time.

Although it is recognised that a general reduction in avoidable emergency admissions is included with the composite measure for the nationally stipulated quality premiums, the CCG has chosen a more ambitious figure in this particular area of Respiration because it

would bring about a real quality improvement for patients and would demonstrate sufficient “stretch” compared to the 0% of the national target.

It should be noted that target would exclude any impact of an influenza epidemic.

2) To bring about a reduction in prescribing for three high risk antibiotics

Rationale - SSCCG has recognised as a priority the need to reduce the number of healthcare acquired infections (HCAI.) One of the factors, based on root cause analysis of HCAIs, has been the prescribing of high risk antibiotics both in primary and secondary care, without an appropriate indication according to local or national guidance.

We plan to work with constituent practices on the reduction of prescribing of three high risk antibiotics:

a. Quinolones b. Co-amoxiclav c. Cephalosproins

Work will include peer review sessions on prescribing activity for the three antibiotics at locality level during Quarters 1 and 2. There will be a CCG wide learning event to highlight appropriate prescribing by the end of Quarter 3. There will an offer to audit prescribing activity of the three antimicrobials and linking to appropriate / inappropriate indications.

Measures - 5% reduction in the overall number of items of quinolones, co-amoxiclav and cephalosporins. A baseline measurement of Quarter 3 2012-13 will be taken and the reduction will be measured on Quarter 3 2013-14 activity

3) To reduce the number of GP referred patients (during normal working hours) who receive an Accident and Emergency Department (AED) assessment before being admitted into Aintree Hospital

Rationale - at present approximately 89 % of non-elective GP referrals to Aintree University Hospitals are booked in via the AED department before being admitted. In many cases the CCG believes that this is not essential and can be detrimental to patient care and to the patient‘s experience. This additional step in the patient pathway also results in an inefficient use of resources.

Measures - To reduce by 5 %, Non Elective Admissions to Aintree where source of referral is GP, and where the patient has attended A&E on the same day. The current baseline figure will be compared with the figure in 12 months time.

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

SSCCG will drive quality improvement in the delivery of care from all providers and 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, 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 our Board.

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 when a '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 they wish 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 Quality Contract meetings with providers, at which provider performance in relation to quality is monitored. Finance representation at the Quality Committee is provided by our Chief Finance Officer and the Quality representation at the Finance and Resource Committee is provided by our Chief Nurse as part of the CCG risk management processes.

'How to Guides', such as the Quality Impact Assessment of Provider CIPs and Rapid Response Review, will be utilised 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 set out in 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 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 Aintree University Hospital to maintain performance of the PLT and ensure that we have early warning of any potential problem and offer alternate patient pathways.

We will work with the Trust, using contractual levers where appropriate, to ensure that no patient waits over 52 weeks and that the Trust moves to a maximum of 40 weeks.

Diagnostic test waiting times

We will ensure:

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

In order to help the Trust deliver the 18 week pathway, we will work with it 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 will work with the Aintree Hospital Trust to deliver the A&E standard. Our community based programme, 'Virtual Ward', which embraces technology with our providers to ensure patient get the best possible outcomes, aims to reduce emergency admissions by better managing people in the community.

Category A ambulance calls

We plan 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, with a further fine for delays of over an hour

Sefton has seen a surge in Category A calls in the later 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 aim to ensure:

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

We will:

- 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
- DNAs and cancellations of 2 week wait target appointments have a significant impact on efficiency and performance, as well as delaying treatment. The CCGs will 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

Cancer waits – 31 days

We plan to:

Maintain good Trust and CCG level performance against this standard and the targets below. Surgical capacity is the most common issue accounting for breaches:

- 96% max one month (31-day) wait from diagnosis to FDT 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

Cancer waits – 62 days

We aim to ensure:

- 85% max 2 month (62-day)wait from urgent GP referral for FDT for cancer
- 95% max 62 day wait from referral from an NHS Screening service for FDT for all cancers
- Maximum 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 E.g. Use of timed diagnostic pathways for specified tumours especially those using specialist surgical centres where multiple trusts are likely to be involved
- Aintree Hospitals have used the services of the Intensive Support Team and continue to implement recommendations. Southport and Ormskirk also plan to use the Intensive Support Team

5.3 Keeping Our Promises: Eliminating mixed-sex accommodation

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 should breaches occur – such as remedial action plans 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 Governing Body Meetings.

5.4 Keeping Our Promises: Reducing cancellations

Cancelled Operations

We plan to ensure:

- 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 (RTT) standard for our population and 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 of a patient breaching this target when they have not chosen to wait longer, or when 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 high quality, timely and cost effective services that 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 we 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 and Military Veteran health

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 South Sefton CCG – 52%

Virtual Ward and via CQUIN's with Liverpool Community Health Trust and Merseycare NHS Trust

Improved access to GP & 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.

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Improving Access to Psychological Therapies (IAPT)

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. Train 10 staff in each area to deliver online therapy in year one
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. Train 5 staff in each area to act as online facilitator in year one
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.

1. 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 4) 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 services 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 south Sefton show an increasing trend in our frail elderly. 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 aim to establish a collaborative network. It is intended that the network involves the following membership:

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

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. All these are intrinsically linked to the true use of NHS services 7 days a week.

As commissioners we will work through the newly established network to specifically shape primary, community and secondary care services and focus on integration with social care, the Ambulance Trust and the third sector. This work will help to drive our 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 Southport and Formby CCG, Liverpool CCG and Knowsley CCG around the University of Aintree NHS Foundation Trust 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 the summer of 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 will expect our providers to publish on their websites their own information about the services they deliver in these specialities 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 work with providers and partners to gather public insight into local health services, and our Quality Lead GP is working with Sefton Healthwatch and Aintree Hospital 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 recognise the opportunity for developing ICT-based solutions and models that support the development of a

participative society where 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 recognise 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) to 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 encourages the local people of south Sefton 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, whose main focus is on the patient experience, 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 will 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 the 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 Sefton Health and Wellbeing Board (HWBB). Our Chair has been a member of the shadow HWBB 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 Sefton Strategic Needs Assessment (SSNS). The results of SSNA 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 CCG commissioning intentions for 2013-14) the focus of five large public events across Sefton in December 2012 and January 2013 (see Appendix 1).

A joint working group for both CCGs in Sefton, called the Engagement and Patient Experience Group (EPEG), has been established, which feeds directly into the Quality Committee of each CCG. This group has a broad membership and is chaired by both CCG Lay Board members and comprises Governing Body practice managers, CCG senior managers, Sefton Council engagement leads, Sefton CVS and Sefton LINk. In future it is hoped members and officers of Health Watch will join the group. EPEG acts by co-ordinating engagement activities and considers patient information from all parts of the system, including practice level Patient Reference Groups, LINk Community Champions, who work in local community settings and feed into CCG localities, LINk local service provider experience reports, and CCG wide systems, such as trends from complaints.

Once in place, we will work with Health Watch to ensure that public involvement plans match local expectations for engagement at all levels.

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We are seeking to work with CMCSU in developing our 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 In Health Associates and Sally Williams of Frontline. We are seeking to use 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 also await 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:

- The universal adoption of the NHS number as the primary identifier by all providers in 2013-14
- We will use our contracts with Trusts to ensure the NHS number is used as the primary identifier, whilst 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 we are not satisfied with completeness and quality of provider data on Secondary Uses Service (SUS). We will ensure that secondary care providers' account for patient outcomes and that they 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 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 an SLA in place with 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

Together with the HWBB, 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, which 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 we have, along with Sefton Council, 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 Merseyside 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 regional work to inform the implementation of the strategy. In particular, we will work in partnership with the NCB Local Area Team in this particular as part of its quality improvement role.

We have an identified lead for Primary Care Quality, and this subject is a standard agenda item at the Quality Committee.

Comply or Explain Procurement Rule:

We will encourage Trusts to (comply) purchase though framework agreements unless they can (explain) articulate a clear reason to take a different approach. To 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 their area and if not then they will be responsible for explaining to patients why not.
Through NHS Constitution, patients have a right to NICE drugs and NHS organisations have a statutory duty to fund them. This will be discussed with trusts during contract negotiations and specified in the NHS Standard Contract

Innovation

The CCG is 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 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 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 the CCG representative on the group. We will use a number of methodologies to ensure the adoption of innovation including improving methodologies and spread.

Our ‘Virtual Ward’ will embrace technology with our providers to ensure patients get the best possible outcomes, for example community nurses using tablets to access patients records in the patients home, thus delivering real time record keeping and reducing duplicate inputting. We will also look at the use of telemedicine in the Virtual Ward 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 across 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.

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 – we have made provision for 1% contingency reserve within our financial plans to deal with the costs of any unexpected growth in activity. CCG plans developing Primary and Community based services will support this change. 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.

QIPP PLANS 2013/14	Description	£'000	Total £'000
Transformational Schemes			**3,492**
Prescribing	ARB	27	
	Statins	54	
	ED	58	
	Other	1,009	
			1,148
Provider Contracts	Tariff efficiency - 4%		**7,052**
Total			**11,692**

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 NCB Local Area Team to agree these schemes between now and final plan submission. We have established risk share arrangements with Southport and Formby CCG, which will include 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 have included a contingency within our financial plans in 2013-14.

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 the Council.

8.2 Contracting for Quality

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 2013-14 contracts and where possible have come to an agreement regarding common CQUINs – the Chief Nurses are leading on the development of specific portfolio related areas. The 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 is 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 our 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, and in addition (as part of the designation) we will require the following services to support A&E):

- Anaesthetics
- ICU / HDU
- Diagnostics
- Path labs

Appendix 1 - How we involved people in 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

Together with Sefton Council, we held nearly 50 public and partner events during 2012 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 SSCCG 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 2 – Clinical and managerial leads for each programme

Area	South Sefton CCG Lead	CCG Team Lead
Alcohol	*Dr Sunil Sapre*	Tina Ewart
Cancer	Dr Debbie Harvey	Sarah Reynolds
Children	*Dr Wendy Hewitt*	Jane Uglow
Contracting	Dr John Wray	Stephen Astles / Jan Leonard
Communication	Roger Driver / Sharon McGibbon	Lyn Cooke / Tina Ewart
Contract Management - Commissioning Unit	Dr Steve Fraser	Tracy Jeffes
Dementia / Mental Health / Learning Disabilities	Dr Ricky Sinha	Geraldine O'Carroll / Kevin Thorne
Dermatology		Billie Dodd
Diabetes	*Dr Nigel Taylor*	Moira McGuiness
End of Life	*Dr Debbie Harvey*	Moira McGuiness
Governance	Lynda Elezi	Tracy Jeffes
Integrated Care / Planned Care	Dr Peter Chamberlain	Stephen Astles / Billie Dodd
IT	Dr Steve Fraser	Alison Johnson
Long Term Conditions	Dr Craig Gillespie	Stephen Astles / Sandra Boner / Jenny Kristiansen
Maternity	*Dr Wendy Hewitt*	Jane Uglow
Medicines Management / Prescribing	Dr Steve Fraser / *Jill Thomas*	Brendan Prescott
Obesity	Dr Paul Thomas	
Organisational Development / Training & Development	Lin Bennett	Tracy Jeffes
Patient and Public Involvement	Roger Driver / Sharon McGibbon	Jackie Robinson / Tracy Jeffes
Prevention and Public Health	Dr Paul Thomas	Morag Reynolds / Margaret Jones
Primary Care Quality	*Dr Bal Duper* / Lin Bennett	Angela Parkinson / Debbie Fagan
Quality	*Dr Gina Halstead*	Debbie Fagan / Steve Astles / Billie Dodd
Unplanned Care / 111 Care	Dr Andy Mimnagh	Billie Dodd / Stephen Astles / Malcolm Cunningham

**Italics* – not a Board member

Appendix 3 – South Sefton Local Priorities Mapping

<table>
<tr><th colspan="4">South Sefton Local Priorities Mapping</th></tr>
<tr><th colspan="4">To bring about a reduction in Respiratory Disease admissions through A&E at Aintree Hospital</th></tr>
<tr><th>Health and Wellbeing Strategy Priorities 2013 – 2018</th><th>South Sefton CCG Commissioning intentions</th><th>Feedback from Big Chat</th><th>Feedback from Sefton Strategic Needs Assessment Consultation</th></tr>
<tr>
<td>Strategic Objective

Support Older people and those with long term conditions and disabilities to remain independent in their own homes.

Consultation and engagement identified that the following was important :-
“ Maintaining independence by supporting people to remain well, with care closer to home, improvement of primary care through virtual wards, good access to public transport and early intervention, prevention and diagnosis for those with limiting long term illness and / or disabilities</td>
<td>Improving Primary Care
Health Checks – continuing to promote the scheme to detect those at risk of heart disease and diabetes

Improving Community care
Virtual ward , further develop the programme which brings together a range of health professionals to better manage patient conditions so they do not need hospitalisation and to support them in the understanding of their condition and what they can do to stay well- including patients with dementia, long term conditions and those at end of life.

Long term conditions
Alongside the virtual ward , we want to increase screening and provide specific initiatives to improve the care of dementia, lung disease and heart disease patients

Improving the use of hospital care
Reducing emergency admissions to hospital – along with the virtual ward we want to develop a 7 day urgent care team to investigate monitor and support patients at risk o deterioration whilst in hospital, promoting the appropriate us of emergency services to South Sefton residents.

Ensuring hospital and community services work better together – working to ensure patients journey between hospital, community and primary care services is as smooth as possible, including better discharge planning , services for diabetes and cancer through our virtual wards</td>
<td>“Access to timely services”

“Proper and effective advice and support for people with long-term conditions.”

“Self-help support. Need to distinguish when self-care is appropriate and when it is appropriate to seek professional”

“As soon as the patient is diagnosed with LTC/WHATEVER, get the Proper Discharge Planning in place – NOT SELECTIVELY

Everyone to get same service level to eliminate gaps in Discharge planning”

“Thinking of the virtual ward, can the patient still get a second opinion?”

“The challenge of multi complex health needs, i.e. Lung disease, COPD, Cancer etc.”

“Tele health technology”

“Virtual wards – keep people at home and deliver services”

“Long-term conditions, working age of people, diabetes – need to focus on these through early intervention and support to prevent people developing more complex needs.”

“Try to get appropriate use of secondary care”</td>
<td>“ More access to services at a local level , rather than going in to hospital –using voluntary and community organisations locally” (Bootle)

“Better respite for long term illness sufferers and better promotion of these services” (Bootle)

“Give confidence in self-management” (Bootle)

“Hospital at Home service will positively support older people with long term conditions” (Maghull)

“Virtual Ward and Long term conditions objectives – a good idea”
(Maghull)

“more social care in hospital to support discharge”
(Maghull)</td>
</tr>
</table>

South Sefton Local Priorities Mapping

To bring about a reduction in prescribing for three high risk antibiotics

Health and Wellbeing Strategy Priorities 2013 – 2018	South Sefton CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support people early to prevent and treat avoidable illness and reduce inequalities in Health** **Consultation and engagement identified** **Find different ways to support people early to avoid them needing expensive acute services and surgical procedures**	**System Wide Improvements** We will work with public health to support prevention initiatives , provide training to health and social care staff to support their patients and clients and support those with long term illnesses to manage their conditions	“Self care needs to improve, not all bad backs need physiotherapy, people need to take some pain relief and see if it gets better on its own, the same for coughs and colds etc. We need to change people’s mind about running to the hospital and GP with every niggle.” “Look at prescriptions – issue of wasted repeats” “Understanding when to access services ie campaigns for coughs”	“ Take control of own lives , manage sickness” (Bootle) “ Stop pharmacy repeat prescriptions service” (Crosby) “Cost of medication not being used”

To reduce the number of GP referred patients who receive and AED assessment before being admitted to Aintree Hospital

Health and Wellbeing Strategy Priorities 2013 – 2018	South Sefton CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support people early to prevent and treat avoidable illness and reduce inequalities in Health** **Consultation and engagement identifies Primary care services need to be local and accessible, reducing waiting times for GP appointments ,accessible walk in centre, focus on early diagnosis to prevent cancer, heart disease, stroke and improve falls prevention service.** **Find different ways to support people to avoid them needing expensive acute services and surgical procedures**	**System Wide Improvements** Improving cancer services. We will recruit a McMillan GP to influence how cancer services are provided for patients from detection through to end of life , working closer with the Mersey Cheshire Cancer Network Early Detection Project manager to support GP practices around cancer rates amongst their patients- all with the aim of increasing survival rates	“The challenge of multi complex health needs, i.e. Lung disease, COPD, Cancer etc.” “Early, prompt and effective diagnosis and treatment.” “Issue of cost effectiveness of blanket screening” “FR Has to go to Clatterbridge for meds not available locally.” “Focus on prevention would reduce need for acute services” “People who don’t see the benefit long term ie smokers with cancer they don’t see that smoking will give them cancer 10 years down the line so they don’t care about it now just when it is too late” “Health checks/Health screening offered/targeted at specific ages”	“Clusters of people with cancer and Asthma not being investigated properly”(Crosby) “Sefton residents have to go to Clatterbridge. In 2017 the new Royal Hospital will have a unit. Cancer unit at Aintree, consultant doesn’t hold a clinic in Aintree so has to go to Clatterbridge. But must be realistic about what can be achieved in the next few years. This is also an issue in terms of costs of travel. (Crosby) “Early diagnosis and intervention by screening will save money in the long run, prevent unnecessary treatment and hospital stays but need pump priming for screening)” (Crosby)

Appendix 4 – 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 – South Sefton Clinical Commissioning Group

Appendix 5 – 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 (56% split)	5	3	3	3	2	2	2	2	2	3	2	2		31
		12/13 Actual [2]	1	1	3	5	3	3	1	1	4	4			26	31
		13/14 Plan [3]	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*1.67*	*20*	*20*
	Community-Acquired	12/13 Plan (56% split)	3	3	3	4	3	2	2	2	3	3	3	2		33
		12/13 Actual [2]	3	2	6	4	3	3	3	5	2	1			32	38
		13/14 Plan [3]	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*2.00*	*24*	*24*
	Total	12/13 Plan	8	6	6	7	5	4	4	4	5	6	5	4		64
		12/13 Actual	4	3	9	9	6	6	4	6	6	5	-	-	58	70
		13/14 Plan [4]	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*3.67*	*44*	*44*

[1] Please note that these targets apply only to South Sefton 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	5	8	11	14	16	18	20	22	24	27	29	31	31
		13/14 Plan [3]	2	3	5	7	8	10	12	13	15	17	18	20	20
	Community-Acquired	12/13 Plan	3	6	9	13	16	18	20	22	25	28	31	33	33
		13/14 Plan [3]	2	4	6	8	10	12	14	16	18	20	22	24	24
	Total	12/13 Plan	8	14	20	27	32	36	40	44	49	55	60	64	64
		13/14 Plan [4]	4	7	11	15	18	22	26	29	33	37	40	44	44

25% at 3 months = 11.01

[1] Please note that these targets apply only to South Sefton CCG-responsible patients.

[3] 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.