BaNES, Gloucestershire, Swindon and Wiltshire Area Team

Commissioning Plan 2014/15 and 2015/16

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SECTION 1: INTRODUCTION

Introduction

1.1. NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government. Through its 27 local area teams, NHS England is responsible for directly commissioning:

- Primary care services (including GP services, dental , optometry and pharmacy services)
- Secondary care dental services
- Secondary healthcare services for armed forces serving personnel and families
- Public Health services under Section 7a
- Specialised healthcare services
- Healthcare services for offenders and those within the justice system

1.2. This delivery plan sets out the strategic framework for the development of commissioned health services in the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) area. The BGSW area team work closely with the Clinical Commissioning Groups (CCGs) and their member practices to define a model of care that fits with the national strategic framework while being responsive to local populations. This joint working utilises local knowledge and understanding of the needs of local patients to commission a wide range of services. The model of care supports the delivery of the wider health and wellbeing strategy for the local population.

1.3. NHS England's focus for direct commissioning is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.

The national context

1.4. The Government's NHS mandate[1] originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

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

[1] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

- We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.
- We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.
- We want to ensure patients have a **great experience** of all their care.
- We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

1.5. The health needs and expectations of our population are changing and in order to meet these, the whole health and social care sector will need to move away from outdated divisions of care. Collectively, we are moving towards a system of integrated care, where clinicians work together in flexible teams formed around the needs of the patient, their families and the communities in which they live. The aim is to deliver high quality, cost effective and resilient systems of care that achieve best health outcomes for the population of BGSW.

1.6. The BGSW area has relatively good health outcomes when compared to the England average. However, there are pockets of deprivation across the geography and there are opportunities to improve access to healthcare and reduce inequalities across the whole geography. The age profile of the population and the predicted growth in the over 50s by 2011 means that there are opportunities to improve the management of long term conditions and management of patients with multiple comorbidities.

1.7. NHS England launched *A Call to Action* in July 2013 which set out the challenges and opportunities faced by the health and care systems over the next five to ten years. Ways to raise the quality of care to the best international standards need to be identified for all in our communities, while closing a potential funding gap of around £30 billion by 2020/21. This will require transformational change in how and where health and care services are delivered.

1.8. On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled Everyone Counts: Planning for Patients 2014/15 to 2018/19. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to ***make high quality care for all, now and for future generations*** into a reality[2].

1.9. Change will need to be achieved through:

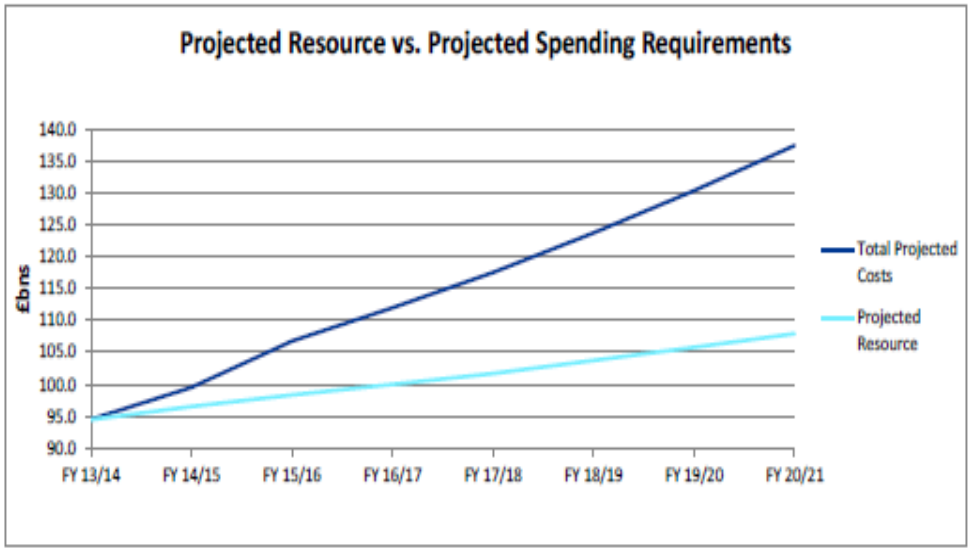
- Listening to patient views
- Delivering better care by realising the benefits of the digital revolution

[2] http://www.england.nhs.uk/2013/12/20/planning-guidance/

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

The financial challenge

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



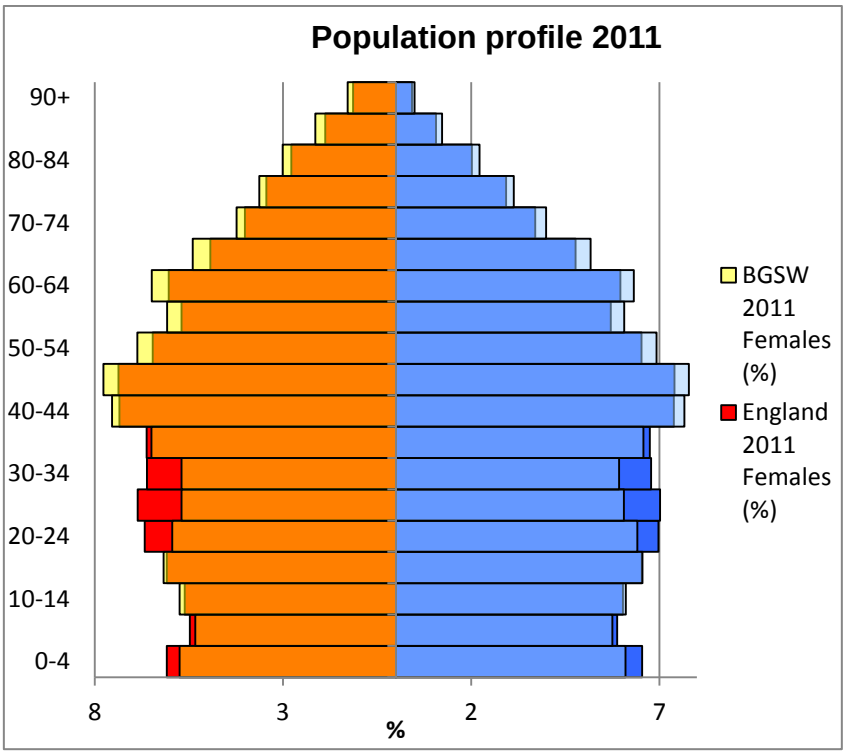
1.11. As a crude approximation the Bath, Gloucestershire, Swindon, and Wiltshire weighted population is 2.5% of the national population, so our financial challenge is circa £0.75 billion of the £30 billion call to action challenge across all NHS commissioners.

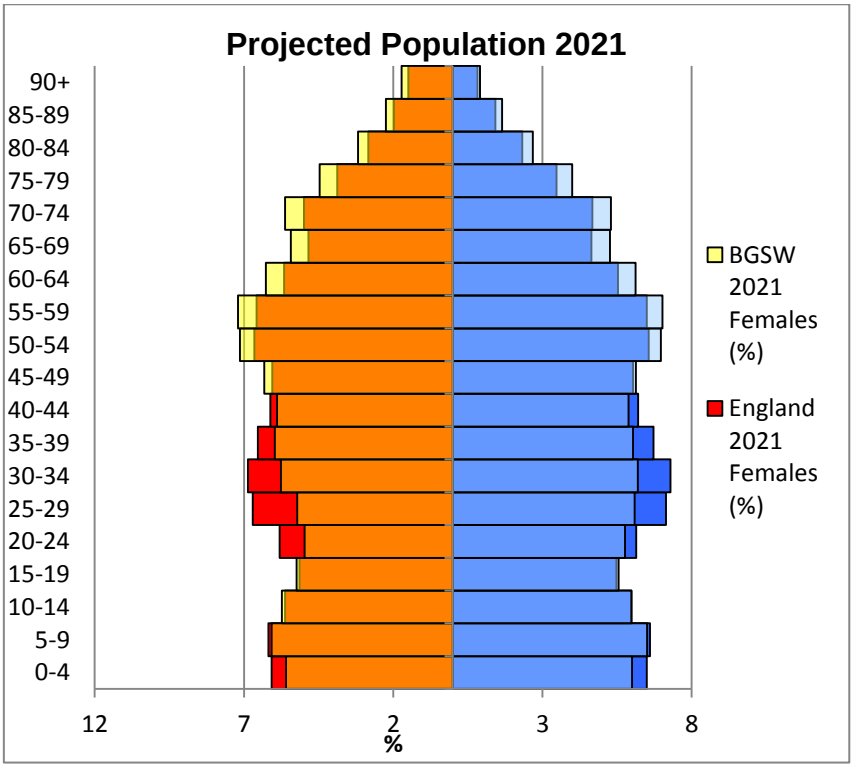
1.12. The affordability challenges (or more accurately the demand challenges) in 2014/15 and 2015/16 are real and urgent. The prospect of resources being

outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases, presents a significant challenge to the way we currently commission and provide care.

SECTION 2: THE DEMOGRAPHIC OF THE BGSW POPULATION

2.1. By 2021 it is projected there will be a 7.6% increase in the total BGSW population, which is shown broken down by gender and age in the following graphs:





2.2. Whilst this increase in total population in itself is significant, it masks a more significant issue in that it is projected that over the same time period there will be a significant increase in number of people aged over 65 years and more specifically over 85 years.

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

Inequalities

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

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

2.6. The 4 areas of BGSW show the differences in deprivation levels based on national quintiles of the Index of Multiple Deprivation 2010 by Lower Super Output area). Generally, deprivation is much lower than the national average in the BGSW area, however there are significant pockets of deprivation, most notably in Swindon and this means there are opportunities to improve outcomes and reduce health inequalities in these areas.

Health Outcomes/Needs	Deprivation	
Source(s)	**Public Health observatory - interactive maps**	IMD
BaNES	Deprivation	4
Gloucestershire	Deprivation	7.2
Swindon	Deprivation	14.3
Wiltshire	Deprivation	2
ENGLAND Comparator	*England Average*	20.3
	England Worse	83.7

SECTION 3: MAINTAINING A FOCUS ON QUALITY

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

- Francis report and the need to improve high quality, safe care.
- Berwick report and the need to foster a safety culture
- Winterbourne report describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.

3.2. Intelligent, collaborative commissioning will be undertaken with partners, including regulators of health care services. Within BGSW we will manage a quality work programme for Primary Care and contribute to that for Armed Forces.

Safety

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

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

- Host the Quality Surveillance Group oversight across BaNES, Gloucestershire, Swindon and Wiltshire
- Implement the new patient safety alerting system
- Continue to drive to reduce the incidences of HCAI
- Implement the new Patient Safety Collaborative Programme
- Implement the new patient safety thermometers
- Take prompt action in response to Care Quality Commission notices and enforcement notices
- Take prompt learning and quality improvement for Serious Incidents and Death in Custody reviews
- Innovate and utilise national models to support safe staffing delivery

Quality in primary care

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

- To work with CCG's in order to support the implementation of robust reporting on adverse events and serious incidents requiring investigation (SIRI) in primary care settings utilising the national database of National Reporting and Learning System (NRLS) which will also support practices with regular reports to support their CQC registration.
- To improve the way that safeguarding training is implemented to ensure that everyone who needs training has been trained. In addition, to improve the way the safeguarding training is embedded in practice so that people really understand what it means and how and when to raise a concern.
- To improve the way in which informed consent is given by patients for procedures performed in primary care.
- To empower all clinical staff to challenge inappropriate or questionable behaviour.
- To embed better two way communication about concerns with Care Quality Commission
- To ensure that GPs with Special Interests (GPwSI) are appropriately monitored for the work that they do.

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

Patient Experience

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

- Improve the complaints systems for primary care, ensuring that verbal complaints (not just written ones) and concerns are recorded, considered and acted upon, and reported to identify trends by subject matter practice and practitioner and share learning

- Ensure the patients voice in heard, listened to and responded to which includes supporting the development of fit for purpose Patient Participation Groups
- Improve the experience of carers in line with the national NHS commitment to carers
- Support the implementation of Friends and Family Test across Primary care services
- Further develop the concept of no decision about me without me and implement patient centred approach
- Implement the Compassion in Practice and methodology of the 6 Cs
- Safeguard those patients who are the most vulnerable working collaboratively with multi-agency partners; having clear process on how staff working in primary care services can access relevant training and support
- Work with organisations to increase the ability of patients and the public to care for their own health
- Promote full respect for patient autonomy in decision making and ensure patients can access advanced care planning options.
- Ensure our systems are simple and straightforward to access and that appropriate choices and option are clearly signposted

Quality in Public Health

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

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

Safeguarding

3.9. To help ensure the most vulnerable people in our communities feel safe, our vision for Primary Care for the next 5 year plan is to:

- Introduce a training framework and strategy for all Primary Care staff that enables all GPs to be trained to level 3 in both adult and child safeguarding.
- Work with GPs to ensure the impact of this training strategy is felt within safeguarding practice by continuing to work closely with Safeguarding teams within CCGs in supporting GPs in developing their reflective practice skills in their own safeguarding practice within their day to day work and also in their annual appraisal process.
- Work in a more integrated way with the Care Quality Commission to understand the needs of the practices that need support to ensure their safeguarding practice is compliant with the full requirements.
- Provide a series of events/opportunities for practice staff to ensure the learning from national serious case reviews and local safeguarding. incidents across BGSW is understood and recommendations responded to
- Introduce a series of audits that will assess improvement in practice from the above and compliance that will then in turn, inform the fuller 5 year training and activity strategy.

3.10. We will achieve this through the continuation of our work with Clinical Commissioning Groups and Local Authority partnerships to ensure that safety of vulnerable people is mainstream activity within the commissioning and contracting process.

SECTION 4: PRIMARY CARE SERVICES (e.g. core services from general practitioners, community pharmacies, dentists and optometrists)

Introduction

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

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

Strategic intention

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

- A common, core offer for patients of high quality patient-centred primary care services.
- Continuous improvements in health outcomes and a reduction in inequalities.
- Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda.
- The right balance between standardisation/consistency and local empowerment/flexibility.

4.4. This document should be read in conjunction with NHS England (BGSW) draft Primary Care Delivery Plan.

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

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

- Population changes - including an aging population, an increase in people living with multiple long term conditions and changing public expectations – are increasing demand for health services.

- Improving our primary care services will improve patient care and will cost less. Better care, closer to home is the only way to maintain quality of care in the face of increasing demand and limited resources.
- Addressing inequalities in access, quality and outcomes will require new and innovative ways of coordinating services.
- Action is needed to address emerging workforce pressures including recruitment and retention problems for GPs and practice nurses.

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

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

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

- Current state
- An extended skill mix in practices and across a range of primary care providers
- Federation of practices
- Colocation of practice / merger of practices to form larger partnerships / primary care units
- Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations)

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

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

- Involving patients and carers more fully in managing their own health and care.
- Ensuring care is of a consistently high quality: effective, safe and with a positive patient experience.

Partnership working

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

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

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4.13. Local professional networks (LPNs) for pharmacy, dentistry and eye health are being established and chairs recruited. Their objectives are aligned to NHS England's commissioning by ensuring representative and robust clinical input to decision making and leading the profession in peer review and support, maximising performance, addressing inequalities and driving continuous improvement.

4.14. We are working closely with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment and have a programme to support Practice Nurse development.

Primary care support services

4.15. NHS England BGSW is responsible for primary care support (PCS) services. These services were successfully outsourced in 2012 and are managed through a programme board. BGSW is continuing to work with other Area teams to ensure that a national solution is achieved.

Secondary Care Dental

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

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

Priorities

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

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

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

- **Choice of GP practice.** From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a

duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. NHS England's area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

- **Friends and Family Test.** There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.
- **Patient online services.** GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments for local GP practices.
- **Extended opening hours.** The extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access to services.
- **Patient participation.** The patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.
- **Transparency of GP earnings.** The British Medical Association's General Practitioners Committee (GPC) will join a working group with NHS England and NHS Employers to develop proposals on how to publish (from 2015/16 onwards) information on GPs' net earnings relating to the GP contract. The first published data would be based on 2014/15 earnings and publication of this information will be a future contractual requirement.
- **Diagnosis and care for people with dementia.** There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.
- **Annual health checks for people with learning disabilities.** There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.
- **Alcohol abuse.** There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.

4.19. NHS England holds 121 GMS contracts , 76 PMS contracts and 2 APMS contracts across the Area Team patch. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

Supporting investment and redesigning incentives

4.20. To support the changes in Primary Care, we will need more than new ways of working to be effective. We will need to invest in better information systems and technology, improved primary care estate and significant workforce development. We will also need to put in place stronger governance systems to hold providers of care out of hospital to account and to assure that the commitments and standards to which we aspire are delivered.

4.21. To support the change and the delivery of our Primary Care Commissioning plan we have identified five key enablers:

- Financial resource, contracts and incentives
- Early Adopter Communities
- Information technology
- Organisational and workforce development including skill mix
- Estate development.

4.22. We have further recognised that the delivery of this strategy will represent a significant programme of organisational change across Primary Care.

Financial resources, contracts and incentives

4.23. Supporting investment and redesigning incentives: supporting a shift of resources towards general practice and ‘wrap-around’ community services and developing innovative new forms of incentives that reward the best health outcomes.

4.24. BGSW are already actively engaged with the CCGs in developing strategic plans that place a much greater emphasis on care outside hospital, and many intend to use general practice as a major component of more accessible and integrated systems of care.

4.25. We are working with the CCGs to explore the with greater clarity the different enablers that we can use to support safe, controlled investment in general practice services, in particular:

- services commissioned by CCGs under the NHS Standard Contract;
- enhanced primary care services commissioned by CCGs under delegated authority from NHS England;
- QOF flexibilities ;
- additional investment through PMS or Alternative Provider Medical Services (APMS) contracts, managed by NHS England but potentially drawing on funding that has been pooled with CCGs;
- The use of the £5 per head of population funding and
- A shift in funds from secondary to primary care

Early Adopter Communities

4.26. As part of the drive by the Primary Care Commissioning Team to invigorate and support innovative integrated care proposals, the AT will be working with the CCGs to identify funding in order to support early adopter sites. We are working with the 4 CCGs and member practices to develop local models of care that will provide the wider Primary Care offer.

4.27. To deliver the aspirations set out in the Primary Care Commissioning Strategy and associated integrated care plans, there will need to be a step change in investment in care out of hospital. We will with CCGs refine and further develop sources of evidence to inform the anticipated quantum shift of activity from hospital (and other care institutions) to primary and community based settings. This includes:

- Understanding the effect of the agreed out of hospital standards on the potential shift of activity
- A review of evidence behind models of integrated care and primary care.
- Alignment of the CCG plans to the Early Adopter objectives.
- An assessment of the anticipated effect of the implementation of the in hospital models of care on out of hospital care
- The completion of a detailed cost benefit analysis framework by all localities across BGSW reflecting emerging understanding of the shift of activity anticipated between in hospital and out of hospital care.

Information systems

4.28. Information and communications technologies have the potential to revolutionise patient experience, transforming how and where care is delivered. We will work with partners in health and social care to align BGSW's IT strategy as a key enabler of the Primary Care Delivery Plan and local integrated care plans. It is widely recognised that the ability to share data across health and social care, and critically with patients and their carers, will be a crucial success factor in the delivery and transformation of out of hospital

care. We will work with key stakeholders across BGSW in the delivery of integrated health and social care records.

4.29. We will capitalise on the transformational improvements in the quality of information technology to enable the delivery of the commitments aspired to within the Primary Care Delivery Plan. This includes the development of shared decision-making tools, transparent and public sharing of benchmarked data. With partners, we will develop and deliver a digital technology strategy to drive down the level of unnecessary face to face contacts, enabling care to be delivered safely and more conveniently.

4.30. The work that we are currently doing with the CSU and the CCGs will result in the development of patient online services described above ('Empowering Patients and the Public') and in developing strategies to share information more effectively between general practice and other providers to support integrated care.

4.31. It is envisaged that the new General Practice Systems of Choice replacement framework (GPSoC- R) will enable general practice to extend its world-leading position in the use of electronic systems by general practitioners and also enable delivery of increasingly rich online services for patients, supporting increasing involvement of patients in their own care and of patients and GPs in shared decision-making

Organisational and Workforce Development

4.32. BGSW recognise that in order to support the change in Primary Care and be able to respond the activity shift that is anticipated, work is underway with Health Education England to understand the workforce implication across the health and social care system. We recognise that the delivery of the Primary Care Delivery Plan will require both a review of current roles and a potential increase in workforce capacity within Primary Care.

4.33. Whilst we are working closely with the Deanery and Health Education England to understand current trajectories for GP and Practice Nurse training, recruitment and retention, we also recognise that many of the developments described may be delivered by allied health and social care professionals and other primary care professionals (with the exception of Dentistry), with the GP as the co-ordinator of care.

4.34. Our workforce development programme will be supported initially by an externally commissioned baseline assessment to encompass future primary care workforce projections and the shift of culture and leadership required to support front line staff to co-ordinate and deliver whole person focused interventions. It is recognised that a robustly developed and credible

workforce plan, including transition plan, is a key requirement for the successful implementation of the Primary Care Commissioning Strategy

Premises

4.35. Based on a broader understanding of the scale of the transformation of care out of hospital, including primary care, work is underway with NHS Property Services, CCGs and with Local Authority partners to understand the estates implication across the health and social care system.

4.36. As members of the 4 Local Authority Spatial Planning groups we are working closely with them and the CCGs to ensure that future estates strategies align with and enable the delivery of our Primary Care Commissioning strategy. Key considerations will be the development of facilities that promote and enable integrated working across organisational boundaries and the delivery of diagnostics and specialist care in out of hospital settings. We will work closely with our partners to ensure any urban development proposals consider the implications of out of hospital service developments. As members of the Spatial Planning groups we are able to make best use of the opportunities that exist through Section 106 and gifted land as both have a positive financial impact on NHS England.

4.37. In doing this, we recognise that there is very limited scope in NHS England's primary care budget to meet the revenue costs associated with expanding general practice premises. The revenue consequences of developing practice facilities have a recurring impact on the primary care budget, and BGSW have a defined process through which to prioritise this funding over many other competing demands on the primary care allocation.

4.38. To this end we are currently reviewing the current level of premises usage and reimbursement and working with the Local Authorities to identify any shared public sector body opportunities for improving value for money and promoting more innovative use of estates.

4.39. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of PMS contracts was undertaken throughout 2012/13 by the former Cluster PCTs. This resulted in the vast majority of PMS contracts being successfully reviewed. A further review of PMS contracts across BGSW will be undertaken in three phases:

- Phase 1 will be to facilitate any further transfer back to a GMS contract that PMS contractors wish to make.
- Phase 2 will be to comprehensively review those contracts where the previous review was not concluded to the satisfactions of the NHS England.

- Phase 3, which will be undertaken in 2015/16, will be to review the objectives of existing PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

4.40. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.

Next steps

4.41. The plan include specific actions to support development of general practice services in ways that reflect the six characteristics of high quality care as we have described in our vision. We intend to work with the 4 provider groups within Primary Care to improve current services and to further identify the contribution each can make to the implementation of the overall vision of Wider Primary Care.

Primary care financial context

4.42. In 2013/14, a surplus of £3.4m is forecast. This surplus is carried forward into 2014/15, as are future surpluses and deficits.

4.43. Expenditure on GP IT is currently excluded from the primary care financial plan. NHS England is reviewing options for future funding of GP IT.

4.44. QOF and the public health element of the global sum payments to practices is included in full within primary care however 15% of QOF and 7.2% of the global sum is nominally attributed to the reporting of S7a public health allocation.

4.45. Primary care services are most directly affected by changes in population. GPs' income is largely based on list sizes, and demands for pharmacy, dental and ophthalmic services also change as the population changes. Overall population demographic growth is forecast to cost £2.4m in 2014/15 (0.9%).

4.46. There are also a number of cost pressures arising out of national directives. For example, an Enhanced Service is proposed for a named GP for those aged 75 and over, and there is to be greater choice of GP practice with Area Teams responsible for any in-hours urgent medical care. There are also

expected to be additional costs for QOF as services are improved and practices increase their level of achievement.

4.47. Primary care services are subject to annual pay and price increases. The Doctors and Dentists Review Body has not yet announced the pay increases for 2014/15, and a 1.3% increase has been assumed in the plans for primary care and 1.5% for dental, costing £3.0m.

4.48. The price increase associated with pharmacy costs is assumed to be 2% at a cost of £1.1m. The price increase associated with ophthalmic is assumed to be 1.5% at a cost of £0.2m.

4.49. As outlined above, demographic growth of £2.4m is included within the plan (0.9%). In 2013/14 the demographic growth for pharmacy was 3.5% and for ophthalmic 2.5%. If this growth is repeated in 2014/15 this would be a cost pressure of £2.2m across these two areas. The Area Team's plan is that the demographic growth for both pharmacy and ophthalmic will be in line with the longer term historic average of 1.5% reducing the cost pressure to £1.0m.

4.50. Premises reimbursements are assumed to increase by 2.75% or £0.5m.

4.51. QIPP has been included within the financial plan at £3.0m in 2014/15 and £2.3m in 2015/16. To date ideas for QIPP are currently being developed. QIPP delivery is a risk until robust plans to deliver the full value are developed and implemented.

4.52. The allocation has been increased in 2014/15 by £5.7m or 1.98% growth.

4.53. The summary financial position is shown below:

Primary Care	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	273,530	276,432
Adjustment for non recurrent spend	-1,980	0
Inflation uplifts	4,409	4,487
Growth	2,443	2,499
Provider Efficiency	0	0
Service Investments	1,030	1,020
QIPP	-3,000	-2,325
Sub total	276,432	282,113
Contingency	1,418	1,441
Headroom	2,063	1,838
Total	**279,913**	**285,392**
Notified Allocation	280,434	284,864
Surplus / (Deficit) carried forward	3,190	3,711
Total Resources	**283,624**	**288,575**
Submitted plan surplus / (deficit)	**3,711**	**3,183**
Planned allocation changes	-300	
Reduction in surplus carried forward		-300
BGSW plan surplus / (deficit)	**3,411**	**2,883**

4.54. The plan delivers a surplus in line with the 2013/14 forecast outturn surplus position.

Secondary and community dental financial context

4.55. This service has financially over spent in 2014/15, with the year end forecast over spend of £1.1m. The area team is working with NHS South West CSU, which provides business intelligence support, and primary care to better understand the reasons for the over spend. Where there is evidence that the area team inherited incorrect financial baseline budgets these will be corrected via allocation transfers with CCGs. The area team is currently estimating that there will be £300k of funding allocation adjustments in 2014/15.

4.56. A review of the total dental pathway will be undertaken during 2014/15 to ensure appropriate activity is treated at each setting of care across secondary, community and primary care. This is expected to generate QIPP savings of £700k in 2014/15 and £800k in 2015/16.

4.57. The financial position is shown below:

Secondary / Community Dental	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	21,161	20,344
Inflation uplifts	518	479
Growth	212	305
Provider Efficiency	-846	-814
Service Investments	0	0
QIPP	-700	-800
Sub total	20,344	19,514
Contingency	97	99
Total	**20,441**	**19,613**
Notified Allocation	20,180	20,500
Surplus / (Deficit) carried forward	-1,084	-1,345
Total Resources	**19,096**	**19,155**
Submitted plan surplus / (deficit)	**-1,345**	**-459**
Planned allocation changes		
Growth		5
Allocation adj with CCG	300	300
Reduction in deficit carried forward		300
BGSW plan surplus / (deficit)	**-1,045**	**146**

4.58. Although the 'headline' allocation has increased over 2013/14 levels, the need to absorb the previous year's deficit creates additional cost pressure moving into future years.

4.59. The 2014/15 plan is a deficit of £1m which is in line with the 2013/14 forecast outturn deficit of £1.1m despite the impact of the 2013/14 deficit reducing the 2014/15 allocation.

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

Introduction

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

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

a) Immunisation programmes
b) Cancer screening programmes
c) Non-cancer screening programmes
d) Children's public health programmes (The Healthy Child programme from pregnancy to age 5)
e) Child health information systems
f) Public health services for people in prison and other places of detention including those held in the young people's secure estate
g) Sexual assault services

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

5.4. It is the responsibility of Public Health Teams within the Area Team (made up of NHS England and Public Health England staff) to commission safe and effective programmes as listed above in order to achieve positive health outcomes; reduce inequalities; and to ensure value for money sand increased productivity within allocated resources.

Public health strategic intent

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

5.6. The summary plan for public health is included as Appendix 2 (Public Health Plan on a Page). The public health services commissioned by NHS England

directly support the achievement of the NHS outcomes framework domains and ambitions, in particular:

Domain 1 - Prevent premature deaths and increase life expectancy	The preventative immunisation and screening programmes enable interventions to stop people from dying prematurely, securing additional years of life for people with treatable conditions (outcome ambition 1).
Domain 2 - People with LTCs get the best possible quality of life	Screening programmes support the early identification of health conditions, enabling people to receive treatment and support much sooner, improving their quality of life (outcome ambition 2). Immunisations (such as the 'flu jab) can also improve the quality of life for those in particular at-risk groups. In addition, early diagnosis can ensure more planned and integrated care can be put in place, reducing avoidable hospital stays (outcome ambition 3).
Domain 4 - Patients have a great experience of their care	Continual performance management, working with providers and other partners, ensures the highest standards of patient experience from the public health services we commission.
Domain 5 – Patients in our care are kept safe and protected from all avoidable harm	Keeping patients safe from avoidable harm is the core purpose of our public health services.

Roles and responsibilities

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

NHS England	Is accountable for letting contracts and ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. We are responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.
Public Health England(PHE)	Develops the national standards and operational guidance and provides expert leadership and advice to NHS England teams. They also play a leading role in collecting and sharing data and monitoring quality assurance.
Local authorities	In addition to leading the local public health system, they provide information, advice and oversight to the public health arrangements of NHS England, PHE and providers through local Health protection Boards and Health and Wellbeing Boards. They also commission sexual health services where cervical samples are taken and public health programmes for children and young people aged 5-19 years, including school nursing services which carry out school based immunisations for some areas. From October 2015 commissioning responsibility for public health programme covering pregnancy to five

	years old (ie. Health Visiting and the Family Nurse Partnership) will transfer to local authorities.
CCGs	Are responsible for quality improvement in services delivered by GP practices, such as immunisation and screening services. As commissioners of treatment services for patients who receive positive screens, they have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen-positive patients and meet quality standards. CCGs also hold the contracts and payment mechanism (MPP) for maternity services which provide antenatal and newborn screening.

Partnership working

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

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

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

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

5.12. Joint working is also important with the commissioners of treatment pathways (e.g. paediatric services for children identified with congenital hip dysplasia or ophthalmology outpatients in the case of the diabetic eye screening

programme) to ensure that any changes through re-tendering of services do not adversely affect the referral pathway for screen-positive patients.

Priorities

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

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

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

- New trajectories for roll out of the family nurse partnership and the health visitor programmes
- A revised specification for pneumococcal vaccination
- The introduction of HPV testing in women with mild/borderline changes in their cervical screening
- Revised performance baselines for bowel and diabetic eye screening
- The extension of the bowel screening programme for men and women up to age 75
- A minor change to the service specification for seasonal flu
- A meningitis C catch up programme for university entrants
- The continuation of a time-limited MMR campaign for people over 16 and a catch-up campaign for teenagers
- The continuation of the temporary programme for pertussis for pregnant women
- The implementation of DNA testing for sickle cell and thalassemia screening
- A shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds
- The extension of the childhood flu programme (to 4 year olds initially).

5.15. The Public Health Plan on a Page included as Appendix 2 provides details of the local commissioning intentions that relate to these national requirements.

Public Health financial context

5.16. By commissioning effective screening and immunisation programmes with improved coverage and up-take, the public health programme will contribute to delivering financial efficiencies across the health economy by disease prevention, reduced incidence and early identification of cancers (breast,

bowel and cervical) and life threatening disease – e.g. Abdominal Aortic Aneurism.

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

- Introducing relevant public health CQUIN targets to new contracts and reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease.
- Identifying risk of disease and disability early through the commissioning of safe and effective Screening Programmes
- Work with providers to demonstrate the value of the universal Healthy Child Programme Improve life chances and access to services for children and families through the effective commissioning and safe transition of Health Visiting and Family Nurse Partnership Programmes
- Implement Health Visiting and Family Nurse Partnership workforce trajectories (including a new Family Nurse Partnership Service for Wiltshire) to increase the numbers of qualified health professionals locally and to ultimately improve outcomes for children and families.
- Work with Public Health England to implement new immunisation programmes as they arise (e.g. MenC for University entrants) and to expand existing programmes to new cohorts (e.g. Shingles and Childhood Flu).
- Ensure commissioned services represent best value for money and are evidence based
- Benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and beyond to ensure equity of provision.
- Reprocurement of services where regulations dictate or where driven by financial and performance necessity.
- Using revised data sets to ensure screening programmes (e.g. – New-born Blood spot first and second line testing) is costed on the basis of accurate birth data
- Assessment of school based immunisation provision against capacity and other competing Public Health targets and implement local solutions for BGSW.
- Develop robust commissioning plans to include armed forces personnel and their dependants in all Public Health commissioned services.

5.18. In 2013/14, a surplus of £0.526m is forecast. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent surplus / deficits are carried forward.

5.19. The public health financial plan in 2014/15 delivers a breakeven position and includes 0.5% contingency. The 2015/16 plan currently shows a deficit of £777k. This is due to the expected allocation growth in 2015/16 of £778k being currently excluded from the notified value. Once the expected growth is applied the financial plan in 2015/16 is breakeven.

5.20. The 2014/15 and 2015/16 plan both include 0.5% contingency of £185k and £189k respectively. This is in line with the planning guidance. No headroom or QIPP is included within the plan in line with the planning guidance.

5.21. There are a number of cost pressures arising out of national directives. The changes for Meningitis C, HPV and childhood influenza vaccinations add £2.1m. The full year costs of the increase in health visitors and the additional cohorts in 2014/15, and the expansion of Family Nurse Practitioners adds a further £1.3m.

5.22. The financial plan includes £1.8m for investment and £0.6m for activity growth in 2014/15. The total investment / activity growth funding of £2.4m is less than the £3.4m cost pressures outlined above as some of these cost pressures have been funded in 2013/14.

5.23. The allocation in 2014/15 includes £1.3m for health visitor uplifts and £0.1m for meningitis C. Costs pressures above this level are to be funded locally.

5.24. NHS England is required to report nationally public health spend against the section 7a allocation. However some of the costs associated with S7a such as public health QOF and the public health element of GP global sum (7.2%) are within primary care allocations. As a result the area team is required to report against both the public health position and the S7a position.

5.25. The summary financial position is shown below:

Public Health	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	34,574	36,842
Inflation uplifts	813	838
Growth	636	679
Provider Efficiency	-962	-1,163
Service Investments	1,782	420
QIPP	0	0
Sub total	36,842	37,617
Contingency	185	189
Total	**37,028**	**37,806**
Notified Allocation	37,028	37,028
Surplus / (Deficit) carried forward	0	0
Total Resources	**37,028**	**37,028**
Submitted plan surplus / (deficit)	**0**	**-777**
Planned allocation changes		
Growth		778
BGSW plan surplus / (deficit)	**0**	**0**

SECTION 6: ARMED FORCES

6.1. NHS England (BGSW) commission armed forces health services (for serving personnel and their families) on behalf of all areas in the South of England including London.

6.2. NHS England have a statutory responsibility to ;

- To ensure equitable access to effective treatments for patients in England in line with service specifications and clinical policies
- To ensure that armed forces patients 'suffer no disadvantage' as laid out in the Armed Forces Covenant on-going
- To continue to embed the single operating model contained within Securing Excellence for the armed force and their families. To review the model by October 2014
- Working collaboratively with the Defence Medical Services to deliver the priorities contained within the Armed Forces National Partnership Agreement. To review and refresh the agreement. Summer 2014.
- To establish Armed Forces networks, through collaboration with CCGs to ensure that services are locally integrated by March 2015
- A common service specification for the improvement of veterans mental health services is developed and implemented by December 2014
- To implement a programme of data quality improvement including the development and publication of a performance and quality dashboard Summer 2014

To ensure that all objectives are;

- Underpinned by an exemplary approach to patient and public engagement
- A comprehensive performance management framework
- Full implementation of the direct commissioning assurance framework

6.3. NHS England has agreed capacity plans, detailing anticipated demand for services, for armed forces healthcare activity for 2013/14. NHS England (BGSW) has agreed capacity plans with providers in the south of England and more contracts will be placed in 2014/15 in order to increase the availability of services for armed forces and their families.

6.4. There are some challenges in terms of the availability and accuracy of data to support commissioning decisions. This is partly due to providers not always identifying patients as serving armed forces personnel or their families NHS

England (BaNES, Gloucestershire, Swindon and Wiltshire) is working with national NHS England leads for information and finance to resolve these issues.

6.5. A review of current commissioning for quality and innovation payments (CQUINs) across existing contracts is identifying the CQUINs which most support the armed forces population. These will be adapted and promoted as part of contract negotiations.

6.6. A detailed 5 year plan for Armed Forces Commissioning is being developed in parallel to this plan and should be read in conjunction.

What this means for Wiltshire and Swindon

The Army Regular Basing Plan

6.7. "The Army Regular Basing Plan sets out the future lay down of the British Army as it moves back to the UK from Germany and restructures to deliver its future operating model", *Army 2020.*

6.8. The plan honours the policy commitment made in Strategic Defence and security Review (SDSR) to bring UK forces back from Germany by 2020. The Army is on track to bring 50% of its forces back by 2015 and the remainder in 2020.

6.9. The Defence Infrastructure Organisation will deliver service family homes and new single living accommodation for Armed Forces personnel.

6.10. The plan also forms a part of a wider commitment to give service personnel greater stability allowing their families to integrate better into local communities, their spouses to find long term jobs and their children to have continuity in education.

6.11. It is envisaged that by 2020 an additional 4000 Armed Forces personnel will be stationed in Wiltshire. It is anticipated that there will be 2000 additional personnel at Larkhill, 900 at Bulford, and 1100 in Tidworth.

6.12. The Lyneham base will be re-established as a training facility and will provide capacity for up to 5000 armed forces personnel. Work is underway with the MOD to understand the full impact of this development and when this will take place.

6.13. In Swindon healthcare is provided by GWH to those who are based at the Military College should they need the services of secondary care.

6.14. In preparation for the increase in Armed Forces personnel and their families it will be crucial for partner organisations, both those commissioning and providing services, to work together to ensure that the incoming armed Forces personnel and families have full access to all services including;

- Maternity
- Primary and secondary care
- Public Health services
- Education
- Housing
- Transport
- Crime and Justice

6.15. The Commissioning organisations that will need to work together to ensure a full range of services are available to the incoming Armed Forces personnel and their families include:

- NHS England as the commissioner of Primary Care Services and elements of Public Health services along with secondary care service for Armed Forces personnel.
- Wiltshire Council as the commissioner and provider of education; housing; social care; transport; environmental services and/leisure.
- Wiltshire and Swindon Clinical Commissioning Groups as the commissioners of secondary care services for reservists and armed forces personnel dependants not registered with DMS.
- Wiltshire Police as commissioners and providers of community policing and the wider crime and justice services.

6.16. In order to ensure that the planning and onward delivery of these services for the incoming Armed forces and their families is as comprehensive as possible the suggestion put to Wiltshire Health and Well Being Board (HWB) was to set up a working group with representatives of the commissioning organisations (listed above) and the MoD in order to develop a joint commissioning plan for this specific population and their families.

6.17. Wiltshire HWB agreed that the joint commissioning of services be discussed at the Military Civilian Integration Partnership hosted by Wiltshire Council with the objective of developing and agreeing a joint commissioning plan for Armed

Forces personnel and their families who are currently or will be residing in Wiltshire.

Armed forces financial context

6.18. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) commission armed forces health services (for serving personnel and their families) on behalf of all areas in the South of England and London.

6.19. In 2013/14 a deficit of £1.2m is forecast. The deficit from 2013/14 is not carried forward into 2014/15, although subsequent surplus / deficits are carried forward.

6.20. The 2013/14 deficit has in part been created by former PCT's not being able to fully identify armed forces activity within financial baseline returns. The area team has been unable to complete a full review of financial baselines in order to agree adjustments with CCG's during 2013/14 due to national activity and financial reporting limitations. These limitations are currently being addressed via the national activity reporting subgroup. Once robust armed forces activity reporting information becomes available the area team will review historic baselines and transact funding adjustments with CCGs during 2014/15. The 2014/15 plan includes £300k as an estimate of baseline funding adjustments.

6.21. The area team have received the full reserve of 910k held nationally. This has been used to reduce the rollover over spend moving into 2014/15.

6.22. Troop repatriation from Germany will commence during 2014/15 with a significant number of serving members of the armed forces and their dependants being based in Wiltshire. In line with national advice the Area Team's 2014/15 plan does not include demographic or non-demographic growth at present as the financial impact has not been agreed. The national advice is movements within England will offset each other and the repatriation from Germany will be considered once the financial impact is agreed. The Area Team has however identified the likely cost pressure within the risks and mitigations section of the plan rather than within the base case plan. The risk is circa £0.5m in 2014/15. It is unlikely that the MOD will agree to passing over funding to the NHS once the repatriation takes place as they have already allocated the savings within the MOD.

6.23. There is no QIPP within the 2014/15 financial plan. However QIPP has been included within the plan for 2015/16 at a value of £0.6m. This represents 2% of allocations. It is expected that there would be a requirement to deliver QIPP within armed forces in line with other areas of direct commissioning.

6.24. The summary financial position is shown below:

Armed Forces	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	28,536	27,601
Veteran MH adj as not prog cost	-600	
Inflation uplifts	782	745
Growth	0	1,730
Provider Efficiency	-1,117	-1,104
Service Investments	0	0
QIPP	0	-565
Sub total	27,601	28,407
Contingency	45	141
Headroom	0	0
Total	**27,646**	**28,548**
Notified Allocation	27,646	27,646
Surplus / (Deficit) carried forward	0	0
Total Resources	**27,646**	**27,646**
Submitted plan surplus / (deficit)	**0**	**-902**
Planned allocation changes		
Veterans mental health	0	0
2013/14 allocation to be corrected	0	0
2014/15 allocations adjustments	0	0
Growth	0	581
Reduction in deficit carried forward		0
BGSW plan surplus / (deficit)	**0**	**-321**

SECTION 7: SPECIALISED COMMISSIONING

Aims and vision

7.1. NHS England's ambition is to achieve equity and excellence in the provision of specialised care and treatment. We will achieve this through excellent commissioning which:

- is patient centred and outcome based. The patient must be placed at the centre of planning and delivery and commissioners, working with providers, must deliver improved outcomes for them across each of the five domains of the NHS Outcomes Framework
- is fair, consistent throughout the country and ensures that patients have equal access to services regardless of their location
- improves productivity and efficiency.

7.2. The *Everyone Counts* five-year strategy planning guidance sets out the following strategic commissioning approach for specialised services:

- Ensuring consistent access to effective treatments for patients in line with evidence-based clinical policies, underpinned by clinical practice audit.
- A clinical sustainability programme with all providers, focused on quality and value.
- An associated financial sustainability programme with all providers, focused on better value through a two-year programme of productivity and efficiency improvement.
- A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.
- Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients, in particular services and care pathways to include a prime contractor model and co-commissioning with CCGs.
- A systematic rules-based approach to in-year management of contractual service delivery

Call to Action

7.3. NHS England is developing a national five-year strategy for specialised services as part of *A Call to Action*. It will strengthen our existing vision and approach.

7.4. Patients, the public, clinicians and NHS England staff are being engaged in its development. It is being developed alongside the implementation plan for the UK strategy for rare diseases. It is anticipated that the process will not only develop the strategy but will also clarify our understanding of our current starting point, the needs of our populations and the baseline from which we are developing our services.

7.5. The call to action will build upon the following values and principles for specialist commissioning, which emerged following the *Carter Review* in 2006:

- A stronger patient voice in specialised services
- More robust governance arrangements
- Proper costing of care pathways
- Better linkages between specialised and non-specialised services
- Uniform monitoring of patient activity
- Horizon scanning as a way of informing future commissioning plans
- Truly integrated care and a seamless patient pathway
- The involvement of clinicians in the development of service standards and outcome measures.

7.6. Engagement began in late 2013 and a draft strategy is being developed alongside a series of local engagement events within each area team. This draft strategy will go out for public consultation between March and May 2014 and the strategy will be finalised in July 2014.

7.7. Local five-year strategies and plans need to be developed alongside this call to action, taking account of the issues raised and the emerging national strategy.

Services concentrated in centres of excellence

7.8. A key priority of the NHS England planning guidance to 2019 is to continue to improve patient outcomes by concentrating relevant services in centres of excellence, where there is clinical evidence that this is effective.

7.9. Work is being undertaken at a national level to understand current service landscapes and patient flows, to identify opportunities for quality improvements and efficiencies and to set out a process for achieving improvements.

7.10. BNSSSG Area Team commission Specialised Service on behalf of BGSW and work in partnership through a collaborative approach.

Pathway integration

7.11. We need to continue working together with CCGs to integrate pathways of care for patients who need specialised treatments. While patients may attend a specialist service for some specific treatments or procedures, their on-going care will be managed by their GP in the community and the majority of any rehabilitation, therapies or other follow-up will be through CCG-commissioned services.

7.12. Close joint working is needed to ensure that these care packages are integrated and that there are no gaps. This is particularly important where CCG-commissioned tier 3 services or other interventions are required as a formal stepping-stone to specialised tier 4 services (for example in obesity services).

Financial sustainability

7.13. Improvements in the commissioning of specialised services need to be delivered against a backdrop of ensuring that patients and citizens get the best value from every pound spent on health services. Services need to be financially sustainable for the future. Our plans need to be explicit about how we will work with local and national partners to close the projected funding gap and deliver on the QIPP agenda.

7.14. In helping to deliver value for money for the taxpayer, commissioners and providers should support the implementation of *Better Procurement, Better Value, Better Care*. For specialised commissioning in particular, this means ensuing that supplies are purchased at the best price.

7.15. In addition, pathways of care should be commissioned to be as streamlined and efficient as possible, avoiding duplication and designing out inefficient steps and processes to deliver better value and better care for taxpayers and patients.

How we will deliver change

7.16. Close working with a wide range of stakeholders is essential to deliver the improvements we want to see in specialised commissioning. At a national level, NHS England works with a range of stakeholders to determine the service standards and outcomes expected through the development of clinical strategies set out within the five national Programmes of Care (PoC).

7.17. Clinical Reference Groups (CRGs) develop the PoCs with expert engagement including all healthcare professionals related to the particular service area. In addition, a strong patient focus is achieved via formal patient and public involvement processes and on-going engagement with patients and carers as part of the strategic planning and local delivery functions.

7.18. We work in partnership with CCGs and other local stakeholders to make commissioning decisions to ensure the whole patient pathway is as locally responsive as possible in meeting patients' needs and that we manage providers collaboratively.

7.19. Locally, we also work closely with academic health science networks (AHSNs), strategic clinical networks, local authorities, health and wellbeing boards, overview and scrutiny committees and commissioning support units. Each area team has dedicated public health support and this helps to ensure that we have a clear population view of health needs for specialised services.

SECTION 8: HEALTH AND JUSTICE

Aims and vision

"True justice for the most vulnerable is about pulling people into treatment, not pushing them away from the support they need. People should get the same quality of services in prison as they do in the community...we have to do more in early intervention, to support children and young people before they reach crisis point...we need diversion services to be a cornerstone of better care and support for offenders with mental health problems"

The Secretary of State for Health, speaking about health and justice commissioning at a joint event with the Ministry of Justice, March 2011

8.1. NHS England aim to commission services that offer care of the very highest standard and the best health outcomes for people in prisons and other justice settings. Ensuring that these people receive the same standards of care that they would in the community is a core principle that underpins our approach. In addition, we want to drive quality improvements in the care and outcomes delivered.

8.2. In the BGSW area there is one prison that is located in Erlestoke in Wiltshire. The prison is a category C prison for male sentenced offenders and provides 494 places.

8.3. The BNSSSG commission Health & Justice services on behalf of BGSW Area Team. Through the services they commission, we want to make progress towards the government's objectives of reducing violence - in particular by improving the way the NHS shares information about violent assaults and supports victims of crime - and developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community.

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

Responsibilities

8.5. Through a single operating framework (developed jointly with the National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) we

are responsible for commissioning health services in the following places:

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

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

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

Priorities

8.7. The key priorities in commissioning for health and justice from 2014/15, set out in the *Everyone Counts* five-year strategy planning guidance, are:

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

and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs.

- Continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.
- A number of developments for sexual assault referral centres to develop the service and make it more equitable (listed as a public health ambition in the *Everyone Counts* five-year strategy planning guidance).

8.8. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice.

For example, changes in the use of the custodial estate (for example from a prison to an immigration and removal centre) can happen at short notice, leading to a fundamental change in the health needs profile of the people who will be accommodated there.

8.9. Consideration needs to be given to the implications of an ageing prison population and commissioners need to be aware of the growing need for the delivery of a range of social care alongside healthcare in prisons.

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

Partnerships

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

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

8.13. These partnership approaches need to be further developed and expanded to ensure they are able to reflect the increased focus on the integration of services and the inclusion of reducing re-offending rates and other related indicators in the public health outcomes framework.

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

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

SECTION 9: PATIENT AND PUBLIC VOICE AND ENGAGEMENT

Aims and vision

"We must put citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing Services."

Tim Kelsey: National Director of Patients and Information, NHS England

9.1. Through 'Putting Patients First: The NHS England Business Plan for 13/14 – 15/16' NHS England has an on-going commitment to transparency and increasing the patients' voice in improving patient care. The plan describes an 11 point scorecard which NHS England will introduce for measuring performance of key priorities, focused on receiving direct feedback from patients, their families and NHS staff. This plan supports 3 of the 11:

- Priority 6 – Outcomes Framework – Domain 4 'Ensuring that people have a positive experience of care
- Priority 9 – NHS Constitution rights and pledges, including delivery of key service standards
- Priority 10 – Becoming an excellent organisation

9.2. In primary care the BGSW Area Team will focus on working in partnership with local communities which includes patients their families and carers to improve the quality of primary care services which will in turn influence commissioning.

9.3. Providing the culture and opportunity for the patient, their family or carer to give feedback – positive and negative- and responding and learning from this is at the heart of the commissioning and delivery of high quality service. The establishment of Patient Participation Groups (PPGs) within GP Practices have been encouraged over a number of years to help promote patient voice and responsiveness. The development of these groups has been varied in a number of ways: these include- the number of groups established, their membership and function as well as their ability to influence. Therefore working with patients, carers and practitioners across boundaries and organisations our ambitious plan aims to:

- Improve the opportunity and culture that enables patients', their families and carers to give feedback – positive and negative – including raising complaints in relation to primary care services. This will include the promotion and understanding with the patient' rights, responsibilities and the pledges set out in the NHS Constitution 2013.

- Complete the development of a model of best practice that enables PPGs to use patient insight to influence service improvement and the commissioning of services.
- Scope the number and type of PPGs in existence including the level, quality and impact of PPG activity
- Work with local Healthwatch organisations to develop PPG networks / Forums with the purpose of 'peer' support, sharing of best practice and development/learning opportunities.
- Devise mechanisms to ensure patient engagement and participation is integrated into primary care assurance and commissioning cycle
- Service improvement and commissioning decisions are better supported when people are involved in identifying problems and in designing solutions together. Working to develop and strengthen our partnerships we will:
- Work with stakeholder groups to look at their sources of feedback and how we can ensure we maximise opportunities to learn from this rich source, as a catalyst, to proactively influence change and drive improvements for patients
- Give consideration to equality and diversity issues faced by those group of people who are seldom or less likely to be heard and develop a means of enabling their feedback and participation as far as reasonably possible

9.4. The development of the best practice model that enables PPGs to use patient insight to influence service improvement and the commissioning of services is being undertaken with Healthwatch Swindon. It is vital that this work is linked to other developments in this field. Therefore we will:

- Continue to liaise with the National Association of Patient Participation (NAPP) to ensure the model is integrated into the into the 'assurance framework' for 'healthy participation and PPGs' that is currently being developed by them and to seek the opportunity to collaborate with NAPP in the rollout of their work.
- Liaise with Devon, Cornwall and Isles of Scilly Area Team as they undertake the development of PPG wide assembly to ensure sharing of information and learning and the limitation of duplication.

Without knowing exactly what this model of the use of patient insight by PPGs will look like as this is in its early stages of development it is important that we consider certain 'tests' to check out success. Some will be more measurable than others. The tests include:

9.5. Range of knowledge and opportunity

- Roles and responsibly are defined and agreed by each PPG and their practice
- PPG members are aware of the information that should be available to them
- Opportunities for PPG to support the practice in the collection and review of data are established

A range of material and resources to support the model being rolled out will be described and where they are not immediately available to implement the model on wider scale (across BGSW) resource sought immediately. Within the 5 year plan is the intention to role facilitate the model being used across all PPGs across BGSW.

9.6. Influence

- Participating PPG members have access to a wide selection of information on the experience of patients relating to the Practice
- The PPG influence service change
- The PPG is valued by the Practice team
- Other patients in the practice will see the activity and influence of the PPG

9.7. A trusted process

- There is feeling of mutual respect and developing/development of understanding form the participating PPG members and practice staff
- Fears ,concerns and challenges by PPG members and staff are raised and addressed

9.8. No issue is left behind

- No question/issue raised in the processes to develop the model will be lost; each will be responded to.

9.9. The difference can be seen and felt

- PPGs are using the model and members report they see and feel they are making difference
- Participants will be in the constant loop of feedback
- The opportunities to give feedback are clear to those using the services
- “You said” – “ we did” will in the public domain
- There will be clear successes to celebrate and failures to genuinely be learned from

9.10. Cultural change is part of success

- It must galvanise people by reaching hearts and minds of staff, patients and the wider public

Each of these deliverables is capable of objective evaluation.

SECTION 10: SUMMARY OF BGSW AREA TEAM FINANCIAL POSITION

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

2014/15						
	Prior Year Surplus / (Deficit) £'000	Notified Allocation £'000	Expenditure £'000	Submitted Surplus / (Deficit) £'000	AT Surplus / (Deficit) Net of Expected Allocation Adjustments £'000	Target Surplus £'000
Primary Care	3,381	283,624	279,913	3,711	3,411	2,836
Secondary / Community Dental	-1,085	19,096	20,441	-1,345	-1,045	191
Public Health	526	37,028	37,028	0	0	0
Armed Forces	-1,200	27,646	27,646	0	0	276
Total BGSW	**1,622**	**367,394**	**365,028**	**2,366**	**2,366**	**3,304**

2015/16						
	Prior Year Surplus / (Deficit) £'000	Notified Allocation £'000	Expenditure £'000	Surplus / (Deficit) £'000	AT Surplus / (Deficit) Net of Expected Allocation Adjustments £'000	Target Surplus £'000
Primary Care	3,411	288,575	285,392	3,183	2,883	2,886
Secondary / Community Dental	-1,045	19,155	19,613	-459	146	192
Public Health	0	37,028	37,806	-777	0	0
Armed Forces	0	27,646	28,548	-902	-321	276
Total BGSW	**2,366**	**372,404**	**371,359**	**1,045**	**2,708**	**3,354**

10.2. The Area Team surplus / (deficit) position is different to the plan submission surplus / (deficit) position due to anticipated allocation adjustments that have yet to be transacted. Current planning rules result in in year surplus / (deficit) values being carried forward into future years. Therefore in year deficits cumulatively increase within the submitted plan where allocations exclude growth in 2015/16. The current notified allocation for armed forces and public health exclude growth for 2015/16.

10.3. As mentioned there are a number of allocation adjustments assumed within the area teams plan but excluded from the notified allocations. These are summarised as follows:

- Public health growth in 2015/16 - £778k
- Secondary care dental allocation adjustments with CCGs in 2014/15 - £300k
- Armed forces growth in 2015/16 - £581k
- Armed forces veteran mental health allocation - £600k

10.4. GP IT is currently excluded from the area teams plan. NHS England is currently reviewing the funding arrangements for GP IT and future submissions of plans would take account of any future guidance.

10.5. The primary care financial position would deliver a surplus of £3,411k in 2014/15 and £2,883k in 2015/16, which would result in nil draw down of retained surplus and in line with the planning guidance to deliver at least 1% surplus margin.

10.6. The treatment of capital and deprecation remains unclear. There remains a likelihood that deprecation costs will need to be funded within current notified allocations. This would be an additional cost pressure to the current plan.

10.7. The plans include £3.7m QIPP to be delivered in 2014/15 and £3.1m in 2015/16. The 2014/15 value is split £0.7m secondary / community dental and £3.0m primary care. A detailed proposal to deliver savings across the whole dental pathway is currently being developed including detailed activity information. As primary care expenditure is predominately driven by registered population size the opportunity to deliver QIPP is restricted. There are however schemes that are currently being assessed for in year QIPP delivery including primary care dental claw back, list validations, premises reimbursements.

10.8. The planning guidance requires the area team to include 0.5% contingency across all programme areas, and 2.5% non-recurrent headroom in 2014/15 and 2% in 2015/16 across all programme areas apart from public health. The area team plans include the contingency requirement however the full headroom has only been included once a 1% surplus can be delivered.

10.9. Further iterations of the financial plan are expected to be required over the next few weeks into the new financial year addressing the total financial pressures across NHS England in total.

SECTION 11: SUMMARY

11.1. This paper details the commissioning a plans of NHS England (BGSW). Comments from stakeholders and partners are welcomed.

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

- NHS England's Armed Forces Commissioning Plan
- NHS England's Primary Care Delivery Plan
- NHS England Specialised Commissioning Strategy
- The 4 CCG 5 year plans

Appendix 1 – PRIMARY CARE PLAN ON A PAGE

NHS England

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13	**Strategic Context & Challenges**	**QIPP Improvements**	**Organisational Development**
▪ *Deliver GMS /PMS core contract requirements* ▪ *Contribute to delivering the NHS Outcomes framework* ▪ *Contribute to delivery of the Public Health Outcomes Framework* ▪ *Deliver aspects of The Mandate relating to Primary Care* ▪ *Deliver Quality Premium programme in primary care* ▪ *Implement Electronic Prescription Service* ▪ *Implement Summary Care Record* ▪ *Appraisal and Revalidation of GPS* ▪ *Safeguarding arrangements in primary care*	▪ *Everyone Counts – Planning for patients* ▪ *Mandate emphasis on primary Care* ▪ *Equalisation agenda for all GMS /PMS* ▪ *Improvements of primary care services and reduction in variation* ▪ *Development of LPNs across independent provider groups* ▪ *New Dental Contract* ▪ *Commissioning Secondary Care Dental* ▪ *Implementation of Assurance Frameworks for Primary care contractor groups* ▪ *Patient Access to electronic records by 2015*	▪ *List validation of General Practice* ▪ *Validation of Optical Payments* ▪ *Validation of Dental claims* ▪ *Back office efficiencies* ▪ *Review of QOF payments* ▪ *Review of APMS contracts* ▪ *Better use of contractual levers including those for underperformance* ▪ *Redesign of Medicines use review system* ▪ *QP 6-14 Peer review of outpatient referrals ,emergency admissions and A&E attendances*	▪ *Agree work plans with CCGs to improve primary care performance and reduce variation in primary care* ▪ *Set up LPNS for Dental, Pharmacy and Optometry to develop pathways and carry out needs assessment* ▪ *Establish training programmes for staff in order to implement SOM effective*

	National Priorities 2013-15	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Assurance	Safe transfer of ; ▪ PCT contracts to NHSCB ▪ Business critical systems and processes ▪ Management of the performers list ▪ Home Oxygen service to CCG ▪ GP appraisal and revalidation system ▪ SCR programme to CSU to develop into patient accessible record	▪ Business systems checked for consistency ▪ National Performers list policy has been adopted ▪ Home Oxygen service transferred safely to CCG ▪ Appraisal and revalidation systems reviewed for consistency ▪ EPS transferred to CCG and continuation of roll out evident ▪ SCR programme transferred to CSU - further development of electronic patient record ▪ Transition plan for HCP 0-5 commissioning transfer to LA has been agreed	▪ Business systems and processes consistent across country ▪ Performer list policy adhered to nationally ▪ Home Oxygen service responsive to patient need ▪ Appraisal and revalidation system working with high uptake ▪ EPS roll out completed ▪ Electronic patient record accessible to all patients ▪ HCP 0-5 commissioning safely transferred to LA ▪ Control of Entry regulations in place and operating well
Quality	▪ Develop a strategy for quality improvement in primary care ▪ Develop web based database of GP quality indicators ▪ Adhere to national performance assessment frameworks for each provider group ▪ Develop further the reporting system for quality concerns , SUIs and never events in primary care ▪ Safeguarding arrangements in place across all primary care contractors ▪ Improve access to primary care services ▪ Improve patients satisfaction of primary care services	▪ Implementation of the quality improvement strategy for primary care has been achieved ▪ Implementation of the web based tool for GP quality indicators has been developed and adopted ▪ Robust reporting system is in place for reporting quality concerns SUIs, never events in primary care ▪ Safeguarding systems evident and operating across all independent contractor groups	▪ Quality improvements in primary care are visible ▪ GP quality indicators drive improvement in outcomes ▪ Robust Assurance systems are in place for primary care increasing safety and quality for patients ▪ Robust Safeguarding arrangements in place across all parts of the health and social care system
Single Operating Model	▪ Implement single operating model across all contract groups	▪ The single operating model is embedded in management of primary care provider groups	▪ Nationally consistent way of doing business in primary care
General Practice	▪ Implement online access to primary care medical record ▪ Implement the equalisation approach to GP contracts ▪ Implement on line patient appointments and repeat prescription service ▪ Develop e.consultation service	▪ Work underway with CCG and CSU to develop SCR into patient accessible electronic record ▪ Discussion underway with LMC and practices re equalisation of contracts ▪ Work progressing with online appointments and prescribing and e.consultation service	▪ Patients can access health records electronically ▪ Equalisation of GP contracts finalised ▪ Patients able to book appointments and order repeat prescriptions on line ▪ e.consultation services rolled out in general practice
Securing Excellence-Dentistry	▪ Introduction of new Dental Contract ▪ Establishment of Dental LPN ▪ Commission Secondary care dentistry ▪ Ensure that services are responsive to need ▪ Ensure robust OOH / 7 day service in place ▪ Promote access to dentistry ensuring rate of new patient relates to need	▪ Preparation for the new Dental Contract ▪ Fully operational LPNs in place ▪ Contracts in place with acute providers for secondary care dentistry ▪ Implement specialty pathways for dental as they are developed ▪ Implement the Assurance Management Framework for Primary care dentistry	▪ New Dental contract implemented ▪ LPNs driving improvement in commissioning ▪ Robust Assurance systems are in place for primary care increasing safety and quality for patients
Pharmacy & Optometry	▪ Revised policy /regulations for Control of Entry for Pharmacists ▪ EPS programme transferred to to CCG /CSU ▪ LPNS to be established for Pharmacy and Optometry (eye care)	▪ Revised Control of Entry regulations adopted by AT and operational ▪ EPS programme being developed through CCG /CSU ▪ Established LPN in place for Pharmacy and Optometry	▪ Control of Entry operating ▪ EPS rolled out across AT patch
FHS	▪ Monitoring of FHS performance to ensure delivery of service within financial envelope and quality measures	▪ Ensure FHS service meeting all quality, service and financial KPIs	▪ SBS providing effective and efficient FHS services

Appendix 2 - PUBLIC HEALTH PLAN ON A PAGE

NHS England

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each	Fairness and Consistency – patients have access to services regardless of	Productivity and efficiency	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe

Pre-existing Priorities

The NHS Outcomes Framework identifies earlier diagnosis as one of four key contributors to address premature mortality and the need for better prevention. The National ambition is to improve and protect health and wellbeing. The aim is to improve not only how long we live but how well we live and to ensure that we support the whole community to live healthily, reducing health inequalities

BGSW will achieve this by working with our partners to:

- **Deliver national Health Child Programme 0-5 years including Health Visiting and Family Nurse Partnership.To improve the health and life chances of families**
- **Deliver the national Immunisation Programmes and improve uptake to increase herd immunity and reduce the risk of infectious outbreaks**
- **Deliver the National Cancer Screening Programmes to help improve early diagnosis of breast, bowel and cervical cancer**
- **Deliver the National non-cancer Screening programme including Diabetic Eye Screening, AAA Screening, the Antenatal and Newborn Screening programmes to improve early diagnosis of disease and disability.**

Strategic Context and Challenges

- **Making every contact count**
- **Implementing the Public Health Outcomes Framework**
- **Embedding a single model of screening and immunisations for NHS England**
- **Safe transition of healthy child programme back to Local Authorities**
- **Implementation of new programmes, keeping abreast of the pace of change**
- **Improving uptake of section 7a commissioned services for marginalised and at-risk groups.**

In order to achieve the above challenges BGSW will complete a local benchmarking and assurance process against the National Specifications and work with providers to develop timely action plans for compliance.

We will also work with NHS England and PHE data sources to assess not only coverage data but Public Health and demographic data to ensure that services are fair and equitable and to allow for the development of targeted approaches to improving uptake.

QIPP Improvements

The Public Health team will ensure that all commissioned programmes demonstrate value for money in line with QIPP principles, and that high quality, evidenced based cost effective services are delivered. This will include the systematic application of robust financial and contract performance monitoring and review processes.

We will also achieve QIPP by:

- **Ensuring we are targeting the right people**
- **Identifying risk of disease and disability early through the commissioning of safe and effective Screening Programmes**
- **Reduce the impact of infectious disease outbreaks and ill-health by commissioning safe and effective Immunisation Programmes**
- **Improve life chances and access to services for children and families through our Health Visiting and Family Nurse Partnership Programmes**
- **Ensure commissioned services represent best value for money and are evidence based**
- **Benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and**

Organisational Development

The focus of organisational development for BGSW is:

- **Working closely with the PHE embedded Screening and Immunisation team to ensure an integrated approach to commissioning**
- **Working in partnership with other Area Team commissioning and contracting teams (Primary Care, Specialised Commissioning, Armed Forces, & Health and Justice) in order to maximise resources**
- **To continue to develop relationships with commissioners and providers in the local health economy**
- **To provide training and development opportunities to the Public Health team**
- **The continuation of the partnership approach developed with the local authority and Health & Well-being boards.**

The above priorities will allow the BGSW Public Health team to commission the section 7a Services in an integrated and effective manner to benefit the health of the population of BGS&W.

	National Priorities 2014-15	Expected Outcomes of Implementing National Guidance locally in 2014-15	End State Ambition 2015-16	Additional Local Priorities 2014-2016
Immunisation	• Seasonal Flu Programme for children is to be further rolled out (including 4 years olds, and commencing delivery in secondary schools) • Extension of Men C to University entrants, • Continuation of MMR catch up, Pertussis in pregnant women, Shingles in 70/79 year olds • Minor changes to the seasonal flu specification • Implementation of the revised specification for pneumococcal vaccination	• Increased participation in the flu vaccination programme to reduce avoidable hospital admissions and severe complications in at-risk patients. • Completion of immunisation uptake improvement programmes particularly for at risk and marginalised groups. • Increased herd immunity and resultant improvements in Public Health as a result of the extension of the childhood flu programme	• Full participation in vaccination programmes with accurate and timely data available at general practice level • Sustained high uptake levels without local pockets of opt out risking overall population health	• Continue to develop governance process for assuring improvements in immunisation uptake • Evaluate performance and set local targets for improvement for all new and existing programmes • Review and revise all local contracts and contracting mechanisms to improve performance • Assess the school-age immunisation provision against capacity and other competing Public Health targets • Assess all contracts outside of primary care for possible re-tendering • Implement CQRS as a mechanism for data collection and payments for primary care
Screening Programmes (Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Age extension for existing Bowel Screening Programme (men and women 75years) • Introduction of HPV testing as part of the Cervical Cancer Screening Programme for women with mild and border line changes • Implementation of the new performance baselines for bowel screening.	• Full rollout of age extension Bowel and Breast Screening programme with sustained timely access to diagnostics and subsequent treatment where required • Increased participation in screening programmes with reduced variation between local populations • Benefits across the health system of early detection and diagnosis of cancer	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and an overall more positive experience from the health service	• Continue to develop governance process for assuring improvements in cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary and appropriate • Re-commission the cervical screening programme for armed forces personnel to represent a fair and equitable programme across the system. And potentially develop commissioning intentions for the other screening programmes in relation to armed forces and their dependants
Screening Programmes (Non-Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Introduction of the new performance baselines for Diabetic Eye Screening • Implementation of the DNA test as part of the Sickle Cell and Thalassaemia Screening Programme • Ensure that the payment for the antenatal and newborn screening and immunisation programmes are recognised within the Maternity Pathway Payment and that there is not a subsequent reduction in activity or quality	• Increased participation in screening programmes with reduced variation between local populations • Review of the participation in antenatal and new born screening services, analysis of the root causes of variation and the spreading of identified best practice • Benefits across the health system of early detection and diagnosis of disease and disability.	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and early detection of disability, and an overall more positive experience from the health service • Full participation in screening programmes to support goal of giving every child a healthy start in life	• Continue to develop governance process for assuring improvements in non-cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary and appropriate • Benchmark programmes across the region with a view to standardise payments and improve VFM
0-5 years Programme (including HV and FNP and Child Health Information System)	• Implement the 14/15 workforce trajectory for Health Visiting Call to Action, and continue to review and report performance on a monthly basis. • Continue to collect and monitor the quarterly data in relation to Health Visitor outcomes • To plan and work towards the transition of the Healthy Child Programme (0-5) to local authority. Transition Boards/Groups will provide regular updates to all stakeholders • Implement the new trajectory for Family Nurse Partnership expansion Wiltshire	• Increase in Health Visiting workforce and resultant improvements in service delivery • Expansion of Family Nurse Partnership to improve outcomes for young vulnerable first time mothers and their families.	• In 2015, commissioning responsibility for this aspect will transfer to Local Authority partner organisations and the ambition is for the expected service capacity and all national standards to be sustainably delivered prior to transfer.	• Ensure safeguarding and quality arrangements in place reported through Quality Surveillance • Ensure arrangements in place to ensure coordinated and integrated commissioning • Ensure the commissioning and implementation of the existing and planned new Family Nurse Partnership Programmes
NHS England and PHE agreements	• Develop common strategies to improve outcomes • Implement Every Contact Counts and develop public health advice service • Continue to strive for improved and more timely data collection and analysis to better commission the Section 7a Services.	• Close partnership working of all Public Health functions with coordinated and integrated commissioning intentions for 2014/15	• Full utilisation of Public Health Advice service by public to measurably improve domain outcomes for the local population	• Continue to develop governance arrangements • Ensure local prison services have appropriate access to Public Health services

Appendix 3 - ARMED FORCES COMMISSIONING PLAN ON A PAGE

Armed Forces Health Commissioning

Our vision is to provide high quality and safe care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

System Values

- Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare through the principles of:
- Equity of offer;
- Equity of access; and
- Equity of outcome.
- Ensure that special consideration is given to those injured as a proper return for their sacrifice

System Principles

- Prioritising patients in the decisions we take
- Listening and learning
- Making evidence based decisions
- Being opening and transparent
- Being inclusive
- Striving for improvement

System Objective One

Services for the armed forces are commissioned in line with the commitments of the Armed Forces Covenant

System Objective Two

We work in partnership with the MoD to commissioning healthcare in line with the partnership and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role

System Objective Three

We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive

System Objective Four

We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

Delivering better care through the digital revolution

a) increase use of choose & book, including advice and guidance functionality, within DPHC
b) increase the use of telemedicine as an alternative to face to face care where appropriate;
c) increase access to national screening programmes
d) link DMS systems to Child Health Information Systems

Co-ordinated access to Musculoskeletal pathway

(a) Improved use of choose & book and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
(b) re-design MSK pathways to make best use of recognised good practice in rehabilitation

Improved access to mental health services

a) Improve care co-ordination on service discharge
b) Improve signposting to appropriate mental health services
c) Improve the use of recognised good practice services for veterans' mental health such as online counselling

WIS leavers to have an agreed health plan

Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

Overseen through following governance arrangements

- Area Team Corporate Management Group
- Area Team (AT) Strategy Steering Group
- Direct Commissioning Performance Group
- Joint Commissioning Group
- Armed Forces Oversight Group

Measurement

- Increased choose and book referrals
- Waiting times
- Co-produced workforce measures
- Access to screening programmes
- Number & % of agreed health plans
- Armed forces network metric

Sustainability

- We will consider sustainability and affordability in our approach to decision making.
- We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability

Appendix 4 - SPECIALISED COMMISSIONING VIA BNSSSG AREA TEAM

Vision

That everyone in England can access a range of high quality, good value specialised by working in collaboration with patients and partners to deliver

Specialised Objective One
To ensure patients can access specialised services are commissioned to national standard and specifications

Delivered through compliance

Assessment of all clinical services against specifications
Agreement of derogation plans to enable providers either to meet standards or to enable re-provision
Implement changes to vascular surgery to improve safety and save lives working through the Strategic Clinical Network and Clinical Senate functionality

Specialised Objective Two
To improve access and increase throughput to standard radiotherapy and IMRT

Delivered through expansion

Review of existing capital plans for expanded capacity
Agree future configuration of capacity
Adopt best techniques for fractionalisation, etc

Specialised Objective Three
To improve capacity and care pathways for patients requiring specialised mental health services (CAMHS, secure, etc)

Delivered through re-provision

Local capacity changes including strategic view of NHS provision
Implementation by CCG of enhanced tiered services and embedding of Case Managers

Specialised Objective Four
Development of ODN model to progress prime contracting and to support concentration of provision of specialised services from fewer centres

Delivered through strategic change

Build on local examples of good practice (such as TYA MDAT) to support access to specialised children's services across the South West

Overseen through the following governance arrangements

- Specialised Commissioning Oversight Group
- Area Team Executive
- Specialised Commissioning Delivery Group
- Specialised Commissioning Collaborative
- HWBB and HOSCs

Measured using the following success criteria

- NHS England operating a balanced and sustainable specialised commissioning budget
- Delivery of the mandate
- Local acceptance of changes in clinical delivery to facilitate concentration on fewer centres

System values and principles

- No-one tries harder for patients and the community
- We will maximise value by seeking the best outcomes for every pound invested
- We work cohesively with our colleagues to build tolerance, understanding and co-operation

Appendix 5 - HEALTH & JUSTICE PLAN ON A PAGE

5 Year Strategic Plan and Vision

Working together to achieve excellence in health outcomes and experience in justice settings for people in BaNES, Gloucestershire, Swindon and Wiltshire

Priority One

To reduce health inequalities and improve the health outcomes for people in contact with the justice system through provision of high quality services that are equivalent to community services

Performance Management framework

- Active management of contracts to a set of standardised quality criteria
- Consistent improvement in patient valued outcomes

Pathway Review

- Ensuring integration across pathways

Priority Two

Reducing reoffending

Multi agency working & planning to enable Transforming Rehabilitation

- Understanding workforce requirements
- Reducing duplication of work

Priority Three

Strengthen leadership and patient voice to inform and improve the efficiency and effectiveness of services delivered through increased joint planning, collaboration and commissioning with commissioning partners

Early intervention and prevention

- Understanding workforce requirements
- Reducing duplication of work

Commissioning improved health in justice outcomes

- Moving towards a single framework
- Embed patient voice and engagement in service developments and the commissioning cycle

Improving victim experience and outcomes

- Evidence of working with vulnerable people
- Listening to and understanding the support they need

System Objective Four

Value for money

Assure partners, patients and the public that resources are well targeted, adequate and offer the best outcomes for patients

- Increase available benchmarking tools.
- Evidence HNA's inform service design

Overseen through the following governance arrangements

- Bristol, North Somerset, Somerset & South Gloucestershire Criminal Justice Board.
- Informed by Strategic Clinical Network for Health in the Justice system and for Mental Health
- NHS England BaNES, Gloucestershire, Swindon & Wiltshire Executive Team (Direct Commissioning Assurance)
- NHS England Health and Justice Oversight Group
- Local Authority (Overview & Scrutiny Committee

Measured using the following success criteria

- Number of offenders going back through the system
- Sustained engagement with CRC and NPS – no offending within a 12 month period and no duplication of services offered.

High level risks to be mitigated

- Information governance – linking IT systems across different organisations involved in the pathway.
- Data collection – consistency; measuring agreed outcomes.
- Expertise available to support the patient voice and engagement in justice settings.
- Engagement with key stakeholders to ensure the success of the strategy and encourage joint commissioning where appropriate.

How we seek assurance

- Regular local finance meetings with Providers and AT finance.
- Ensure HNA's are current and public health information informs targeted spend
- Engage in regular benchmarking activity and where necessary testing the market to ensure Value for Money for services provided