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AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE MEETING

Date: Thursday, 12 September 2013

Time: 6.30 pm

Place: Meeting Room 10, Ground Floor, Trafford Town Hall, Talbot Road, Stretford, M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

To note attendances, including Officers, and any apologies for absence.

2. **MINUTES** 1 - 6

To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 12 February 2013.

3. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

4. **NOTING THE COMMITTEE'S CHAIRMAN AND VICE CHAIRMAN**

The Committee are requested to note the Committee's Chairman and Vice Chairman, as agreed at the Council's Annual Meeting:-

Chairman: Councillor Judith Lloyd
Vice Chairman: Cllr John Lamb

5. **MEMBERSHIP OF THE COMMITTEE** 7 - 8

To note the Committee's Membership as agreed at the Council's Annual Meeting.

6. **TERMS OF REFERENCE** 9 - 12

The Committee is requested to note the terms of reference, as agreed at the Council's Annual meeting.

7. **111 SERVICE UPDATE** 13 - 18

To receive a report of Trafford CCG's Chief Operating Officer.

8. **RESPONSE TO THE REVIEW OF DENTISTRY IN CARE AND RESIDENTIAL HOMES**

To review the action plan arising from the Committee's review. **TO FOLLOW.**

9. **ALCOHOL SERVICE PERFORMANCE**

To receive a report of the Executive Member, Community Health and Wellbeing. **TO FOLLOW**

10. **HEALTH AND WELLBEING BOARD UPDATE** 19 - 26

To receive a report of the Executive Member, Community Health and Wellbeing.

11. **OVERVIEW AND SCRUTINY ANNUAL IMPACT REPORT: 2012/13** 27 - 42

The Committee is requested to agree the Overview and Scrutiny Annual Impact Report for 2012/13 which will be presented to Council on 18 September 2013.

12. **HEALTH ENGAGEMENT EVENT - 11 APRIL 2013** 43 - 76

The Committee are requested to receive and agree the report arising from the health engagement event.

13. **HEALTH SCRUTINY COMMITTEE WORK PROGRAMME: 2013/14** 77 - 80

The Committee are requested to agree their work programme and suggest any further items, where appropriate.

14. **UPDATE ON THE WORK OF THE JOINT HEALTH SCRUTINY COMMITTEE / OUTCOME OF SECRETARY OF STATE REFERRAL**

To receive an oral update from the Committee's Chairman, who is also the Vice Chairman, of the Joint Health Scrutiny Committee.

15. **TOPIC GROUP UPDATE**

To receive an update from the Topic Group Chairman.

16. **URGENT BUSINESS (IF ANY)**

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

17. **EXCLUSION RESOLUTION (REMAINING ITEMS)**

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of "exempt information" which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and specified on the agenda item or report relating to each such item respectively.

THERESA GRANT
Chief Executive

Membership of the Committee

Councillors J. Lloyd (Chairman), J. Lamb (Vice-Chairman), J. Brophy, Mrs. A. Bruer-Morris, J. Harding, J. Holden, K. Procter, S. Taylor, Mrs. V. Ward, Mrs. J. Wilkinson, Mrs. P. Young and B. Shaw (ex-Officio)

Further Information
For help, advice and information about this meeting please contact:

Helen Mitchell, Democratic Services Officer
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This agenda was issued on **Tuesday, 3 September 2013** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

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HEALTH SCRUTINY COMMITTEE

12 FEBRUARY 2013

PRESENT

Councillor J. Lloyd (Chairman), J. Lamb (Vice-Chairman), S. Taylor, J. Brophy, Mrs. A. Bruer-Morris, D. Butt, K. Procter, J. Holden, J. Harding, Mrs. J. Wilkinson and B. Shaw (ex-Officio)

In attendance

Peter Forrester Democratic Services Manager

Also Present

Councillor Councillor Dr. K.M. Barclay and A. Razzaq, Director of Public Health.

APOLOGIES

Apologies for absence were received from Councillor Mrs V. Ward

25. MINUTES

RESOLVED: That the minutes of the meeting held on 9 January 2013 be agreed as a correct record and signed by the Chairman.

26. DECLARATIONS OF INTEREST

The following declarations of Personal Interests were reported to the meeting:

Councillor Lloyd, in relation to the Stroke Association;
Councillor Brophy, in relation to her employment within the NHS;
Councillor Taylor, in relation to her employment within the NHS;
Councillor Mrs. Bruer – Morris, in relation to her employment within the NHS.
Councillor Mrs. Wilkinson in relation to VCAT.

RESOLVED: That the Declarations of Interest made to the meeting be noted.

27. RESOLUTION FROM THE JOINT HEALTH SCRUTINY COMMITTEE

The Committee received an update on the work of the Joint Health Scrutiny Committee set up by Trafford and Manchester Councils to receive, and be consulted upon, the New Health Deal for Trafford.

The Committee were informed that at a meeting held on 14 January 2013, the Joint Committee passed the following resolution.

> "The committee agrees that in the event that NHS Greater Manchester, following the recommendations from the Trafford Strategic Programme Board, rejects the Committee's concerns, and proceeds with the proposals decided at the Programme Board's meeting of 19 December 2012, to

authorise its Chair and Vice Chair to refer to the proposals to the Secretary of State as a substantial variation which is not in the interests of the health service and patients of the Borough of Trafford and the City of Manchester".

The Chairman reported that following the meeting of NHS Greater Manchester on the 24th January, a referral had been made to the Secretary of State for Health on behalf of the Joint Committee. The Democratic Services Manager outlined the next stages of the referral process to the Committee.

The Democratic Services Manager updated the Committee that Regulations about the future of Health Scrutiny had been issued on the 8th February. The Committee had responded to the Government's proposals in autumn 2012 (Minute No 15 refers). The Regulations required the Council to consider how it wished to discharge its health scrutiny functions. The Committee repeated its view that Health Scrutiny Committee should remain responsible for this.

RESOLVED:-

That the Health Scrutiny Committee note the resolution of the Joint Health Scrutiny Committee.

28. UPDATE ON THE SHADOW HEALTH AND WELLBEING BOARD

The Committee received a detailed report on the work of the shadow Health and Wellbeing Board (SHWB) which had been operating since May 2012. The report set out details of the responsibilities of the Board, an update on the progress it had made in the period since its establishment and governance arrangements.

The Executive Member for Community Health and Wellbeing and the Director of Public Health attended the meeting to present the report and answer any questions from the committee.

They reported that the SHWB had started to oversee the development of strategies and plans to address health inequalities and improve health and wellbeing. The Shadow Board also maintained an overview of the delivery of the priorities set out in existing joint strategies. A Joint Strategic Needs Assessment (JSNA) had been produced and published and would be refreshed from 1st April 2013.

They also reported that the SHWB had overseen the development of the draft Trafford Joint Health and Wellbeing Strategy (JHWS) 2013-16. The Strategy had been co-produced with key stakeholders (local residents, statutory bodies, voluntary sector and the Trafford Partnership). The JHWS was at Phase 3 consultation and engagement and work was continuing during January – March 2013 to receive feedback on the identified eight priority areas of childhood obesity, child and emotional wellbeing, physical activity, reduction in alcohol harm, long term conditions, deaths from heart disease, stroke and cancer, support for people with enduring mental illness and dementia and to reduce common mental disorders. The JHWS would be formally launched at the Trafford Partnership Annual Conference in April 2013. The Director of Public Health said that he would circulate a summary document to Members of the Committee.

The Committee were also informed about the transfer of responsibility for public health to the Council and the actions that were being taken to achieve an effective transition.

Members of the Committee asked a number of questions of the Executive Member and the Director of Public Health about the work of the HWB and the transfer of public health to the Council and thanked them for their attendance and informative presentation.

The Committee were informed that the Health and Wellbeing Board (HWB) would become a statutory Committee of the Council under section 102 of the Local Government Act 1972 from 1st April 2013. The Scrutiny Committee stated that it was important that the HWB and the Committee developed an effective working relationship. The Committee were informed that an initial event to develop these relationships would be held in the spring. The Chairman and Vice Chairman would also meet with the Executive Member for Community Health and Wellbeing to discuss the matter in more detail.

RESOLVED:

1) That the report be noted.
2) That the Chairman and Vice Chairman report back on proposals to ensure that the Committee provides effective scrutiny of the work of the Health and Wellbeing Board.

29. NHS HEALTH CHECK SUPPORT PROGRAMME

The Committee were advised that responsibility for commissioning the risk assessment element of the NHS Health Check would transfer to local authorities in April 2013 as part of their wider responsibilities for public health.

A LGA circular stated that local authorities and Health and Wellbeing Boards (HWB) were being encouraged to familiarise themselves with how the NHS Health Check programme was being transferred in their areas.

The Committee indicated that they would keep this under review as part of their scrutiny of the HWB.

RESOLVED:

That the report be noted.

30. EXECUTIVE RESPONSE TO BUDGET SCRUTINY 2013-14

The Executive's response to budget scrutiny was submitted for the Committee's information. The Chairman informed the Committee that the Scrutiny Committee had considered the response in detail at its meeting on the 6th February.

RESOLVED:

That the report be noted.

31. RESPONSE TO THE HEALTH SCRUTINY COMMITTEE'S LETTER: AGEING WELL REVIEW

Further to Minute 15, the Committee received a letter on the Ageing Well review from the Programme Manager – Personalisation and Market Development. The Committee had asked for further information about recommendations 23 and 25 and the letter set out the approach that was being taken in respect of those recommendations.

The Committee noted that the Executive Member for Transformation and Resources has not yet responded to their recommendation about Members being directly informed by email of any consultations on services potentially affecting vulnerable groups before consultations are publically launched (recommendation 14).

RESOLVED:

1) That the response to recommendations 23 and 25 be noted
2) That the Executive Member for Transformation and Resources be reminded about the outstanding response to recommendation 14.

32. TOPIC GROUP UPDATE

Councillor Butt updated the Committee on the progress being made by the Topic Group looking at Dignity in Care. Members had been allocated tasks and were working through them. A meeting of the Topic Group would be held on the 19th February.

The work of the Topic Group reviewing Personalisation was outlined by Councillor Holden. A detailed work plan had been prepared and this would be circulated to Members of the Committee shortly.

RESOLVED:

That the updates be noted.

33. URGENT BUSINESS (IF ANY)

The Chairman allowed the following item to be considered as urgent business as it related to an issue which had arisen following the publication of the agenda to allow the Committee to be promptly apprised of a significant national development with potentially significant implications within its remit.

34. THE FRANCIS REPORT : OUTCOMES AND POTENTIAL IMPLICATION FOR HEALTH SCRUTINY

The Committee received a report setting out a summary highlighting the key issues identified in the Francis Report on the failings of patient care at the Mid Staffordshire NHS Trust between 2005 and 2009. The report has highlighted a number of issues that were relevant to the Health Scrutiny function. The report

highlighted the important of effective local scrutiny of health services and the issues that Members would need to take into account.

The Committee asked that a report be produced that set out any improvements that may need to be put in place.

The Chairman also informed the Committee that she had been made aware of the relocation of urology services from Trafford General Hospital to University Hospital, South Manchester. Members were concerned they had been made aware of the matter via press release rather than being informed directly. The Committee asked Officers to request further information as to why the decision had been taken to change the service and that further information be provided to them.

RESOLVED:

1) That the report be noted.
2) That a further report on the impact of the Francis Report ion Health Scrutiny be submitted to future meeting.
3) That Officers be asked to find out more information about the transfer of the urology service and circulate this to Members of the Committee in due course.

The meeting commenced at 6.30 pm and finished at 8.40 pm

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TRAFFORD COUNCIL

MEMBERSHIP OF COMMITTEES 2013/14

Notes on Membership:

(1) The Health Scrutiny Committee shall have a membership of 11, or, where this does not achieve the political balance required under the Local Government and Housing Act 1989, whatever figure is necessary to reflect the proportional representation of political groups.

(2) The Health Scrutiny Committee shall be chaired by a Councillor who is not a member of the largest political group on the Council, unless there is no such person serving on the Committee. The person appointed as Vice-Chairman shall be a member of the largest political group on the Council.

(3) The Chairmen of both the Scrutiny Committee and the Health Scrutiny Committee shall be appointed as ex-officio Members of the opposite scrutiny committee.

COMMITTEE	NO. OF MEMBERS
HEALTH SCRUTINY COMMITTEE	11 (plus the Chairman of the Scrutiny Committee as an ex-officio Non-Voting Member)

CONSERVATIVE GROUP	LABOUR GROUP	LIBERAL DEMOCRAT GROUP
Councillors:-	Councillors:-	Councillors:-
Mrs. Angela Bruer-Morris	Joanne Harding	Mrs. Jane Brophy
John Holden	Judith Lloyd **CH**	
John Lamb **V-CH**	Kevin Procter	
Mrs. Viv Ward	Sophie Taylor	
Mrs. Jacki Wilkinson		
Mrs. Patricia Young		
TOTAL 6	**4**	**1**

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HEALTH SCRUTINY COMMITTEE

Terms of Reference

1. To act as the Council's Overview and Scrutiny Committee for the purposes of all relevant legislation including, but not limited to the Health and Social Care Act 2001 and the National Health Service Act 2006.

2. All health scrutiny powers provided under the Health and Social Care Act 2001 are delegated to the Health Scrutiny Committee.

3. The Health Scrutiny Committee will have the power to refer a proposed substantial variation in service delivery to the Secretary of State. If the Committee wish to exercise this power, then this must also be agreed by the Chairman of the Scrutiny Committee who will be an ex-officio member of the Health Committee and will hold the power of veto in respect of any proposed referral of a substantial variation to the Secretary of State.

General Role

4. Subject to statutory provision, to review and scrutinise decisions made or actions taken in connection with the discharge by the Council of its functions and by relevant partner authorities in relation to health and well-being issues.

5. In relation to the above functions:

   a) to make reports and/or recommendations to the full Council, Executive of the Council, any joint committee or any relevant partner authority as appropriate

   b) to consider any matter affecting the area or its inhabitants

6. To put in place and maintain a system to ensure that referrals from the Health Scrutiny Committee to the Executive, either by way of report or for reconsideration, are managed efficiently and do not exceed the limits set out in the Constitution.

7. At the request of the Executive, to make decisions about the priority of referrals made in the event of reports to the Executive exceeding limits in the Constitution, or if the volume of such reports creates difficulty for the management of executive business or jeopardises the efficient running of Council business.

8. To report annually to full Council on its workings, set out their plans for future work programmes and amended working methods if appropriate.

Specific functions

9. Maintain a strategic overview of progress towards the achievement of the ambitions and priorities within Trafford's Sustainable Community Strategy in relation to health and well-being matters.

10. Identify the Committee's strategic priorities and determine the Overview and Scrutiny work programme to facilitate constructive evidence based critical-friend challenge to policy makers and service providers within the resources available.

11. Assist and advise the Council in the continued development of the Overview and Scrutiny function within Trafford.

12. Receive, consider and action as appropriate requests:

    a) from the Executive in relation to particular issues; and

    b) on any matters properly referred to the Committee

13. Identify areas requiring in-depth review and allocate these to an appropriate Topic Group. The Committee in consultation with the leader of the relevant Topic Group will set the terms of reference, scope and time frame for the review by the Topic Group.

14. In relation to the terms of reference of the Committee it may:

    a) assist the Council, Executive and shadow Health and Well-being Board in the development of its budget and policy framework by in-depth analysis of policy issues;

b) review and scrutinise the decisions made by and performance of the Executive and/or committees and Council officers both in relation to individual decisions and over time;

c) review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;

d) review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the overview and scrutiny committee and local people about their activities and performance;

e) conduct research, community and other consultation as it deems appropriate in the analysis of policy issues and possible options;

f) question and gather evidence from any other person with their consent.

g) consider and implement mechanisms to encourage and enhance community participation in the development of policy options;

h) question members of the Executive and/or committees, senior officers of the Council and representatives of relevant partner authorities on relevant issues and proposals affecting the area and about decisions and performance;

i) liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working; and

j) undertake any other activity that assists the Committee in carrying out its functions.

Delegation

15. The Health Scrutiny Committee shall have all delegated power to exercise the power and duties assigned to them in their terms of reference.

TRAFFORD COUNCIL

Report to:	**Health Scrutiny Committee**
Date:	**12 September 2013**
Report of:	**Gina Lawrence, Chief Operating Officer - Trafford CCG**
Report for:	**Noting**

Report Title

NHS 111: Update

Summary

Following recent media reports, the Committee's Chairman requested an update on the 111 service.

Recommendation(s)

1. To note the update;
2. To consider any further action as appropriate.

Contact person for access to background papers and further information:

Name: Tim Weedall, Head of Scheduled Care, Trafford CCG
Extension: 0161 873 9591

Background Papers: None

NHS 111

INTRODUCTION AND BACKGROUND

1. NHS 111 was introduced to make it easier for the public to access urgent healthcare services. It was considered that patients in England were confused about where they should turn for medical care when GP surgeries were closed, or when they were away from home, and almost a third of people who needed out of hours care went straight to A&E.

2. The NHS 111 service was co-designed by the NHS and Department of health and specified nationally so that a consistent identity and quality of service would be maintained across the country. It is commissioned and (will be) delivered locally by the NHS in a way that is most appropriate for any given area. Calls are answered by trained advisers, supported by experienced clinicians, who assess the caller's needs and determine the most appropriate course of action, including:

    - Information, advice and reassurance
    - Referral to a service that has the appropriate skills and resources to meet the needs of the caller.
    - Ambulance dispatch where the caller is facing an emergency
    - Signposting to an alternative service where out of scope of NHS 111

3. NHS 111 operates on four core principles:

    - Completion of a clinical assessment and information on the first call without the need for a call back.
    - Ability to refer callers to other providers without the caller being re-triaged
    - Ability to transfer clinical assessment data to other providers and book appointments where appropriate
    - Ability to dispatch an ambulance without delay.

4. NHS 111 is an urgent care phone line and was always intended to replace NHS Direct's 0845 4647 service. However, it has also become standard to incorporate GP out-of-hours (OOH) telephone access too. While this has never been centrally mandated, local commissioners felt it appropriate to avoid unnecessary duplication of services, and to simplify the route to NHS care for patients.

5. NHS 111 also has a clear clinical governance regime based on meaningful and effective local clinical leadership. Coupled with this is the principle that NHS 111 clinical governance is about the whole patient journey and not just the telephone call at the outset.

6. NHS 111 was first launched as a series of four small-scale local in August 2010, run either by the North East Ambulance Service NHS Foundation Trust or NHS Direct. In December 2010, the former Secretary of State announced a deadline for a full roll-out of April 2013.

7. Local commissioners were given the responsibility for commissioning and procurement of NHS 111 services, supported by a small subject matter expert team (telephony and call-centre) hosted by the Department of health. The North West was identified as a 'site' and NHS Blackpool were identified as the lead commissioner. Clinical leadership was provided by Dr Jerry Martin of NHS Bury.

8. The proposal was once the commissioners and the central Department of Health team had signed off a site as being ready to go live it would enter into a 'soft-launch' phase where out of hours numbers would be routed into 111, so the service only had to cope with existing demand. This was proposed to last between 2 – 4 weeks at which point the service would be advertised locally, with leaflet-drops. Radio adverts, and information in GP surgeries.

SOFT-LAUNCH OF NHS 111 IN NORTH WEST

9. NHS 111 went live in the North West Region via a 'soft launch' on 21 March 2013, following authorisation by the Department of Health. This authorisation followed assurance from the new provider, NHS Direct (which won the contract all three NW clusters) that staffing levels were correct.

10. During the evening of 21st March it became very clear early on following the switch-over that the system was failing with patients waiting up to forty minutes to have a call answered. In order to ensure patient safety a decision was taken – where possible – to switch calls back to local Out of Hours (OOH) providers.

11. Mastercall were the OOH provider for Stockport and Trafford and were able to take back calls.

12. An Emergency Contingency Planning meeting was held on 22 March comprising NHS Stockport, NHS Trafford and Mastercall where it was confirmed Mastercall could get back staff made redundant to cover the call handling and clinical triage and ensure a safe service over the Easter period.

13. Following this meeting all Trafford GP practices were contacted to switch phone systems back to Mastercall or amend answer phone messages asking patients to ring the Mastercall number. A briefing was issued by NHS Trafford to all GPs/Practice Managers.

14. Trafford and Stockport CCGs further agreed that Mastercall would continue to deliver the OOH service for a further three months and this was later extended until a new clinical model has been agreed for the NW and a procurement process completed to identify a new provider. This is consistent across the North West where OOH providers have taken back calls.

15. Across the whole of the NW 70% of calls were taken back from the new service to other providers, in most cases the OOH providers. In Greater Manchester it is only Salford CCG which is still currently using NHS 111 with NHS Direct as the provider

16. The issues that arose during the soft-launch impacted across the North West and also the West Midlands, where NHS Direct was also the provider. NHS Direct won a number of contracts to deliver NHS 111 nationally but the NW and West Midlands were the largest.

17. As a consequence Deloitte were commissioned by NHS Direct, NHS England and the National Trust Development Authority to undertake a review of the launch issues. Their report has been published and summarises the main failures as lack of capacity in the provider (NHS Direct) to manage the demand. This was caused by:

- A shortage of fully trained staff
- Calls taking longer to manage than had been expected
- Some difficulties with managing onward flows for calls

18. NHS Direct were required to produce rectification plans; however, these were considered to be unaffordable when also considered alongside the major credibility issue. North West Clinicians did not feel this could be re-gained and it was subsequently agreed that a new clinical model would be designed and the service re-procured.

19. As reported recently in the media, NHS Direct decided to pull out of the contracts rather than continue until the procurement of the new provider. As a result a stability partner needed to be found and North West Ambulance Service NHS Foundation Trust was identified locally. The decision to ask ambulance services to provide an interim service was made nationally by NHS England.

20. While Trafford patients have been advised to contact the out-of-hours service, some patients will still be using the 111 service as the number is in the public domain. These patients will continue to be handled as required by the specification.

21. There have been no serious incidents involving Trafford patients as a result of the issue with the NHS 111 service.

THE NEW CLINICAL MODEL

22. It was agreed by all CCGs that a new clinical model for NHS 111 should be developed for use across the North West.

23. Having received confirmation from the government that they remain committed to the NHS 111 concept, clinicians from across the North West met to consider the model of NHS 111, working within the framework of the national model. The North West NHS 111 Clinical Group was established to lead this piece of work and identified the mandated elements of a NHS 111 service as:

    - Number is 111, available 24/7/365
    - Electronic data transfer to enable ambulance dispatch, without the need to transfer/re-triage the call
    - Capture of patient demographics, as a minimum, and pass these on to any provider the caller is referred to
    - Offer of a clinical assessment (although this does not have to be a definitive clinical assessment)

24. The North West Clinical Group further identified the following elements of NHS 111 that are not mandated:

    - Calls to GP OOH services do not have to be routed via NHS 111; this is a commissioner decision.
    - Appointment booking is for local determination 9for all providers)
    - The NHS 111 service does not have to include assessment by clinicians. Cases that cannot be completed by a call handler (because of the complexity) could be referred to another service for that element of the assessment to be completed.

25. The Clinical Group met three times and subsequently defined a new clinical model. However, at the Association of Greater Manchester CCGs meeting in July, an exercise was requested to estimate the costs of potential clinical models for the NHS 111 service to be re-launched by September 2014.

26. As a result, a paper on NHS 111 was presented to the GM Association of CCGs Association Governing Group (AGG) on 8th August 2013. The paper set out the potential options for the new NHS 111 clinical model with comparative costs – the existing service design costs £6.9m for the North West.

27. NHS Direct has now given notice to withdraw from the contract and the stability partner during the transition has been agreed as NWAS. There is the possibility that the stability partner may request additional resources particularly if there is additional clinical input although savings from the stepping down of NHS Direct could mitigate the additional costs.

28. The AGG felt there were benefits of joining up 111 with Out-of Hours (OOH) which would also benefit from joint procurement arrangements.

29. The North West model, proposed by the clinical group is as follows:

- NHS 111 calls would be received by the new service and through initial triage, calls requiring a 999 disposition would be identified and an ambulance dispatched; calls requiring health information would be completed and information supplied; and those needing sign-posting to other services would be so directed. This mirrors the existing service.

- However, the recommended model provided the option for those calls with a primary care disposition to be sent on for definitive clinical assessment and management within Out of Hours providers (an alteration to the original model where all dispositions were part of the NHS 111 service). It would remain possible for a mix of handling the final primary care disposition at CCG level if CCGs required a mix of the 2 options for final definitive clinical assessment.

- In hours, the definitive clinical assessment would be performed by a senior clinician (this being defined as nurse practitioner, senior paramedic or doctor) A variation of this is for the assessment to be performed by a doctor although this option was considered by the North West Clinical Group but discounted as likely to be both unaffordable and unachievable with the need for large scale doctor appointment.

30. The AGG noted that some clinicians from Greater Manchester hold strong views that this doctor-only option needs further consideration and the AGG queried whether the corresponding reduction in A&E costs had been analysed against the cost of more senior clinical input.

31. The costs have yet to be discussed by the Chief Finance Officers and there are still questions regarding value for money, affordability, what the 111 service replaces (what is stopped because of its introduction) and the impact on out of hospital plans.

32. The AGG recommended that the model described above is progressed with the doctor-only variable to available as an option.

33. The AGG agreed the importance of alignment of 111 and Clinical leadership with the Urgent Care networks, especially the Local Clinical Assurance Groups.

34. A GM commissioning foot print was agreed, to be procured as part of the North West umbrella.

GOVERNANCE

35. The current and future GM organisation and governance structure for NHS 111 is attached in Appendix 1.

36. The Local Clinical Advisory Group (LCAG) covers Trafford, Stockport and Tameside & Glossop CCG's. Dr Chris Tower from Trafford has agreed to be the Interim Chair of the group. Dr Tower has recently been appointed Associate Director of NHS Trafford CCG for Urgent Care.

37. The LCAGs have continued to meet to fulfil their clinical governance assurance function for the service. This remains an important role in terms of assuring the quality of the current service and also learning lessons to inform the future model. Investigation and analysis of complaints remains important and this is done via the use of Health Professional Feedback forms. There have been no serious incidents recorded involving Trafford patients.

PROCUREMENT

38. The indicative procurement timeline assumed an invitation to tender in September; however, this has been delayed as debates over the clinical model have continued.

39. The contract award is now expected to be early 2014 with a phased mobilisation proposed to be completed by end of September 2014.

UPDATE

40. As the situation with regard to NHS 111 continues to develop a verbal update will be provided to the meeting by Gina Lawrence, Chief Operating Officer for NHS Trafford CCG on any changes to the proposals detailed in the report.

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **12th September 2013**
Report of: **Executive Member for Health and Wellbeing**
Cllr Karen Barclay

Report Title

Health and Well Being Board (HWBB) Update

Summary

This paper provides an update of the Health and Well Being Board (HWBB) including revised membership arrangements and progress on the draft Joint Health and Wellbeing Strategy. The strategy will be formally approved at the October meeting of the Health and Wellbeing Board (HWBB) and will be presented to Full Council in November for final approval. The strategy will then be formally incorporated into the Council's Policy Framework.

Recommendation(s)

- That the Health Scrutiny Committee notes the update of the revised HWBB membership arrangements and the progress of the draft strategy prior to submission to the HWBB and Full Council.

Contact person for access to background papers and further information:

Name: Abdul Razzaq, Director of Public Health
Extension: 0161 912 1300

Relationship to Policy Framework/Corporate Priorities	This strategy supports all of the Corporate priorities, with a focus on supporting Trafford to be a safe place to live - fighting crime, supporting services to be focussed on the most vulnerable people and reshaping Trafford Council. The core principles can be applied across the organisation and embedded into other policies/frameworks
Financial	There are no direct financial implications arising from the adoption of a draft JHWBS. The financial implications will occur when the strategy's priorities and outcomes are implemented which may result in different commissioning and resource outcomes. Working with partners such as Trafford Clinical Commissioning Group will encourage joint commissioning. Resources may need a shift into early intervention/prevention. The public health grant and current review of public health services and programmes will support this strategy. Some less effective interventions may need to be de-commissioned and this strategy provides a focus that ensures we align our joint commissioning plans to the 8 priority areas over the next 3 years. The Strategy has been prepared in house. Sufficient funding has been identified in the public health budget to develop the JHWBS work. Future (3 year) financial implications would be subject to a further report.
Legal Implications:	The Health and Social Care Act 2012 sets out the responsibilities of Health and Wellbeing Boards (HWBB) for the production of the Joint Health and Wellbeing Strategy. The strategy will be a key driver of integrated commissioning to reduce dependency and costs across the system. The Act also states that NHS and local authority commissioners will be expected to give due regard to the Joint Strategic Needs Assessment (JSNA) which has already been adopted and Joint Health and Wellbeing Strategy.
Equality/Diversity Implications	An Equality and Diversity Impact Assessment has been completed. Equality issues have been considered as part of the Needs Assessment and during the development/consultation of the strategy. This strategy aims to reduce health inequalities and the action plan framework highlights support for vulnerable groups.
Sustainability Implications	This draft strategy is supported by sustainability analysis of the health of our population in the JSNA that has informed the priorities. The strategy sets out a number of long-term

	sustainable principles that future proposals should be in accordance with.
Staffing/E-Government/Asset Management Implications	The draft strategy/action plan will be delivered by existing staff resources within the council, especially by the Children, Families and Wellbeing directorate, and resources in conjunction with external partners and agencies where appropriate. Feedback will consist of electronic submissions and all documents will be accessible through the council web pages: www.infotrafford.org.uk/hwbstrategy The draft strategy highlights the potential of an asset based approach and supports asset management for economic growth. There are no asset management implications.
Risk Management Implications	There are some possible strategic risks associated with commissioning of new services/interventions, but overall intention would be to focus on early intervention /prevention and reduce long term risks as a pro-active rather than reactive response is required. Governance arrangements are in place for each of the 8 priority areas.
Health & Wellbeing Implications	An evidence based approach to health and wellbeing has been utilised to develop this strategy and action plan framework. Implications are stated in the report and strategy, especially regarding the wider determinants of health.
Health and Safety Implications	The Health and Wellbeing board are working with the Safer Trafford Partnership to drive forward the priorities. The only implications are that improvements will be made regarding health and safety.

Health and Well Being Board Update

1. **Functions of Health and Well Being Board**

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.

- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.

- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

2. Regulations relating to Health & Well Being Boards: Statutory Instrument 2013 No. 218

The regulations relating to health and wellbeing boards have been published as Statutory Instrument 2013 No. 218 entitled, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/218/ contents/made

The regulations modify certain legislation as it applies to health and wellbeing boards and disapply certain legislation in relation to the boards. The provisions which are modified or disapplied are in the Local Government Act 1972 and the Local Government and Housing Act 1989.

Under section 194 of the Health and Social Care Act 2012, a health and wellbeing board is a committee of the council which established it and for the purposes of any enactment is to be treated as if appointed under section 102 of the Local Government Act 1972. It is therefore a 'section 102 committee', as it is sometimes called within local government. However, the regulations modify and disapply certain provisions of section 102 and other sections of the Local Government Act 1972 and also provisions of the Local Government and Housing Act 1989 in relation to health and wellbeing boards.

This means that it is best not to think of health and wellbeing boards according to the strict model of other section 102 committees, but to think of them as a basic section 102 committee with some differences. The sections below discuss the characteristics shared by health and wellbeing boards with other council committees and where they do or may diverge under the new regulations.

The modifications and disapplications which apply to health and wellbeing boards within the regulations generally also apply to subcommittees and joint sub-committees of boards.

3. Membership of Health & Well Being Boards

The Health and Social Care Act 2012 indicates that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of members. Specifically, the Act:

- sets a core membership that health and wellbeing boards must include:
    - at least one councillor from the relevant council
    - the director of adult social services

    - the director of children's services
    - the director of public health
    - a representative of the local Healthwatch organisation (which will come into being on a statutory footing on 1 April 2013)
    - a representative of each relevant clinical commissioning group (CCG)
    - any other members considered appropriate by the council

- requires that the councillor membership is nominated by the executive leader or elected mayor (in councils operating executive arrangements) or by the council (where executive arrangements are not in operation) with powers for the mayor/ leader to be a member of the board in addition to or instead of nominating another councillor.

- under the regulations (Regulation 7) modifies sections 15 to 16 and Schedule 1 of the Local Government and Housing Act 1989 to disapply the political proportionality requirements for section 102 committees in respect of health and wellbeing boards – this means that councils can decide the approach to councillor membership of health and wellbeing boards.

- requires that the CCG and local Healthwatch organisation appoint persons to represent them on the board.
- enables the council to include other members as it thinks appropriate but requires the authority to consult the health and wellbeing board if doing so any time after a board is established.
- the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparation of JSNAs and the development of JHWSs and to join the health and wellbeing board when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the board.

The Shadow Health and Wellbeing board opted for a small membership in line with the guidelines set out by the Department of Health. The membership of the board during 2012/13 was as follows:

- Executive Member for Community Health and Wellbeing
- Executive Member for Adult Social Services
- Executive Member for Supporting Children and Families
- Shadow Executive Member for Community Health and Wellbeing
- Non Executive Member GM Cluster Board
- Corporate Director of Communities and Wellbeing
- Corporate Director of Children and Young People
- Director of Public Health
- Chair of Pathfinder Clinical Commissioning Group
- Nominated Director Pathfinder Clinical Commissioning Group
- Pathfinder Clinical Commissioning Group Lay Member
- Chair of LINk until such time that it becomes Health Watch

The Executive Member for Community Health and Wellbeing is the Chair of the Board and the Chief Clinical Officer, Trafford Clinical Commissioning Group is the nominated vice chair.

4. Priorities of the Health & Well Being Board

The Health and Well Being Board development and sub governance sessions in March, April and May 2013 have highlighted that the following areas of work are central to the work of the Board:

- Ensure the effective delivery of the integrated care plans;
- System reform and integrated care redesign of health and social care services.

5. Proposed New Health and Well Being Board Membership

Following recent Health and Well Being Board development sessions and feedback from the Health and Well Being sub governance task and finish group it is now proposed to amend the membership of the Board to the following:

- Executive Member for Community Health and Wellbeing
- Executive Member for Adult Social Services
- Executive Member for Supporting Children and Families
- Shadow Executive Member for Community Health and Wellbeing
- NHS England representative
- Corporate Director of Children, Families and Well Being
- Director of Public Health
- Chief Clinical Officer Trafford Clinical Commissioning Group
- Nominated Director Trafford Clinical Commissioning Group
- Chair of Health Watch

The Health and Well Being Board sub group proposed that the main providers from the NHS and voluntary/third sector should be invited onto the board as they would be crucial partners in bringing about the system reform and improvement in the next few years. In order to meet the Health and Well Being Board identified priorities and objectives for integrated care and system reform it is proposed that the following provider organisations would also become members of the Health and Well Being Board.

- Central Manchester University Hospital NHS Foundation Trust
- University Hospital South Manchester NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- A representative from the Trafford voluntary/third sector

The providers have been contacted and have agreed to provide a senior level strategic Director to attend the Trafford Health and Well Being Board.

Other provider organisations such as Trafford Housing Trust, Trafford Leisure Trust and Care Providers are represented on the Trafford Partnership or existing Provider Forums and the Board will seek their continued involvement and engagement through existing governance arrangements.

A joint workshop is planned for the Autumn 2013 where the Health and Well Being Board, Strong Communities Board, Safer Trafford and Children's Trust Board would meet to share their priorities and discuss areas of further collaboration.

6. Draft Joint Health & Well Being Strategy (JHWS)

The draft Joint Health and Wellbeing Strategy (JHWS) has been developed following an extensive, three phase public consultation involving a wide range of organisations, groups and residents. During the consultation, virtually all respondents supported the proposed vision, priorities and actions.

The Strategic Vision is:

"Public health is everyone's business. We will reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy and fulfilling life".

Following consultation, eight highest scoring priorities were selected. These priorities now form chapter areas in the draft strategy and were coproduced by a variety of organisations including, Trafford Council, CCG, Trafford Community Leisure Trust and a wide range of public and third sector partners.

The draft strategy is an overarching plan to deliver the Trafford health and wellbeing vision. It focuses predominantly on the health and social care-related factors that influence health and wellbeing. The important wider determinants of health and wellbeing, such as crime, employment and housing, are referenced through other key strategies.

The draft strategy emphasises the importance of partnership working and joint commissioning of services to achieve a more focused use of resources and better value for money. The strategy discusses alignment with other strategies, e.g. Children and Young People's Strategy, CCG Integrated Plan, the CCG Quality Strategy/ Integrated Care Strategy and the Crime Prevention Strategy.

In May 2013 the North West Employers Organisation published a '*Review of Joint Health and Wellbeing Strategies in the North West'* in which the three stages of consultation used to progress the Trafford strategy was highlighted as good practice.

7. Draft Health & Well Being Strategy (JHWS) - Current Position

The current draft strategy has been amended following feedback from members of the HWBB. All partners involved in its production are supportive of the final draft. Once approved, a full communication strategy, including the production of a user friendly summary document will be overseen by the HWBB.

In addition, a partnership Health and Wellbeing Action Plan Group has been established to develop a supporting action plan to ensure detailed implementation plans for the strategy are in place. The action plan will be approved and overseen by the HWBB.

8. Recommendation

- That the Health Scrutiny Committee notes the update of the revised HWBB membership arrangements and the progress of the draft strategy prior to submission to the HWBB and Full Council.

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TRAFFORD COUNCIL

Report to: **Council**
Date: **18 September 2013**
Report for: **Information**
Report author: **Helen Mitchell, Democratic Services Officer**

Report Title

OVERVIEW AND SCRUTINY ANNUAL IMPACT REPORT: 2012/13

Summary

The enclosed report documents the achievements of the Overview and Scrutiny function during the 2012/13 municipal year.

Recommendation

1. **That Council note the enclosed Annual Impact Report.**

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TRAFFORD COUNCIL

Overview and Scrutiny

Annual Impact Report

2012/13

Chairmen and Vice Chairman's Introduction

This year has proved to be another successful one for Overview and Scrutiny, which is especially pleasing considering it is our first full year under the new format. I would like to take this opportunity to thank all Scrutiny Committee Members, with special consideration to Topic Group Chairmen, for their efforts and dedication to scrutiny. The reviews undertaken in relation to doorstep crime and community asset framework have added a valuable contribution to improving the services delivered by the Council and partners.

During the period under review the Health Scrutiny Committee has been heavily involved in the scrutiny of the New Health Deal proposals for Trafford, an aspect of which was the downgrading of the A&E Department at Trafford General Hospital. Inevitably this aspect of the proposals attracted considerable public interest not only in the NHS proposals but the role and work of the Health Scrutiny Committee. Members of the Committee fully participated in the Joint Health Scrutiny Committee established with the City of Manchester which rejected the NHS New Health Deal for Trafford proposals and made a referral to the Secretary of State for Health.

The two topic groups established under the new arrangements have been working on two very important issues relating to health and social care in Trafford: dignity of older residents in the care of NHS hospitals and personalisation of care in the community. Both these topics are reported upon more fully elsewhere in this report.

We would like to take this opportunity to thank the Democratic Services team, Council Officers and partners for their continued hard work, which without we would not have achieved what is set out within this Annual Impact Report.

Councillors Brian Shaw and Mike Cordingley & Councillors Judith Lloyd and John Lamb

Chairmen and Vice Chairmen of the Scrutiny & Health Scrutiny Committees

Statutory Scrutiny Officer Introduction

I'm pleased to fully support the comments made by the Chairmen and Vice Chairmen of the Scrutiny and Health Scrutiny Committees as well as those made by the Topic Group Chairmen. In my first year as Statutory Scrutiny Officer, officers and Members have worked together to bring about a positive improvement to the ways in which scrutiny operates at Trafford. We are more focussed in delivering outcomes which are at the heart of what Members wish to achieve. Scrutiny Members' work programme was challenging in parts and included some excellent examples of pre-scrutiny such as the development of proposals to establish the local scheme for Council Tax, Trafford Assist (Local Welfare Assistance Scheme) and the Community Asset Framework.

I very much look forward to working with Members and Officers in the coming years to further enhance the impact that the function has on the Council and its partners.

Peter Molyneux

Trafford Council
Overview and Scrutiny Annual Report 2012/13

Introduction

Overview and Scrutiny exists to assist in the improvement of governance and public services. It ensures the Council's Executive and partners are publicly held to account for their decisions and actions, and to promote open and transparent decision-making and democratic accountability. It also has a wide remit to explore how the Council and its partner organisations could improve services for the people of Trafford by:

1. Reviewing existing policy and contributing to the development of new policy.
2. Acting as a 'critical friend' to those making decisions.
3. Holding decision-makers to account for their decisions and actions.
4. Challenging performance to ensure that services are meeting the needs of local communities.

This annual report looks at how the Overview and Scrutiny function performed its role in 2012-13 and provides a snapshot of the contribution it has made.

Review of Scrutiny

In 2012/13, and following a review led by the former Overview and Scrutiny Core Committee, the Council changed the structure of Scrutiny. The principal change was that standing overview and scrutiny committees with broad remits were discontinued in favour of more outcome focussed topic groups with varying size and membership. The new structure for Overview and Scrutiny comprises:-

1. A Scrutiny Committee to determine and co-ordinate a prioritised work programme and to carry out scrutiny of key strategic issues.
2. A Health Scrutiny Committee to determine and co-ordinate a prioritised work programme focussing solely on key health and social care issues.
3. Four Topic Groups to undertake focussed reviews agreed by the Scrutiny and Health Scrutiny Committees in order to support the delivery of the overall Scrutiny work programmes. The Topic Groups are self-selecting and the membership changes depending on Members' preferences for participating in a specific project.

These radical changes have taken time to embed in terms of how Members and Officers engage with Overview and Scrutiny, and also within the wider democratic framework of the Council.

To be successful, Overview and Scrutiny needs active participation, not only from Scrutiny councillors, but also the input of many others – Executive Councillors, officers, representatives of external organisations, the voluntary sector, interest groups and individual citizens. In 2012/13, we involved a number of participants from these groups and we are very grateful for their input and time.

Key Activities of Scrutiny Committee

Membership 2012/13

Councillors from top left to top right – Cllrs Brian Shaw, Mike Cordingley, Steve Adshead, Ray Bowker, Chris Candish and Rob Chilton
Councillors from bottom left to bottom right – Cllr Mrs Pam Dixon, Anne Duffield, David Higgins, John Reilly, Denise Western and Judith Lloyd

Welfare Reform – As a result of the significant national changes to welfare provision, the Executive Member for Finance asked Scrutiny Committee to review the Executive's approach to a localised scheme of administering Council Tax Benefit. After a series of meetings Scrutiny Members provided a number of comments and issues for the Executive Member to consider which enhanced the final report which was taken to the Executive. The process also enabled Scrutiny Members to have an overview of the scheme's development and subsequent public consultation.

Executive's Response to the Review of Domestic Violence – Following the review undertaken by the former Community Wellbeing Select Committee, the response to the review was presented to Scrutiny Members for their consideration. Members welcomed the progress made but were concerned that some of the recommendations which focussed on prevention, early intervention and funding were not agreed. The Committee has agreed to follow these up in due course. A further recommendation was made in respect of a co-ordinating Executive Member for Domestic Violence issues which was agreed by the Executive.

Trafford Assist - The Executive Member for Community Health and Wellbeing provided Scrutiny Committee with a report detailing the establishment of Trafford Assist. Scrutiny Members provided 'critical friend' challenge to the Executive Member and requested that a risk assessment be put in place prior to the Executive deciding on the matter.

Children's Centres Call In – The Executive's decision to reconfigure the provision of services and number of children's centres across the Borough was called-in in March this year. After a detailed discussion, the Committee felt decided that it was not necessary to refer the matter back to the Executive.

Budget Scrutiny – Following the redesign of the overall approach to budget scrutiny, Scrutiny Members, the Executive and Corporate Management Team felt that the process was more focussed and meaningful that in previous years. As a result of this process, Members have agreed to follow up a number of key recommendations such as the impact of business rates retention, changes to waste management and the review of Human Resources. These will be followed up through the year.

Town Centres – Scrutiny Members received a comprehensive report from the Executive Member for Economic Growth and Prosperity on activity, both past and planned, in relation to the economic development of the Borough's town centres. After careful consideration, Scrutiny Members noted that they wished to see a bigger focus on supporting town centre partnerships, enhanced town centre master-planning and that further consideration be given to the development of a method or mechanisms to objectively assess the success of interventions. The Committee will be receiving an update on progress later this year.

Key Activities of Health Scrutiny Committee

Membership 2012/13

Councillors from top left to top right – Judith Lloyd, John Lamb, Jane Brophy, Mrs Bruer-Morris, Joanne Harding and John Holden
Councillors from bottom left to bottom right - Kevin Procter, Sophie Taylor, Mrs Viv Ward, Mrs Jacki Wilkinson, Dylan Butt and Brian Shaw

North West Ambulance Service – The suggested closure of Stretford Ambulance Station caused community concern in Spring 2012 and Members met to discuss the implications of the decision with the Ambulance Trust. At this meeting, Members assured themselves that performance would not be adversely affected by the decision and that the sale of land would release savings for the Trust.

New Health Deal for Trafford – The acquisition of Trafford Healthcare Trust and the subsequent proposal to transform services was a significant piece of work for Members of the Committee over the entire year. Members were involved at every stage of the process and provided comments to NHS Greater Manchester on a number of occasions. Once formal consultation had commenced, both Manchester and Trafford Councils established a Joint Committee for the commissioner to consult with and, as agreement was not reached, the matter was referred to the Secretary of State for Health in February 2013. At the time of writing, the Joint Committee still awaits a response.

Executive's Response to the Ageing Well Review – Following the review undertaken by the former Health and Wellbeing Select Committee, Members monitored the recommendations to ensure that those which were accepted by the Executive were being progressed.

Executive's Response to Review of Dentistry in Care and Residential Homes – A short piece of independent scrutiny was undertaken by Councillor Dr Karen Barclay, former Member of the Health and Wellbeing Select Committee, following concerns from residents in relation to

the absence of a prompt dental service for those in care and residential homes. Members reviewed the actions arising from the recommendations and are keen to keep a close eye on the commissioning of the new service by NHS England.

Health and Wellbeing Board Update - Members welcomed the progress made by the Shadow Health and Wellbeing Board in its first year and questioned the Executive Member for Community Health and Wellbeing and the Director of Public Health on the transfer of public health duties. The work of the Board will form a key part in the Committee's work programme for next and future years.

Francis Report – Arising from the comprehensive review of the failings of the Mid Staffordshire NHS Trust to ensure patient care and safety, Members received a brief report on the impact of the review on Overview and Scrutiny. Members were very keen to ensure that the scrutiny function was able to discharge its duties effectively and, in the spirit of the review's outcome, Members requested a future report on the ways in which the Health Scrutiny Committee should look to improve.

Health Scrutiny Engagement Event – The Committee along with Trafford Clinical Commissioning Group, hosted an information and engagement event in April 2013 involving the Health and Wellbeing Board, Healthwatch, Care Quality Commission, NHS England and Council Commissioners. This collaborative event brought together partners in order to share an understanding of each other's unique roles in the new health landscape. The event also provided an enhanced basis of future working relationships.

Work of The Topic Groups

Topic Group A: Review of Doorstep Crime

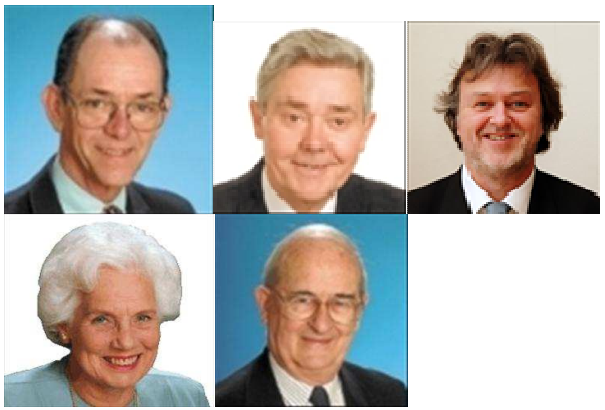
Councillors from top left to top right - Rob Chilton, Ray Bowker and Brian Shaw
Councillors from bottom left to bottom right – Chris Candish, Mrs Jacki Wilkinson and Mike Cordingley

Topic Group A's review during the municipal year 2012/13 involved an in-depth review of the issue of doorstep crime within the Borough, and the multi-agency approach to tackling the problem. After meeting with Council Departments, the Police, voluntary groups and victims of doorstep crime, we were able to put forward a number of recommendations aimed at sharpening our response to this growing problem, and ensuring that more vulnerable residents feel as supported as possible.

The Topic Group's report was presented formally to the Executive on 24 June 2013 and a response is awaited.

Councillor Rob Chilton, Chairman of Topic Group A

Topic Group B: Review of Community Asset Framework



Councillors from top left to top right – John Reilly, Ray Bowker and Mike Cordingley
Councillors from bottom left to bottom right – Mrs Pam Dixon and David Higgins

The major work of Scrutiny topic group B has centred on scrutinising Economic Growth and Prosperity's development of a Community Asset Framework. This included a detailed study of the Asset Management approach to Community lettings, Community Right to Bid & Community Asset Transfer. This review allowed for Scrutiny to examine a wide range of issues across all aspects of the management of our let estate.

We were delighted that the Executive Member and his Corporate Director valued our input, and took measures to include our comments and address our concerns in their report to Executive on 24th June 2013.

Whilst Topic Group B view our involvement in this review as "work in progress", we feel confident that by working with the EGP Directorate, the best outcome for both Trafford Council and our user groups are within reach.

Councillor John Reilly, Chairman of Topic Group B

Topic Group C: Care of Elderly Trafford Residents in NHS Hospitals

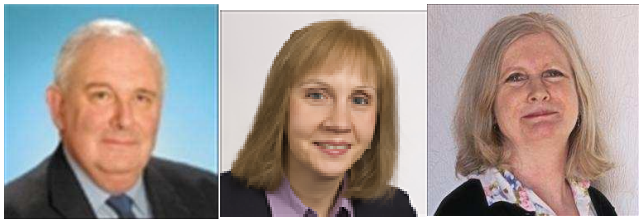
Councillors from top left to top right – Dylan Butt, Joanne Harding and John Lamb
Councillors from bottom left to bottom right – Kevin Procter and Sophie Taylor

As part of the Health Scrutiny work programme, Topic Group C focussed on 'Care of Elderly Trafford Residents in NHS Hospitals' i.e Dignity in Care agenda. It was linked to the corporate priority of positive Health and Wellbeing. Members were explicit that this piece of work should be undertaken with no limitations on when it should report to the Executive owing to timescales for planned visits. The first stage of the review took place during 2012/13 with a review of Hospital practices for discharge, medication/pain relief, nutrition and hydration, hospital associated infections, nursing quality and complaints procedures with a visit to Wythenshawe Hospital. Evidence was also taken from a sample of in-patients.

Stage 2 of the review which will progress through 2013/14 features two visits to Trafford General Hospital and Salford Royal Hospital. To understand the views of residents, Topic Group Members have invited and received evidence from citizens on the quality of their care at the three hospitals which are the focus of this piece of work. The combined final report will make recommendations to NHS Trusts which will be shared with the Executive on compliance with dignity practices. My thanks to all the members of Topic group C and the assigned officer for their extensive input during Stage 1.

Councillor Dylan Butt, Chairman of Topic Group C

Topic Group D: Review of Personalisation



Councillors from top left to top right – John Holden, Jane Brophy and Judith Lloyd.

The Topic Group has been tasked to look at the implementation of Personalised Budgets as they affect social care within the borough.

Members of the Topic Group have visited LMCP Care Link, Trafford Centre for Independent Living and Away Days in order to speak with service users and providers in order to understand their experience of the personalisation process.

The next stage of the review is to visit a home care service and, amongst other issues, to explore the process of applying for Personal Budget. A final look at the way individuals experience the use of their budgets in various care environments is under way and a first report is expected in August.

Cllr John Holden, Chairman of Topic Group D

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TRAFFORD COUNCIL

Report to: Health Scrutiny Committee
Date: 12 September 2013
Report for: Decision
Report of: Democratic Services Officer, Helen Mitchell

OUTCOMES OF THE HEALTH SCRUTINY ENGAGEMENT EVENT

Summary

Members of the Health Scrutiny Committee along with colleagues and Councillors from the Health and Wellbeing Board, Clinical Commissioning Group, Healthwatch, Trafford Council and the Care Quality Commission met on 11th April to outline their roles and responsibilities and shared ideas in relation to working together to improve health outcomes.

This report documents the themes which emerged from the session and recommendations for change. These recommendations aim to enhance partnership working and subsequently support the achievement of positive outcomes for Trafford residents.

Recommendation(s)

1. **To note the report and the supplementary report provided by NHS England;**

2. **To agree the recommendations contained within -**

Recommendation 1: That partners explore the use of shared work programmes where appropriate and share their own work programmes widely in order to avoid duplication, share information and maximise resources.

Recommendation 2: That formal dialogue between the Health Scrutiny Committee and the Health and Wellbeing Board be established to ensure that relevant and timely information is shared.

Recommendation 3: That partners commit to encouraging open discussion and eliminate the use of jargon. This is in addition to using case studies more often and to value the contribution of partners and residents in order to enhance understanding and local health services.

Recommendation 4: That a workshop in relation to Integrated Care be organised to establish the current status of this programme of work and future developments.

Recommendation 5: That partners commit to exploring all reasonable ways in which to achieve maximum value from staff, buildings and services whether it be through changing operating models, the shared use of buildings or other practices.

Recommendation 6: That efforts be made to raise the profile of success stories relating to health and social care to demonstrate the good work undertaken by partners.

Contact person for access to background papers and further information:
Name: Helen Mitchell
Extension: 1229
Background Papers: None

Background Information

As a result of the significant changes to the health landscape locally, it was agreed by the HOSC and the CCG, to organise an event to establish the roles and responsibilities of partners within the new health landscape and to come to a shared understanding of how they should work together.

Members of the Health Scrutiny Committee along with colleagues and Councillors from the Health and Wellbeing Board, Clinical Commissioning Group, Healthwatch, Trafford Council and the Care Quality Commission (CQC) met on 11th April to discuss this.

The event was introduced and facilitated by Linn Phipps, North West regional advocate for Health Scrutiny from the Centre for Public Scrutiny.

Presentations:

Each of the organisations and Committees represented had the opportunity to present their roles and responsibilities, vision for the future as well as opportunities and challenges that they face in the coming months and years. It provided a very introductory opportunity to establish 'who does what and how'.

Roundtable Discussions:

The discussions addressed the following questions -

'What role do we play collectively in the new health landscape and how can we add individual value?'

'*How can we work together to overcome challenges?*'

Key Issues Raised

- Avoid duplication
- Encourage the establishment and development of strong, trusting working relationships
- Share information more effectively
- Mutual appreciation for the roles and responsibilities of partners
- Shared vision and values
- More use of case studies to enhance understanding
- Encourage open discussion
- No more jargon
- Enhanced understanding of Integrated Care
- Removing physical and operational barriers
- Celebrate success

Conclusions Drawn and Recommendations

With this in mind, it may be helpful to establish an appropriate mechanism in which partners share their annual work programmes with one another in order to **avoid duplication of effort and share relevant information.** As a result of this, similar programmes of work can be identified and partners will have the opportunity to work

together. This would result in the development and enhancement of working relationships.

'We all need to work together so that the Joint Health and Wellbeing Strategy is achieved.'
Councillor Dr Karen Barclay, Chairman of Trafford Health and Wellbeing Board

Partners noted that there was a need to **value the unique contributions of all our stakeholders** including our residents and to encourage **open discussion** in order to clarify understanding and seek the views of others. In order for this to happen, **strong and trusting working relationships** need to be both established and developed with the 'key players' within the new health landscape.

The use of **personal stories/case studies** to enhance learning was also raised and that steps should be taken to **tackle the use of jargon** when discussing health services.

'We don't want to be seen as an add on, we want to be seen to be adding value'.
Councillor Judith Lloyd, Chairman of Trafford HOSC

'GP Member opinion is good, we need that vitality in there.'
Dr Nigel Guest, Trafford CCG

'We need to know what people's experiences are – it's not about numbers anymore.'
Ann Day, Chairman of Healthwatch Trafford

Integrated Care was referred to on a number of occasions at the event, specifically in relation to what it means on a practical level to the public. It was suggested that a workshop should be organised to enable partners to understand its implications on patients.

Discussion took place on taking necessary and appropriate steps in order to achieve the best outcomes for our residents. One table noted that the **shared use of buildings** was an important step forward in order to remove organisational barriers and a further table made reference to **innovative use of operating models** for health and social care. It was also highlighted that partners need to **recognise and celebrate successes** as well as deal effectively where improvements need to be made.

'Our good providers don't make the news which is a shame.'
Emma Popay, Care Quality Commission

As a result of the discussions, the following recommendations have emerged -

Recommendation 1: That partners explore the use of shared work programmes where appropriate and share their own work programmes widely in order to avoid duplication, share information and work towards the achievement of strong working relationships.

Recommendation 2: That formal dialogue between the Health Scrutiny Committee and the Health and Wellbeing Board be established to ensure that relevant and timely information is shared.

Recommendation 3: That partners commit to encouraging open discussion and eliminate the use of jargon. This is in addition to using case studies more often and to value the contribution of partners and residents in order to enhance understanding and local health services.

Recommendation 4: That a workshop in relation to Integrated Care be organised to establish the current status of this programme of work and future developments.

Recommendation 5: That partners commit to exploring all reasonable ways in which to achieve maximum value from staff, buildings and services whether it be through changing operating models, the shared use of buildings or other practices.

Recommendation 6: That efforts be made to raise the profile of success stories relating to health and social care to demonstrate the good work undertaken by partners.

Event Feedback

Feedback received was very positive overall, with attendees welcoming the opportunity to network and to gain a basic understanding of who does what in the new landscape. A small number of comments related to the presentations being overlong and too detailed which negatively impacted on the opportunity for questions. Further comments were received in relation to the lack of a microphone and challenges associated with parking arrangements, the timing of the meeting and the location of the room within the Town Hall. If any future events are organised, these comments will be considered and acted upon

Manchester City Council
Report for Resolution

Report to: Health and Wellbeing Board – 8th May 2013

Subject: Putting Patients First – NHS England Priorities for 2013-14 & 2014-15

Report of: Warren Heppolette - NHS England

Summary
This report provides detail of NHS England's operating model, explaining how the mandate from the government will be delivered and how outcomes for people will be improved. It clarifies within that the specific objectives and ambitions to be delivered through the Greater Manchester Area Team.

NHS England has set out an 11-point scorecard reflecting core priorities, against which we will measure our performance and within which two measures take precedence – firstly, direct feedback from patients and their families and secondly getting direct feedback from NHS staff.

Recommendations

Wards Affected:

Contact Officers:

Name: Warren Heppolette
Position: Director of Operations & Delivery
Telephone: 0161 625 7913
E-mail: warrenheppolette@nhs.net

Background documents (available for public inspection):

http://www.england.nhs.uk/everyonecounts/
http://www.england.nhs.uk/pp-1314-1516/

Putting Patients First – NHS England Priorities for 2013-14 & 2014-15

1.0 Introduction

A New Health & Social Care System for England

The new health and care system became fully operational from 1 April to deliver the ambitions set out in the Health and Social Care Act. NHS England, Public Health England, the NHS Trust Development Authority and Health Education England will take on their full range of responsibilities.

Locally, clinical commissioning groups – made up of doctors, nurses and other professionals – will buy services for patients, while local councils formally take on their new roles in promoting public health. Health and wellbeing boards will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities.

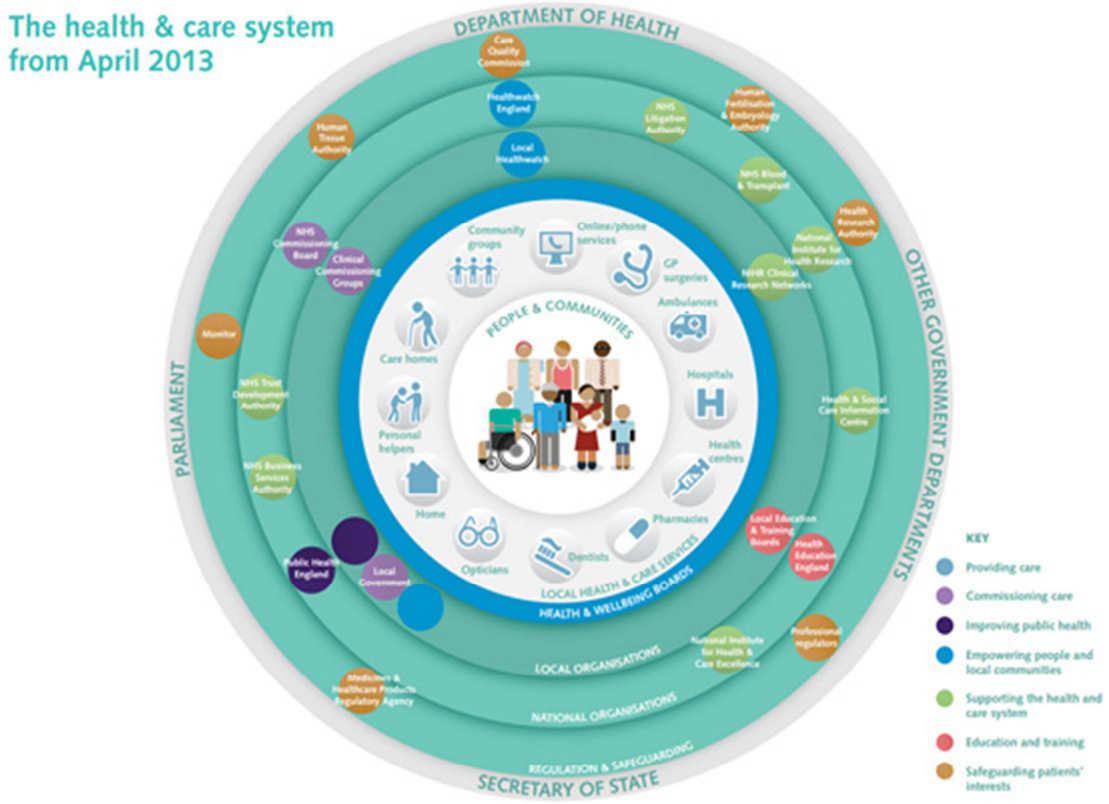
These changes will have an effect on who makes decisions about NHS services, how these services are commissioned, and the way money is spent.

Some organisations such as primary care trusts (PCTs) and strategic health authorities (SHAs) have been abolished, and other new organisations such as clinical commissioning groups (CCGs have taken their place.

A new regulator, Monitor is established to protect and promote the interests of NHS service users. The NHS Trust Development Authority will support the work to ensure that the vast majority of hospitals and other NHS Trusts will become foundation trusts by 2014.

In addition, local authorities will take on a bigger role, assuming responsibility for budgets for public health. Health and wellbeing boards will have duties to encourage integrated working between commissioners of services across health, social care, public health and children's services involving democratically elected representatives of local people. Local authorities are expected to work more closely with other health and care providers, community groups and agencies, using their knowledge of local communities to tackle challenges such as smoking, alcohol and drug misuse and obesity.

However, none of these changes will affect how people access NHS services in England. The way patients book a GP appointment, get a prescription, or are referred to a specialist will not change. Healthcare will remain free at the point of use, funded from taxation, and based on need and not the ability to pay.



Purpose of the Report

1.1 This report provides detail of NHS England's operating model, explaining how the mandate from the government will be delivered and how outcomes for people will be improved. It clarifies within that the specific objectives and ambitions to be delivered through the Greater Manchester Area Team.

1.2 The year 2013/14 is a critical one for the NHS. The only acceptable legacy of the Francis report is that the NHS changes as a result of its findings. The Department of Health has published the response to the Francis report, and we will play our full part in delivering the actions described in it. We will put patient care at the centre of all we do through our focus on patient satisfaction and outcomes. The healthcare system is also facing the challenge of significant and enduring financial pressures. People's need for services will continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services within the resources available. In underpinning the move to a new system, where quality is at the heart of everything we do, we have a set of clear core priorities. We will measure progress against these to produce an 11-point NHS England Scorecard:

Priority	Description	Scorecard measurement
1 – Satisfied patients	**Establishing the Friends & Family test for patients, updated and published monthly**	**Net score of positive versus negative feedback (scale -100/+100)**
2 – Motivated, positive NHS staff	**Establishing the Friends & Family test for NHS staff, updated and published monthly**	**Net score of positive versus negative feedback (scale -100/+100)**
3 – Outcomes Framework – Domain 1	Preventing people from dying prematurely.	Progress against Improvement areas 1.1 – 1.7 of the Outcomes Framework
4 – Outcomes Framework - Domain 2	Enhancing quality of life for people with long term conditions.	Progress against Improvement areas 2.1 – 2.6
5 – Outcomes Framework – Domain 3	Helping people to recover from episodes of ill health or following injury.	Progress against Improvement areas 3.1 – 3.6
6 – Outcomes Framework – Domain 4	Ensuring that people have a positive experience of care.	Progress against Improvement areas 4.1 – 4.9
7 – Outcomes Framework – Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm.	Progress against Improvement areas 5.1 – 5.6
8 – Promoting equality and reducing inequalities in health outcomes	Promoting equality and inclusion through NHS services. Highlighting and reducing inequalities in health outcomes across all Outcome domains. This will include parity of esteem for people with mental health issues.	Progress in reducing identified health inequalities on all indicators for which data are available
9 – NHS Constitution rights and pledges, including delivery of key service standards	Direct commissioning and support and assurance of CCG processes will ensure continued delivery of the NHS Constitution rights and pledges. Carrying out work to embed the NHS Constitution in everything we do.	The proportion of people for whom NHS England meets NHS Constitution standards
10 – Becoming an excellent organisation	Ensuring the staff of NHS England understand their roles, are properly supported and are well motivated. Seeking comprehensive 360 degree feedback from local and national partners.	Staff survey results 360 degree feedback
11 – High quality financial management	Living within our means whilst delivering our priorities.	Actual spend versus budget

2.0 NHS England Eight Key Activities

2.1 Having set out the 11 scorecard priorities by which people can judge our overall progress, this section explains the means through which NHS England will go about achieving them. NHS England does of course have a more detailed set of requirements with this government set out in its Mandate. These are captured in Annex 2 of the business plan as part of our public accountability. NHS England will deliver better outcomes for patients in eight ways:

- Supporting, developing and assuring the commissioning system;
- Direct commissioning;
- Emergency preparedness;
- Partnership for quality;
- Strategy, research and innovation for outcomes and growth;

- Clinical and professional leadership;
- World class customer service: information, transparency and participation; and
- Developing commissioning support.

2.2 Through these eight core work areas we will lead the commissioning system in shaping the climate for success. We will deliver on the ground as commissioners ourselves and we will help develop the entire commissioning system to be in the best possible position to make a difference to the people of England. Through matrix working, every member of staff working for NHS England will be contributing to at least one of these areas in their roles.

2.3 The Area Team will be the local representation of NHS England in delivering the 11 priorities through the eight components of the Operating Model.

2.3 Supporting, developing and assuring the commissioning system

2.3.1 High quality, clinically-led commissioning will be a mainstay of the new healthcare system. Commissioning will focus on issues that matter locally, underpinned by robust public and patient involvement. We will stand alongside CCGs as commissioners of healthcare services, and provide the leadership and support to help them to become excellent commissioners.

2.3.2 CCGs are new organisations and we will continue to support their development as they move through authorisation and beyond. The authorisation process provided an assessment of how each CCG is developing against a set of core commissioning competencies, with Greater Manchester's CCGs performing strongly throughout this process. The results of this will shape the support and development we provide for CCGs. During 2013/14 we will:

- Identify development needs for all CCGs, and establish development programmes from support organisations;
- Establish a maturity model for CCGs, and assessment criteria to monitor progress;
- Establish network arrangements to meet CCG needs for adoption and spread of best practice;
- Establish a programme for collaborative commissioning between CCGs with area teams, local authorities and Public Health England; and
- Support CCGs to deliver the plans that they have developed with local communities.

Greater Manchester Area Team Key Priority 1

Supporting Excellent Clinical Commissioning Groups

2.3.3 The Area Team is clear that one of the principal markers of its success is the degree to which Greater Manchester benefits from 12 highly successful autonomous CCGs. Our shared ambitions in relation to improvements in each of the domains of the NHS Outcomes Framework, our intentions to uphold the NHS Constitutional rights of Greater Manchester's communities and the maintenance of stable and sustainable health and care services will primarily be delivered through the endeavours of the CCGs. Our relationship with CCGs will be one which prioritises and supports improvements in commissioning capability and acknowledges those areas where we stand side by side as co-commissioners with local authorities and other partners.

Greater Manchester Area Team Key Priority 2

2.3.4 As a direct commissioner of services, the Area Team will work in partnership with CCGs and other local commissioners to ensure alignment and integration of their strategy. In carrying out this support and assurance role, we will establish mutual accountability between ourselves and local commissioners, and we will measure our success by the way that we are able to support CCGs to achieve their objectives. Through NHS clinical commissioners, we will seek and publish 360 degree feedback from CCGs and other key stakeholders on how we are promoting autonomy in local organisations, and how effectively NHS England is building relationships.

Choice & Competition

2.3.5 Choice and competition can be an important lever for commissioners to improve the quality and efficiency of services. Choice can help ensure people get services that best meet their needs, and competition can be an important lever for driving up quality and innovation. Competition is not an end in itself and will only be used as a means of improving outcomes. At the national level we are working in partnership with Monitor, the independent regulator of NHS foundation trusts, and with CCG and provider representatives to develop a Choice and Competition Framework. The Framework will offer practical tools, guidance and evidence so that commissioners and providers are able to deliver improved outcomes for people through more effective use of choice and competition.

Resources Tools & Guidance

2.3.6 During 2013/14 NHS England will work with the Commissioning Assembly and other key stakeholders to design the standard contract. The contract will be issued alongside our planning guidance in December 2013, ready for commissioners to use in the 2014/15 financial year. We have established the Quality Premium for 2013/14. The Area Team will continue to work with CCGs

and other partners, including local clinicians and patients, to ensure that the Quality Premium for 2014/15 continues to reward improvements in quality, outcomes and inequalities in a range of national and local measures. In 2014/15 the quality premium will include a measure for mental health outcomes.

Key deliverables: supporting, developing and assuring the commissioning system	Timelines
80% of outcomes improvements identified in CCG plans delivered	April 2014
Overall positive CCG satisfaction with NHS England development support	Annual survey
Choice and competition framework (and supporting documents) published	July 2013
Overall positive CCG satisfaction with resources, tools and guidance provided by NHS England	Annual survey

2.4 Direct commissioning

2.4.1 NHS England is responsible for directly commissioning £25.4bn of healthcare services including primary care, specialised services, secondary care dental services, some public health services, offender health and armed forces health. These services will be commissioned by the 27 area teams of NHS England.

2.4.2 Much of our early focus will be on embedding a number of single operating models for how we will carry out our direct commissioning responsibilities. These operating models will seek to address inequalities in access and outcomes, to take account of unmet need for access to high quality services right across the country and to allow us quickly to apply learning and best practice to different geographical areas. At the same time, we will focus on patient safety, giving clear guidance on how to commission a safer service, manage serious incidents and use safety reviews to support commissioning for improvement.

2.4.3 Where services we commission directly need to join up with locally commissioned services, the Area Team will co-ordinate with CCGs and other partners, to ensure people experience a seamless and integrated service.

Primary care

2.4.4 Primary care has a key role to play in improving health outcomes and reducing health inequalities. We know that good primary care has a positive impact across the whole of the health and social care system. Evidence shows that strong and effective

primary care services are vital for health economies and for delivering high quality, best value health services and healthy populations.

2.4.5 As a single commissioner of primary care services, we have the unique opportunity to redefine the role of primary care in an effective healthcare system and to take steps to address inequalities of access to primary care services, whilst improving the quality of care and outcomes for patients across the country. We aim to do this by:

- Developing and reviewing contract levers to ensure that maximum benefits are achieved through rewarding quality services and better outcomes for patients;
- Managing the smooth transition from Primary Care Trust (PCT) commissioning to NHS CB area teams. The single operating model we will develop will include developing a single approach for effective performance management of primary care;
- Improving the skills of practitioners in primary care through the development of robust workforce planning;
- Developing and maintaining mechanisms to enable revalidation of GPs, ensuring that skills are up to date and clinical standards remain high; and
- Timely, equitable access to primary care services in and out of hours.

2.4.6 Some patients find it more convenient to access GP services away from home. We will evaluate the results of the GP choice pilots and consider how we can apply successes more widely. We will move towards a more equitable system of GP practice funding to support patient choice. We will continue to support and incentivise practices to offer greater access to services through digital means.

Greater Manchester Area Team Key Priority 3

Primary Care and Healthier Together

2.4.7 The Area Team in Greater Manchester is ensuring its direct commissioning responsibilities are undertaken and developed in line with our wider ambitions through the Healthier Together programme of health and care reform for Greater Manchester. To support the development of integrated care strategies and delivery plans across Greater Manchester, work is ongoing to develop further the vision for Primary Care which includes General Practice, Dental, Pharmacy and Optometry. To support this process, the characteristics of a high performing, high quality primary care system have been identified, along with some of the desired outcomes and potential ideas for how these could be achieved.

2.4.8 The developmental objectives for Primary Care are as follows:

- Support the delivery of enhanced integrated care across Greater Manchester to deliver improved outcomes for the whole population

- The systematic and proactive management of chronic disease as a tool to improve health outcomes, reduce inappropriate use of hospitals and positively impact on health inequalities
- Ensuring a focus on key patient groups, including 0-5s, Frail Elderly and those nearing the end of life
- Reduce unnecessary hospital attendances and admissions
- Engagement and empowerment of patients
- Population-based approach to commissioning - directing resources to the patients with greatest need and redressing the 'inverse care law' by which those who need the most care often receive the least.

2.4.9 The table below provides a draft suite of characteristics of a high performing primary care system, together with thematic areas for outcomes . Once the review process is completed and the characteristics are agreed, more definitive work will be done to develop the outcome metrics. The characteristics have been split into themes, i.e. what we are seeking to achieve and enablers, ie the means by which we will secure achievement.

Themes	**Potential Outcomes**
Patients are involved in the design of the primary care system and as partners in the management of their own conditions and health needs	Improved Health Outcomes Improved Patient Experience Reduction in hospital admissions
Integration between primary, social and community care forming part of an overall approach to pathway based commissioning	Reduced admissions to secondary care Reduced hospital lengths of stay Reduced readmissions to hospital Increased measures of patient independence
Long term conditions are effectively managed in primary care with interfaces with secondary care clearly defined and managed	Improved health outcomes Reduced admissions to hospital leading to improved patient experience Reduction in cost
A systematic approach to primary prevention is implemented, eg with regard to alcohol, smoking, exercise	Reduction in numbers of smokers and problem drinkers, reducing costs and improving health A healthier population, more able to play a full role in society
Secondary prevention interventions are defined and in place, eg via the effective use of disease registers, taking measures to reduce high blood pressure, prescription of statins	Improved life expectancy, reduced complications Reduced costs over the medium term

Effective management of those patients with mental health needs	Improved patient experience Improved health outcomes Reduced costs
Effective arrangements for primary care management of end of life care	Improved patient and carer experience Potential to improve quality of care Improved ability to respond to patient preferences
Effective medicines management	Improvements in the quality and safety of prescribing Improved patient experience and health outcomes Reduced costs
Managing elective and urgent care activity	Improved outcomes, (where late referral issues are addressed) Reduction in unnecessary hospital attendances and admissions Improved quality of clinical care Improved patient experience Improved cost effectiveness

2.4.10 The Healthier Together Strategic Direction Case sets out a 10 point plan for the development of primary care which is reproduced below:

i. Clear primary care commissioning plan for 2013/14.

ii. Review of primary care “discretionary” spend to ensure maximum health gain for the population and appropriate system incentivisation.

iii. Transfer of resource from secondary to primary care to deliver enhanced management of long term conditions. This may require initial pump priming to ensure accelerated pace of change.

iv. Explore opportunities for increased working across practices.

v. Provision of support for GPs to help improve health literacy of the population and increase prevention.

vi. Investment in local technological solutions to improve sharing information between care professionals as well as enable patients to access their own records.

vii. Development of clear patient pathways and access points across Greater Manchester.

viii. Additional support where required for CCGs to plan and implement effective integrated care strategies for their local population.

ix. Implement a standardised enhanced role for primary care nursing and create an investment programme to maximize the currently varied and underutilised workforce.

x. Support to increase the amount of training placements for GPs across Greater Manchester.

Specialised services

2.4.11 Specialised services are those services, often provided in relatively few hospitals, accessed by comparatively small numbers of patients, but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Examples include long-term conditions such as renal dialysis, complex interventions such as liver transplants, rare cancers and secure forensic services.

Greater Manchester Area Team Key Priority 4

Greater Manchester's Specialised Services

2.4.12 the Area Team will support the creation of a consistent, robust and evidence-based approach to the way these services are commissioned across the country, regardless of where the services are provided. Nationally NHS England will also establish a specialised services innovation fund to support innovative practice locally. The move to a more consistent approach to specialist service delivery will clearly identify those providers which are operating outwith the standards defined in the national specifications. This will provide important information relating to the configuration of specialist and related or dependent services and it will be important for Greater Manchester to support a clear alignment with the acute service priorities of the Healthier Together programme.

2.4.13 National service-specific clinical reference groups have supported the development of five national programmes of care through wide and expert engagement across clinical and patient stakeholders. Improved patient outcomes will be delivered through quality standards incorporated into the new contracts.

2.4.14 NHS England will develop outcome measures for all specialised services in line with the Outcomes Framework. This will build on previous work to develop and implement outcome measures, for example, the current measures of survival rates in rare

cancers, survival post-transplant in transplant services and the percentage of patients with severe intestinal failure who are discharged home without any need for tube feeding, and the percentage patients with psychosis who can be discharged back to primary care after NICE recommended treatment.

2.4.15 The Cheshire Wirral and Warrington Area Team acts as the lead commissioner for specialised services for the North West. The Greater Manchester Area Team is working across the NW to establish appropriate governance arrangements, which must include engagement with CCGs to ensure a full pathway, total provider approach is taken in relation to the oversight of specialist services.

Public health

2.4.15 Public health is about helping people to stay healthy, changing lifestyle behaviours and preventing disease. Campaigns and interventions are used to promote healthy choices, while disease prevention helps people to avoid getting ill and enables early diagnosis through screening. Public Health encompasses a wide range of services such as immunisation, nutrition, tobacco and alcohol, drugs recovery, sexual health, pregnancy and children's health.

2.4.16 In the main, these services will be commissioned by Public Health England (PHE). NHS England at both national and Area Team levels will work in partnership with PHE so that we mutually support our common goals of improving health outcomes and promoting equality of access. The NHS Act 2006, Section 7a, sets out the important role we have in relation to the commissioning of screening and immunisation services, health intervention services for children aged 0-5 years and sexual assault services.

2.4.17 The 0-5 years programme in particular demonstrates the value of delivering public health programmes in partnership with other statutory agencies that have a responsibility and budget, in this case for the commissioning of children's services. The programme will strengthen the co-ordination of the link between needs assessment and strategy and provide a clear line of sight from the commissioning process through to the delivery of services. The 0-5 years programme includes the continued expansion of numbers of health visitors and family nurse practitioners (FNPs).

2.4.18 Screening programmes will be extended during 2013/14 for bowel cancer, breast screening and Human Papilloma Virus triage in cervical screening. New vaccines will be introduced for rotavirus in infants and for shingles in the elderly, reducing the incidence of painful and unpleasant conditions for sufferers whilst simultaneously reducing the burden on urgent care services.

Greater Manchester Area Team Key Priority 5

Public Health Partnerships

The Area Team will secure positive partnerships with local government partners and Public Health England to develop and deliver against our highest ambitions for public health improvement. This will prioritise improvements in screening and immunisation rates and address areas of variation in both offer and uptake.

Dental health

2.4.19 NHS England will be responsible for commissioning all NHS dental care; across the hospital (secondary), community (e.g. care for people with special needs), and primary dental care settings, and managing some 10,000 contracts with 'high-street' dental practices. Our aim is to deliver excellence in commissioning NHS dental services including improvements in quality and patient satisfaction, and reductions in inequalities of access and outcomes.

Offender health

2.4.20 With commissioning of offender health services, NHS England will be responsible for planning, securing and monitoring an agreed set of services for prisons, young offenders Institutions (YOIs), immigration removal centres, secure training centres, police custody suites, court liaison and diversion services and sexual assault services. In 2013/14, our focus will be to align the justice commissioning intentions with those of the NHS England offender teams and local partnerships, particularly for children and young people.

Armed forces health

2.4.21 NHS England will focus on developing core requirements in new contracts and delivering on a number of commitments such as increasing and improving access to mental health services for serving personnel and veterans, as well as improving prosthetic care for veterans.

Key deliverables: Direct commissioning	Timelines
All area teams will have contracts in place with providers that reflect the requirements of the single operating model for specialised services	June 2013
80% of all commissioning intentions implemented in full	April 2014
All area teams will implement primary care quality assurance for all four contractor services	From April 2013

2.5 Emergency preparedness

2.5.1 The NHS needs to be able to plan for, and respond to, a wide range of incidents and emergencies that could have an impact on health or patient care. These incidents could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. They often require a co-ordinated response at national and local level. The development of the capability and capacity to provide this response is a central element of NHS England's role in safeguarding the public.

Greater Manchester Area Team Key Priority 6

Local Health Resilience Partnership

2.5.2 In 2013/14, NHS England will implement new arrangements for effectively handling these incidents and emergencies, ensuring safe transition from existing organisations. In support of these arrangements the Area Team will lead, along with the nominated lead Director of Public Health, the Greater Manchester Local Health Resilience Partnerships (LHRP). The LHRP, which brings together the Area Team with other local partners, will provide on-going surveillance and a co-ordinated multi-agency response, where necessary.

Key deliverables: Emergency Preparedness	Timelines
Conduct further exercises in each of the NHS England regions to ensure incident response plans and reporting arrangements are aligned with key partner agencies and implement findings	December 2013
Publish updated NHS Pandemic Influenza Guidance in preparation for the Cross Government Pandemic Influenza Exercise (September 2014)	October 2013

2.6 Partnership for quality

2.6.1 Improvements in health and care are linked and the NHS and its public, private and voluntary sector partners can only provide the best and most effective service for patients and public when we work together to achieve their objectives.

Francis and Winterbourne View reports

2.6.2 The Francis and Winterbourne View reports described major failings in the delivery of care. In December 2012 the Department of Health published *"Transforming Care: A national response to Winterbourne View Hospital"*. The report laid out clear, timetabled actions for health and local authority commissioners working together to transform care and provide support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. The report outlined our shared objective to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting

their needs, and working together to commission the range of services and support which will enable them to lead safe and fulfilling lives in their communities.

2.6.3 The Francis report on events at the Mid Staffordshire Foundation Trust made 290 recommendations, but its single, overarching theme is clear: that a fundamental culture change is needed in the NHS to put people first. Robert Francis highlighted five themes when he presented his report. These were:

- A structure of fundamental standards and measures of compliance
- Openness, transparency and candour throughout the system underpinned by statute
- Improved support for caring, compassionate, and considerate nursing
- Stronger healthcare leadership
- Accurate, useful and relevant information

Greater Manchester Area Team Key Priority 7

Quality Surveillance Groups and the National Quality Board

2.6.4 In 2013/14, the Area Team will work with partners to develop our Quality Surveillance Group. We will review all of the existing agreements, in the light of organisational developments and, following the recommendations of the Francis report, we will ensure that we remain focused on the right priorities. We will support board to board meetings to set the strategic direction for these relationships.

Greater Manchester Area Team Key Priority 8

Safeguarding

2.6.5 The accountability and assurance framework sets out clearly the responsibilities of each of the key players for safeguarding in the future NHS. The framework has been developed in partnership with colleagues from the Department of Health (DH), the Department for Education (DfE) and the wider NHS and social care system. The Area Team Director of Nursing is responsible for supporting and providing assurance on the safeguarding of children and adults at risk of abuse or neglect.

2.6.6 The Area Team will work with CCGs to support them to fulfil and excel in their safeguarding role. We will implement the national safeguarding IT infrastructure and mobilise the professional support required to realise the benefits.

Partnership working

2.6.7 NHS England will work alongside other organisations at national and local level to achieve our goals of improving outcomes and reducing inequalities, meeting the requirements of the Mandate and achieving our financial obligations and statutory duties. This includes working alongside partners to jointly commission integrated health and social care packages for people.

2.6.8 NHS England developed a concordat with the Local Government Association (LGA). because of the unique nature of the relationship between health and local government. The local dimension of this partnership will be particularly important and will build on the relationship developed between AGMA and the PCT Cluster to ensure there is no interruption to either the focus or pace of our ambitions around public service reform. We will continue to work closely with AGMA and through the Greater Manchester and the local health and wellbeing boards to ensure joined up commissioning and services. The three priorities are:

- Facilitating shared system leadership through Health and Wellbeing Boards;
- Supporting local mechanisms for joint planning of services ;
- Creating sector led improvement, public service reform and innovation.

2.6.9 NHS England has a shared interest in improving outcomes with national organisations, including the National Institute for Health & Clinical Excellence (NICE), the Care Quality Commission (CQC), the NHS Trust Development Agency (NTDA), Monitor, Health Education England (HEE), and Public Health England (PHE). We have partnership agreements with each of these organisations that will formalise the way we work with them on shared priorities and objectives.

Integrated care and support

2.6.10 Care is at its best when it is centred round the needs, convenience and choices of people and their families and carers. Many individuals have multiple needs, and these often span organisational boundaries. Their experience should be of care and support services that are as seamless as possible.

Greater Manchester Area Team Key Priority 9

2.6.11 Through Health and Wellbeing Boards, we will work with local commissioning partners to develop plans for integrated care in line with the requirements set out in *Everyone Counts* and implement plans for integration in each health and wellbeing area by April 2014.

2.6.12 As a system leader we are tasked in our Mandate from the government to promote integration and seek to remove barriers to it. NHS England is developing with partners a Common Purpose Framework, which will be published in May 2013. This

will set out how we will promote, enable and encourage better integrated care and support across health and social care, including primary and secondary care, mental and physical health, and adult and children's services. Our aim is for person-centred and co-ordinated care and support to become the norm for everyone. In Greater Manchester we would recognise the work taking place through the Healthier Together programme and the priority afforded by NHS Trusts, CCGs and local authorities to a significant scale of ambition around integrated care positions us at the vanguard of national work on health & social care reform. The Area Team is keen, therefore, for Greater Manchester to respond to Ministers' proposals to identify 'pioneers' from examples of integrated care across the country, with the, with the emphasis on identifying and spreading learning for wider, rapid adoption.

Greater Manchester Area Team Key Priority 10

Health & Social Care Reform in Greater Manchester

2.6.13 The Healthier Together programme is part of a wider review of Health and Social care and public service reform in Greater Manchester aimed at saving and improving thousands of lives every year. Our vision is "For Greater Manchester to have the best health and care in the country". The programme will be led by the Greater Manchester CCGs acting together in the context of the ambitions they share with each other and with local partners. The Area Team is fully committed to supporting this programme on behalf of NHS England, as a member of each of the local Health & Wellbeing Boards and as a co-commissioner.

2.6.14 Such leadership requires a recognition that the future health and social care system will look substantially different and that improved quality of health care for Greater Manchester residents will underpin the following key principles of a new system:

- People can expect services to support them to retain their independence and be in control of their lives, recognising the importance of family and community in supporting health and well being;
- People should expect improved access to GP and other primary care services
- Where people need services provided in their home by a number of different agencies they should expect them to planned and delivered in a more joined up way.
- When people need hospital services they should expect to receive outcomes delivered in accordance with best practice standards with quality and safety paramount – the right staff, doing the right things, at the right time.
- Where possible we will bring more services closer to home (for example there are models of Christie led Cancer services delivered from local hospitals)
- For a relatively small number of patients (for example those requiring specialist surgery) better outcomes depend on having a smaller number of bigger services.

- Planning such services will take account of the sustainable transport needs of patients and carers.
- This may change what services are provided in some local hospitals, but no hospital sites will close.

2.6.15 This is a complex ambition. It requires the positive confluence of a number of potentially separate programmes of work;

- Local Authorities working with CCGs, Hospitals and the NHS England to develop models of integrated health and social care
- The work of CCGs and the NHS England in improving the consistency, reliability and accessibility of primary care services
- The work of local acute trusts to develop new models of out of hospital care – consultant geriatricians working as part of local teams for example
- The outcome of a clinically led redesign of some hospital services best planned on a GM footprint for reasons of clinical critical mass, in order to drive further improvement in outcomes from acute care.

2.6.16 Currently there are good models of integrated care in place in many parts of Greater Manchester, but rarely are they at the scale required to effect a significant transfer of resource into prevention of avoidable admissions to hospital and other care institutions. New models of contracting and reimbursement are required, to deliver models targeting not 1% or 5% but at least 20% of the cohort of the risk stratified population. New models of integrated care seeking to reduce avoidable admissions to hospitals and other care institutions will contribute to a changing role for local hospitals. Hospitals are crucially important partners in seeking to develop these new models and most recognise their quality and financial interest in seeing these new models of 'out of hospital care' develop.

2.6.17 Each local authority is working with partners to develop their Local Implementation Plan for integrated care by summer 2013. The Area Team will certainly work with all localities to ensure its direct commissioning responsibilities support an effective alignment with the Health & Wellbeing Board ambitions.

Key deliverables: partnership for quality	Timelines
Delivery of 100% of actions set out in the Winterbourne View concordat and Francis response	June 2014
Integrated care proposals implemented in every health and wellbeing board Area	By April 2014
Quality Surveillance Groups operational in every region and area team	From April 2013
Ensure that there is a capable system of safeguarding that is resilient to the transition and linked to quality assurance	From April 2013

2.7 Strategy, research and innovation for outcomes and growth

2.7.1 In order to deliver our core objectives, it is essential that we develop a strategy for sustained, long-term, service improvement to ensure that the NHS continues to deliver for everyone, whatever their background, against the backdrop of low financial growth and rising demand for healthcare service. We will place much greater emphasis on innovation in healthcare by providing the space and support for local systems to adopt innovative practice. The key elements to our approach in 2013/14 will be:

- *A ten year strategy for the NHS* – NHS England will lead a national and local debate with service users, clinicians, the public and key partner organisations to develop a medium term strategy for the NHS. The strategy will align with the five domains of the NHS Outcomes Framework, identifying evidence-based, optimum, clinical pathways and changing services where necessary. This work will be underpinned by economic modelling to ensure we develop and deliver financially sustainable services for the future. Greater Manchester's work as part of Healthier Together will support and inform this work.

- *Service change* - Over time, the way services are delivered will evolve in line with new technology and clinical practice. NHS England will develop and oversee a framework for major service reconfiguration that will set out the roles, responsibilities and interfaces between the different organisations across the health and care system that will operate from April 2013. The Area Team will support the application of this framework to Greater Manchester's work in the Healthier Together programme.

- *Allocations* - During 2013/14 NHS England will carry out a review of the approach to resource allocation, which will inform future allocations. In particular this will be

an opportunity to consider the full breath of NHS England funding to make sure it is allocated in the best way to address inequalities and improve outcomes.

§ *Pricing* - In 2013/14, the production and dissemination of the tariff will remain a DH responsibility, with NHS England and Monitor taking joint responsibility thereafter. National work in 2013/14 is primarily focused on working with Monitor to design and set the 2014/15 tariff and formal engagement is expected to begin from June onwards. NHS England will also agree priorities for the medium-term, and as part of NHS England's longer term strategy work, to develop a long-term approach to the development of the tariff.

Greater Manchester Area Team Key Priority 11

Innovation, creation, diffusion and spread

§ *Innovation* – NHS England will deliver programmes for rapid diffusion and adoption of innovative ideas, products and services so that everyone can benefit from proven best practice, including disadvantaged groups. In 2013/14, the primary focus will be to embed *Innovation, Health and Wealth* across the new commissioning system, deliver NHS England's contribution to the UK Genomics Strategy and lead the NHS's contribution to the UK Plan for Growth.

§ *Research and Development* - NHS England has a mandate commitment to "ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, to improve patient outcomes and contribute to economic growth". To carry forward this commitment NHS England is developing a research and development strategy early in 2013/14.

§ *Academic Health and Science Networks (AHSNs)* – The Greater Manchester AHSN will develop as the local centre for innovation within the NHS. The network brings together expertise in education, research, informatics and innovation to translate research into practice in mental and physical health.

§ *Academic Health Science Centre* – The Greater Manchester Area Team will support the Manchester Academic Health Science Centre in its re-bidding for national accreditation as an Academic Health Science Centre

Key deliverables : Strategy, Research and Innovation	Timelines
NHS Publication of a long term strategy for the NHS, including a comprehensive primary care strategy	Products throughout 2013/14
Oversee the priority service reconfigurations to ensure outcomes for people are improved	Throughout 2013/14
NHS England flexible procurement programme for genomics strategy in place to sequence 100,000 genomes in UK in the next three years.	Quarter 4 2013/14
Review of NHS allocations	Interim outputs July 2013 Final outputs July 2014

2.8 Clinical and professional leadership

2.8.1 Strong and diverse clinical and professional leadership is essential for high quality commissioning. CCGs have been established to ensure that clinical leadership is at the heart of local commissioning. NHS England will work to ensure that there is the right level of clinical and professional leadership in everything we do.

2.8.2 The Medical and Nursing Director in the Area Team, working alongside clinical networks and senates, will provide clinical leadership to NHS England activities locally and regionally and to the wider commissioning system.

The NHS Nursing Strategy: Compassion in practice

2.8.3 *Compassion in Practice* sets NHS England's shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent mental and physical health and wellbeing outcomes. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution.

2.8.4 The strategy sets out six areas for action to be implemented over the next three years:

- *Staying independent, maximising wellbeing & improving outcomes*
- *Improving patient experience*
- *Delivering high quality care & measuring impact*
- *Building & strengthening leadership*
- *Right staff, right skills, right place*
- *Supporting positive staff experience*

Greater Manchester Area Team Key Priority 12
Compassion in Practice

Compassion in Practice will be embedded as part of the Greater Manchester clinical collaborative networks for safeguarding adults and children involving nursing leaders in primary, secondary and mental health care .

The 7 day services review

2.8.5 Our aim is to promote a comprehensive health service, increasing access to the right treatment and coordinating care around the needs, convenience and choices of patients, their carers and families – rather than the interests of organisations that provide care.

2.8.6 *Everyone Counts* set out plans to move towards routine services being available seven days a week. The first stage objective is to establish a forum and publish a report, in the autumn of 2013, identifying how there might be better access to routine services seven days a week. In this first phase, the review will focus on improving diagnostics and urgent and emergency care. It will include the consequences of the non-availability of clinical services across the seven day week and provide proposals for improvements.

Urgent and Emergency Care Review

2.8.7 The Urgent and Emergency Care Review aims to develop a national framework to enable clinical commissioning groups (CCGs) to commission high quality urgent and emergency care services across NHS England for April 2015. The first stage of the Review is to publish high level principles in 2013. The most serious emergencies require rapid access to highly specialised skills and equipment; however, many less serious cases can be safely treated in community settings.

Clinical senates and networks

2.8.8 Clinical senates will bring together a range of professionals to take an overview of health and healthcare for local populations and provide CCGs, health and wellbeing boards and NHS England with strategic, independent advice and leadership on how services should be designed. They will draw on a variety of health and wider care perspectives to provide the best overall care and outcomes for people, including those of professionals who sometimes go unheard.

2.8.9 NHS England will also host four Strategic Clinical Networks, these are as follows:

- Cancer
- Cardiovascular
- Maternity and children
- Mental health, dementia and neurological conditions

Leadership on health inequalities, equality and diversity

2.8.10 There are still too many longstanding and unjustifiable inequalities in access to services, quality of care, health outcomes and patient experience. It is our ambition that everyone receives excellent care, which takes account of their background, who they are and where they live.

2.8.11 During 2013/14, NHS England will re-launch the Equality Diversity Council (EDC) with a structured work programme, embedded within each of the NHS England directorates, which will support the promotion of equality and the reduction of health inequalities across society. Within this period, the Equality Diversity System (EDS) will also be refreshed to embody the values of the NHS Constitution and help NHS organisations to reduce inequalities in health. The EDS will be rolled out to the NHS to help promote equality and reduce health inequalities. It will form the basis of NHS England's equality objectives for the forthcoming business planning period, in collaboration with the NHS EDC. We have also established an Equality and Diversity Group to improve the diversity of NHS England itself.

The NHS Leadership Academy

2.8.12 The NHS Leadership Academy is a system wide body, whose vision is to be recognised as a national centre of excellence for leadership development and talent management in the NHS. Its mission is to develop outstanding leadership in health to improve the quality of services and outcomes for everyone.

NHS Improving Quality

2.8.13 NHS Improving Quality (NHS IQ) has two overarching priorities; to drive the implementation of the NHS Outcomes Framework through effective improvement programmes, and to build improvement capacity and capability across the whole of NHS England.

Key deliverables: Clinical and professional leadership	Timelines
7 day service review report published	Autumn 2013
Urgent and Emergency Care Review: high level principles published	Spring 2013
Commencement of 70% of the actions set out in 'Compassion in Practice' (our three year nursing strategy)	By April 14
Delivery of Leadership Academy core programmes to 2,000 clinical and non-clinical staff	March 2014

2.9 World class customer service: information, transparency and participation

2.9.1 NHS England is committed to transforming the way information is made available to the public and wider healthcare system. We will improve data and information availability to better support public and patient participation.

Intelligence: supporting decision making and choice throughout the service

2.9.2 Health and care data represents one of our greatest public assets and putting it to work is key to improving outcomes for all people. We will build a modern data service, through the *care.data* programme, which will provide timely, accurate data linked across the different components of the patient journey and the outcomes resulting from treatment.

Patient and public voice: putting the citizen at the heart of the NHS

2.9.3 NHS England aims to create the conditions for an equal, balanced and reciprocal relationship between citizens and the NHS. A national Civil Society Assembly will be established to encourage collective participation. NHS England will develop a coherent, linked package of shared-decision making aids so that people can actively participate with their clinicians in making choices about their care and treatment. We will make available personal health budgets for people who could benefit from them, subject to evaluation of the national pilot programme.

Patient insight, including roll out of the friends and family test

2.9.4 A deeper understanding of how users of NHS services view aspects of the care they receive is essential to make services better. National staff and patient surveys facilitate the benchmarking of services, and are particularly valuable in helping improve the experience of groups who may be socially disadvantaged.

2.9.5 As set out in the government's NHS Mandate, one specific aspect of this will be the roll out of the Friends and Family Test. This will enable staff and patient feedback to be gathered in a more responsive and granular way. The Friends and Family test information will be shared routinely through the Quality Surveillance Group.

Customer relations: Giving people control and choice when they want it

2.9.7 To be a truly patient centred service, the choice and control that the NHS offers to people in the services they receive must be maximised. We will work to make the NHS Constitution a reality, including the right for people to make fully informed decisions about how, when and where they access healthcare. This includes choice both at the point of GP referral and along the care pathway.

Strategic systems and technology: digital first

2.9.8 The Health Online Programme makes use of modern technology to transform the service offer of the NHS, empowering patients and citizens to take control and make informed choices. As part of this, people will have online access to their health records if they want it, by 2015. The 'Paperless NHS' programme includes the re-launch of Choose and Book which aims to make electronic referrals universally and easily available to patients and their health professionals for all secondary care services by 2015.

Communicating patient and public values

2.9.9 NHS England will put in place the essential communications infrastructure to support its national, regional and area teams. Commissioning Support Units will provide a joined-up communications service on behalf of NHS England's regional and area teams, so that we engage effectively with local stakeholders, public and media. We will deliver a programme of stakeholder and learning development events to share key information, motivate and engage with key audiences. As part of this, NHS England will build a website that is robust and engaging for both the public and our staff.

Key deliverables: World class customer service: information, transparency and participation	Timelines
Publish outcomes data from national clinical audits for every consultant practising in the ten surgical specialties set out in *Everyone Counts*	Summer 2013 (10 specialties), all by March 2015
Roll out of friends and family test and an increase in the % of trusts improving their score	Acute and A&E services – April 2013; Maternity – October 2013
Online primary care: 100% providing patients with a facility to order repeat prescriptions, access their records and book appointments	March 2015
Reducing inequalities: 100,000 citizens trained in basic online skills to boost health literacy	April 2014
Civil Society Assembly demonstrates over 80% satisfied with the involvement of patients and the public in the planning and commissioning of NHS services by NHS England.	Baseline 2013/14
100% of CCGs will be able to deliver personal health budgets, including direct payments, for patients receiving NHS Continuing Health Care.	April 2014

2.10 Developing commissioning support

2.10.1 Locally designed, clinically-led commissioning will be at the core of the healthcare system. Success will depend on clinicians focusing on the differing needs across their local population and able to devote time and clinical leadership to addressing those needs. This will require access to excellent and affordable commissioning support services.

2.10.2 Developing a robust market for the provision of commissioning support services should widen the skills and resources available to commissioners and create efficiency in the marketplace. NHS England will design and publish in June 2013 a strategy to develop affordable and sustainable commissioning support services, setting the standard for excellence. This strategy will also include a quality regulation framework to ensure sustainability of the market.

2.10.3 The current NHS England-hosted CSUs are likely to form a key part of this market and will be supported and developed to become commercially viable by March 2016.

2.10.4 Over the past 18 months, CCGs have been working with CSUs to define and specify their requirements. NHS England's role in hosting these organisations includes

assuring they are viable, supporting their development as well as developing a future market for commissioning support services.

2.10.5 NHS England must provide assurance that CSUs are commercially robust, and that potential commissioning and financial risks are well-managed. At the same time we need to maximise their ability to become freestanding, responsive commercial enterprises. We are developing fair, balanced frameworks for monitoring and assuring that CSUs are as effective as possible.

2.10.6 NHS England is launching a development programme to support CSUs to become effective and efficient organisations. This programme will focus on leadership development, data and information management and the procurement of potential delivery partnerships.

Key deliverables: Developing commissioning support	Timelines
Robust processes are in place to assure the performance of all CSUs (service quality and financial)	From April 2013
Final strategy for the development of commissioning support services published	November 2013
CSUs commercially viable and externalised	March 2016
Creation of a diverse and responsive commissioning support market	March 2016
Positive feedback from customers on services provided by CSUs	Twice a year

3.0 Developing NHS England

3.1 NHS England takes on its full responsibilities from April 2013, however 2013-14 will be a year of transition in a number of areas. As a new organisation there is a considerable focus for the first year on establishing and investing in its most vital resource – its people. This section sets out how we aim to achieve this.

Staffing

3.2 NHS England has eight directorates from which to draw resources to help deliver improved outcomes for people. The majority of our functions will be carried out at a local level through four regional teams and twenty seven area teams, supported by the operations directorate.

Organisational development

3.3 Our approach to organisational development will be central to our success. It is important that we reinforce and develop a single organisational culture and build a shared vision of improving outcomes for people.

NHS England Governance

3.4 Delivering NHS England business is a large-scale complex task. A corporate programme office has been established to provide a resource to the organisation in terms of project support, as well as providing assurance to the Board regarding corporate performance and business plan delivery. Risk identification and mitigation is an important element of this and will be managed and reported on using the Board Assurance Framework.

Public and Parliamentary accountability

3.5 NHS England is accountable for delivering the mandate set for us by the government to respond to correspondence, Parliamentary questions and complaints, and as a statutory body we have formal duties to respond to Freedom of Information and Data Protection Act requests. Teams have been established to respond to briefing requests from various stakeholders, and FOI requests and calls from the public. A formal protocol has been agreed with the Department of Health setting standards for timeliness and quality that we will meet.

Equality and Health Inequalities Strategy – including the Equality Diversity Council and the Equality Diversity System

3.6 One of NHS England's central commitments is to promote equality across the NHS and reduce health inequalities in access to, and outcomes from, healthcare services. It is our ambition that everyone receives care that takes account of their background, who they are and where they live. NHS England will publish equality data and information using EDS, that demonstrates how NHS England is meeting the Public Sector Equality Duty (PSED) and performance against its agreed equality objectives. We will also include an assessment in the NHS England annual report of how well NHS England and CCGs have met their legal duties regarding health inequalities.

Assessing our success in building the new organisation

3.7 It will be important to measure how successfully we have met the objectives outlined above. We will do this through a range of measures, including feedback from all our partners. We are already working with NHS clinical commissioners to co-produce an independent 360 degree survey to provide feedback to NHS England from every CCG in the country which will form part of these measures, along with a regular staff survey; and other indicators under development.

4.0 CONCLUSION & RECOMMENDATION

4.1 This paper summarises the business plan priorities of NHS England. It also seeks to clarify specific elements of responsibility which local partners might expect of the Area Team. A good deal of the content represents intentions and work which is already underway and will be familiar to local partners. Beyond that work described for which the Area Team will be the delivery partner, the opportunity remains for local partners to engage, inform and influence that work which is being progressed at the national level.

4.2 The Health & Wellbeing Board is invited to consider the priorities of NHS England (formally the National Commissioning Board) through the Local Area Team to understand how these priorities might best support the aims of the board and the Joint Health and Wellbeing Strategy.

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Date of Meeting	Topic	Organisation / Officer Responsible / Executive Member Responsible	Objectives and Desired Outcomes	Methods or venue	Timescale
12 September 2013	Review of recommendations – Review of Dentistry in Care and Residential Homes	Cllr Dr K Barclay /Abdul Razzaq/NHS England	To monitor progress made	Trafford Town Hall	Cllr Dr K Barclay /Abdul Razzaq/NHS England
	Alcohol Service Performance	Cllr Barclay/Linda Harper	To understand the service offered and performance against agreed standards	As above	One Meeting plus potential items for Topic Groups/Future Meetings
	Report – Health Scrutiny Engagement Event	Helen Mitchell	To understand key themes emerging from the event and agree their action	As above	One Meeting
	NWAS 111 – Update	CCG/Mastercall/NHS England?	To understand the issues faced by the service and what action is being taken	As above	One Meeting
	Topic Group Update	Chairmen	Receive update	As above	One Meeting

	HWBB Update	Board Member/s	Receive update	As above	One Meeting plus potential items for Topic Groups
	Healthwatch Referrals/Update	Ann Day/Healthwatch Board Members	Receive update and act on referrals where appropriate	As above	One Meeting
4 December 2013	Ageing Well/Volunteering Review	Linda Harper / Cllr K Barclay	To establish whether progress has been made	Trafford Town Hall	One Meeting
	Stroke Performance	CCG	Understand current performance levels	As above	One Meeting
	Topic Group Update	Chairmen	Receive update	As above	One Meeting
	Integration of Health and Social Care Teams	Jo Willmott/Cllr Dr Barclay	Receive update on progress	As above	One Meeting
	Healthier Together	NHS England/CCGs	Respond to consultation	As above	One Meeting
	Healthwatch Referrals/Update	Ann Day/Healthwatch Board Members	Receive update and act on referrals where appropriate	As above	One Meeting
5 March 2014	NWAS Community Strategy Update	Sarah Smith	To establish progress against the strategy	Trafford Town Hall	One Meeting

	Dementia Strategy/Policy	Cllr K Barclay/Cllr Young Linda Harper?	To establish progress	As above	One Meeting
	HWBB Update	Board Member/s	Receive update	As above	One Meeting plus potential items for Topic Groups
	Healthwatch Referrals/Update	Ann Day/Healthwatch Board Members	Receive update and act on referrals where appropriate	As above	One Meeting
	Topic Group Update	Chairmen	Receive update	As above	One Meeting

Topic Group C: Review of Dignity in NHS Hospitals (due for completion – Summer 2013) ⟶ Review of Healthy Weight Strategy (due to commence on completion of previous review)
Topic Group D: Review of Personalisation (due for completion July 2013) ⟶ Review of Visible Arts Programme (due to commence on completion of previous review)

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