HEALTH AND WELLBEING BOARD

15 MARCH 2016

COMMISSIONING PLANS FOR LOCAL HEALTH SERVICES COMMISSIONED BY NHS ENGLAND

Report from: Pennie Ford, Director of Assurance and Delivery, NHS England South (South East)

Author: Pennie Ford, Director of Assurance and Delivery, NHS England South (South East)

Summary

This paper summarises commissioning intentions for 2016/17, for the following NHS England commissioned services:

1) Health services for the armed forces
2) Health and justice healthcare services
3) Specialised services
4) Public health and primary care services

1. Budget and Policy Framework

1.1 In December 2015, NHS England, NHS Improvement (the new body which will bring together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England and NICE came together to publish the latest planning guidance for the NHS.

1.2 Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', sets out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

1.3 As part of the planning process, all NHS organisations are asked to produce two separate but interconnected plans:

1. A local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021; and

2. An Operational Plan by organisation for 2016/17. This will need to reflect the emerging Sustainability and Transformation Plan

1.4 The Chairman has agreed to accept this report as an urgent item because it is timely for the NHS commissioning plans to be considered alongside those of the Council and the Clinical Commissioning Group, which are also on the agenda for this meeting. The report could not be despatched with the main agenda as the information needed to be supplied from separate commissioning teams across the NHS England South region and sufficient time was needed to collect this information and compile the report.

2. Background

2.1 Operational Plans for 2016/17 for NHS organisations, reflecting their 2016/17 commissioning intentions, need to be finalised in April 2016.

2.2 The five-year Sustainability and Transformation Plans will need to be finalised by the summer of 2016.

2.3 Attached to this report are summary papers regarding the commissioning plans for the NHS England direct commissioning responsibilities.

1) Health services for the armed forces
2) Health and justice healthcare services
3) Specialised services
4) NHS England South East Public Health Section 7A and Primary Care Direct Commissioning Operational Plan 2016-17

2.4 Armed forces, health and justice and specialised services are commissioned on a regional basis by NHS England South.

2.5 Primary care services (general practice in hours, dental, pharmacist, optician) and Public Health services (Section 7A screening & immunisation) are commissioned by the local office, NHS England South (South East).

3. Engagement activity

3.1 NHS England carries out engagement with patients and the public on the development of its directly commissioned services as appropriate and in accordance with our legal duties.

4. Risk management

4.1 There is no risk for the Health and Wellbeing Board

5. Financial implications

5.1 There are no financial risks for the Health and Wellbeing Board.

6. Legal implications

6.1 There are no legal implications for the Health and Wellbeing Board. For NHS England it should be noted that the Board of NHS England has not yet signed off final plans.

7. Recommendations

7.1 The Health and Wellbeing Board is asked to note the report and comment as to whether the NHS England commissioning intentions reflect the local priorities agreed by the Health and Wellbeing Board.

Lead officer contact

Pennie Ford, Director of Assurance and Delivery, NHS England South (South East)

Appendices

1. Health services for the armed forces
2. Health and justice healthcare services
3. Specialised services
4. NHS England South East Public Health Section 7A and Primary Care Direct Commissioning Operational Plan 2016-17

Background papers

None

Summary of NHS England Armed Forces commissioning intentions for 2016/17

NHS England has been commissioning services for the Armed Forces and those families registered with a defence medical services (DMS) practice in England since 1 April 2013.

The **single operating model** will be applied to all contracts in 2016/17. NHS England will normally only hold one NHS standard contract with any provider and will use mandated formats for activity and local price plans. NHS England will only make payment where treatment complies with relevant published policies.

Whilst clinical commissioning groups (CCGs) are responsible for commissioning the vast majority of services for veterans, NHS England has specific duties and separate funding to commission the following veterans' services:

• Veteran specific psychological therapies in response to "Fighting Fit" at a regional level.

• Veterans' prosthetic services including the Veterans' Prosthetics Panel (VPP) in response to "A Better Deal for Military Amputees".

• Assisted conception services for those in receipt of compensation for loss of fertility.

• On line psychological support services for Veterans and families.

• Inpatient post-traumatic stress disorder (PTSD) service for Veterans.

We are undertaking a strategic review in 2016/17 to improve access to Veterans' Mental Health Services, which will be informed by engagement with our stakeholders. The objective is the development of a sustainable model for future Veterans' Mental Health Services.

What we expect from providers

•We expect our providers to have due regard to the Armed Forces Covenant in managing their waiting lists and inter-provider transfers;

• We expect our providers to offer priority treatment to Veterans, for service attributable conditions, subject to the clinical priorities of other patients.

Commissioning for Quality and Innovation (CQUINs)

Armed Forces personnel and their families move home more frequently than the general population due to their military commitment. In seeking assurance that providers of NHS services are compliant with the Armed Forces Covenant in relation to 'no disadvantage' as a result of these moves, we intend to focus our 2016/17 proposed CQUIN on ensuring that patients who move:

• whilst on a waiting list, join the waiting list at their newly identified provider at the same point on the waiting list;

• during a treatment programme, are able to continue to access this treatment at their new provider without a break in their programme of care.

This proposed CQUIN will address these issues by completing an access policy review with providers and the inclusion of these explicit elements of the Covenant within a revised version of the policy to be confirmed within the 2016/17 contract year.

Jenny Kirby
Head of Armed Force Health
NHS England South and London

National health and justice strategic commissioning intentions 2016/17

Improving the quality of care

1 Commission services in all programme areas which meet **national patient quality and safety standards**

2 Commission services to meet the **Intercollegiate Healthcare Standards** (CYPSS) across the Children & Young People's Secure Estate

3 Implement the agreed recommendations of the Harris Review and the Prisons and Probation Ombudsman (PPO) report into **Deaths in Custody**

4 **Engage and involve** patients, families, the public and clinicians in the planning, commissioning and delivery of healthcare services within the secure and detained estate.

Reducing health inequality and delivering our section 7a commitments

5 **Reduce health inequalities** by improving delivery and uptake of national screening and immunisation programmes within the secure and detained estate

6 Support the phased roll-out of **smoke-free prisons** in England by improving the delivery and uptake of smoking cessation programmes

7 Review the commissioning and delivery of adult **substance misuse services** to secure high quality care, improve outcomes and support "through the gate" programmes

8 Commission **Sexual Assault Services** in line with the revised national specification.

Delivering integrated care across the secure and detained estate

9 Commission **liaison and diversion services** across each area of England which are integrated with police custody healthcare and wider community mental health provision to promote parity of esteem

10 Commission **police custodial healthcare,** assuring the delivery of high quality and safe patient care.

11 Improve the pathways for those moving through the custodial or detained estate, to support **integrated care** and the wider national "through the gate" programme and the children and young people (CYP) transitions agenda

Improving the infrastructure

12 Embed phase 1 of the **Health & Justice Information System** and complete phase 2 by March 2017.

13 Improve the data quality of **Health & Justice Indicators of Performance** reporting and extend the dataset to support key strategic programmes

Local issues of focus and interest for Medway

- **Children and young people in contact with criminal justice settings**

Within the Medway geography sits Cookham Wood young offenders' institute (YOI) and Medway Secure Training Centre (STC). NHS England continues to focus much of its time and energy in working with key agencies (e.g. Medway Local Authority and the Youth Justice Board) in further improving patient safety, safeguarding practice and quality of health services into the YOI and STC, which it is responsible for commissioning.

Transfer of commissioning responsibility from the Youth Justice Board to NHS England on 1 April 2015, for Secure Training Centres, resulted in a new service being implemented in September 2015, alongside the new 60:40 education split to the regime in both **STC's and YOI's**. The cultural shift in the provision of comprehensive services in both YOI's and the STC in the South East continues to require close monitoring and support as the impact of shrinking the YOI Estate from 8,000 capacity to 1,000 capacity (with only 4 instead of 11 YOI's in the country) has meant a marked shift in the nature of the young people being detained in custody.

More than 30% of the YOI's populations have committed a capital offence and the level of violence being displayed in the YOI's is very high. The needs of the young people are very complex and often sustained by gang related crime. The lack of suitable clinical space in which to safely see young people is the result of delayed fabric work at HMYOI Cookham Wood, which further exacerbates cancelled healthcare appointments.

The Child and Adolescent Mental Health (CAMHS) Transformation Programme has created a strong opportunity for the needs of children and young people (CYP) in the secure estate to have their mental health needs considered, on release from the secure setting, by CCG CAMHS commissioners. Health and Justice Commissioners will continue, during 2016/17, to lobby within the Transformation Framework for the needs of CYP on release from secure settings and for those CYP who are victims of sexual assault and need access to talking therapy. Assuring the content of CCGs response plans to the CAMHS Transformation Agenda has provided health and justice commissioners with a real opportunity to work with CCGs and local authorities to improve parity of esteem for CYP on release from secure settings and those who are victims of sexual assault.

- **Sexual Assault Referral Centres (SARCs) and services**

After broad stakeholder engagement, the commissioning of a Paediatric Sexual Assault service for Kent and Medway has begun in earnest. This activity is overseen by the Kent and Medway Sexual Assault Referral Centre (SARC) Board.

The South East will continue its involvement in the national programme of sexual assault services development and strive to ensure that its locally commissioned services reflect the nationally agreed service specifications and professional bodies' guidance on standards of delivery. The South East is represented on the National Sexual Assault Services Board and Assurance Group. The areas of focus described below relate to both the acute / forensic provision and aftercare services.

- Liaison and close working with colleagues at Police & Crime Commissioners' Office in order to support their continued engagement in and funding of both Adult and Child independent sexual violence advisor (ISVA) provision.
- Embed the Health and Justice Indicators of Performance (HJIP) Suite in each SARC during 2016/17, as agreed by the national team.
- Implementation of sustainable, efficient and effective paediatric SARCS across the South East, which reflects the National Paediatric SARC Framework.
- Continue to promote and encourage the development of the SARC workforce – particularly Forensic Nurse Practitioners and Paediatricians / GUM Consultants in developing the skill set required to undertake Forensic Medical Examinations and provide senior clinical leadership with each SARC.
- Work with local authority and CCGs colleagues to develop and embed SARCs within safeguarding pathways
- Increase public awareness of sexual assault services and self-referral pathways that don't require police involvement.
- Development of effective pathways, particularly mental health pathways for victims using SARCS.
- Continued engagement with Survivor Voice and others to represent the victim voice.

- **Police Urgent Mental Health Responses**

Ambition to extend the function of the Liaison and Diversion Service operating out of Medway Police Custody Suite to response officers, in support of the developing Street Triage Service across Kent and Medway. A pilot of the model from Northfleet Custody Suite has made real, positive benefits to people experiencing a mental health crisis in the North of Kent. NHS England commissioned mental health nurses working in police custody between 8am and 8pm to respond to calls from police officers to attend the scene and offer assessment, advice and onward sign posting following Force Control Room Mental Health Practitioner initial screening.

Informing the sustainability and transformation plans for specialised services in the South East

1. Background and units of planning

This report should be considered in conjunction with the South Specialised Commissioning Sustainability and Transformation Plan (STP), and the South Operational Plan for 2016-17, which is in development.

The planning guidance, "Delivering the Forward View: NHS planning guidance 2016/17-2020/21" is clear that this must be a truly place based plan and the STP in relation to specialised services will be led from the 10 collaborative commissioning hubs, of which the South East is one.

The STP will be an overarching plan to support better health, transformed quality of care delivery and sustainable finances, underneath which will be a number of specific delivery plans - which due to the scale of the population critical mass for specialised commissioning will be on different geographical and CCG footprints.

The fixed points within the STP will be the Tertiary and Prime Provider model, to ensure critical mass is achieved in any given footprint.

The South East Collaborative Commissioning Oversight Group (CCOG), set up since December 2014), has reviewed the above stance and is supportive. The CCOG's membership and terms of reference is to be reviewed to support the emerging STP footprints across clusters of CCGs.

CCGs are encouraged to collaborate with specialised commissioning to improve service efficiency, joint working models are to be further developed and an incentive scheme will be developed by NHS England to help support this.

2. Environmental context

The South East geography covers a population of 4.5million, based on an area of 4000 sqm. We have 20 clinical commissioning groups across the South East footprint, and work closely with North East Hants and Farnham CCG on cross border flows and specialised mental health.

We hold contracts for specialised services with 11 acute NHS providers and 2 NHS mental health providers, with a small number of national contracts for a range of independent sector providers. In 2015-16 we handed over the Frimley Park NHS Foundation Trust Hospital contract to the Wessex team at NHS England.

There are significant cross-boundary flows of patients for tertiary and quaternary specialised services into London providers and smaller patient flows to Portsmouth and Southampton Hospitals from the West Sussex locality. Close working relationships are therefore in place with both the London and Wessex specialised commissioning teams to support joined up working on patient pathways and shared care arrangements. London is also represented on the South East Specialised Commissioning Collaborative Commissioning Oversight Group as an active member.

Brighton and Sussex University Hospitals NHS Trust (BSUH) is our largest provider of specialised services, currently a Tier 2 provider, and has secured a capital investment for its 3Ts (Tertiary, Teaching and Trauma) full business case of circa £500 million. The Trust will become a Tier 1 (income over £150m) provider as its revenue base increases.

The revenue consequence for specialised care is a small percentage of this overall and relies on repatriation from London for a range of specialities, which has been supported in principle by the London regional team.

The merger between Royal Surrey County Foundation Trust NHS FT and Ashford and St. Peters Hospitals NHS FT is anticipated in 2016 and this will make it a Tier 2 provider.

The other Tier 2 (income over £50m) providers are East Kent Hospital's University NHS FT (EKHUFT) and Maidstone and Tunbridge Wells NHS Trust.

All the above Trusts, with the exception of EKHUFT, are cancer centres for the South East population.

Most providers are district general hospitals with a small number of specialised services.

3. Our priorities

Our priorities reflect the specialised (prescribed) services 2016-17 commissioning intentions and the Five Year Forward View, with specific reference to the well-developed Collaborative Commissioning arrangements with our CCGs as key strategic partners, and agreed service priorities which are outlined by programme of care in Appendix 1.

Our key priorities for 2016/17 are:

- Highest quality safety, outcomes and patient experience in all services provided;
- Achieve NHS Constitutional requirements;
- Move to a place based commissioning model;
- Ensuring an integrated approach in commissioning of pathways with our CCG colleagues through Collaborative Commissioning, ensuring safe transfer of services that are to be devolved to CCGs and clarity on those services described for collaborative commissioning in 2016-17, with a focus on specialised mental health and cancer;
- Reduction in inequalities in outcomes;
- Securing services within the resources available and best possible value for money;
- Services are as close to home, as well as high quality, as possible across all specialised services;
- Ensuring service transfers between CCGs and NHS England, and vice versa, are enacted within the national guidelines;
- Delivery of the contractual requirements within the central guidance on tariffs and contracting, ensuring efficiency and productivity gains are made;
- To run a shared and open book operational planning process for 2016/17

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

4. Patient safety and quality

Within the past 12 months a great deal has been achieved in operationalising the processes to ensure there is a whole system view of patient safety and quality with our partners. This has worked well and will continue to be refined and developed throughout 2016/17. Some key aspects will be:

- Continue with the South process for quality and services reviews, taking into consideration any revised operating arrangements;
- Continue to operate quality governance framework with our clinical commissioning groups, to ensure there is a system wide view of patient safety and quality;
- Continue to support the adoption of recommendations for the post Winterbourne (now Transforming Care) Care and Treatment Reviews;
- Review the newly forming quality metrics and monitoring for specific quality intelligence on specialised services, working with the Quality Surveillance Team as required.

5. Engaging with the public and stakeholders

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

6. Risks

- Delivery of quality, innovation, productivity and prevention (QIPP) for 2016/17, note the former reliance on transactional QIPP, recognising requirement through collaborative commissioning to move to more transformational and sustainable schemes as we move into 2016-17 and beyond;
- Conclusion of 2016-17 contract round to national timetable, due to delay in national products;
- Achieving national service specification/national standards compliance where issues are complex and service reconfigurations are potentially indicated and specific cross boundary flow issues, internal to the South East and on our borders including vascular, specialised urology cancer, radiotherapy, and interventional cardiology services;
- Reducing the number of service providers in line with national strategy where it is not possible to reconcile factors such as drive time and activity thresholds;

- Availability of appropriate specialised mental health placements, specifically following the outputs of care and treatment reviews and for child and adolescent mental health (CAMHS) placements. We will look to develop a South East specialised mental health collaborative commissioning oversight group to support the work programme in 2016-17, based on the successful work in 2015-16 and to look to the proposal of secondary care providers holding tertiary budget. We are aware of South East expressions of interest in this new model;
- Referral to treatment times (RTT) for specialised services, in order to meet the NHS Constitutional requirements, is a challenge in terms of identifying early at an individual patient level and receiving supporting contract data. We will continue to work closely with providers and CCGs on this;
- Financial balance; working with our CCG partners within a collaborative commissioning context to understand the spend at a per head of population level across England will support the wider work of needs assessment and capacity requirements across key service areas. Continuing to embed good principles of contract management will support delivery, however support with transformational change to ensure longer term safe and sustainable services will be key;
- Organisational capacity to deliver all of this.

7. Finance and performance

A breakeven position is expected in 2016/17, following identification of key risks and mitigations.

2015-16 has been a challenging year in terms of the structural deficit budget, which contributed to a forecast outturn over performance position including a 2.8% efficiency achievement. There has been a significant over performance on activity which has been analysed and a number of consistent issues have contributed to over performance, including cancer/chemotherapy increases, specialised cardiology increases and spend on high cost drugs and devices. The increase in cancer/chemo activity is in line with the predicted level of growth nationally.

Performance meetings with providers are routinely held to focus on recovery actions.

We are working closely with both our providers with supporting data quality improvement plans and the South, Central and West Commissioning Support Unit (CSU) in improving our business intelligence.

8. QIPP (quality, innovation, productivity and prevention)

Building upon both the success and learning in 2015-16 the South team have developed a regional approach to the planning of QIPP for 2015/16 and into 2016-17. This is aimed at ensuring both consistency, where it benefits, and building a stronger delivery platform through a single project management office (PMO) function within the South, with executive oversight through the regional governance arrangements. All national schemes have been assessed for local benefits and are integrated within the plans.

Locally we have a business model for QIPP, which ensures the consistent reporting of PID delivery and implementation, and also allows for further intervention on clinical engagement models as appropriate to the scheme in terms of RAG risk and

quantum. We also hold a fortnightly internal QIPP Delivery Group, a quarterly QIPP Delivery Group with CCGs and a South East provider forum. QIPP plans have been discussed in detail at these meetings, which supports understanding of the 2016-17 ambition at a provider level.

Appendix 1 Excerpt from South/South East Operational Plan 2016-17

National service reviews commenced in 2015/16 that will continue/ make recommendations in 2016/2017
Stereotactic Radiosurgery/Radiotherapy- evaluation of procurement underway. We will implement any contractual changes required.
Radiotherapy capacity –review commenced.
Genomic laboratories – procurement strategy under development. Implementation not anticipated in 2016/17
Paediatric cardiac services – providers currently self- assessing against updated service specification.
PET/CT –procurement strategy under development
Intestinal Failure Service –procurement process underway. We will implement any contractual changes required.

National service reviews planned to commence in 2016/17
Mental Health – Low and Medium Secure Services, Child and Adolescent Mental Health Services
Cardiac Services
Paediatric Surgery Services(inc Paediatric Intensive Care)
High cost drugs and devices
Cancer – implementation of the national Taskforce recommendations
Spinal Surgery Services
Spinal Cord Injury services
Hyperbaric Oxygen Treatment
Prosthetics services
Infectious Diseases Services (Adult)
Haemoglobinopathy Services

A number of regional service review priorities have also been developed. Some are already underway and others will commence during 2016/17. These reviews will help to determine the future shape of services across the South. Where the relationship between quality, value and patient volumes is strong, we expect there will be some consolidation of services and this will be reflected in our emerging five year strategy.

Regional service reviews planned for 2016/17
Mental Health – a programme of work to support access to services and meeting referral to treatment (RTT) standards for Tier 4 Child and Adolescent Mental Health services, Personality Disorder Beds, Perinatal Mental Health Services, Gender Identity Surgery and Low and Medium Forensic Mental health
Cancer- a review of commissioning arrangements for robotic assisted surgery and a possible review of urological cancer surgery to address derogation issues
Paediatric Surgery services , linking with national work programme
Workforce compliance review of neonatal services

South East service reviews – Kent & Medway Specific
Vascular - from 2015-16 • Case for Change approved & signed off • Procurement process sign off – March 16 • JHoSC April 16 • Consultation May 16 • Procurement June-October 16 • Full Implementation April 17
Augmentative & Alternative Communication Aids • Working with providers, CCGs and service users across Kent & Medway to ensure compliance with national service specification and constitutional standards
Cancer Urology Surgery • To implement the action plans in place following a review in 2015-16, by the Quality Surveillance Team, across West Kent and to reflect the recommendations emerging from the National Task Force on potential cancer population footprints
Paediatric Surgery • To support the work reviewing arrangements supporting the strategic planning for acute care (A21/229 corridor) in relation to all specialised services, including paediatric surgery
Review of High Cost Drugs and Devices • As this is around 25% of the South spend on specialised care, some key work will be in place for 2016-17, to ensure value for money and adherence to clinical policies and thresholds

NHS England

Appendix 4

NHSE SE PH Section 7A and Primary Care Direct Commissioning Operational Plan 2016-17 External use

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1 Contents

SECTION 1: INTRODUCTION

1. INTRODUCTION

This document aims to set out the national and local context for NHS England Public Health Section 7A and primary care directly commissioned services in the South East (Kent, Surrey, Sussex).
Its aim is to both provider an overview and detail the 2016-17 strategic commissioning plans of:

- Public Health Section 7A services
- Primary Care services (including General Practice; Dental; Pharmacy and Optometry).

It is both a strategy document in its own right and a resource document for other commissioners in the South East (e.g. Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). It is anticipated that commissioners will want to factor the plans set out here into their local 2016/17 operational plans and use it to inform "placed based" 5 year System Transformation Plans (STPs).
The plans set out here underpin the delivery of the Five Year Forward View and articulate how NHS England directly commissioned services contribute to the reshaping of the NHS urgent and emergency care systems, strengthen primary care and ensuring elective care continues to meet constitutional standards as requested by "Delivering the Forward View NHS planning guidance 2016/17-2020/21" December 2015. The challenge faced by the NHS over the next five years is to save £22bn nationally for reinvestment. In total the NHS needs to identify £30bn with £8bn to be received from the Government in 2016/17 with the system needing to find the rest. Some of these savings will come from further provider efficiencies including primary care and some need to be found through commissioning of services.

All NHS England commissioning is undertaken in partnership with CCGs and it is expected that there will be strategic alignment across the commissioning system. There are many examples of obvious patient pathway linkages between services commissioned by NHS England and those commissioned by other commissioners. As the commissioner of, for example, cancer screening services across the South East, NHS England makes a clear contribution to the one of the NHS key priorities of "improving the quality of care and access to cancer treatments". The NHS England South East Office also plays a key role in the development of 'New Models of Care' and is working with Vanguard sites; Prime Ministers Challenge Fund sites and CCGs to enable whole system change and to help deliver a financially sustainable system.

The development of co-commissioning within NHS England directly commissioned services is also a key enabler to allowing a 'placed based' approach to service delivery and development tailored to the needs of local populations and flexibly reflecting the 'assets' in any given Health and Social Care community. NHS England is fully supportive of CCGs beginning to take on co-commissioning (from Primary Care to Specialised services) to achieve improvements in outcomes for patients and their families.

This is not a standalone document and the plans set out here should be read in conjunction with national NHS England Business Plans including the most recent "Delivering the Forward View: NHS planning guidance 2016/17-2020/21.

This document provides 'sign posts' to national thinking and sets out the specific implications for the South East.

2. PUBLIC HEALTH SECTION 7A SERVICES

2.1 Strategic Vision for NHS England South (South East) Section 7A services

The national ambition is to improve and protect health and wellbeing for the population. Specifically, the aim is to improve not only how long we live but how well we live and to ensure that we support the whole community to live healthily, reducing health inequalities.

Across the South East (Surrey and Sussex and Kent and Medway), the Local Office of NHS England's Public Health commissioning team will work with the embedded Public Health England Screening and Immunisation Teams, CCGs and LAs to contribute to the national ambition to improve outcomes and reduce health inequalities by improving accessibility and uptake of the following areas covered by Section 7A of the 2006 NHS Act (Public health functions agreement)[1]:

- **Immunisations** that reduce the risk of infectious disease outbreaks targeting areas of lower uptake, working with providers to improve performance to achieve national targets by 2018/19
- **Screening (cancer and non-cancer) programmes** that help improve the early diagnosis of major disease, disabilities and death such as Cancer, Aortic Aneurysm, diabetic retinopathy and ante natal newborn pathologies to improve coverage for more vulnerable, harder to reach groups to bring their outcomes and health in line with the rest of the population by 2019 and thus address inequalities.

Screening and immunisation programmes each year, contribute significantly to the wider prevention agenda and implementation of the Five Year Forward View (FYFV) as well as tackling core national priorities such as improving mortality from cancer.

All Public Health Programmes have a system wide impact to prevent infectious diseases through immunisations, support early detection of disease through both cancer and non-cancer screening programmes.

[1] *NHS Public health functions agreement 2016-17 Department of Health and NHS England. 17th December 2015. Gateway Reference 04523.* https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2016-to-2017

2.2 Further information on specifics of Section 7A

The NHS Public Health Functions Agreement (Section 7A or s.7A) of the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines specific responsibilities for the National Health Service England (NHS England) for the commissioning of certain public health services as part of the wider system design to drive improvements in population health. The agreement is based on a shared commitment to protect and improve the public's health – the Department of Health, NHS England and Public Health England share the vision of working in partnership to achieve the benefits of this agreement for the people of England. In line with the Government's strategies for the NHS and the public health system, we aim to:

- improve public health outcomes and reduce health inequalities, and
- contribute to a more sustainable public health, health and care system.

2.3 Scope of Section 7A services in 2016-17

- Cancer Screening Programmes – cervical, breast, bowel
- Non Cancer Screening Programmes – Abdominal Aortic Aneursym; Diabetic Eye Screening; Ante Natal and Newborn (e.g. fetal anomaly; newborn and infant physical examination, newborn hearing and blood spot)
- Immunisation programmes including flu vaccinations and childhood immunisations delivered in general practice; flu vaccinations delivered by community pharmacies; and flu and other immunisations delivered by specialised immunisation teams/school based immunisation teams
- Quality improvement in Child Health Information Services (CHIS), including Child Health Records Department (CHRDs) and IT Systems;
- Public health services (screening, immunisation) for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate
- Sexual Assault Referral Services (SARS).

The full service list can be found in Annex A, pages 17- 18 NHS Public health functions agreement 2016-17.

The lead NHS England commissioner for the first five items in Kent, Surrey and Sussex is the Local Office of NHS England South (South East) and for the latter item is the NHS England South Region health and justice commissioning team.

Those in contact with the criminal justice services are disproportionally affected by mental health, alcohol and substance misuse than the general population. Likewise young people held in custody are deemed more vulnerable having learning difficulties. Time in prison is an opportunity to promote health by providing health checks and screening for illnesses. Screening for blood born viruses allows increased health

outcomes when detected early and prevents onward transmission. The population in contact with the criminal justice systems has seen a rise in people over 50 year olds and has highlighted the need to address social care needs in this group. Shorter prison sentences and community licences means that health services need to work collaboratively together if to address public health priorities, such as smoking management and physical inactivity.

2.4 National Section 7A Objectives 2016/17

In order to achieve this NHS England under the NHS Public Health Functions Agreement 2016/17 (s.7A) has two objectives:

1) commission high quality public health in England, with efficient use of Section 7A resources, seeking to achieve positive health outcomes and reduce inequalities in health

Achieving this objective would mean that:

- NHS England has agreed contracts with providers that are registered with the Care Quality Commission (CQC) for those services within the contract, that these contracts deliver the s.7a agreement and that NHS England effectively manages these contracts to deliver the required performance;
- the national level of performance for each s.7A service has been improved or at least maintained, in relation to the relevant indicator or indicators set out in the NHS Public Health Functions Agreement 2016/17
- variation in local levels of performance between different geographical areas will have been reduced (while national and local levels of performance have been improved or maintained)
- patients have been able to access quality services delivered by providers with suitably qualified workforce
- NHS England will have shown evidence in relation to high quality of services that:
  - Agreed service specifications for s7A services will have been fully implemented in contracts with providers
  - the quality of patient experience will have been assessed as being both satisfactory and improving
  - NHS England will have commissioned the public health services set out in S7a within the financial allocations laid out in NHS Public Health Functions Agreement 2016/17 which are set nationally at levels that reflect expectations of efficiency gains in commissioning.

2) **Implement planned changes in s.7A services from those provided in 2015-16 in safe and sustainable manner, promptly and thoroughly**

Achieving this objective would mean that:

- Stop smoking services will have been increased in order to support the move towards a smoke free environment in prisons in England

- Opt-out Blood Borne Virus (BBV) testing will have been rolled out across adult prison estate in England to full implementation by end of 2016/17 (all people in prison will be offered BBVs on an "opt out programme" on a phased implementation to cover all prisons in England and those found to be infected to be offered referral for assessment, care and/or treatment
- Men ACWY immunisation programme introduced via variation to 2015-16 agreement will continue to be commissioned
- Men B immunisation programme introduced September 2015 will continue to be commissioned for infants ensuring immunisation offered at 2, 4 and 12 months of age
- Roll out of shingles vaccination programme will continue from 1 September 2016, shingles vaccine should be offered to patients who are aged 70 years on 1.9.16 and as a catch up to those patients aged 78 years on 1.9.16.
- Measles, mumps, rubella (MMR) vaccination uptake will continue to have been improved with the aim of bringing those areas with low uptake up to the current average, and with a specific focus on MMR vaccination coverage for one dose (5 year olds)
- Influenza immunisation will have been rolled out to all children aged 2,3 and 4; and to all children of appropriate age for school years 1, 2 and 3.
- NHS England will take forward responsibility for commissioning operational bowel scope screening centres (as at 1st April 2016) as part of the NHS Bowel Cancer Screening Programme
- NHS England will work with PHE who will continue to take responsibility for ensuring the final wave 3 bowel scope screening centres are operational by the end of December 2016.

For national objectives re SARC services – see NHS England Health and Justice commissioning intentions 2016-17.

Performance indicators and **key deliverables** for both the two national objectives are detailed in NHS Public Health Functions Agreement 2016/17 (Annex B page 19 -24 Annex B2 page 25-27).

2.5 NHS England South East principles for 2016/17

The Public Health team (NHS England and embedded Public Health England Screening and Immunisation Teams) will ensure that all commissioned programmes demonstrate value for money in line with QIPP principles, and that high quality, evidence-based cost effective services are delivered.

Specifically the Public Health Team will:

- Ensure all efforts are made to reduce variation and improve coverage and uptake of screening (particularly for vulnerable groups, prison services and armed forces personnel) and immunisation services (particularly MMR and child flu in general practice) given South East performance in some programmes is the lowest in the South Region and compared to other parts of the country;

- Work jointly with commissioning partners including CCGs and Local Authorities to implement coherent integrated commissioning plans along care pathways and ensure that system demand and capacity planning is enabled;
- Work with all providers of Section 7A services to ensure service delivery complies with standardised core national service specifications. Where service providers are not currently working to the national specifications, then services and programmes will be benchmarked against the national service specifications and action plans jointly agreed that clearly outline any gaps in provision, service developments proposals and timescales for alignment.
- Work with partners to apply specific CQUIN schemes to incentivise service improvement for Section 7A related services, focusing on initiatives that improve access for the entire population of Kent, Surrey and Sussex (including those in offender institutions) to tackle inequalities and address parity of esteem. Where appropriate 'stretch' targets will be introduced to improve coverage and uptake.
- Actively pursue Parity of Esteem for people with mental health problems who require screening and immunisation services
- Ensure that all services clearly demonstrate how they are delivering improved outcomes for patients. This will include the systematic application of national and locally agreed outcome measures and KPIs.
- Work with providers and other stakeholders including the South East Coast Strategic Clinical Networks to demonstrate effective patient engagement and user experience informing continuous improvement.
- Ensure that all commissioned programmes demonstrate value for money in line with QIPP, delivering high quality, evidence-based cost effective services. This will include the systematic application of robust financial and contract performance monitoring and review processes. We will prioritise work with partners to implement pathway/system wide re-design.

2.6 Local NHS England South East S7A objectives 2016-17

The focus for the public health team is to ensure that the Section 7A national programmes are delivered according to the national specifications and that they deliver good outcomes (protection from infectious disease or early diagnosis of significant disease).

A number of aims and objectives have been identified by the public health team in relation to the services they are responsible for in 2016-17:

- Plan and deliver implementation of the new programmes and changes to programmes as laid out in the NHS public health functions agreement 2016-17 (and summarised in Section 2.2.2) and within available allocations;
- Continue to close the gaps in service delivery where national service specification standards and S7A deliverables are not being delivered through ongoing service reviews to ensure services are not only good quality but also represent value for money – particularly in CHIS and DESP services where service specifications amended 2015-16
- Resolve flow of activity data within contractual processes working with PHE QA and dedicated CSU support secured by NHS England for business intelligence;

- Plan and deliver local re-procurements and new procurements, as required to deliver the objectives and functions of S7A and those which may result from local CCG or LA commissioning decisions for 0-19 children services, including in Surrey - DESP and Breast Screening, CHIS and school immunisation services; in Kent and Medway CHIS and school immunisation services. Professional procurement advice and support is provided through the NHS England SLA with Gem Arden/South CSU.
- Resolve ongoing issues in using CQRS for practice payments of immunisations working with national team, general practices and NHS England primary care contracting team
- SE programme board to plan and oversee delivery of S7A services in prisons, established during 2015/16 will continue, which involves joint working between NHS England public health, PHE South East and health and justice commissioning teams;
- Continue focus on improving data quality to ensure that the reported achievement of national targets are robust (particularly immunisations) including inter-operability solutions between GP practice systems and CHIS
- Support to local NHS England South East and System Resilience Groups winter plan and surge planning in relation to diagnostic capacity required for screening programmes and delivery of annual flu programme;
- Apply specific CQUIN schemes which will cover the following areas, with details available later in the year:
  - Screening and immunisation uptake amongst hard to reach groups, as identified by 2015/16 health equity audits, or, if no HEA carried out, uptake in people with learning disabilities and black and minority ethnic groups (BME) groups
  - CHIS service interoperability;
- For specific local objectives re SARC services please refer to NHS England South Health and Justice commissioning plans.

2.7 Finance summary

The services included in Section 7a are national programmes with the allocations coming under the agreement from Public Health England. **Screening and immunisation programmes across NHS South East are based and delivered on a population base**. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes (as outlined in Appendices 4 and 5).

During 2015/16 there were a number of cost pressures arising out of national directives:

- Meningitis ACWY roll out
- Childhood Influenza
- Delivery of flu vaccination by pharmacies
- Extension to the Bowel Screening Programme
- Preparation for delivery of bowel scope

- Pertussis in pregnant women
- Catch up campaign for neonatal BCG arising from international shortage of vaccine.

A deficit was generated within the Kent and Medway Area Team area of £2.4m for 2014/15 as a result of the cost pressures and changes such as those listed. This is attributed to the cost of vaccines charged by the NHSBSA which were deducted from CCG budgets by the Department without passing the funding onto Area Teams. This underlying deficit continued into 2015/16 and will continue into 2016/17.
The reduction in allocation between 2014/15 – 2015/16 and 2015/16 – 2016/17 reflects the transfer of funding to local authorities for the 0 – 5 programme.
A significant portion of the public health budget is locked into contracts where the price has been fixed through block contracts and recent procurements. However, a range of cost saving QIPP initiatives, including procurement opportunities are being explored but there is a high risk these will not be able to address the legacy underlying deficit.
The following table details the investment in NHS South East Section 7a programmes:

	2014/15			2015/16			2016/17 (draft)		
	Allocation £'000	Expenditure £'000	Variance £'000	Allocation £'000	Expenditure £'000	Variance £'000	Allocation £'000	Expenditure £'000	Variance £'000
Public Health	120,514	119,464	1,050	97,643	97,642	1	67,429	67,429	0

The following are appended to this plan:

- **Appendix 1:** Public Health Summary Work Plan 2016/17
- **Appendix 2:** Public Health Commissioning Intentions 2016/17 DRAFT (NHS England National)
- **Appendix 3:** Public Health Commissioning Intentions September 2015 (NHS South East)

3. PRIMARY CARE SERVICES

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

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, clinical leadership and engagement visibly driving the commissioning agenda.
- The right balance between standardisation/consistency and local empowerment/flexibility.

NHS England believes the areas discussed in this plan can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review. A significant policy shift was introduced in 2015/16 with **co-commissioning of primary medical care**.

During 2015/16, two CCGs successfully commenced delegated commissioning of GP primary medical services. In 2016/17 it is expected that 8 other CCGs in NHS South East will follow suit providing that they meet the required levels of assurance by April 2016. CCGs that remain at Level 1 (Greater involvement) work together with NHS England to commission the specified services (currently primary medical services) whilst NHS England retains the legal responsibility for commissioning the services and the duty to involve the public.

Under delegated commissioning, NHS England delegates full responsibility and funding for the commissioning of primary medical services to CCGs. While NHS England retains ultimate liability for the exercise of all of its functions, including those delegated to CCGs, the CCGs are bound by their own public involvement duty in respect of the services they commission (section 14Z2 of the Act). The Delegation Agreement and Terms of Reference make clear that it is the responsibility of CCGs to involve the public in the commissioning of services. NHS England will nonetheless require assurance that the duty to involve the public is being discharged effectively by the CCG as part of the CCG assurance process.

It is suggested in the Five Year Forward View that general practice is on a journey that will take it along a development path, progressing through a number of stages:

i. Current state
ii. An extended skill mix in practices and across a range of primary care providers
iii. Federation of practices

iv. Co-location of practice / merger of practices to form larger partnerships / primary care units

v. Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations), many operating as accountable care organisations.

There are clear expectations within the NHS planning guidance for 2016/17 for transformation in primary care services that address the sustainability and quality of general practice including workforce and workload issues as well as infrastructure/estate enabling more weekend and evening appointments, new primary care models of care that are not purely reliant on GPs and that support the emerging urgent and emergency care networks.

The following table provides more detail of the strategic intentions for the key primary care services:

General practice	General practice is the cornerstone of the NHS. Improving the nature of services provided outside hospital and supporting the public in self-care will be key ingredients for a sustainable NHS. Transformation in general practice must seek to maintain the internationally recognised strengths of the general practice model. Improving access is a priority, ensuring prompt access to GP services through 111, services that are available from 8am to 8pm seven days a week, and more rapid response to patient concerns through the use of telephone consultation. There will also be more personalised care and equality of access to services for everyone irrespective of where they live or their social status. We will work with CCGs, providers and other partners to identify and address inequalities. To achieve these ambitions will require a more scaled-up approach to general practice. This will mean working towards fewer, larger practices or federations or groupings of smaller practices where expertise is pooled and there can be increased focus on efficiency and innovation. This will enable patients to have seven-day-a-week access to a greater range of high quality primary care services. There will also need to be increased capacity in general practice and workforce plans need to include realistic projections for the number of GPs and practice nurses required, taking consideration of the presently aging workforce and changes in the career aspirations and expectations of newly qualified staff.

	Data and information are fundamental to providing high-quality, personalised care, improving productivity and empowering patients and clinicians to transform local services. It will be essential that GPs are supported by effective, efficient and integrated information technology systems. Patient access to electronic health records has been shown to improve health outcomes and reduce workload and costs so in line with the national strategy this will be supported. Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing costs so will be facilitated. Primary care services operate within communities and have strong links with the voluntary sector and community services. Strengthening and further integrating these can ensure resilient healthy communities addressing the root causes of ill health.
Community pharmacy services	Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E. Working with the LPC to ensure that we have the right number of pharmacists, with the right roles, working from the right locations will be important if we are to take advantage of the opportunities to provide a wider range of professional services from community pharmacies. The clinical pharmacists in general practice pilots will support the introduction of integration with general practice across a number of locations in the South East. With electronic prescribing service (EPSR2) deployment expected to be near completion, the intention is to increase utilisation of the repeat dispensing service in cooperation with CCG Medicines Management Leads. This should help to reduce the pressure on NHS111, OOHs and A&E at weekends as patients would be able to access repeat medicines direct from their pharmacy Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions. Community pharmacy has now been commissioned nationally to provide a flu vaccination service to the “at risk” groups to support take up rate. New Local Pharmacy Service contracts will commence for the former essential small pharmacies (ESPLPS) that will include requirements to provide more services in order to support general practice and OOHs
Dentistry	NHS England commissions dental services in both primary and secondary care, providing an opportunity to commission

Primary care	services across the whole patient pathway.
Dentistry Secondary care	We will also work with primary care dental providers and through the LDC to ensure that referrals continue to be made and handled appropriately; this will be through the recently procured Dental Electronic Referral System (DERS) which has been rolled out in Kent and will follow to Surrey and Sussex during 2016. We will work to deliver the national secondary dental commissioning intentions for 2016/17
Optometry	Many services provided in secondary care ophthalmology, such as for glaucoma and special needs optometry, could be carried out more efficiently and conveniently in High Street optometry services. Core contracts for optometry will be developed and refined with the LPN and LOC and we will work with CCGs to co-commission services that can be moved from secondary to primary care. Eye health needs assessments have been produced to aid this process.

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

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.

We will work with Health Education England - Kent, Surrey and Sussex (HEKSS) to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment. This includes supporting the rollout of national and local workforce tools to support workforce planning.

NHS England will continue to work with CCGs in the active pursuit of Parity of Esteem for people with mental health problems. This includes in relation to ensuring CCGs are commissioning effective Increasing Access to Psychological Therapies (IAPT) services, as well as exploring a range of other initiatives. This not only includes direct service provision through the national contract but training and awareness raising activities.

3.1 Primary care support services

NHS England South East absorbed a number of services previously provided by PCS called "out of scope" during 2015/16. The establishment of the NHS England primary care support team was increased accordingly. The full impact of the new Capita contract is not yet known but we are working with the PCS team and CCG colleagues to ensure efficient delivery of these support services which particularly involve patient and practice queries. We will also be working with CCGs that are moving to delegated commissioning to determine how we will continue to best support transferred out of scope activities.

3.2 Commissioning Intentions

- **Appendix 4:** Primary Care National and NHS South East Commissioning Intentions 2016/17.
- Locally, NHS England is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), re-procure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2017). Where CCGs are taking on delegated primary medical care commissioning then handling of the end of APMS contracts due to end by March 2017 will be transferred to the CCG.
- The following APMS contracts are scheduled to end during the next two years are:

	APMS Contracts expiring within two years	CCG Area
1	Sheppey Healthcare Centre (Surgery and Walk-in Centre) - DMC Healthcare Ltd	Swale
2	Minster Medical Centre, Sheppey – Minster Medical Group	Swale
3	Walderslade Surgery, Chatham - DMC Healthcare Ltd	Medway
4	Boots Surgery, Chatham - College Health Ltd	Medway
5	Medway Healthcare Centre (Surgery and Walk-in Centre) - DMC Healthcare Ltd	Medway
6	The Sunlight Centre, Gillingham - Medway Community Healthcare CIC	Medway
7	Green Suite, Rochester Community HLC. - Thorndike Surgery	Medway
8	St Stephens, Ashford – South Ashford Medics	Ashford
9	White Horse (Surgery and Walk-In Centre) - Fleet	Dartford, Gravesham and

	Healthcare Gravesend Ltd	Swanley
10	Brighton Station Health Centre (Surgery and Walk-In Centre) - Care UK	Brighton & Hove
11	Ashford Health Centre, Middlesex (Surgery and Walk-In Centre) – Greenbrook Healthcare	N.W. Surrey
12	Hastings Medical Practice (Surgery and Walk-in Centre) – Integrated Care 24	Hastings & Rother
13	Eastbourne Station Health Centre (Surgery and Walk-in Centre) – Integrated Care 24	Eastbourne, Hailsham & Seaford (Delegated CCG)

3.3 PMS Review

NHS England South East is committed to a comprehensive review of PMS contracts to ensure these offer value for money, fairer funding and deliver services that are aligned to patient need, as well as CCG and NHS England strategies.

The PMS 'premium' equates to £9.9m as of April 2015 reducing to £6.6m by April 2020 if we do nothing, this is due to rising GMS global sum capitation payments through Minimum Practice Income Guarantee (MPIG) erosion. A local review of the 135 South East PMS contracts commenced in the second quarter of 2015/16 and is scheduled to complete by end of June 2016 with new contracts from 1st July 2016, contingent on support of CCGs who will receive any released PMS funds. CCG are required to set their local commissioning intentions cognisant of the decommissioning of 'non-core' PMS services and utilising freed up PMS resources. It is recognised the transitional support offer to practices will not immediately release PMS funds for CCG reinvestment, as this will be phased over four years to July 2020.

3.4 Dental – Primary Care

2016 will see the implementation of up to two Dental 'prototypes' replacing the four pilot scheme contracts implemented in 2012. These new schemes will test new ways of working using the care pathway approach giving patients a clearer understanding of available treatment and seamless working with intermediate and complex levels of care.

- A package of needs assessments will be refreshed/developed with Public Health England as listed below:
    - Oral Health Needs Assessment – general South East
    - Orthodontics – South East
    - Sedation – South East
    - Out of Hours – South East

- Orthodontic provision is an area of significant risk due to time limited PDS contracts with significant re-procurement required. South East contracts will be extended for two years in readiness for a new contract from April 2018'

3.5 Community Pharmacy

Both Local Professional Networks (LPNs) will continue to work on a number of pilots across the South East, for example the distribution of a green bag by pharmacies (for patients to take their medicines to hospital urgent or elective care). Other pilots include repeat medicines service to reduce pressure on urgent and emergency care services by removing the need to issue prescriptions

All Health and Wellbeing Boards (HWB) have published their Pharmacy Needs Assessment (PNA) which must be referred to by applicants for new pharmacies and NHS England Pharmaceutical Services Regulations Committee when determining such applications. The PNAs will be updated by way of supplementary statements which show any changes to pharmaceutical services in the HWB area, for example the opening of new pharmacies, changes of opening hours and changes of ownership.

The delivery of flu vaccinations in community pharmacies will be monitored by the use of the pharmoutcomes IT platform locally (until the national solution becomes available), in addition NHS BSA collate data when pharmacies sign up to the service on a weekly basis. The new service also permits pharmacies to provide the service to care homes.

Work is required with local authorities to explore and 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.

3.6 Optometry

- Working to improve quality through development of a contract assurance process, utilising QIO reports, leading to production of the annual plan for post payment verification visits.
- Working with LPNs / CCGs to develop new commissioned services and referral pathways

3.7 Other local and national priorities for 2016/17 include:

- Implementation of the New Deal for General Practice
    - **Primary Care Transformation Fund (PCTF)** (previously referred to as primary care infrastructure fund) – continuation of premises development work that commenced in 2015, this will now be critically

linked to CCGs development of local estate strategies to inform priorities in support of increased clinical capacity out of hospital and reducing unplanned admissions to hospital and the development of Digital Road Maps. The PCTF also now includes IT not just estates.

- **Workforce 10-point plan** - In order to address primary care workforce issues, NHS England, Health Education England (HEE), the General Practitioners Committee (GPC) and the Royal College of General Practitioners (RCGP) have produced a collaborative, ten point GP workforce action plan. Focusing on three main areas of improvement – recruitment, doctor retention, and support for returning doctors.
- **Clinical Pharmacists in general practice** – pilot schemes will commence prior to April 2016, supporting integration of pharmacists into general practice and freeing up GP time.
- **Improved quality metrics** to better identify standards of care
- **Vulnerable practices support scheme** announced by NHS England in 2015 to secure improvements in vulnerable GP practices to help build resilience in primary care and to support delivery of new models of care. The national pilot programme is making available £10m of support for practices identified in difficulty and practices under pressure ensuring patients have continued access to high quality care. National criteria have been selected to enable eligible practices to be identified and prioritised including practices rated by CQC as 'inadequate', those rated as 'requiring improvement' where there is greatest concern; and, those assessed by local commissioners in need of support in view of local intelligence. NHS England is working with CCGs to ensure the programme brings maximum benefit to practices and patients over the period of the pilot.

- **Prime Minster Challenge Fund** pilots – evaluation and roll-out of successful workstream models leading to 7-day access.
- **Care Quality Commission** inspection regime and support for practices in 'Special Measures' working in partnership with nursing and quality directorate and designated leads in CCGs given their statutory responsibility for quality of primary care
- **Reviewing the differing Minor Surgery Directed Enhanced Service specifications**, which cover specific types of procedures carried out by GPs.
- **Violent/excluded patient scheme review**
- **Reviewing and, if appropriate, re-procuring the occupational health service** for GPs and other primary care contractors.
- **Reviewing and where appropriate re-procuring interpreting services** to support patients in accessing primary care contractor services.
- **Continued commissioning of the GP IT enabled services** (information governance support service, NHS mail administration and support, Registration Authority and service desk for these services) in 2016-17

A significant proportion of the primary care budget is accounted for through the national contracts, which means a large amount of the expenditure is pre-

determined. However, a range of QIPP initiative will continue to be progressed including:

- The continuation of the successful list cleansing programme that was put in place in Kent during 2014/15;
- Vigorous contract management and taking opportunities to rationalise services (e.g. to reduce rent & rates costs)
- PMS review (see above)
- Re-procurement of APMS contracts (see above)

3.8 Secondary care dental

There is a great challenge across the NHS to deliver services for increasing demand and to quality standards on a restricted budget. To do this there needs to be a change in the way services are delivered. The commissioning intentions for 2016/17 continue this process of change and lay the groundwork for further future change. In particular the commissioning intentions look to implementing the dental commissioning pathways, ensuring compliance with RTT/18 weeks target and ensuring that data is collected and submitted in a standard and comparable format.

We are aware that Trusts also face budget constraints and want to work with Trusts to ensure that the changes can be implemented with minimum destabilisation.

There is on-going work by NHS England to develop specialist commissioning guides for each of the dental specialties, which contain detailed descriptions of the various services, their workforce and training along with information on possible clinical pathways, needs assessment techniques, standard service specifications, outcome measures and other quality metrics. Until these are in place steady state commissioning will continue with existing providers.

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

See **Appendix 5:** National secondary care dental commissioning intentions 2016/17

The scope of the secondary care dental services, commissioned by NHS England includes:

GDC Dental Specialty Name	Securing Excellence Speciality Description
Special care dentistry	This is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors. It pertains to adolescents and adults.

GDC Dental Specialty Name	Securing Excellence Speciality Description
Oral surgery	This deals with the treatment and ongoing management of irregularities and pathology of the jaw and mouth that require surgical intervention. This includes the specialty previously called Surgical Dentistry.
Orthodontics	This is the development, prevention, and correction of irregularities of the teeth, bite and jaw.
Paediatric dentistry	This is concerned with comprehensive therapeutic oral health care for children from birth through adolescence, including care for those who demonstrate intellectual, medical, physical, psychological and/or emotional problems.
Endodontics	This is concerned with the cause, diagnosis, prevention and treatment of diseases and injuries of the tooth root, dental pulp, and surrounding tissue.
Periodontics	The diagnosis, treatment and prevention of diseases and disorders (infections and inflammatory) of the gums and other structures around the teeth.
Prosthodontics	The replacement of missing teeth and the associated soft and hard tissues by prostheses (crowns, bridges, dentures) which may be fixed or removable, or may be supported and retained by implants.
Restorative dentistry	This deals with the restoration of diseased, injured, or abnormal teeth to normal function. This includes all aspects of Endodontics, Periodontics and Prosthodontics.
Oral medicine	Concerned with the oral health care of patients with chronic recurrent and medically related disorders of the mouth and with their diagnosis and non-surgical management.
Oral microbiology	Diagnosis and assessment of facial infection - typically bacterial and fungal disease. This is a clinical specialty undertaken by laboratory based personnel who provide reports and advice based on interpretation of microbiological samples.
Oral and maxillofacial pathology	Diagnosis and assessment made from tissue changes characteristic of disease of the oral cavity, jaws and salivary glands. This is a clinical specialty undertaken by laboratory based personnel.
Dental and maxillofacial radiology	Involves all aspects of medical imaging which provide information about anatomy, function and diseased states of the teeth and jaws.

GDC Dental Specialty Name	Securing Excellence Speciality Description
Oral and maxillofacial surgery	Involves the diagnosis and treatment of any disease affecting the mouth, jaws, face and neck. This includes surgical dentistry (impacted teeth, dental cysts, dental implants etc.), injuries to the face, salivary gland problems, cancers of the head and neck, facial deformity, oral medicine, (ulcers, red/white patches, mouth cancer), facial pain and temporo-mandibular joint disorders. Not considered a dental specialty, but encompasses significant oral surgery elements that would be considered NHS CB remit.

3.9 Financial investment - SOUTH EAST

The draft variance for 2016/17 meets the Business Rules by producing a surplus in line with the forecast outturn in 2015/16., as well as setting aside 1% of the allocation for uncommitted non-recurrent purposes and creating a reserve equivalent to 0.5% of the allocation.
The reduction in allocation between 2015/16 and 2016/17 reflects the transfer of funding to the Co-Commissioning CCGs.

4. SUMMARY

The 2016/17 Public Health figures reflect the final transfer of 0 – 5 Services to local authorities from October 2015, and the Primary Care figures reflect the transfer of responsibilities for commissioning some primary care services to Co-Commissioning CCGs.
It is important that this plan is not read in isolation and should be read in conjunction with:

- Kent and Medway CCG operational plans
- Surrey and Sussex CCG operational plans
- The NHS England (Kent and Medway and Surrey and Sussex Area Teams 2014/15 strategic commissioning guidance for primary care and public health
- NHS England Health and Justice strategic planning advice
- The Annual Public Health Reports for Kent, Medway, West Sussex, East Sussex, Brighton and Hove and Surrey
- The Joint Strategic Needs Assessments for Kent, Medway, Surrey, East Sussex, West Sussex Surrey and Brighton and Hove
- The Health and Wellbeing Plans for Kent, Medway, Surrey, East Sussex, West Sussex Surrey and Brighton and Hove

For NHS England public health commissioning, the strategic direction is largely determined through national work programmes due to the population based

approach required. Local plans are shaped around these national documents as well as local commissioner plans.

The strategic development of primary care is being considered at a national level and through the establishment of co-commissioning arrangements for primary medical care.

APPENDIX 1: PUBLIC HEALTH SUMMARY PLAN 2016/17

2016/17 Public Health Work Plan with Milestones					
Objective	**Success criteria:** How will you know you have achieved the objective? What evidence will you need?	**Actions**	**Milestones**	**Date**	**Achievement**
Immunisation – improved coverage and uptake to reduce the incidences of outbreaks and avoidable disease	Coverage and uptake of childhood and adult immunisations meets national targets • 95% uptake of childhood immunisation programmes to ensure herd immunity • 75% uptake of flu vaccination in over 65 and under 65 at risk • Achievement of agreed targets for new programmes for childhood flu, adolescent Men ACWY/university entrants, Shingles. Ensure immunisation needs of those in health and just system are met through contractual arrangements with providers	**Maternal Flu and Pertussis** Implementation of maternal flu and pertussis by maternity providers across Kent	• Work with screening and immunisations team, CSU and maternity providers • KPI delivered	March 2017	
		Immunisations: Cessation of Rubella screening as part of the Infectious disease screening in pregnancy programme	Communications plan	June 2016	Programme ceased
		Cessation of the infant Men C programme (3 months old).		March 2017	Programme ceased
		Further rollout of shingles programme to further cohorts	Prepare budget and delivery plan	March 2017	
		Improvement in uptake and coverage of MMR – spotlight on one does for 5 year olds; target school entrants (pre-school)	Prepare budget and delivery plan	March 2017	KPI improvement
		Men ACWY provision – (year 9 or 10 replacement of Men C programme); year 10 catch up started Jan 2016 completed; catch up years 11 &12 when students reach year 13);	Prepare budget and delivery plan	March 17	KPI improvement

		freshers offer (up to age 25)			
		Childhood Flu Continue roll out of national programme to further cohorts (2,3 4 years of age 31.8.16; years 1,2,3 (ie 5.6.7 year olds inc those turning 8 on or after 1/9/16) Ensure all service providers are registered on the national LPF **Adult Flu** Establish service models with maternity and other at risk groups (eg all renal units) and continue the pharmacy based model introduced in 2015/16 Ensure workforce vaccination programmes offered Ensure prison service flu vaccination planned and delivered Media campaigns locally co-ordinated PHE, NHSE and LAs and providers **School Based Imms** Review in year of school based Imms and prepare for re-procurement Surrey, Kent and Medway in line with LA 0-19 service specifications. At present Surrey re-procurement initiated with NHSE as associate to CCG/LA commissioning intentions	Work with providers to ensure service models are robust Work with key stakeholders to review Imms as partnership to school nursing programmes commissioned by LAs Surrey School Imms procured	April 17 (with full coverage surrey April 2018)	
		Men B introduction – Ensure offered 2,4, and 12 months of age	Work with providers to ensure programme fully understood and	March 2017	

			implemented & budget prepared		
		Co-commissioning – opportunities to improve uptake of immunisation and screening services	National guidance issued Gateway 03444. May 2015	Ongoing	
Screening – improved coverage and uptake to support early diagnosis and intervention and reduce avoidable ill-health	Ensure all screening programmes achieve national targets Ensure that the programmes achieve value for money and reach all the relevant screening populations including those hard to reach who traditionally don't access screening services Ensure screening needs of those in health and just system are met through contractual arrangements with providers Ensure delivery of s.7A services for armed forces personnel and their mobile families as part of the Armed Forces Covenants increasing access and integration for cervical cancer, bowel cancer, breast cancer, AAA and DESP programmes working with central team	**Cervical Screening** Undertake an in-depth systematic review of the cervical screening programmes to identify existing provision, review costs and quality targets and make recommendations for commissioning in 15/16. Include access through CASH and women in the military.	Undertake review of services, identify where current contracts and resources are Identify where future investment maybe required and look for opportunities for re-commissioning.	March 17 March 17	
		Breast Screening Re-procure Surrey Breast Screening Service to commence from April 2017 **DESP** Re-procure Surrey DESP Screening Service to commence from April 2017 Improving the quality of grading Introduction of centralised IT system **Bowel Screening** Receive commissioning of bowel scope programmes in place as of 1.4.16 from PHE with expansion to full roll out of centres Requires providers to be JAG accredited	National KPIs delivered Review existing pathways for military services Identify where future investment maybe required and look for opportunities for re-commissioning. Demand & Capacity plans	April 17 April 17	Surrey Breast Screening service re-procured Surrey DESP Screening service re-procured
Collaborative Working with	**Improved uptake of screening and increase in early diagnosis**	**Ensure collaborative working with CCGs in line with CCG plans to**	Establish working links with CCGs to identify	**Ongoing**	**In progress**

CCGs to imp uptake & coverage for imms & screening programmes	**of disease particularly cancers**	**improve early diagnosis of cancers**	how we can work collaboratively on specific issues across the area		
Improved Child Health information systems and data quality	**Complete and robust data sources for children covering the entire child population in Kent, Surrey and Sussex requiring fit for purpose CHIS service in line with national digital strategy and with intention to transfer CHIS commissioning to LAs in 2020**	**Work with Child Health Information Systems providers to ensure the data is accurate and the benefits maximised** **Delivery of national CHIS spec issued 2015/16** **Review whether to procure inter-operability solution for Sussex, Kent and Medway to improve data flow between CHIS and GP systems** **Re-procure CHIS in Surrey due to Surrey CCG childrens community services procurement plans** **Re-procure CHIS Kent and Medway as required in light of LA 0-19 service plans**	**Programme Boards established covering K&M; Surrey; Sussex** **Action plans developed 15/16 based on new service specification to be delivered** **Consider role out of inter-operable solutions to improve data as has been completed in Surrey** **Safe re-procurement of CHIS/child health records department** **Safe re-procurement of CHIS/child health records department**	**Mar 17** **Dec 16** **April 17 (for all Surrey April 18)** **April 17**	**Achieved** **In progress** **Review once impact of national spec understood**
ANNB screening	Ensure Newborn hearing screening providers meet requirements of external peer review and quality standards of audiology services NB – NHSE Service specification but funding is through the CCG maternity tariff to acute providers			March 17	Requirements met

	Review delivery of 6-8 week checks undertaken by Kent and Medway GPs Ensure repeat testing in every pregnancy for sickle cell and thalassaemia	Ensure 6-8 week checks are delivered and data reported to CHIS in a timely manner		March 17 March 17	In progress
PH services for adults and children in secure and detained settings including moving to a smoke free environment in prisons	**Ensure screening services** **Ensure immunisation services** **Commission Stop Smoking management services working with NOMS** **Offer BBVs on opt out programme**	**Work with prison healthcare providers and Health and Justice commissioners to ensure all eligible groups in prisons and places of detention are offered relevant screening and immunisation programmes**		**March 17**	

APPENDIX 2: 2016/17 PUBLIC HEALTH COMMISSIONING INTENTIONS (NATIONAL)

Appendix 2: National Public Health Section 7A Commissioning Intentions 2016-17 (Gateway 04598) 27th January 2016

Key extracts are as follows:

4 Improving coverage and uptake (page 7)

Action is required to reverse the trend of declining uptake and coverage of the cancer screening programmes (in particular cervical and breast) for all equality groups with protected characteristics, in line with the national cancer strategy 2015.
Cover of vaccination evaluated rapidly (COVER) published in September show there is a small reduction in performance, commissioners, Public Health England and local providers will be required to work together to reduce variation and bring all areas up to the performance of the best.
Quality improvements are required to reduce variation in performance of the immunisation programmes with a particular focus on the Measles Mumps and Rubella (MMR) immunisation programme in the context of the cessation of the Rubella Screening Programmes, and also for the children's flu programme delivered in general practice.

Focus on increasing access and integration for Bowel Cancer, Breast Cancer, Abdominal Aortic Aneurysm and Diabetic Retinopathy Screening Programmes for armed forces personnel and their mobile families (this is also part of the Armed Forces Covenant) building on the pathway changes delivered for cervical screening across Defence Medical Services and NHS.
Stop Smoking services will be been increased in order to support the move towards a smoke free environment in prisons in England. Opt-out BBV testing will be rolled out across adult prison estate in England to full implementation by the end of 2016/17

The provision of the sexual assault referral centres (SARC) service were enhanced in 2015/16 by the piloting of the Sexual Assault Referral Centres Indicators of Performance (SARCIPS) ahead of full rollout by April 2016. Services will be further enhanced by the amendments to include sign-posting enquiries for child sexual assault and or exploitation (CSA/ CSE), via collaborative relationships between NHS England, PHE, the Police, Police and Crime Commissioners (PCCs), clinical commissioning groups (CCGs) and local authorities.

4.1 Equality and diversity (page 8)

Providers of all the s.7A programmes will be expected to demonstrate what systems are in place to address inequalities and ensure equity of access to the s.7A programmes. This will include, for example, how the services are designed to ensure that there are no obstacles to access on the grounds of the 9 protected characteristics as defined in the Equality Act 2010.
Providers will be expected to have procedures in place to identify and support those persons who are considered under-served, including but not exclusive to, those who are not registered with a GP; homeless people and rough sleepers, asylum seekers; gypsy traveller groups and sex workers, those in prison; those with mental health

problems; those with drug or alcohol harm issues; those with learning disabilities, physical disabilities or communications difficulties. Providers will comply with safeguarding policies and good practice recommendations for such persons.

5 Capital funding (page 9)

S.7A allocations do not include funding for capital costs. The Provider is responsible for maintenance and re-procurement of equipment. Equipment must meet any national requirements and standards.

6 Digital by 2020 – Infrastructure and Technology (page 9)

NHS England supported by the Health and Social Care Information Centre (HSCIC) has commissioned the development of a children's health information services digital strategy. The outcome is to describe the pathway which will achieve “access to child health information for all involved in the care of children and young people. Key strategic themes are accessibility, interoperability, and sharing info at point of care to safeguard and protect wellbeing of children and young people.

7 Public and patient engagement (page 9)

In upholding the NHS Constitution, NHS England is committed to ensuring that patients are at the centre of every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England, through the local office, will ensure that this is demonstrated in the way care is provided and will monitor it through our formal contracting process with providers.
It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.
Providers are required to demonstrate real and effective patient participation, both in terms of an individual’s treatment and care, and on a more collective level through patient groups/forums, particularly in areas such as service improvement and redesign. And to commission and/ or deliver in house assessment of the quality of the patient experience, with expectations that this will be at least satisfactory with improvement plans in place as appropriate.
Specifically providers should report outcomes of the Friends and Family Test for services specific to s.7A to identify levels of satisfaction every quarter and areas for potential improvement.

8 Training (page 10)

Providers have the responsibility to ensure that service provision:

- is delivered and supported by suitably trained, competent healthcare professionals who participate in recognised ongoing training and development for example, as per PHE National Minimum Standards for Immunisation Training;

- Providers must make provision to ensure all staff training is current and covers competencies required, and evidence to give assurance to commissioners of this as appropriate, allowing for appropriate annual CPD in line with s.7A programme requirements, such as study day or completion of e-learning as appropriate;
- is supported by regular and accurate data collection using the appropriate returns

9 Data collection (page 10)

Providers will be expected to comply with the data reporting requirements

10 Planned programme changes 2016/17 (page 10-16)

- Stop Smoking services will have been increased in order to support the move towards a smoke free environment in prisons in England
- Opt-out BBV testing will have been rolled out across adult prison estate in England to full implementation by the end of 2016/17
- The Men ACWY immunisation programme, introduced in August 2015 via a variation to the 2015-16 agreement, will continue to be commissioned
- The Men B immunisation programme, introduced in September 2015, will continue to be commissioned
- The rollout of the shingles vaccination programme will continue, and from 1 September 2016, shingles vaccine should be offered to patients who are aged 70 years on 1 September 2016 and as a catch up to those patients aged 78 years on 1 September 2016.
- Measles, mumps and rubella (MMR) vaccination uptake will continue to have been improved, with the aim of bringing those areas with low uptake up to the current average, and with a specific focus on MMR vaccination coverage for one dose (5 year olds).
- Influenza immunisation will have been rolled out to all children aged 2, 3 and 4; and to all children of appropriate age for school years 1, 2 and 3
- NHS England will take forward responsibility for commissioning operational bowel scope screening centres [as at 1 April 2016] as part of the NHS Bowel Cancer Screening Programme.
- NHS England will work with PHE, who will continue to take responsibility for ensuring the final wave 3 bowel scope screening centres are operational by the end of December 2016.

11 Changes in year (page 17)

Diabetic eye screening – improving quality of grading testing including training tools

Diabetic eye screening – centralised IT system.

13 Contracts (page 18)

2016/17 NHS Standard Contract will be used for all new contracts and where existing contracts do not expire at 31 March 2016, Deeds of Variation will be produced by NHS England.

APPENDIX 3: 2016/17 PUBLIC HEALTH COMMISSIONING INTENTIONS (LOCAL – SOUTH EAST)

Appendix 3: Extract from local NHS England South East S7A commissioning intentions September 2015

National Section 7A Public Health National Commissioning Intentions for 2016-17 are expected to be published in final updated form after the Spending Review in November 2015. The commissioning intentions below, for the geography covered by NHS England South (South East), are therefore draft and written to give providers and local commissioners (CCGs and Local Authorities) a summary of the direction and intent of NHS England South (South East) and continue to build on the 2015/16 NHS England Section 7a Commissioning intentions.

- Core **national specifications** for Section 7a services need to be in place for all services. Where current service providers are not working to national specifications then an action plan will be required to demonstrate how this is to be achieved followed by evidence of delivery of that action plan;

- Contracts for **Cancer and Non Cancer Screening Programmes** will continue to be delivered through Acute or Integrated Trusts (excluding Antenatal and New-born Screening Programme which is commissioned by CCGs through the maternity tariff but remains within the Section 7A responsibility of NHS England) aligned to NHS England specialised contracts where in place;

- In line with other Local Offices of NHS England, where contracts are **block contracts**, then the services will be expected to pick up the costs of any contact within the block including temporary residents. Any 'non-contractual activity' (e.g. temporary residents) should be dealt with by invoicing the provider where the contact is resident not through the local office (NHS England South (South East)

- Providers of screening programmes will participate fully in national **quality assurance** processes and respond in a timely manner to recommendations made. This will include submitting the following data to quality assurance (QA) teams within PHE who work alongside commissioners:
    - data and reports from external quality assurance schemes
    - minimum data sets as required – these may be required to be submitted to national external bodies
    - self-assessment questionnaires / tools and associated evidence
    - audits or data relating to nationally agreed internal quality assurance processes

- The NHS England public health commissioning team and Public Health England Screening and Immunisation Team based in the local office of NHS England South (South East) will continue its annual programme of **systematic review of screening and immunisation programmes** (including Child Health Information Systems) to ensure compliance with national targets/indicators, to identify areas of non-compliance and risks to programme

delivery, to identify where future investment is required and to ensure equality of delivery and sustainability of the programmes/services in the longer term. Where appropriate stretch targets will be introduced to improve uptake of national programmes. Non delivery of previously identified non-compliant areas may require NHS England to re-commission those services.

- NHS England South (South East) will work in collaboration with Wessex and South Central public health commissioning teams, local CCGs and the local authority in the re-commissioning of **breast and diabetic eye screening services in Surrey** due to the Virgin contract (of which NHS England is currently an associate contract holder) ending in March 2017;

- Work with **Child Health Information Systems** (part of community service systems) providers to ensure the data is accurate, interoperability with GP information systems and the benefits maximised. NHS England South (South East) will work with local CCGs and the local authorities in the re-commissioning of CHIS and **specialist immunisation** services in Surrey as a result of the end of existing contracts in 2017 (Virgin) and 2018 (Central Surrey Health). A review of the Sussex CHIS services will determine if re-commissioning is required due to the publication of a national CHIS specification in 2015;

- NHS England South (South East) public health commissioning team will work with the NHS England primary care contracting team and all CCGs to **improve uptake of immunisations** in general practices as well as data capture of vaccinations delivered into GP IT systems;

- Develop and agree **annual flu prevention programme** to ensure population coverage to prevent spread of influenza with focused campaigns and full involvement of the system Resilience Groups in each local health economy

- Support will continue to be provided to **Offender Health Commissioners** to ensure that Section 7A Public Health services into prisons comply with national standards

- **CQUiNs** - NHS England South (South East) public health commissioning team will discuss with providers the range of local quality and service development indicators (in addition to nationally required indicators) and continue to work with national NHS England and Public Health England teams to identify a more appropriate way of applying CQUIN payments for screening programmes

The following are the key priorities for the South East are:

- Immunisation
    - Data Quality
    - Co-commissioning opportunities
- Screening Programme Reviews –

    - Cervical Screening
- Child Health Information Service (CHIS) and Record Departments implementation of national specification
- Working with stakeholders to improve the delivery of the 6-8 week NIPE checks delivered by GPs across Kent and Medway
- Collaborative working with Clinical Commissioning Groups and CSU to improve uptake and coverage of immunisations and screening programmes and improve early diagnosis of disease particularly cancer

APPENDIX 4: Primary Care Services Commissioning Intentions 2015-2017

Priorities for 2015-17

Strategy

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

Quality

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

General Practice

- Continue with implementation of the Single Operating Model across all provider groups
- Continue to work with CCG and CSU to develop SCR into patient accessible electronic record
- Work with practices to roll out online services, such as access to appointments , prescribing and e.consultations
- Continue implementation of equalisation of contracts
- Implement 7 day working in General Practice as part of the Primary Care Strategy
- PMS – Align PMS contracts with local emerging Primary Care Strategy to achieve better outcomes and value for money
- APMS – Align APMS contracts with local emerging Primary Care Strategy to achieve better outcome and value for money
- Align premises development plan with emerging Primary Care Strategy
- Implementation of changes agreed as part of the annual contract negotiations (see next slide)
- Work with CCGs to ensure that a comprehensive premises development plan is developed to assist investment and planning

Dental Services

- Work with central team on the development of the Assurance management framework for Dental services
- Further embed the single operating model for dental services
- Prepare for the implementation of the new Dental Contract
- Fully operational LPNs in place
- Ensure contracts are in place with acute providers for secondary and community care dentistry
- Implement specialty pathways for dental as they are developed
- Implement the Assurance Management Framework for Primary care dentistry
- Review of care pathways to decrease the number of referrals into secondary care
- Review case mix in specialised services and develop new pathways
- PDS – rationalise and align KPIs with local priorities

- Contribute to national Orthodontic review – resulting in extension of contracts or procurement
- Ensure robust OOH /7 day service is in place
- Promote access to dentistry ensuring rate of new patient relates to need

Community Pharmacy

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

Optical services

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

Family Health Services

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

Other services

- Work with the central team to develop the Single Operating for translation and interpretation services
- Work with the central team to develop the single Operating model for Occupational Health services
- Contribute to National review of clinical waste and prepare for tender in 2015/16 – new service in place 2016/17
- Ensure contracted GP IT enabled services for all CCGs in NHS England South East in 2016/17 linked to development of digital road maps

Dear

Commissioning Intentions 2016/17

I am writing to inform you of NHS England South (South East) Commissioning Intentions for secondary care dental contracts.

I have set these out by Treatment Function Code (TFC). As you are aware NHS England commission TFCs 140,141, 142,143,144,217 and 450. The specific codes commissioned from your Trust are set out in Schedule S2C of the contract.

There is a great challenge across the NHS to deliver services for increasing demand and to quality standards on a restricted budget. To do this there needs to be a change in the way services are delivered. The commissioning intentions for 2016/17 continue this process of change and lay the groundwork for further future change. In particular the commissioning intentions look to implementing the dental commissioning pathways, ensuring compliance with RTT/18 weeks target and ensuring that data is collected and submitted in a standard and comparable format. We are aware that Trusts also face budget constraints and want to work with Trusts to ensure that the changes can be implemented with minimum destabilisation.

Heading	National Commissioning Intentions
Data	Implementation of Standard data document (attached)
	Collecting and reporting based on GDP practice code-all referral forms to include the requirement to provide the GDP practice code
	Requirements for flex and freeze reporting
Oral Surgery and Medicine	Referral management of referrals - only accept referrals via a specified referral management and triage service where such arrangements are in place; where no formal referral management arrangements in place, local triage at time of receipt (linked with a CQUIN)
	Recording data in Tiers 1,2, 3a and 3b (linked with a CQUIN)
	Reduction of Tier 1 treatments, retaining sufficient numbers for training purposes only and returning remainder to referrer (QIPP)
	Active clinical engagement in MCN (linked with a CQUIN)
	Prior approval required for all orthognathic surgery procedures (guidance and request form to be supplied)
	Development of oral surgery specification for secondary care
	Implementation of LPN recommendations following

	publication of national commissioning guides and local review of pathways
Paediatric	Implementing new pathways
	Active clinical engagement in MCN with links to Special Care MCN
	Outreach from secondary to CDS/primary care
	Development of paediatric dental specification for secondary care
	Implementation of LPN recommendations following publication of national commissioning guides and local review of pathways
Restorative	Developing an Implant policy, specification and accredited providers list
	Standard referral form for restorative specialties
	Active clinical engagement in MCN
	Implementation of LPN recommendations following publication of national commissioning guides and local review of pathways
Orthodontics	Referral management of referrals - only accept referrals via a specified referral management and triage service where such arrangements are in place; where no formal referral management arrangements in place, local triage at time of receipt (linked with a CQUIN)
	Recording data in Tiers 1,2, 3a and 3b (linked with a CQUIN)
	Reduction on Tier 3a treatments, retaining sufficient numbers for training purposes only and returning remainder to referrer; all Tier 2 treatments to be returned to referrer (QIPP)
	Reporting by IOTN
	Developing an Orthodontic specification for secondary care including use of PAR scoring
	Prior approval required for all orthognathic surgery procedures (guidance and request form to be supplied)
	Working with Trusts to prevent repeat NHS courses of treatment
	Working with other Providers to ensure adults who do not require treatment under a multi-disciplinary team are not receiving secondary care orthodontic treatment under the NHS
	Implementation of LPN recommendations following publication of national commissioning guides and local review of pathways

Other	Looking at 1st appointment to follow up ratios
	Recording of GA and IV sedation figures
	Trust must work with any referral management system that is in place linked with Clause 261 of GDS/PDS contract requiring following of regulations and guidance. Where no formal referral management arrangements in place, Trust to carry out local triage of referrals upon receipt to return those which are inappropriate (linked with a CQUIN)
	Working on early warning for dental RTT

In order to support these Commissioning Intentions CQUIN for 2016/17 will focus on the changes needed to deliver the new pathways and to integrate dental services and put the patient at the centre

CQUIN indicator	Achievement measure
Tier 1,2, 3a and 3b – recording of data for oral surgery and orthodontics; to include restorative when published	Collection and submission of data on priority pathways procedures by Tier - 35% of CQUIN
Participate in referral management and triage	Implementation of specified referral management and triage arrangements to include electronic transfer of x-rays where available or local triage where referral management services not in place - 30% of CQUIN
Active participation in Managed Clinical Networks (MCN)	Consultant led MCN with collaborative oversight of appraisal of performers - 35%

QIPP

Reduction in 1st to follow up identified

Use of OP Procedure Codes where applicable to replace EL codes

Oral Surgery Reduction on Tier 1 treatments, retaining sufficient numbers for training purposes only and returning remainder to referrer

Orthodontics Reduction Tier 3a treatments, retaining sufficient numbers for training purposes only and returning remainder to referrer (all Tier 2 should be returned to referrer)