

Liverpool Primary Care Trust Operational Plan 2010/2011

12th March 2010

1.0	Introduction	1
1.1	Context	1
1.2	PCT Strategic Goals.....	3
1.3	World Class Commissioning.....	4
1.4	Partnership	5
1.5	Role of Practice Based Commissioners and Neighbourhoods	5
1.6	Transforming Community Services	6
1.7	Equality and Diversity	7
1.8	Operational Plan Priorities	7
2.0	Operational delivery aligned to the strategic goals	8
2.1	Delivering the things that make a big difference.....	8
2.1.1	Health Inequalities	8
2.1.2	Prevention	9
2.1.3	Childhood Obesity	9
2.1.4	Breastfeeding	10
2.1.5	Teenage Pregnancy	11
2.1.6	Healthy Child Programme	11
2.1.7	Alcohol.....	12
2.1.8	Tobacco Control	13
2.1.9	Cancer Screening.....	14
2.2	A better understanding of self-care and how health services can support it.....	15
2.2.1	Long Term Conditions and Self-Care	15
2.2.2	Patient Experience	16
2.2.3	Health Literacy.....	17
2.3	Gold Standard Primary Care and Community Services	18
2.3.1	Outside of Hospitals	18
2.3.2	Neighbourhood Delivery	19
2.3.3	Transforming Community Services (provider development)	20
2.3.4	Primary Care Access.....	20
2.3.5	NHS Health Checks.....	21
2.3.6	Diabetes	21
2.3.7	Respiratory Conditions	22
2.3.8	Sexual Health	23
2.3.9	MRSA	23
2.3.10	Clostridium Difficile	24
2.4	Gold Standard Hospitals	25
2.4.1	Urgent Care	25
2.4.2	Cancer	25
2.4.3	CVD	26
2.4.4	Stroke	27
2.4.5	Military Personnel.....	28
2.4.6	Delivering Same Sex Accommodation (DSSA)	28
2.4.7	Venous Thromboembolism (VTE)	29
2.5	End of Life Services	30
2.5.1	End of Life Care.....	30
2.6	Personalised Care	31
2.6.1	Maternity and Neonatal Services.....	31
2.6.2	You're Welcome	32
2.6.3	Carers.....	32
2.7	An end to waiting	34
2.7.1	Dentistry	34
2.7.2	18 Weeks.....	34
2.8	Joined up Services.....	36
2.8.1	Older People.....	36

2.8.2	Children with Disabilities.....	36
2.8.3	Child and Adolescent Mental Health Services (CAMHS)	37
2.8.4	Safeguarding	38
2.8.5	Emergency Preparedness: Merseyside.....	38
2.8.6	Emergency Preparedness: Liverpool PCT	39
2.8.7	Dementia	39
2.8.8	Mental Health	40
2.8.9	Crime and Violence	41
2.8.10	Domestic Violence.....	41
2.8.11	People Living in Vulnerable Circumstances	41
2.8.12	People with Learning Disabilities.....	42
2.8.13	Offender Health	43
2.8.14	Drugs Strategy.....	43
2.8.15	Third Sector	44
2.8.16	Sustainability	45
3.0	Enablers	46
3.1	Managing Resources.....	46
3.2	Developing Workforce	51
3.3	Approach to Quality	55
3.4	Research and Development	56
3.5	Informatics	58
4.0	Conclusion.....	65
	Appendix A – Showing the Three Tiers of the Vital Signs	66
	Appendix B - Local Area Agreement - Liverpool First Priority Indicators	68
	Appendix C – Liverpool PCT Performance Metrics	72
	Appendix D – NHS North West Operating Framework Schedule	77

1.0 Introduction

1.1 Context

Liverpool Primary Care Trust (PCT) is committed to improving the health and wellbeing of Liverpool people and ensuring that the best health care services are in place. The PCT's vision, described in the five year Strategic Commissioning Plan, is to achieve transformational improvements in health and in service provision and significant reductions in health inequalities.

This Operational Plan 2010/11 is based on the goals of the PCT's Strategic Commissioning Plan 2009/14, the vision described in NHS North West's 'Healthier Horizons', the priorities identified in the Joint Strategic Needs Assessment, and the requirements of the NHS Operating Framework 2010/11. Its purpose is to set out clear priorities, deliverable actions and measurable results for the next 12 months.

In addition, the Department of Health recently published NHS 2010/15: From Good to Great setting out a five year plan to focus the NHS on becoming more preventative, people-centred and productive. This confirms the Quality, Innovation, Prevention and Productivity (QIPP) programme required to adapt the NHS to the new national economic environment.

'Healthier Horizons' established a clear vision for the future based around putting quality at the heart of everything in the NHS, and to achieve this it is essential to build on the success to date in delivering the national priorities and targets outlined in the 2010/11 Operating Framework:

- Improving cleanliness and reducing infection
- Improving access to primary and secondary care
- Keeping adults and children well
- Experience, satisfaction and engagement
- Emergency preparedness.

The Joint Strategic Needs Assessment (JSNA) is a process that describes health, care and wellbeing needs both currently and in the future. The priorities are agreed jointly with partners through the Local Strategic Partnership (Liverpool First). This gives clarity about the key priorities partners should be tackling. The 15 areas that emerged from the JSNA are: inequalities in health, coronary heart disease, stroke, cancer, diabetes, respiratory disease, alcohol, infant mortality, mental health, sexual health and genito-urinary medicine, older people, people with physical and/ or sensory impairments, people with learning disabilities, carers, children and younger people.

Alcohol and dementia have been identified in the JSNA as issues to be investigated in more depth. Both these issues are included in the current NHS Operating Framework as topics to address. The JSNA process will formulate and organise a way of answering the questions that can be used to guide the investments to achieve better outcomes.

NHS North West has devised and shared a set of clear expectations for planning and subsequent actions across five levels of QIPP delivery. These five levels are;

- Level 1 – Individual Organisation (Liverpool PCT)
- Level 2 – Key bilateral relationships within health economies
- Level 3 – Sub regional footprints (North Mersey)
- Level 4 – Regional wide contributions

- Level 5 – National contributions

Over recent months the North Mersey work streams have been put in place and each is led by a Chief Executive Officer. Representatives from each Trust have been working collaboratively together to define Terms of Reference and develop work plans. The Governance Framework has been designed to deliver Level 3 QIPP across North Mersey and includes the following:-

- The Compact Board - attended by North Mersey Chairs, Chief Executives Officers, Medical Directors and Local Authority Chief Executive Offices.
- The Assurance Committee - attended by Chairs and Non-Executive Directors
- The Steering Committee - attended by the Chief Executive Officers.

The overall direction of the programme is clinically led through the Clinical System Transformation work stream. Each clinical pathway redesign is led by a Medical Director. The PCT has also designed a high level plan for driving the Clinical System Redesign.

The Clinical System Transformation work stream will be enabled and supported through a number of functional workstreams; each is led by a CEO.

- Commissioning
- Prevention
- Finance
- Human Resources
- Information Management and Technology
- Estates
- Clinical Support Services
- Communications

In relation to the five year Financial Plan, the Finance workstream is well established and Directors of Finance now have a shared understanding across North Mersey through collaborative working. The focus for 2010/11 is for each Trust to deliver its CIP plans at Level 1. At this stage the Provider Trusts have identified CIP plans in the region of £58m; this is still work in progress. Further work is also taking place to share lessons learned from CIP Plans and to understand interdependencies across the North Mersey healthcare system. PCT plans have also identified the extent of savings required for 2010/11. Although it will be challenging there is confidence these plans will be achieved.

The QIPP process and Compact also link to Liverpool PCT's draft Good Corporate Citizenship Sustainability Strategy. This sets out how Liverpool PCT will use resources wisely, to achieve health objectives and the PCTs wider commissioning role in working with partners, suppliers and communities to secure a healthy, low carbon and sustainable Liverpool in the long term.

Liverpool PCT is leading 2010 Year of Health and Wellbeing for the Liverpool City Region. During the year the aim is to establish new ways of considering and acting for health among stakeholders including strategic partners and communities. This major collaborative effort exemplifies future partnership working centred on innovative, co-ordinated and concerted city wide and community actions targeted at improving health and wellbeing.

1.2 PCT Strategic Goals

Liverpool PCT has been working with local people and stakeholders to establish a five year Strategic Commissioning Plan (SCP). It is important that the thread of the Strategic Commissioning Plan runs throughout the Operational Plan, so that local partners will recognise the connections that were made during the involvement and engagement of the last 18 months.

The Strategic Commissioning plan has eight ambitious goals:

- Goal 1: Delivering the things that make a big difference
- Goal 2: Better understanding of self-care and how health services can support it
- Goal 3: Gold standard primary care and community services
- Goal 4: Gold standard hospitals
- Goal 5: End of life services
- Goal 6: Personalised care
- Goal 7: An end to waiting
- Goal 8: Joined up services

These goals have been decided through a process of analysis, debate and engagement with patients, the public and clinicians. There are three factors that run through these goals:

- They are the most pressing in terms of population health need – the key message is one of huge gaps in health status and of a population that in patches is one of the least healthy in the country.
- They are what matter to local people – the PCT has engaged extensively with the public through the Big Health Debate and other events.
- They make sense to local clinicians – working with clinicians through the Professional Executive Committee (PEC), Practice Based Commissioning (PBC) consortia and Providers to understand the needs of local people, has encouraged clinical leadership and ownership of the ambitious strategic goals.

Progress against this vision will be measured through a series of indicators. Ten high level outcome indicators have been identified against which the success of this plan will be measured. The indicators are as follows:

- Inequality in life expectancy across the city will be reduced
- Increased male and female life expectancy
- Improved cardiovascular disease mortality rate
- Improved cancer mortality rate
- Increased smoking quitting rates in the population
- Reduced infant mortality rate
- Reduced admissions to hospital due to alcohol misuse
- Improved quality in primary care
- Improved rates of infection in hospital
- Improved access to psychological therapies

1.3 World Class Commissioning

World Class Commissioning (WCC) is a national initiative which aims to deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. The performance of the PCT in relation to WCC was judged through a combination of self assessment, self certification, documentary evidence and ambitious outcome setting. Overall the PCT's assessment in 2009/10 was in the top 10% of performers in England. There is a strong emphasis on organisational development based on the competencies of WCC:

- locally lead the NHS
- work with community partners
- engage with public and patients
- collaborate with clinicians
- manage knowledge and assess needs
- stimulate the market
- promote improvement and innovation
- secure procurement skills
- manage the local health system
- make sound financial investments

In order to achieve this, the PCT commissions for the best possible health outcomes, including reduced health inequalities and ensuring the best possible health care by:

- Making sure health outcomes, clinical quality, excellent customer care, sustainability and value for money are at the heart of the commissioning process and that patient views and clinical engagement drive this agenda.
- Engaging with internal and external stakeholders on health outcomes and priorities, developing further robust two-way communication mechanisms with patients, clinicians and stakeholders.
- Commissioning for continually improving excellent services through planning and commissioning with key partners.
- Redesigning pathways of care with key partners to deliver maximum health gain.
- Working in a new way that enables people to deliver more effectively, matching organisational priorities with people's skills. Organisational development and clear lines of accountability will support this approach.
- Putting in place robust systems and processes for performance management and measuring the outcomes achieved.
- Ensuring transparency, consistency, accountability and engagement.
- Being a model employer and advocate for local employment.
- Ensuring long term service sustainability and cohesion.
- Introducing a local delivery system for health care and health improvement services for Liverpool neighbourhoods in partnership with others.
- Acting as exemplars of good corporate citizenship and through commissioning and partnership encouraging sustainable development
- Leading strategic partnership action for improved health outcomes across all

sectors to establish long lasting collaborations and community engagement with wellbeing, as a result of 2010 Year of Health and Wellbeing.

- Conducting an equality impact assessment of the commissioning and procurement process.

1.4 Partnership

This plan cannot be delivered by the PCT alone. Indeed, this is not just the PCT's plan, it is Liverpool's plan. This means an approach where the PCT facilitates the NHS family of service providers - namely 'NHS Liverpool' - to come together to improve health and well being and ensure the delivery of world class health services. This includes offering ongoing support to children, vulnerable adults and older people exploring new approaches such as the arts and culture to support health and working in partnership with those outside the health sector at both strategic and operational levels to improve health outcomes. 2010 Year of Health and Wellbeing aims not only to communicate wellbeing issues with communities but also to provide means for partners, businesses and statutory agencies to understand their potential contribution to health and wellbeing and to make health a strategic goal for their organization, forming a platform for long term partnerships for reducing health inequalities.

It is a wide-ranging partnership encompassing partners at the City Council; in local NHS Trusts, in the community and voluntary sectors, politicians from all parties, local community leaders, and most importantly, the people of Liverpool themselves. Wider partnerships, including with the police, fire service and third sector organisations, all have the potential to improve health through the range of local services they provide.

There is a good base on which to build. Merseyside has over 1000 active community and voluntary organisations. These are locally-run, accountable and supported by committed local people providing a potentially substantial collection of local champions to increase the health literacy skills of the population.

There are also excellent hospitals and many committed and skilled staff working in the NHS and social care services in the city, including primary care and community services. The links with Liverpool City Council and other partners in the city have never been stronger.

The aims of 'A New Health Service for Liverpool', which describes a progressive outside of hospital strategy, will be maintained. However, it must be emphasised that this operational plan is about improving health as much as about improving services. It brings in the latest thinking and intentions around quality, equalities, integrated care, sustainability and promoting well being through neighbourhood delivery of diverse health and wellbeing services with the individual and communities.

1.5 Role of Practice Based Commissioners and Neighbourhoods

In order to deliver this approach, the PCT is committed to fostering a Neighbourhood approach to improving health and local health services. Neighbourhoods have been identified across the city as part of the Outside of Hospital programme, with associated groups of clinicians beginning to come together to work with local people and services to achieve better health outcomes for the population.

Neighbourhoods will provide an exciting opportunity to improve health and wellbeing at a local level. By working with populations of 20,000 – 25,000, the PCT can far better understand and facilitate local drivers for change, thus tackling health inequalities through the empowerment of local communities' delivery of focused health improvement programmes, working alongside the third sector.

Practice Based Commissioners are key to this. Practice Based Commissioning

(PBC) has developed and grown in Liverpool over the past four years. Alongside the Professional Executive Committee (PEC), it now provides a solid platform for leadership and clinical engagement in commissioning, with an emphasis on designing and overseeing the implementation of new service models. Practice Based Commissioners will be instrumental in enabling the PCT to deliver many of the priorities listed in this document for 2010/11.

The key focus for PBC over the coming year will be to ensure more appropriate demand for specialist services through securing improved primary and community services. As part of this, PBC will be leading the development of specifications for clinical services at the neighbourhood level. This will include GP services and community health services, with a real emphasis on how these clinicians ensure the early identification and proactive management of people with health needs, working ever more closely with local health improvement services.

This will also require on-going discussion and dialogue with secondary care clinical and managerial colleagues and a leadership role in the recently published 'Transforming Community Services', built on a solid primary care infrastructure, while at the same time incorporating commissioning of primary care for public health outcomes.

1.6 Transforming Community Services

The publication of 'Transforming Community Services: Enabling new patterns of provision' in January 2009 has required the PCT to review and reflect on the current position and future plans for community services. The PCT are clear this initiative is about transformation, health and service improvement and not about organisational form.

Over the past two years, the PCT has made significant strides in developing commissioning and in-house provision as strong and separate entities. Thus the requirements with regard to the separation of commissioning and provision have been met on a number of fronts. During the coming year the PCT will be:

- Implementing its commissioning strategy for community services, building on the extensive work undertaken to date.
- Considering and refining its supply side and market strategies, which will include reviewing and developing its contestability and procurement strategies.
- Developing and building on its existing plans and specifications for:
 - Promoting Health and Well Being and Reducing Inequalities
 - Services for Children and Families
 - Acute Services Closer to Home
 - Long Term Conditions
 - Rehabilitation and Long Term Neurological Conditions
 - End of Life Care
 - Mental Health

This will involve rigorous service reviews and ensuring a whole-systems approach to pathways and service design so that needs are met effectively and that choice is available to patients.

- Ensuring stakeholders are involved in every element of the process
- Developing its strategy for infrastructure and assets

- Undertaking impact, equality and diversity assessments of plans

Continuing the work on the separation of commissioning and provision within the PCT will involve staff from the outset in any consideration of organisational change.

1.7 Equality and Diversity

Valuing diversity and promoting equality are the key principles in driving forward the PCT's commissioning intentions. Liverpool PCT appreciates that effective commissioning takes account of the diversity of the populations accessing a range of services, requiring effective profiling of local populations. Liverpool PCT supported NHS Northwest in piloting the new Equality Performance Improvement Toolkit (EPIT) dashboard, which supports performance monitoring of the PCT and providers in a structured, transparent consistent way. An assessment shows the PCT are achieving in all areas.

As the patient experience is embedded within the quality performance process, due regard and consideration will be given to the specific experiences of our Equality Target Groups. Patient experience is not a new concept to Liverpool PCT, but the national agenda to support patient experience will enable better information on all commissioned services.

A Quality Council has been established which will have representation from a wide range of disciplines and representatives of communities.

Equality considerations are evident throughout this Operational Plan 2010/11, supported by EPIT self assessment. There is specific reference within Liverpool PCTs plans how to aim to progress equality duties, and address specific health inequalities.

The specific uptake of services and health inequalities of CVD, cancer, diabetes, teenage pregnancy and end of life care, has been acknowledged and plans to address these.

Social Marketing is an award winning concept that has been embedded within the local organisations, acknowledging its benefits in terms of understanding attitudes, behaviours, particularly within the Equality Target Groups.

This Operational Plan will be supported by the Single Equality Scheme to drive the plans forward within 2010/11.

1.8 Operational Plan Priorities

The next section of the plan outlines the actions that the PCT will be undertaking during 2010/11 in order to meet the health needs of the people of Liverpool. These priorities have been developed using the prioritisation policy which was endorsed by the PCT Board in November 2009. It is set out in the format of the PCT strategic goals and includes the priorities to be progressed along with metrics defined as World Class Commissioning (WCC) outcomes, Local Priority outcomes (LPO), Vital Signs (VS), Key Lines of Enquiry (KLOE) and Local Area Agreements (LAA).

2.0 Operational delivery aligned to the strategic goals

2.1 Delivering the things that make a big difference

The PCT aims to tackle those determinants of health which will bring about the biggest improvements in the wellbeing of the local population, reducing the gap between the health rich and health poor. There will be a focus on localities with the highest levels of deprivation and groups suffering the greatest inequalities, whilst also ensuring the impact of whole population services.

2.1.1 Health Inequalities

Health inequalities will be addressed by actions throughout the operational plan, as they are due to a variety of causes. These include lack of access to services, individuals or groups being missed by services and not fully appreciating the difference those interventions can make. By raising the standard of delivery in the NHS to a uniformly high standard some of the health inequalities will be reduced.

Unequal access to economic, environmental and social resources means those in poorer circumstances are more likely to experience poor health. The Marmot Review has recently been published and will guide the development of joint approaches to health inequalities.

Others actions will be more targeted to reach specific groups or populations. This requires a coordinated approach by the different partners in the NHS and also working with other stakeholders.

Priorities:

- Work with the Local Authority over the next 18 months to implement interventions that are focused, evidence-based and implemented systematically with sufficient scale to make a difference at population level.
- Deliver on those areas which have the greatest impact on life expectancy based on guidance by the Health Inequalities National Support Team, and joint working with partners.
- Establish systems with partners that ensures coordination of interventions which have the greatest impact on deliver reductions in mortality in the short term through focussing on those most at risk. This builds on the good work already underway to reduce seasonal excess deaths.

Metrics:

WCC	Level up the life expectancy in the most deprived areas towards that of the least deprived, as measured by the Slope Index of Inequalities Increase life expectancy with a particular focus on delivery of services for CVD, stroke, cancer, colorectal cancer, lung cancer, COPD and pneumonia, and seasonal excess deaths
LPO	Reduce the life expectancy gap from birth, between Spearhead PCTs and the England average, by 10% by 2010 Reduction in deaths from accidents
VS LAA	VSB01: Reduce All age All Cause mortality by 2010 (The period 2010 is defined as the three-year rolling period 2009/11 and will include all deaths up to 31st of December 2010)

2.1.2 Prevention

The PCT can make significant improvements in meeting and improving the immediate and future health needs of communities and equality target groups. Prevention and protection can help people stay healthy, support those at risk of ill health and provide a quick diagnosis when symptoms of ill health are present. The PCT will deliver these improvements through schemes that will promote physical activity, building upon 5-a-day and prevention interventions.

The PCT will continue close working with partners, including the Local Authority and Health Protection Agency, to protect the health of population through prevention, early detection and control of communicable disease, delivery of environmental health programmes and emergency planning and response.

Priorities:

- Optimise delivery of the four key lifestyles programmes: Liverpool Active City; Taste for Health; Smoke Free Liverpool and the Alcohol Programme.
- Deliver the Public Mental Health Strategy following consultation with key stakeholders.
- Build public health capacity within front line services through the brief interventions training programme. This will ensure signposting to relevant lifestyles programmes and increase numbers of patients receiving brief advice in all settings.
- Fully implement the Healthy Communities Cancer Collaborative approach to early detection across Liverpool.
- Commission, support the implementation of, and performance manage a range of weight management programmes, including commercial, pharmacy and expert led city wide services in the community.
- Prioritise Five Ways to Health and Wellbeing as opportunities for policy and action develop through 2010 Year of Health and Wellbeing.

Metrics:

LPO	<p>Increase the numbers of schools that have access to smoking prevention education</p> <p>Halt the rise in adult obesity by 2010 and thereafter reduce prevalence as measured by the Quality Outcomes Framework</p> <p>Increase the numbers in the population who are physically active as measured by Sport England Peoples Survey (Annual)</p> <p>Increase the numbers in the population who access a Health Trainer and go on to make a positive lifestyle change</p> <p>Increase the proportion of individuals who have the flu vaccine</p>
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2.1.3 Childhood Obesity

Childhood obesity remains a challenge for the PCT. The framework for weight management services will help the PCT to procure pre-qualified services quickly and easily to address the needs of the children of Liverpool; in addition the local delivery

of the National Child Measurement Programme will provide the PCT with the opportunity to target intervention services.

Priorities:

- Improve the links between primary and secondary care by utilisation of the children’s care pathway.
- Increase the knowledge and understanding of food provision and nutrition within nurseries.
- Ensure the effective delivery of routine feedback of NCMP results to parents of all reception and year 6 children, and develop a process for linking parents into local schemes and interventions.
- Deliver a social marketing and insight plan for the development of interventions to target segments of the population including BME, disabled children and their families.

Metrics:

LPO	<p>Increase the percentage of schools achieving National Healthy Schools Status to 85% by April 2011</p> <p>Increase the percentage of 5-16 year olds receiving two hours of physical education and sport within the school day and up to three additional hours of sport beyond the school day</p> <p>Increased take up of school lunches to 51% by 2011</p>
VS	<p>VSB09: To reduce the year on year increase in reception and year 6 age children who are overweight or obese by 2012 (Children and Young Peoples Plan 2009/11)</p>
LAA	<p>To halt the year on year increase in 11 year olds who are overweight or obese by 2012 (Children and Young Peoples Plan 2009/11)</p>

2.1.4 Breastfeeding

Breastfeeding is a vital part of a healthy start for babies and also reduces child obesity. The PCT is developing effective approaches to promote breastfeeding initiation and support mothers to continue to breastfeed longer, including implementing the principles of the UNICEF Baby Friendly Initiative in hospitals and community settings.

Priorities:

- Implement the UK Baby Friendly seven point plan by the following measures:-
 - To commission a peer support programme during 2010/11
 - To train a minimum of 80% of clinical staff by September 2011 in breastfeeding management
- Develop and launch a breastfeeding social marketing strategy in 2010.
- Increase the uptake of Healthy Start vitamins for pregnant women, new mothers and children up to four years.

Metrics:

LPO	To increase initiation rates by 2% and duration rates at 6–8 weeks to 31% (PCT will monitor and report at 6-8 weeks)
VS	VSB11: Prevalence of breastfeeding at 6-8 weeks from birth
LAA	Prevalence of breastfeeding at 6-8 weeks from birth

2.1.5 Teenage Pregnancy

Teenage pregnancy is a key issue of social exclusion and health inequalities that can significantly limit young people's chances to fulfil their potential. The delivery of well publicised, accessible and high quality contraception and sexual health services for young people is key to reducing the number of unintended pregnancies.

Whilst the PCT teenage pregnancy rates had been reducing over recent years, recent figures indicate an upward trend. Therefore, greater effort is being applied to re-establish the reduction in rates to ensure the 2010 target is met.

Priorities:

- Expansion of access to long-acting reversible contraceptive (LARC) methods.
- Pilot five school based health drop-ins which offer basic sexual health services including pregnancy testing.
- Pilot a sexual health outreach post to work in partnership with key children's services.

Metrics:

LPO	Increased access to health services for young people
VS	VSB08: Conception rate per 1,000 females ages 15-17

2.1.6 Healthy Child Programme

From April 2010, Children's Trust Boards will be responsible for developing, monitoring and reviewing the Local Children and Young People's Plan (CYPP). The Healthy Child Programme (HCP) 0-5 and the Healthy Child Programme 5-19 set out support for giving children and their families the best start in life.

Healthy Child is one of the initiatives, which the PCT has identified as having the maximum impact on improving the health of Liverpool.

Priorities:

- Ensuring neonatal services are compliant with national standards.
- Develop HCP team-working to include; antenatal programmes; health-based programmes with children's centre's ensuring that each centre has access to a named health visitor; joint working between primary care, health visiting and school health.
- Deliver the Healthy Child Programme for school-age children including development of a service standard which will set out what services will be available to all parents in all areas.

- Develop the team around the school/locality based model in collaboration with the Children's Trust.
- Support the National Healthy Schools Programme to develop the role of schools in promoting pupils' health.
- Publish the Transition Strategy and continue to develop transition pathways between children's health services and adult health services.
- Increase uptake of MMR1 and MMR2, pre-school booster, school-leaving booster and HPV catch-up programme.
- Continue with the development and implementation of community based fluoride toothpaste schemes targeting young children aimed at reducing dental decay levels and referrals for dental extractions.
- Develop links between primary dental care and early years settings to increase the provision of evidence based preventive dental care and advice.

This programme links to; 2.1.3 Obesity; 2.1.4 Breastfeeding; 2.1.5 Teenage Pregnancy; 2.3.8 Sexual Health; 2.6.1 Maternity and Neonatal services; 2.6.2 You're Welcome; 2.8.2 Children with Disabilities; 2.8.3 Children and young peoples mental health and emotional wellbeing services; 2.8.4 Safeguarding

Metrics:

WCC	Reduce Infant Mortality
VS	VSB10: Individuals who can complete immunisation by recommended ages VSC29: Hospital admissions caused by unintentional and deliberate injuries to children

2.1.7 Alcohol

Liverpool is disproportionately affected by alcohol related harm, and this is further exacerbated by pockets of severe poverty which are linked to high levels of alcohol misuse. The PCT will continue to work in close partnership to reduce the harm caused by alcohol.

Priorities:

- Continue to develop and deliver the Liverpool Alcohol Improvement Programme action plan in partnership with stakeholders.
- Develop and implement a comprehensive and effective alcohol treatment and support service across the city, and in doing so develop a primary care alcohol pathway.
- Deliver a programme of targeted and opportunistic alcohol screening and brief interventions activities for the early identification and prevention of alcohol problems across a range of settings.
- Work with Citysafe to ensure Alcohol Treatment Requirements (ATRs) address domestic violence offenders.
- Monitor deaths from liver disease.

Metrics:

WCC	Reducing the rate of increase of hospital admissions due to alcohol misuse to an agreed trajectory
LPO	Reduction in harmful levels of alcohol consumption measured through the Alcohol Harm Reduction Programme Improved effectiveness of assessment and treatment
VS	VSC26: Reducing the rate of increase of hospital admissions due to alcohol misuse to an agreed trajectory
LAA	Reducing the rate of increase of hospital admissions due to alcohol misuse to an agreed trajectory

2.1.8 Tobacco Control

Smoking prevalence in Liverpool has continued to fall over the last year. A new tobacco strategy will provide the PCT with the opportunity to successfully build on their current model.

Priorities:

The PCT will ensure delivery of a comprehensive tobacco control programme in line with the 10 High Impact Changes to include;

- Partnership Working
- Data Collection
- Use tobacco control to tackle inequalities
- Deliver consistent, coherent and co-ordinated communications
- An integrated stop smoking approach
- Build capacity in tobacco control
- Tackle cheap and illicit tobacco
- Influence change through advocacy
- Helping young people to be tobacco free
- Maintain and promote smoke free environments
- Undertake an audit which provides an overview of the current access, demand and supply for services, in order to identify and target those individuals most in need of support services.

Metrics:

WCC	Increase smoking quit rate to 1378 per 100,000 population aged 16 and over, equating to 4935 four-week quits in 2010/11
LPO	Reduction in smoking prevalence from 28% to 27%
VS	VSB05: Smoking Prevalence: the number of 4 week quitters who attended NHS Stop Smoking Service

2.1.9 Cancer Screening

The PCT will work with Merseyside and Cheshire Cancer Network to ensure that all screening services have made plans to start the extension of breast cancer screening offered to women aged 47-49 and 71-73 from April 2010. Bowel cancer screening will be extended and offered to men and women aged 70-75 from 2010. Cancer screening complies with prevention and quality in the QIPP agenda.

Priorities:

- Deliver the requirement to ensure at least 8% of women in the 47-49 age range have been invited for breast screening by March 2011.
- Work with local partners to develop a local infrastructure for the commissioning of the bowel screening programme. We expect to begin local commissioning of this programme from our local screening centre by April 2011. We support the national commissioning of age extension for bowel screening.

Metrics:

WCC	Reduce cancer mortality in Liverpool
VS	VSB03: Reduction in cancer mortality in Liverpool VSA09: Proportion of women aged 47-49 and 71-73 offered screening for breast cancer VSA10: Proportion of men and women aged 70-75 taking part in bowel screening programme VSA15: Proportion of women receiving cervical cancer screening test result within 2 weeks

2.2 A better understanding of self-care and how health services can support it

Self-care has a big influence on health outcomes but in the past this has not received the attention it deserves. The aim is to ensure that people’s ability to improve their own health, and manage long-term health conditions, is enhanced. To achieve this the PCT will engage with the wider community and improve the contribution NHS staff can make to self care. The Year of Health and Wellbeing will be used to foster improved approaches to self care.

2.2.1 Long Term Conditions and Self-Care

Living with a long-term condition can impact upon an individual’s ability to participate fully in society, both in limiting physical capacity and the psychological impact of a permanent change in health status. Incidence of depression is higher for people with a long-term condition compared to the rest of the population. Individuals with a long-term condition (LTC), such as diabetes, coronary vascular disease (CVD) and chronic obstructive pulmonary disease (COPD) and their families are more intensive users of health and social care services.

Priorities:

- Implementation of self management plans for all patients with COPD, asthma and diabetes.
- Implement individual care plans for all patients with a long-term condition.
- Support implementation of the Public Health Improvement Neighbourhood model.
- Re-examine the delivery models for pulmonary, cardiac and stroke rehabilitation programmes to ensure suitability and effectiveness.
- Review the utilisation of telemedicine for patients with COPD.

Metrics:

LPO	<p>Increase uptake rates for structured self care programmes by 20% (cardiac, pulmonary and expert patient programme)</p> <p>Reduction in non elective hospital utilisation for patients with a long-term condition</p> <p>Increase in compliance with prescribed treatment</p>
VS	<p>VSC11: People with long-term conditions feeling independent and in control of their conditions</p> <p>VSC12: Timeliness of social care assessment</p> <p>VSC20: Reduce emergency bed days</p> <p>VSC21: Hospital admissions for ambulatory care. Reduction in emergency admissions due to Ambulatory Case Sensitive conditions specifically COPD, heart failure, ENT and asthma (Refer to 2.2.1 Long Term Conditions)</p>
LAA	<p>People with long-term conditions supported to be independent and in control of their condition</p>

2.2.2 Patient Experience

Stakeholder engagement works with patients and the public to resolve important local healthcare issues and deliver excellent customer care. The PCT's Stakeholder Engagement Team work with all stakeholders including patients, clinicians and the public, putting them at the centre of what the PCT does. The PCT will continue to expand and develop successful initiatives such as the Expert Patient Programme (EPP) and develop existing relationships with Local Involvement Networks (LINKs). Local patient experiences, satisfaction measures and views will be reflected in the Quality Accounts, and patient feedback on all services will be available on NHS Choices by December 2010.

Priorities:

- Establish a Liverpool PCT led Quality Council.
- Carry out an insight audit across the PCT to bring together information and intelligence on patient views/experience.
- Lead consultation processes including Liverpool Community Health, Outside of Hospital programmes and others. Ensure providers implement systems that enable them to respond to the views and experiences of patients and improve patient experience.
- Support a regular schedule of PCT led independent patient surveys seeking views of patients to drive quality/establish measures for year on year improvement; to include the Privacy and Dignity survey.
- Embed the Co-commissioning Toolkit to secure an evidence base on views of patients that are systematically gathered (in line with commissioning cycles) to drive service improvement.
- Develop systems to ensure that outcomes of consultations, disaggregated by equality target groups, will inform service design and identify local issues/concerns for communities/patients.
- Ensure the systematic use of patients' experience to inform commissioning decisions.

Metrics:

VS	VSB15: Self reported experience of patients/service users VSB16: Measure of public confidence in local NHS
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2.2.3 Health Literacy

Health literacy is the capacity to obtain, interpret, understand and use information about health and services to promote and protect health. It is the ability to make sound health decisions in the context of everyday life, at home, in the community, in the workplace, the health care system and the political arena.

People with low health literacy routinely face difficulties in accessing, comprehending and using health information to make appropriate health decisions. Their ability to understand their own health needs and navigate complex health care systems is compromised as a result and often the health and financial consequences are profound.

Priorities:

- Work collaboratively with steering group partners (e.g. city libraries, schools and adult education etc) to develop a city-wide action plan that identifies short, medium and long-term objectives for health literacy improvement.
- Develop and implement a marketing plan for core health services (including urgent care).
- To establish community and neighbourhood specific health literacy plans.

2.3 Gold Standard Primary Care and Community Services

Securing gold standard Primary and Community Services is fundamental to achieving the health outcomes required by the PCT. Gold standard primary and community services will promote and maintain good health, identify people at the early stages of illness and offer on-going proactive management, and deliver accessible services which support people to remain in their own homes wherever appropriate.

2.3.1 Outside of Hospitals

'A New Health Service for Liverpool – Outside of Hospital' strategy was published by Liverpool PCT in July 2007. This set out a way forward for the future of primary and community health care services in Liverpool following extensive consultation through the 'Big Health Debate'.

The aim of the strategy is to enable primary care and community services to achieve the highest possible quality of care, while achieving the potential for delivering the right services, in the right place, by the right professional, at the right time. This will involve the delivery of a wider range of services and the appropriate movement of services, currently provided inside hospitals to settings closer to people's homes. It will require significant service redesign and real clarity regarding the pattern of clinical services to be delivered and the responsibilities for this delivery across providers.

By 2013 the programme will deliver a step change in the quality of primary care at practice and neighbourhood level and a range of services delivered locally that had been delivered in a hospital setting. The facilities delivered as part of the programme will enable a three tier model of service delivery to be implemented. These facilities will consist of the development of up to three NHS Treatment centres, between 20 and 25 Neighbourhood Health Centres and the retention up to 40 GP Practice premises. The population of Liverpool will then have access to a GP within a 15 minutes walk of their home, access to a Neighbourhood Centre within a 15 minutes public transport journey from their home and access to a treatment centre within a 30 minute public transport journey of their home. Clearly each stage will be evaluated to ensure that outcomes have been achieved and are value for money.

Priorities:

- Implement, across primary, community and secondary care, pathways for aspects of the following specialties:
 - Dermatology
 - Gynaecology
 - Gastroenterology
 - Vascular
 - Musculo-skeletal medicine
- Develop the specification for primary care services at neighbourhood level.
- Complete work to ensure that service redesign outcomes deliver agreed shift in services from secondary care.
- Complete construction on NHS developments at Garston, Speke and Oriel Drive, providing a wider range of surgeries.
- Financial close for the joint NHS / Local Authority scheme at Childwall.
- Financial close for the schemes at Townsend Lane, Mere Lane and Princes Park.
- Complete refurbishments of Belle Vale HC and Riverside HC.

Metrics:

LPO	<p>Increase in primary care intervention</p> <p>Improving the quality in primary care as measured by the Improving Standards Matrix</p> <p>Reduction in demand on secondary care out-patients appointments. We expect to see a reduction in referrals of 20% in Dermatology, 20% in Gynaecology and 10% in Gastroenterology</p>
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2.3.2 Neighbourhood Delivery

Working at a neighbourhood level is about bringing the PCT closer to people and places and providing the strategic leadership necessary to bring service providers, partners and communities together around an agreed action plan for health

The Neighbourhood Hub and Spoke Model aims to bring together clinical and health improvement services to establish pathways which offer quality treatment allied to support for people to enable them to make ongoing healthier lifestyle choices and to deliver the Outside of Hospital Strategy. The first phase has been launched in Ellergreen.

Priorities:

- Capacity building to support local neighbourhood organisations to deliver health improvement activity to meet key public health targets (e.g. increasing physical activity, increasing number of people quitting smoking, increasing access to health trainers, advocating for improvements e.g. through healthy homes).
- Improve specific clinical outcomes as identified through each of the hub and spokes, such as in Ellergreen, where the clinical priorities are COPD and diabetes.
- In relation to the Outside of Hospital Strategy, Ellergreen neighbourhood has been used to test out the health improvement model at this very local level. This will be rolled out across the city by the end of 2010.
- Develop and support the health trainer concept in a variety of NHS and non-NHS settings at neighbourhood level to deliver health improvements, particularly to hard to reach sections of the population.
- Develop a communications plan to ensure partner organisations and the general public understand how they can support and engage with the neighbourhood model and partnership structures.

Metrics:

LPO	<p>Deliver Local Area Agreement targets at neighbourhood level for All Age All Cause Mortality (AAACM), breastfeeding, obesity year 6, alcohol and people with long-term conditions supported to be independent</p> <p>Improved performance on key health indicators e.g. chlamydia, vaccinations and immunisations and screening</p> <p>Reduce the gap between expected and reported disease prevalence register levels</p>
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2.3.3 Transforming Community Services (provider development)

The PCT has set out its key aims and objectives in its five year commissioning strategy “Transforming Community Health and Wellbeing Services in Liverpool”. The forthcoming period will be about driving forward sustainable improvements in health and service delivery in community provided services leading to a reduction in inequalities.

Priorities:

- Commence service reviews in line with TCS Strategy in conjunction with stakeholders (using a risk-prioritised approach) to highlight current service capacity, fitness for purpose, assessment of the dimensions of quality, performance, productivity, efficiency and equity of access in line with QIPP principles.
- Undertake consultation on the future organisational form of the PCT provided services and services to be transferred.
- Ensure robust plans are in place to deliver agreed organisational form by March 2011.

Metrics:

LPO	Increased quality, productivity and efficiency in community-provided services Increased shift of activity from secondary care providers to out of hospital provision
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2.3.4 Primary Care Access

The PCT has worked with GP practices and other partners to improve the responsiveness of primary care services and to improve on the current level of 79% of GP practices offering extended opening outside core hours.

Liverpool PCT will build on better access by ensuring ongoing improvements in patients’ experience of access, as measured through the GP patient survey, and by continuing to ensure that the new GP health centres and GP practices deliver effective and innovative services.

Priorities:

- Review all enhanced services.
- Implement the Improving Standards Matrix and produce practice comparable information, across all areas, to support discussions with practices about performance.
- Implement the contract management framework and a PCT policy on exception reporting.
- Develop a practice ‘neighbourhood’ specification which enables access to a full range of services.

Metrics:

LPO	Increase activity at the Equitable Access Centre in Everton Road
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VS	<p>VSA06: Patient reported measure of GP Access</p> <p>Improve patient's experience of the accessibility and responsiveness of the practice they are registered with, as measured through the quarterly patient survey, PE7, PE8 by 2%</p> <p>VSA07: General Practices offering extended opening</p>
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2.3.5 NHS Health Checks

Under the NHS Health Check programme everyone between the ages of 40 and 74 will be entitled to undergo an assessment of their risk of heart disease, stroke, diabetes and kidney disease. People will be helped to reduce their risk through lifestyle changes such as smoking cessation or weight management, or clinical management such as prescribed statins.

Priorities:

- NHS Health Check programme delivered to 5% of eligible cohort of population aged between 40-74 years in 2010/11, 12% delivered by 2011/12 and 20% by 2012/13.
- Identify areas with the highest incidence of CVD and undertake a targeted approach to awareness raising campaigns for signs and symptoms of CVD.
- Implement model of delivery for health checks.
- Review impact of implementation on other prevention services.
- Establish performance measures for health check programme.
- Agree evaluation methodology with stakeholders and the population.

Metrics:

LPO	Reduction in variance between actual and expected number of population with CVD
VS	VSC23: Vascular risk – numbers of practices with PCT validated registers of patients without symptoms of CVD events greater than 20% in next 10 years

2.3.6 Diabetes

Services for patients with diabetes are a key area requiring transformational change to deliver the New Health Service for Liverpool programme and are a key part of the North Mersey QIPP programme. Keeping up momentum on diabetic retinopathy screening will continue to make a significant contribution to the prevention of sight loss amongst people with diabetes. In Liverpool a great deal of work has been undertaken within primary care to understand the level of services delivered. Liverpool PCT will continue to reach the target of 100% of people with diabetes being offered screening for the early detection of diabetic retinopathy.

Priorities:

- Maintain achievement of offered and screened targets for retinal screening, reduce exclusion and exemption rates, and target populations with the worst screening rates and outcomes. Complete role out of fixed sites for retinal screening and phase 2 of co location of services
- Establish IT systems for sharing of data across primary care (and possibly community services), secondary care, eye screening and ophthalmology to support the patient pathway
- Agree model in the community for more complex patients. Review the role of the new injectable therapies in primary care
- Ensure the PCT amputation rates are consistent or below peer PCTs
- Implement the North Mersey Model of care for diabetes

Metrics:

LPO	Reduced complication rates as measured by lower limb amputation Reduce the gap between expected and actual prevalence rates to improve life expectancy of diabetic patients
VS	Existing Commitment: People with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy VSC27: Patients with diabetes in who the last HbA1c is 7 or less

2.3.7 Respiratory Conditions

Asthma and Chronic Obstructive Pulmonary Disease (COPD) are respiratory conditions with the greatest incidence and potential impact on the population of Liverpool.

Chronic Obstructive Pulmonary Disease is the third highest identified cause of death within Liverpool, with 12076 (QOF registers, March 2009) individuals with the disease process. Liverpool has the highest number of people on a COPD register (2,656 per 100 thousand) compared to other core cities. Recognition of the impact of the disease in relation to lives lost, quality of life and burden of impact on those with greatest need has focused the PCT to address current service provision, utilisation of resources and improvement in health inequalities. COPD is a designated work programme within North Mersey QIPP programme.

Asthma is a significant disease impacting upon the health of the population and children in particular. Effective management of the disease in children has the potential to increase school attendance and as such long term health potential and economic opportunities.

Priorities:

- Agreement and implementation of COPD pathway across the whole health economy.
- Reconfiguration of services to improve patient pathway for quality, innovation, productivity and preventing admissions.
- Working closely with Practice Based Commissioners to implement the Paediatric Asthma Pathway.
- Implementation of best practice and recommendations of 'Asthma Local Impact

Project' in practice.

- Implement the 'Difficult to manage Asthma pathway'.

Metrics:

LPO	Reduction in premature deaths due to respiratory conditions Decrease of 5% in the number of patients with mild COPD developing moderate or severe COPD Increase school attendance for children with asthma by 20% 10% reduction in non elective admission to secondary care for Asthma
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2.3.8 Sexual Health

Liverpool Community Health has stated its commitment to the delivery of the chlamydia screening target. A mechanism has been identified for generating additional tests through a combination of planned activities and proactive management of services, enabling the achievement of challenging targets. The delivery of well publicised, accessible and high quality contraception and sexual health services for young people is key to reducing the number of unintended pregnancies.

Priorities:

- Ensure that robust plans are in place to deliver the 35% chlamydia screening target, focusing on core sexual health services, primary care and embedding the programme into wider health and non-health services.
- Maintain the delivery of the targets relating to access for GUM services.
- Complete the HIV and sexual health services review and make recommendations for change that ensure that a range of services are available that offer a quality service and are value for money. Determine HIV prevalence and evaluate current research programme exploring methods and tools for early diagnosis of HIV.
- Ensure that all commissioned services have completed an equality impact assessment.

Metrics:

LPO	Increased access to contraception, particularly long acting reversible contraception, and access through non-health settings as measured by provider activity
VS	Existing Commitment: Access to GUM Services VSB13: Chlamydia screening

2.3.9 MRSA

Liverpool PCT has made significant reductions in MRSA infections, however, we are striving for significant further improvement and our approach reflects this ambition.

Priorities:

- Challenge all providers to continually reduce rates of MRSA using the Quality and Clinical Governance frameworks.
- Support all providers of healthcare to demonstrate full compliance with all legislation related to the prevention of infections, through use of a comprehensive Assurance Framework.
- Deliver on the specified infection control programme across primary care that is tailored to prevent and reduce all infections in patients and staff across the city's health and social care settings.
- Expand MRSA screening to cover 100% of relevant emergency admissions at the earliest opportunity and by 2011 at the latest.

Metrics:

VS	VSA01: Reduction in MRSA
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2.3.10 Clostridium Difficile

This is the final year of a three year plan for which healthcare organisations were tasked with reducing Clostridium difficile (C difficile) infections by at least 30 %. Liverpool PCT aspires to reduce C difficile infections further than the national mandate.

C difficile has been identified as one of the PCTs World Class Commissioning Health Outcomes reflecting our intention to continue to drive down rates of this infection beyond 2011.

Priorities:

- Continue to deliver on the PCT Strategy to reduce C difficile infections acquired in the community.
- Challenge all providers to continually reduce rates of C difficile using the Quality and Clinical Governance frameworks.
- Support all providers of healthcare to demonstrate full compliance with all legislation related to the prevention of infections, through use of a comprehensive Assurance Framework.
- Deliver on the specified infection control programme across primary care that is tailored to prevent and reduce all infections in patients and staff across the city's health and social care settings.
- Strive for 100% uptake of the deep clean initiative in the city's care homes.

Metrics:

WCC	Reduction in number of C difficile infections
LPO	Reduction in inappropriate use of antibiotic prescribing through surveillance, audit and feedback to all providers
VS	VSA03: Reduction in number of C difficile infections

2.4 Gold Standard Hospitals

Local hospitals should deliver services which are safe and effective and patients should feel they have been well cared for and empowered, taking an active part in making choices about their treatment and be able to look after themselves in the future. Key to achieving this will be the planned redevelopment of local hospitals.

2.4.1 Urgent Care

Urgent care (and alcohol) has been identified as a priority area for transformation in the NHS North West QIPP agenda. Liverpool PCT will lead the transformation of the urgent care pathway across North Mersey to redesign services, improve quality of care and release efficiency savings.

Priorities:

- Develop the North Mersey QIPP and priorities the work programme for urgent care to reduce demand, improve quality of care and realise cost efficiencies.
- Ensure alignment of acute and community based services to ensure optimal use of existing community based services through the development of an integrated triage at the acute provider trust.
- Develop new ambulatory care pathways to ensure patients are directed to the most appropriate service first time and to reduce emergency admissions with short lengths of stay (refer to 2.4.4 Stroke).
- Develop a marketing and communications plan for urgent care across North Mersey footprint.

This programme links to; 2.1.7 Alcohol, 2.8.1 Older people, 2.2.1 Long Term Conditions, 2.8.7 Dementia, 2.3.1 Outside of Hospitals, 2.3.7 Respiratory Conditions.

Metrics:

LPO	<p>Reduce demand for acute emergency services by 10% by March 2011</p> <p>Reduction in emergency admissions with a zero length of stay</p> <p>Reduce demand and conveyance for ambulance services</p> <p>Deliver maximum 20 minute ambulance turnaround time at acute hospitals</p>
VS	<p>Existing Commitment: Ambulance – Category A 19 minutes standard</p> <p>Existing Commitment: Ambulance – Category A 8 minutes standard</p> <p>Existing Commitment: Ambulance – Category B 19 minutes standard</p> <p>Existing Commitment: Total time in A&E</p>

2.4.2 Cancer

Liverpool PCT is committed to the implementation of the Liverpool Cancer Strategy five year plan which outlines the actions that will be taken to reduce cancer incidence, morbidity and mortality and improve the experience and outcomes of cancer patients. Greater, more local access to radiotherapy is a priority for Liverpool patients and the PCT is committed to developing radiotherapy services locally to facilitate the 31 day standard by December 2010. All priorities listed comply with QIPP agenda.

Priorities:

- Implement the Liverpool PCT Cancer Strategy.
- Engage with regional and national networks to identify key diagnostic tests and baseline current performance and access.
- Lead on a procurement process for additional radiotherapy services for the local population.
- Use the Mersey and Cheshire Cancer Network (MCCN) annual patient experience survey to inform commissioning.
- Develop a Haematological Malignancy Diagnosis Service across MCCN.
- Deliver an acute oncology district general hospital service.
- Reducing inequalities in cancer by:
 - Using staging data to identify communities most at risk
 - Working with targeted communities to change health seeking behaviours
 - Using lessons learned from Healthy Community Collaborative
 - Assessing screening data by geography/practice, ethnic group, age group, disabled etc. and use this to target hard to reach groups
 - Using the results of the equity audit carried out by Merseyside and Cheshire Cancer Network to determine the levels of variation in access to cancer services by GP practice
- Use the Liverpool PCT Cancer Awareness and Early Diagnosis Action Plan 2010/11 to increase earlier presentation of the signs and symptoms of common cancers among prioritised groups through the application of social marketing principles and the city-wide roll out and mainstreaming of effective 'community level' programmes.
- Pilot and apply the Merseyside and Cheshire Cancer Network (MCCN) Quality Performance Framework in Liverpool.

Metrics:

WCC	Reduce cancer mortality
LPO	Increased community awareness of sign and symptoms
VS	VSB03: Reduction in cancer mortality VSA08: Breast cancer symptoms 2 week wait VSA11: 31 day cancer subsequent treatment VSA12: 31 day cancer target subsequent treatment target (radiotherapy) VSA13: 62 day cancer target treatment target

2.4.3 CVD

Cardiovascular disease (CVD) is the single largest cause of death within Liverpool. The city is currently ranked the 13th highest for CVD. 'High Quality Care for All' set the challenge of delivering greater equity with regard to health outcomes. To meet this challenge, the differences in health status and outcomes within and between different communities will be addressed. CVD is a designated programme within the North Mersey QIPP programme.

Priorities:

- Redesign and re-commission cardiac rehabilitation services to meet the populations need and demand.
- Utilise General Practice Improving Standards framework and long-term condition locally enhanced service support so GP's can optimise pharmacological interventions for patients with Heart Failure, Hypertension and Hypercholesterolemia.
- Ensure achievement of national service framework and MINAP requirements for patients discharged from secondary and tertiary care.
- Support primary care, at a neighbourhood level, to case find members of the population at risk of developing CVD, utilising the General Practice Improving Standards framework.
- Implement the Heart Failure pathway across health economy.

Metrics:

WCC	Reduction in CVD mortality
LPO	<p>Increase the number of the population identified as at risk of CVD; reduce variance between actual and expected prevalence</p> <p>Increase the number of the population receiving optimum treatment for Heart Failure, Hypertension and Hypercholesterolemia by 15%</p> <p>Increased number of patients completing cardiac rehabilitation programme by 50%</p>
VS	<p>VSB02: Reduce CVD mortality</p> <p>Existing Commitment: Time to reperfusion for patients following heart attack</p> <p>VSC24: Patients admitted with a heart attack taking appropriate medicine</p>

2.4.4 Stroke

Liverpool PCT is committed to driving up standards of stroke/TIA (transient ischaemic attack) care to reduce mortality and morbidity through the implementation of the National Stroke Strategy. Evidence shows that outcomes are better when patients are admitted directly to stroke units rather than medical assessment units and treated and cared for by a multidisciplinary stroke-skilled team.

Priorities:

- Develop and implement stroke pathways that facilitate direct admission to a stroke unit for patients admitted with acute stroke facilitating the achievement of VSA14 for stroke. Improve pathways to ensure that patients with acute stroke have a brain scan within one hour.
- Develop a model for the delivery of 24/7 hyperacute stroke services inline with the National Stroke Strategy and undertake an Equality Impact Assessment of the service and feed the outcomes into the developments.
- Introduce TIA pathways across all providers to ensure patients with higher risk TIA are seen and treated within 24hrs and lower risk patients are seen and treated within two weeks.

- Extend the provision of ESD services to support patients for six months post discharge who have suffered an acute stroke and ensure equity of access to services.
- Develop plans for AF screening, treatment and management with appropriate anti coagulation and antiplatelet drug therapy (linking with CVD programme and PBC).
- Identify areas with the highest incidence of stroke and mortality and develop plans to identify specific areas and undertake a targeted approach to awareness raising campaigns for signs and symptoms of stroke.

Metrics:

LPO	Reduction in stroke mortality to meet CVD trajectory Increase the numbers of patients receiving thrombolysis post stroke from 3% to 10% 2010/11
VS	VSA14: Increase the number of people admitted to hospital following a stroke who spend 90% of their stay on a Stroke Unit For patients with higher risk TIA (ABCD2 score of four or more) increase the number of patients seen and treated within 24hrs

2.4.5 Military Personnel

Military personnel, their families and veterans have specific requirements of the NHS.

Priorities:

- Ensure military personnel, their families and veterans in Liverpool will have equal access to timely health care and dental services and veterans will have priority access for service-related conditions subject to clinical need. All providers will be required to ensure this takes place

2.4.6 Delivering Same Sex Accommodation (DSSA)

In January 2009, the secretary of state announced an intensive drive to all but eliminate mixed sex accommodation. Liverpool PCT commissioned a number of measures to support local delivery plans to achieve this. A declaration of compliance in March 2010 confirmed compliance with a commitment from Liverpool PCT to continuously adhere to the requirements as set out in the 2010/11 Operating framework and the standard NHS contract.

Priorities:

- Ensure clear commitment and championing from provider boards.
- Implement comprehensive internal communications strategies.
- Ensure appropriate training, skills, and knowledge to deliver against the expectations.
- Ensure staff to be compliant with locally determined policies and procedures.
- Ensure all providers will be monitored on their continuous compliance status of delivering same sex accommodation through the clinical quality contract performance meetings and formal reporting bi monthly.

- Carry out a risk assessment and root cause analysis to be undertaken in the event of mixed sex occurrence, including those with clinical justification.

Metrics:

LPO	To reduce to zero the mixing of men and women in healthcare accommodation
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2.4.7 Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. A goal of the national VTE Prevention Programme is to reduce avoidable death and long term disability from VTE.

VTE prevention is a CQUIN scheme for 2010/11 and will be monitored through the contract review process.

Priorities:

- Ensure clinical staff to understand the goal and are able to risk assess patients, record the outcomes, prescribe and administer appropriate prophylaxis.
- Plan and organise data collection on risk assessment of all adult inpatients.
- Report on clinical audits or appropriate prophylaxis and root cause analysis of inpatient pulmonary embolisms (PE's) and deep vein thrombosis (DVT's).

Metrics:

LPO	Reduce mortality and long term disabilities caused by VTE 90% of all adult inpatients will receive a venous thromboembolism (VTE) risk assessment on admission to hospital using the national tool, by April 2011
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2.5 End of Life Services

Around half of people say they would like to be cared at home if they were terminally ill, but at present only about a fifth of people die at home are able to, supported by the services they need.

2.5.1 End of Life Care

Liverpool PCT aims to deliver the End of Life Care strategy in line with QIPP principles, promoting high quality care for all adults at the end of life, such as enabling choice of place of death.

Priorities:

Implement the Liverpool PCT End of Life Care strategy, which was developed with wide stakeholder engagement in 2009/10 in line with national and local end of life care guidance:

- To further define and develop service specifications to enable the provision of community-based services that meet the end of life care requirements, and national quality standards for both general and specific priority conditions, such as dementia.
- To extend the use of the electronic supportive care register to all NHS contracted providers of end of life care. This provides a systematic framework, in line with national end of life care tools which assist in the optimisation of service delivery. It contains prompts to enable timely conversations to be had with the patient/carer/families.
- To extend care home training to enable compliance with the use of end of life care tools and standardised assessment of their needs.
- To ensure that appropriate end of life care training and audit (e.g. quality markers) is mandated and accessed by staff within provider organisations.

Metrics:

LPO	10% reduction in deaths occurring in hospital by 2012 Improve pain management for people at the end of life
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2.6 Personalised Care

People want to be treated with dignity and respect. While most people have a positive experience of NHS care, at times services fall short of patient expectations. The PCT aims to move from good to great through the development of a significant customer service excellence programme.

2.6.1 Maternity and Neonatal Services

It is critical that quality and safety in maternity services continues to improve. Putting women and their partners at the centre of local maternity service provision starts with encouraging women to see a midwife, or a maternity healthcare professional for a health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.

In addition to working with local authority and PCT provider partners, Liverpool PCT is working with the maternity service provider to improve access to maternity services in line with the Maternity Matters Framework which promotes early booking and choice of maternity lead professional.

Priorities:

- Improve antenatal pathway and revise the choose and book process to enable women to receive their first appointment within 12 weeks and 6 days of conception
- Ensure all women who request a home birth are able to have one (unless there are contrary clinical indications).
- Improve the midwife: birth ratios to improve personalised care, home birth, community antenatal care and postnatal provision of care.
- Improve the maternity patient pathway to support the provision of community midwifery and ensure continuity of care throughout pregnancy by reducing the numbers of midwives a woman sees.
- Implement a Downs Syndrome screening programme to meet National Standards.
- Maintain the partnership working for the smoking cessation programme, ensuring women are provided the opportunity and are supported to quit smoking during and after pregnancy.
- Antenatal care: to offer smoking cessation programme for all pregnant women.
- Antenatal care – screening: To offer all pregnant women the choice of screening for Downs Syndrome and for infectious diseases (Hepatitis B, HIV, Syphilis and Rubella susceptibility).

Metrics:

LPO	<p>Reduction in smoking in pregnancy</p> <p>Antenatal care: Increase the % pregnant women who are offered the choice of a screening test for Downs Syndrome which complies with the UK National Screening Committee model for Best Practice 2007/10</p> <p>Pregnancy pathway: 90% of women to see three or less midwives throughout their pregnancy pathway to enable continuity of care</p> <p>Home births: to increase the volume of home births to the national average of 3.0% (from 2.6%) of all births by March 2011</p> <p>Reduction in obesity in pregnancy</p>
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	Improved maternal and neonatal care
VS	VSB06: Percentage of women who have seen a midwife or maternity healthcare professional by 12 weeks

2.6.2 You're Welcome

The 'You're Welcome' quality criteria standards set out principles that will help health services to "get it right" and become young people friendly as highlighted in the Child Health Strategy and the Healthy Child Programme. 'You're Welcome' will help the PCT to transform the health services they commission by improving the acceptability, accessibility, quality and choice of services for young people.

Priorities:

- Develop a local action plan for the implementation of You're Welcome, outlining local targets for the achievement of the quality mark within all health services that regularly see young people by 2020, and ensure that the action plan is agreed by the Children's Trust.
- Identify both Professionals and Young People to undertake You're Welcome verifier training with a view to them being part of a number of citywide verification panels.
- Work with relevant Commissioners to ensure that the You're Welcome quality mark is built into future commissioning arrangements for all health services that are regularly seeing young people aged 11-19 years.
- The first wave of the You're Welcome roll out programme in Liverpool will take place in May 2010.
- The Communications Plan will raise the profile of You're Welcome whilst at the same time providing practical information on how organisations and young people can be fully engaged in this initiative. Services will be targeted in line with DH prioritisation.
- Staging You're Welcome Awareness events to be increased opportunities for relevant organisations to support this programme.

2.6.3 Carers

In line with the Carers Strategy, the PCT continues to work closely with local authority partners to publish joint plans on how combined funding supports carers in a personalised way.

Priorities:

- To establish a joint plan with LCC about how we intend to support carers which will provide details on how the PCT and LCC combined funding will support breaks for carers, including short breaks, in a personalised way in accordance with the National Carers Strategy.
- To ensure that carers have access to health services appropriate to their needs to help maintain their physical and mental wellbeing.
- To ensure that the NHS works with LCC to support joint carers assessments when this is appropriate.
- To work with appropriate agencies to ensure the particular needs of those caring

for people with dementia are addressed.

- Liverpool PCT will work with LCC to ensure there is improvement:
 - In patients receiving clear information on the quality of each service offered by every NHS
 - To support the work of clinicians to inform the public, patients and carers about health choices and choice of service providers
 - In NHS Choices by integrating it into local support and advice for their patients and encouraging GP practices to improve the information about service.

Metrics:

LPO

Carers with a long-term condition supported to be independent and in control of their condition

2.7 An end to waiting

We have moved a long way in a short time to reduce waiting times for hospital care from years to 18 weeks. We want to extend this success across the whole healthcare system, reducing the time people have to wait for healthcare, for example, to see a GP, to get home care and adaptations and rehabilitation services.

2.7.1 Dentistry

A key priority for Liverpool PCT is commissioning to increase access for everyone seeking NHS dental services by March 2011. The PCT will continue to develop NHS dental services to meet local needs for access, quality of care and oral health. To provide a consistent measure of whether PCTs maintain this aim, a new indicator of public experience of accessing dental services will be introduced as an existing commitment from 1 April 2011.

Priorities:

The PCT has identified key priority areas for dental services within Liverpool in 2010/11:

- Improve patient access to dentistry in accordance with the achievement of the dental vital sign (VSB18) and the PCTs Oral Health Equity Audit.
- To improve quality in dental services in Liverpool through the development of a quality framework working in partnership with providers.
- Continue to work with providers to implement 'Delivering Better Oral Health' to ensure prevention is embedded in local dental services.
- Revise the oral surgery pathway for service users in order to improve access and the patient experience.
- Ensure any new dental procurements, together with performance management of existing dental contracts, will lead to benefits including increased dental access, enhanced quality of care and the promotion of prevention.

Metrics:

LPO	Increase the number of children receiving fluoride varnish in Liverpool by 20% by 2011 Increase the number of NHS dental practices that have a dental nurse trained to provide preventive treatments to a minimum level of 50%
VS	VSB18: Improving access to dental services by 2.5% from December 2009

2.7.2 18 Weeks

Liverpool PCT will maintain the requirement that no-one should wait more than 18-weeks from the time they are referred to the start of their hospital treatment, and will continue to deliver on the 18 week targets for admitted and non-admitted patients.

Priorities:

- Work with providers to ensure maintenance of delivery of 18 week targets for all specialties, including audiology. Those specialties at risk of failing have already been identified and discussions are in place with providers as to actions required to improve performance.
- Support NHS Liverpool Community Health Services in participation of national pilot for Allied Health Professionals (AHP) measurement of Referral to Treatment Times (RTT).
- Use the emerging outcomes from the pilot of AHP RTT monitoring to work with the other Liverpool providers to develop and implement systems to monitor AHP RTT waits and to inform contracting and Transferring Community Services discussions between Liverpool PCT and NHS Liverpool Community Health Services.
- Work with four hosted providers to improve slot availability, each trust is working to a detailed plan to deliver this supported by the PCT Choose and Book team.
- Establish a mechanism to offer patients alternative providers where current treatment is not within 18 week targets and this is not through patient choice or because of a complex pathway.
- Work with the PCT Stakeholder Engagement team to identify opportunities to understand patient experience of 18 weeks as part of the wider patient and public engagement work.
- Work with providers to review their Access Policies with regard to undertaking Equality and Diversity Audits against their policies and protocols for dealing with patients.

Metrics:

VS	VSA04 / VSA05: the percentage of patients whose referral time is less than 18 weeks for admitted and non admitted patients
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2.8 Joined up Services

Patients want services to be more joined up, to avoid repeating things to many different people and to avoid confusion about whom to go to for help. This will be addressed through closer working with the local authority and other partners.

2.8.1 Older People

The PCTs Older People's Service aims to support older people to maintain health, wellbeing and independence for as long as possible whilst affording choice and control for the individual. Through close partnership working, the service will continue to improve the early and accurate diagnosis of dementia, further develop the falls strategy and reduce emergency bed days.

Priorities:

- Extend the Liveability service to North Liverpool in partnership with Leisure Services and Primary Care to encourage older people to increase participation in physical activities.
- Joint implementation of the Extra Care Housing Strategy.
- Implement the Promoting Independence Strategy which focuses upon prevention and active ageing activity.
- Input to the specification for domiciliary care services to ensure that a higher level of care and support is available at the neighbourhood level to support people at home.
- Joint development of a re-ablement strategy.
- Define and agree levels of care to ensure that people are appropriately placed according to their needs, for use by the Transfer of Care Team on discharge from hospital.
- Develop a robust integrated care pathway, which includes people with Osteopenia/Osteoporosis.
- Review service provision to ensure appropriate services for older people with learning disability.

Metrics:

LPO	To have 2% or more of people over the age of 65 accessing the re-ablement service which meets the nationally reported average Reduce the number of fall related admissions to hospital for fractured neck of femurs
VS LAA	VSC10: Reduction in delayed Transfers of Care VSC11: People with long-term conditions feeling independent and in control of their conditions VSC12: Timeliness of social care assessments

2.8.2 Children with Disabilities

The PCT continues to ensure services are in line with the Child Health Strategy including:

- Delivering a high quality Healthy Child Programme (Child Health Promotion

Programme);

- Implementing the adolescent-friendly 'You're Welcome' standards;
- Implementing the Aiming High for Disabled Children with LA partners, improving the experience of services for children with a disability and their families, including palliative care.

Priorities:

- Develop an Integrated Care Pathway for children and young people with neuro disability and complex healthcare needs across acute community and primary care.
- Benchmark patient experience at transition points, in order to improve the handover process in the future.
- Work with primary care around the every disabled child matters framework to ensure children with a disability access their GP for primary care needs.
- Deliver on priorities within the Aiming High programme assessment carried out by the NWSHA.
- Develop specific information on services for children and young people including service provision and decision making process.

Metrics:

LPO	Improvement in quality of life for disabled children PSA121 Improvement in respiratory health by a reduction in respiratory infections and admissions to hospital for children with neuro-disability
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2.8.3 Child and Adolescent Mental Health Services (CAMHS)

Liverpool CAMHS developments reflect local needs and are congruent with local, regional and national priorities including Standard 9 of the National Service Framework and the Liverpool Children and Young Peoples Plan. Consultation with children, young people and their carers is performance managed against locally developed participation standards.

Priorities:

- Consult on, launch and implement children and young peoples mental health and emotional well being strategy 2010/13.
- Re-specify the specialist CAMHS delivery model to provide a locality based service in line with neighbourhood structures.
- Achieve outcomes Targeted Mental Health in Schools (TAMHS) pilot.
- Implement transition action plan as identified in the Transition Strategy.
- Review current provision and develop the range of age appropriate provision for young people aged 16-18years, including community based and hospital based services.

Metrics:

LPO	Reduce inappropriate referrals to specialist mental health provision by 10% year on year Reduce DNA's within specialist mental health provision by 10% year on year Improve Mental Health and well being for children and young people by introduction of reducing stigma programme and pilot of early intervention and prevention model in schools (TAMHS), measured by the national 'TELLUS' survey of Children and Young People
VS	VSB12: Evaluating the impact of CAMHS (percentage of PCTs and Local Authorities who are providing a comprehensive CAMHS)

2.8.4 Safeguarding

Liverpool PCT will continue to review the policies, skills, competencies, partnership arrangements with other agencies, monitoring and assurance procedures to ensure statutory responsibilities are in place.

Priorities:

<ul style="list-style-type: none"> • Review the progress by providers of the PCT Safeguarding Children Strategy work plan for 2010/11. • Audit compliance of safeguarding children minimum standards by independent contractors. • Receive assurance that the PCT providers review and revise their existing safeguarding children policies and procedures in line with the 2010 Working Together to Safeguard Children statutory guidance once it is published. • Develop safeguarding pathway from CAHMS to social care, embedding a Community Assessment Framework in the early referral process. • Receive assurance that Independent sector providers comply with statutory guidance and DH National Minimum care standards regulations before spot purchasing services. • Maintain the non-placement of under 16's on adult mental health wards in accordance with the Mental Health Act. • Maintain the non-placement of under 18's on adult mental health wards unless their individual needs require such an admission.

Metrics:

LPO	Improvement in assurance of safeguarding standards by independent contractors
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2.8.5 Emergency Preparedness: Merseyside

Liverpool PCT plays an important role in health protection and emergency planning in Liverpool and across Merseyside. The PCT operates at three distinct levels – gold (as lead PCT for Merseyside), silver (Liverpool PCT) and bronze (provider organisations) and are acknowledged as a key emergency planning organisation in the North West.

Priorities:

- Develop and implement a five year strategy for improving NHS Resilience in Merseyside.
- Develop the capability to monitor and oversee the urgent care system across Merseyside.

2.8.6 Emergency Preparedness: Liverpool PCT

Priorities:

- Continue with the delivery of the role specific and induction training programmes, including the development of an e learning package.
- Ensure the major incident rooms for the PCT are fully prepared for operational response.
- Conduct a major incident ‘table top’ exercise to ensure compliance with the NHS Emergency Planning Guidance 2005.

2.8.7 Dementia

Working in partnership the PCT and Liverpool City Council have published the Liverpool Dementia Strategy, the primary aim of this strategy is to improve the quality of life and quality of care for people living with dementia and their carers.

Priorities:

- Increase the number of carers of clients receiving community based services receiving a ‘carers break or a specific ‘service for carers’”.
- Make optimum use of primary care registers to manage dementia by comparing actual numbers to expected numbers by GP practice and review recording and coding practices (prevention and productivity).
- Improve outcomes for carers of people with dementia by establishing a QOF Carers Register and supporting GP practices to identify or ‘case-find’ carers.
- Support Liverpool City Council to improve timeliness of social care assessment and care packages, including streamlined information sharing processes.
- Contribute to the alcohol harm minimisation agenda and the Alcohol Improvement Plan in relation to older people and alcohol.
- Ensure people with a diagnosis of dementia are not excluded from rehabilitation and therapeutic services by increasing access to intermediate care, speech and language teams and falls prevention.

Metrics:

LPO	Increase the early and accurate diagnosis of dementia (currently 41%) by 5%
	Increase the proportion of people achieving independence three months after entering care/rehabilitation using access to provider services as a proxy measure
	Increase the number of adults and older people receiving direct payments and/or individual budgets (measured by the LCC Self Directed Support Unit)

2.8.8 Mental Health

In line with the New Horizons strategy, the mental health programme has two overarching aims: to improve the quality and accessibility of services for people with poor mental health; and to promote mental health and well-being across the whole the population. Priority has been given to: earlier identification and support for people with poor mental health; reducing demand on secondary health services and improving the inpatient experience; the achievement of better health outcomes, higher employment rates for people with severe mental illness, and a reduction in suicides. In addition there will be increased access to, and reduced waiting times for, psychological therapies so that common mental health problems are treated earlier.

Priorities:

- Promote the 'Five Ways to Well-Being' and develop a social prescribing hub and pathway for vulnerable individuals and groups in Alt Valley/North Liverpool.
- Develop a shared care protocol with primary care for attention deficit hyperactivity disorder (ADHD).
- Work with partners to develop services for refugee and asylum seeker mothers in partnership with child and maternity services.
- Tackle mental health inequalities by improving the accessibility of services for women, black and minority ethnic groups and lesbian, gay, bisexual and transgender (LGBT) people.
- Implement the DH personalisation pilot in community mental health teams.
- Implement the 'Your Well-being in Mind' review and build capacity and care pathways in community mental health services.
- Review the acute care pathway in partnership with primary care and implement a revised model of the pathway.
- Support the implementation of the new personality disorder service.
- Support the implementation of the updated 'Suicide Prevention Toolkit', in particular smoothing the transition from inpatients to community, improving the physical environment and improving performance in relation to three day follow up after discharge.

Metrics:

WCC	<p>Improving Access to Psychological Therapies (IAPT) services for people with mild to moderate depression or anxiety in line with national guidance</p> <p>For IAP services the number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological treatment</p>
LPO	<p>Increase access to settled accommodation and employment for people in secondary mental health services</p> <p>Reductions in delayed discharge for in-patients (monitored weekly and actively responding to need)</p> <p>Reduction in demand on secondary health services</p>
VS	<p>Existing Commitment: Commissioning of early intervention in psychosis services</p> <p>Existing Commitment: Commissioning of crisis resolution / home treatment services</p>

2.8.9 Crime and Violence

The PCT continues to work as a member of the Crime Disorder Partnership to support local action on reducing violent crime – especially serious youth crime, knife crime and violence against women and children. In addition the PCT will be involved in the development of the CDRP Offender Management Strategy for April 2010 as well as ensuring that the new duty to contribute to reducing offending is communicated across the PCT at all levels.

Priorities:

- Ensure the PCT is appropriately engaged in the crime reduction strategies including knife crime tackling Youth Crime/anti social behaviour/violence against women and children/early intervention.
- Ensure appropriate responses are developed to meet the health needs of offenders in particular those with mental health problems.
- Ensure support is given to the Sexual Assault Referral Centre (SARC).
- Further investigate the development of other services to address violence e.g. services in A&E and services in maternity.
- Ensure that in the development of any new building programmes the issue of designing out crime and target hardening is considered in the planning process.

2.8.10 Domestic Violence

In line with the national guidance “Together we can end violence against women and girls”, the PCT will work with partners to help prevent violence and abuse against women and children and support to the victims. In Liverpool the PCT has engaged in this agenda and for example is supporting the low threshold pilot service based at Liverpool Women’s Hospital.

Priorities:

- Develop an overarching domestic violence policy for all PCT commissioned services and is adopted for local use.
- Develop a supportive approach to NHS employees who may have been subject to domestic violence (healthy workforce).

Maintain existing health input into the following:

- Multi Agency Risk Assessment Conference (MARACs) (Hospitals and PCT).
- North Liverpool Domestic Violence Pilot.
- PCT representation on the Domestic and Sexual Violence Forum.

2.8.11 People Living in Vulnerable Circumstances

Supporting people to return to work improves their physical and mental health, while reducing the risk of social exclusion. The wider implications of supporting vulnerable people and their families are addressed in other sections within this plan such as mental health, learning disabilities health inequalities and prevention.

Priorities:

- Develop NHS employment schemes which are externally funded or unpaid to support local vulnerable people into work.

- Prioritise initiatives to support the requirements of the workforce plan, including schemes to attract young people into the PCT.
- Encourage work opportunities for local vulnerable people across the PCT by utilising both NHS employment schemes which are externally funded.
- Support the development and roll out the 'Workplace Wellbeing Charter' across Liverpool.
- Develop third sector organisations to supporting the local health economy and individuals in vulnerable circumstances.
- Finalise and implement the sustainability strategy.
- Create internal work placements via local or national employment schemes that are designed to improve work opportunities for local people (externally funded/unpaid placements).
- Promotion and adopt the workplace wellbeing charter, improve the health and wellbeing of the local workforce.

Metrics:

LPO	<p>Increase in the number of externally funded or unpaid employment schemes known to and supported by the PCT</p> <p>Improve the living conditions and access to health and other local services for vulnerable residents across the City through the Healthy Homes programme</p>
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2.8.12 People with Learning Disabilities

The PCT will follow the recommendations from the Sir Jonathan Michael inquiry. The PCT is aiming to achieve the full inclusion of people with learning disabilities (PWLD) in mainstream health services in order to reduce health inequalities and reduce barriers to accessing in-patient care and treatment in line with DH recommendations (Healthcare for All).

Priorities:

- Increase identification of the needs of the learning disabled population in Liverpool and meet the requirements of the national minimum data set for learning disabilities.
- Ensure Health and Social Care systems are compliant with CQC indicators and Vital Signs for PWLD.
- Ensure a personalised approach to short breaks that meet the needs of service users and their families.
- Improve care pathways for patients with a Learning Disability and forensic needs in the Criminal Justice system or secure accommodation, in partnership with North West Secure Commissioning team, City Council, local Clinicians and Offender Health.

Metrics:

LPO	<p>Reduce health inequalities in people with learning disabilities</p> <p>Reduce the number of 'out of area' placements when local services have not been able to meet the needs of people with a Learning Disability with the most challenging needs in line with the outcomes referred to in 'Valuing People now'</p> <p>Increase the number of annual health checks by GP practices</p>
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2.8.13 Offender Health

The PCT has just completed a whole system review of prison health care in HMP Liverpool that will lead to the redesigning of what will be a primary care led service that builds on the current good level of service delivery but seeks to make some significant improvements that will lead to improved outcomes for the prison population. The key focus for improving the health of the prison population is determined by the Prison Health Care Performance and Quality indicator set and the National Reducing Re-Offending Action Plan drives strategic direction.

Work has already been completed on assessing where along the offender health pathway health interventions are best delivered and this has culminated in discussions with Merseyside Probation Trust in relation to the delivery of health interventions in Probation settings.

Priorities:

- Ensure the delivery of primary health care service is within agreed budget and in line with Prison Health Delivery Plan, ensuring cost effectiveness, greater efficiency and value for money.
- Implement the Integrated Drug Treatment System in both HMP Liverpool and HMP Altcourse in line with National Treatment Agency guidance
 - Increase uptake of hepatitis B vaccination and ensure reliable data obtained to enable effective performance management of services on vaccination uptake
 - Hepatitis C testing strategies and care pathways agreed for prison health services to allow equitable access to treatment services for offenders.
- Ensure the PCT provides an effective response to the health needs of Young Offenders.
- Improve the integration of the health and social care needs of the offender population into mainstream services.
- Protect the offender population against hepatitis B and C.
- Improve the care delivery outcomes for offenders with mental health problems.

Metrics:

LPO	<p>Reduce the health inequalities of offenders across the whole criminal justice footprint by establishing improved access to health and social care provision and increasing health promotion/awareness in line with local need</p> <p>Reduce the pattern of re-offending by improved partnership arrangements with key stakeholders including the Crime & Disorder reduction partnership (CDRP) and 'First for Health & Wellbeing'</p> <p>Reduce infection rates of hepatitis B and C among the offender population</p> <p>Increase the uptake of vaccination for hepatitis B</p> <p>Improve care delivery outcomes for offenders with mental health problems</p>
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2.8.14 Drugs Strategy

To deliver key strategic aims, LPCT will ensure a co-ordinated response to enforcement activity; diversion from the criminal justice system into treatment;

expansion of treatments available whilst in prison and the support services available to offenders, post release.

Work is underway to redesign the community drug treatment system in line with latest guidance and to reflect the changing nature of illicit drug use.

Priorities:

- Address the issues of the aging population in the drug problematic users (PDU's) in the Prisons and community.
- Support the recovery agenda and increase opportunities for social inclusion and reintegration back into society.
- Introduce the personalisation agenda across the drug treatment system to enable prevention, enablement, community plans and person centred care management services.
- Improve uptake of hepatitis B vaccination amongst drug-users and ensure reliable data obtained to enable effective performance management of services on vaccination uptake.
- Agree auditable integrated pathways of care for patients with hepatitis C.
- Implement a system for obtaining reliable data on the number of patients referred, seen and treated for hepatitis C.
- Ensure a high rate of testing in those attending specialist services for drug users.

Metrics:

LPO	Increase the protection of drug users against hepatitis B and C
VS	VSB14: Number of drug users recorded as being in effective treatment

2.8.15 Third Sector

Liverpool PCT recognises the valuable role third sector organisations play in creating healthy, successful communities and that many third sector organisations, including voluntary and community organisations, charities, social enterprises, cooperatives and mutuals share value driven goals close to those of the PCT. It is also evident that third sector organisations can have a good understanding of and be close to the communities which they serve and are often able to identify and deliver innovative solutions for better health and wellbeing. Consequently third sector organisations are well placed help Liverpool PCT to understand how to best serve communities and to reach particular target groups effectively. Liverpool PCT already works with a number of third sector organisations and wishes to improve the quality and scale of engagement in order to maximise health improvement.

Priorities:

- Understand scale and scope of third sector in Liverpool, identifying priority opportunities for improved engagement.
- Identify how resources can be used to support strong third sector and communities they serve including commissioning, grants, estate and skills.
- Develop and adopt third sector strategy Summer 2010.
- Involve and consult third sector to help ensure meet needs of people and communities when;
 - Policy making
 - Designing new programmes and services

- Evaluating programmes and services
- Proposing improvements.
- Review PCT commissioning and procurement processes and effect on third sector.

2.8.16 Sustainability

Sustainable development is “meeting the needs of the present without compromising the ability of future generations to meet their own needs” and is now formal policy in Europe and the UK.

Liverpool PCT has developed its first Sustainability Strategy which sets out our approach in more detail. Implementing our sustainability plans is a long term approach which integrates social, environmental and economic goals and policies to achieve improvements in health inequalities for the long term.

Priorities:

- Consult on the draft Sustainability Strategy spring 2010, and finalise implementation plans for summer 2010.
- Integrate a sustainability programmes and messaging in 2010 Year of Health and Wellbeing programme.
- Progress the Cycling Alliance initiative.
- Develop detailed Carbon Reduction plans and deliver 10:10 commitment to cut carbon emissions during 2010.
- Develop Travel Plan and deliver the Cycle to Work Guarantee commitments.
- Develop a detailed Sustainable Commissioning and Procurement approach.
- Lead the Carbon Collective to promote sustainable development across NHS Liverpool.
- Improve partnership working to address Climate Change adaptation and mitigation.

Metrics:

LAA	Adapting to climate change PSA27
KLOE	3.1 Is the organisation making effective use of natural resources?

3.0 Enablers

3.1 Managing Resources

3.1.1 Overview

In resource terms, 2010/11 is an important year for Liverpool PCT. It is the final year of the current three year Comprehensive Spending Review cycle, and given the potential future impact of the global economic downturn on public services funding, it is likely to be the last year that there will be real-terms growth in financial allocations. However, the PCT has a very solid financial base underpinned by a Financial Strategy that will help meet the challenges that the PCT, and the rest of the NHS, expect to face from 2011/12 onwards.

A key aim of this Strategy is to continue to preserve resilience and flexibility throughout this difficult period and this will enable the PCT to respond in a measured and proportionate way to changes in the financial environment. A significant amount of resource has been lodged with NHS North West (£20m) for return to the PCT next year, and in addition, a total surplus of around £5.3m will be carried forward to 2010/11 under Treasury accounting rules, partly generated by an underlying recurrent surplus of £5.1m. This means that in 2010/11, the PCT will benefit from a total non-recurrent surplus of £25.3m, and from uncommitted base resources of £5.1m, before the mainstream allocation is received.

In line with guidance to moderate the overall level of NHS surplus in 2010/11, the PCT will reduce the lodgement to £14m in 2010/11, and seek to retain a significant non-recurrent surplus in 2011/12 to provide maximum flexibility in the transition to very low expected levels of annual cash growth at the end of this Comprehensive Spending Review cycle. Coupled with an in-year surplus of £5.4m, the PCT anticipates an aggregate surplus of £19.4m in 2010/11, equivalent to 2.0% of turnover. This approach will be linked to careful management of recurrent resources, ensuring that they are only deployed to the strategic objectives of the PCT. The availability of these resources non-recurrently over the last few years has given Liverpool the ability to protect the PCT's medium and long term financial health.

Although the PCT does not expect significant growth in the resource base in the foreseeable future, there is almost £1 billion already being spent on the population's health every year, and during 2010/11 there will be refocusing of effort on ensuring these resources are used in the most cost-effective way possible for the benefit of all patients. Key to success in these aims will be how well the PCT works with partners to collectively manage the health and social care environment both in Liverpool and across the wider North Merseyside area, and robust arrangements are in place on a number of fronts.

3.1.2 Historic Financial Performance

The PCT's favourable financial position is a product of prudent financial management, supported by rigorous long-term financial planning, and healthy financial relationships with NHS partners. Financial performance in the last three years has been positive, as the table below demonstrates:

Figure: Financial performance 2006/07 - 2009/10

Recurrent Surplus/(Deficit)	19.3	29.7	10.1	5.1
Offset by Non Recurrent Expenditure	(15.5)	(19.1)	(3.7)	0.2
Total Net Surplus	3.8	10.6	6.4	5.3

3.1.3 Financial Outlook

The PCT's financial plans reflect the confirmed allocations for 2010/11 and are based on the SHA central guidance. Liverpool PCT expects to receive a total cash uplift of **£46.6m (5.1%)** for the year.

Since its inception, Liverpool PCT has endeavoured to strike a careful balance between targeted investment and effective management of resources. The success of this strategy is clearly demonstrated by external performance and regulatory assessments that have consistently placed the PCT amongst the top performers nationally. As a period of financial uncertainty is approached, in which the majority of PCTs will be concentrating their efforts on maintaining financial balance whilst striving to sustain achievement of core targets, Liverpool PCT will be able not only to maintain current investments, but to increase spending in critical priority areas.

As described in paragraph 3.1.1, the PCT has available funds totalling £63.0m in 2010/11, comprising expected new growth of £46.6m supplemented by internally generated funds amounting to £16.4m, as set out in the table below;

EXPECTED SOURCES OF FUNDS	2010 / 2011		
	Recurrent	Non-Recurrent	Total
	£m	£m	£m
Recurrent Surplus brought forward	5.1	0.0	5.1
Recurrent Growth Allocation	46.6	0.0	46.6
Lodgements and RAB Brokerage			
Return of prior year SHA Lodgement	0.0	20.0	20.0
Return of prior year RAB Surplus	0.0	5.3	5.3
Proposed in-year Lodgement	0.0	(14.0)	(14.0)
	0.0	11.3	11.3
Projected New Resources Available	51.7	11.3	63.0

Excluding resources expected to be consumed by net inflation, contingency provisions, the pick-up of the expected DH under-funding of Central Budget Allocations (£28.4m in aggregate) and a planned surplus of £5.4m, leaves £29.2m available for investment in 2010/11. In 2010/11, Liverpool PCT intends to invest an additional £56.8m in services both to prevent and to treat ill health, in line with our eight Strategic Goals.

The difference between investment plans and available resources (£27.7m) will be generated through an ambitious and carefully targeted programme of cost saving schemes focusing on demand management, efficiency gain and productivity improvement.

This is summarised in the table below;

USE OF RESOURCES	2010 / 2011		
	Recurrent	Non-Recurrent	Total
	£m	£m	£m
Net Resources Available for Investment	12.7	16.5	29.2
Gross Investment Plans	47.4	9.5	56.9
less Savings Plans	(34.7)	7.0	(27.7)
Net Additional Spend	12.7	16.5	29.2

The next table shows how gross investment plans, amounting to £56.9m in 2010/11 will address the eight Strategic Goals of the PCT. Every penny of the proposed new investment is directly linked to taking forward one of the key objectives.

It should be noted that the applications of funds shown below relate to Liverpool PCT resources only. References elsewhere in this document to planned investments include, in some cases, sources of funds external to Liverpool PCT, for example Liverpool City Council.

INVESTMENT PLANS	2010 / 2011		
	Recurrent	Non-Recurrent	Total
	£m	£m	£m
Things that make a Big Difference	3.5	1.8	5.3
Understanding Self-Care	1.6	0.4	2.0
Gold Standard Primary and Community Services	9.1	3.5	12.6
Gold Standard Hospitals	26.3	0.2	26.5
End of Life Care	1.1	0.0	1.1
Personalised Care	3.0	0.2	3.2
An End to Waiting	1.8	0.0	1.8
Joined-up Services	1.0	3.4	4.4
Total Investment Plans	47.4	9.5	56.9

Few PCTs will be planning new investment in health services on this scale in the current financial climate. However, the PCT's robust financial health, first class

financial management and track record of delivering effective demand management through partnership working across all stakeholder groups gives confidence to continue to drive further service transformation for the benefit of all patients.

3.1.4 Achieving Sustainable Financial Balance

This success has been built on a solid platform of strong resource management allied to a clear vision of the future and a pro-active and assertive financial strategy. Whilst recognising the limitations of a zero real growth future, it is clear that the near £1.0bn annual budget presents an opportunity to secure better value for patients from mainstream expenditure programmes. To continue the planned programme of investment in 2010/11, opportunities will be identified to obtain better value for money within current expenditure programmes. The target is £27.7m and the table below describes the broad areas where the savings will be achieved.

SAVINGS PROPOSALS	2010 / 2011		
	Recurrent	Non-Recurrent	Total
	£'000	£'000	£'000
Healthcare Contracts : Demand Management	16,026	(2,000)	14,026
Review/Re-profile Existing Commitments	3,132	0	3,132
Commissioner-led Efficiency/Service Change Proposals	3,546	(1,750)	1,796
Prescribing Savings	5,500	0	5,500
PCT Infrastructure Savings	4,500	(2,250)	2,250
Other Savings	2,000	(1,000)	1,000
Total Savings / Efficiency Proposals	34,704	(7,000)	27,704

As indicated elsewhere in this document, the QIPP agenda is being progressed at both individual organisation and Local Health Economy level and well-developed clinical engagement in service re-design has been embedded across stakeholders.

The partnership of Practice-based Commissioning Consortia, the Professional Executive Committee and Provider Medical Directors, together with a strong supporting infrastructure as the vehicle will deliver better patient pathways with improved outcomes, reduced duplication and better cost effectiveness, and effective control of demand from 2010/11 onwards.

Despite the challenging cost improvement targets, the PCT has ensured that this will not have any adverse impact on service quality, access to healthcare, prevention programmes, health equality or outcomes for patients.

Broadly, the cost improvement targets will be achieved by working together with partners to;

- Manage access to secondary care more appropriately and develop new alternatives to hospital treatment closer to patients' homes
- Identify and eliminate, where possible, duplication of provision and streamline the delivery of care
- Review the way we commission and procure services to ensure we can demonstrate value for money, effectiveness and good outcomes for patients in all areas
- Look for opportunities to streamline our own infrastructure through the use of shared services and functions and the introduction of better systems.

3.1.5 Conclusion

Although challenging financial targets for 2010/11 have been set, the PCT's track record means it is better equipped than most PCTs to achieve these objectives. Performance will be managed throughout the year, along with a number of new mechanisms to help stay on track – for example, a multi-disciplinary team dedicated to identifying opportunities for cost improvement across the full spectrum of commissioning activities.

Additionally, the co-operation and shared vision established across the North Mersey Health and Social Care community will be crucial in a future that will inevitably prove to be difficult for public services, and strong inter-agency support structures will play a key role in ensuring collective success.

Metrics:

KLOE	<p>1.1 Does the organisation plan its finances effectively to deliver its strategic priorities and secure sound financial health?</p> <p>1.2 Does the organisation have a sound understanding of its costs and performance and achieve efficiencies in its activities?</p> <p>1.3 Is the organisation's financial reporting timely, reliable and does it meet the needs of internal users, stakeholders and local people?</p>
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3.2 Developing Workforce

3.2.1 Vision for the organisation

The vision for Liverpool PCT is to create a dynamic learning organisation that enables every employee to be the best that they can. The workforce will have the opportunity to develop the capabilities appropriate for a World Class Commissioning organisation. It will be a workforce that is representative of the community served and that meets the aspirations of the revised Single Equality Scheme.

The PCT wants to be the employer of choice in Liverpool where people want to work, feel valued in the job that they do and are confident that they have the right skills and capabilities to help improve the health of our local population. Leaders will inspire behaviours and values in the workforce so that the PCT is recognised locally and nationally as a gold standard organisation, commissioning the best quality services for the public. The PCT's ambition is to be a world class commissioner, fully integrated with the Local Authority and partners - effecting real changes to health outcomes across Liverpool.

Liverpool PCT has an ambitious agenda both in organisational development terms and in the quality of the health care services that are provided. The aims for the organisation include:

- To be a fair and equitable employer with a workforce representative of the community we serve.
- To provide leadership across the health sector in Liverpool and in the wider North Merseyside health economy.
- To lead the implementation of the Outside of Hospitals programme across the providers of Liverpool.
- To be a trail blazer for partnership working with the Local Authority and provider organisations both in terms of the existence of joint posts allowing our staff to develop skills and capabilities across both organisations, and in the joint commissioning and performance management of health services.
- To be a learning organisation that offers outstanding learning and development opportunities, and identifies and nurtures local talent.
- To be a flexible organisation that responds rapidly and efficiently to change in the external environment, underpinned by robust workforce planning.
- To be committed to exceptional stakeholder engagement in decision making and commissioning, including with hard-to-reach groups.
- For decision making, commissioning and investment to be based on sound data and performance metrics.
- To have clinicians at the forefront of managing change; and the right support given to help develop their leadership skills.
- To have clear, quantifiable evidence that the health of the local population has been improved.
- To be an organisation that effectively manages the market so that a higher quality of care can be delivered with increased efficiency.

3.2.2 The Four PCT Strategic Organisational Development priorities

Leadership - has a two-fold priority. It incorporates both leadership of the PCT by the Board, directors and other management staff, and the role of the PCT as a

significant leader across a wider area. High level actions under this priority will include:

- Board development programme
- Regional and internal leadership development
- Mainstream equality and diversity
- Lead Health and Well Being Charter
- Implement system wide approaches to clinical leadership

Culture - the PCT will play a lead role in creating the innovative organisational environment and conditions that will underpin, enable and promote transformational health and service improvement, embedding the principles of value for money and keeping the patient at the heart of everything. Defining and embedding values and behaviours to support this role is fundamental to progress this priority. High level actions under this priority will include:

- Refresh and launch values
- Create values based systems and processes
- Adopt programme/project management approaches
- Evaluate and refresh internal communications strategy

Continuous Improvement - there will be a systematic approach to managing change based on leading edge approaches, effectively aligning business planning and performance management processes to continually reassess priorities and realign resources appropriately. Thus, the PCT will be able to continue to deliver quality care and reduce health inequalities whilst achieving efficiencies and finding real savings. High level actions under this priority will include:

- Integrate service, finance and workforce planning approaches
- Development of assurance and governance framework
- Menu of commissioning learning programmes
- Consistent Equality Impact Assessment
- Multi-agency delivery of learning and development
- Build and embed into PCT values and behaviours

Talent Management - is about enabling people to be the best that they can be. It facilitates the creation of a workforce that is truly reflective of the community we serve. We aim to build workforce capability and capacity in LPCT and the wider health system by fostering talent pools that can be moved to where there is need in the system. We will align our learning and development, reward and other Human Resource (HR) policies to support this aim. High level actions under this priority will include:

- Pilot talent management approach
- Create a talent pool to recruit hard to reach groups
- Revitalise Human Resource systems and processes
- Review recruitment and selection processes
- Develop the learning and development infrastructure

These four priorities align to the eight PCT strategic goals. They have emerged from detailed diagnostic and route cause analysis of current organisation strengths and areas for development.

The table below summarises the organisational development (OD) priorities that

relate to realising the strategic goals.

	Leadership	Culture	Talent	Continuous Improvement
Goal 1: Delivering the things that make a big difference	✓		✓	✓
Goal 2: Better understanding of self care and how health services can support it	✓	✓		✓
Goal 3: Gold standard primary care and community services	✓			✓
Goal 4: Gold standard hospitals	✓	✓	✓	✓
Goal 5: End of life services	✓		✓	✓
Goal 6: Personalised care	✓	✓		✓
Goal 7: An end to waiting	✓	✓		✓
Goal 8: Joined up services	✓	✓	✓	✓

3.2.3 Challenges for the Workforce Agenda

There is a strong desire amongst providers to proactively respond to the requirements around the emerging Equality and Diversity agenda, including extending the Single Equality Scheme to six strands and the need to undertake Equality Impact Assessments around key strategy and business initiatives, but they are challenged by the fact that expertise in these policies and procedures is not yet widespread across the system.

While an overarching Section 75 has been agreed by LCC and LPCT these arrangements are relatively new and the more formal aspects of governance arrangements and joint working processes with partners will be refined as it becomes clearer what works in the North Mersey context to support staff, and partners to understand and exhibit the behaviours needed for effective partnership working.

The outside of hospital strategy is transforming neighbourhood health centres across Liverpool and providers and responding to the challenge. Liverpool Royal and Broadgreen and Alder Hey have outline business cases currently being reviewed to build new hospitals and Liverpool Council are firmly engaged in the partnership agenda (section 75). These are further supported by the transformation of Children's Services and the development of the Children's Trust, and the widening provider base for health and social care, particularly within the third sector.

The efficiency agenda/QIPP is the single most significant common issue across all providers in Liverpool. Some have developed a very clear response in terms of workforce capacity. The efficiency agenda will encompass a number of the other significant strategic intentions and significant organisational changes. A number of the providers have developed outline business cases and it is clear that QIPP will grow in importance throughout the cycle of the programme or project. Discussions around QIPP have encouraged a major transformation in stakeholder engagement and communication due to contracts, commissioners, performance and clinicians all

focussing on quality improvements and efficiency gains. This will be reflected within local negotiations around contract compliance and targets.

The combination of planning with stakeholders, realistic financial projections for the workforce and strong management of the basics such as recruitment, sickness absence, underpin the plan to deliver QIPP. Innovation is demonstrated in workforce modernisation and the strategic aspirations of the organisations.

Personalisation of budgets across social/healthcare is recognised as having a potentially significant impact on service provision. In effect, individuals can choose to spend their budget with a provider of their choice and this may be outside of the existing system.

Workforce planning - is a key component of the PCT role as system leaders and capability and capacity will be built across the system in areas of need. There will be a continued focus on developing workforce planning across the system to address challenges such as: the need to embed awareness of WCC and development of WCC competencies into all aspects of workforce management including induction and ongoing learning and development; address national skills shortages in some specific health professional skills areas such as specialist therapies; improve IT, English and numeracy literacy levels in entry level staff; and to build capability and capacity in skill sets that are becoming increasingly high in demand such as programme management and strategic commercial procurement skills.

A comprehensive action plan is contained in the Organisational Development Plan 2009/14 including outcomes, metrics, responsibilities, links to World Class Commissioning and timetable for delivery.

Metrics:

KLOE	3.3 Does the organisation plan, organise and develop its workforce effectively to support the achievement of its strategic priorities?
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3.3 Approach to Quality

Through an integrated perspective, it is recognised that clinicians, patients and managers must jointly embrace the need for change and, together, define the priorities and practical steps necessary to deliver a new health service for Liverpool. The approach to quality builds upon the capacity to turn aspirations into actions.

Building on existing work programmes from 2009/10, the PCT will lead on the quality improvement agenda across the city of Liverpool and demonstrate sustained commitment to commissioning safe, effective and patient centred care.

In 2010 the year of health and wellbeing the implementation of the Quality Health Council will serve as a platform to engage all key stakeholders within the health economy in developing a shared view of the health and wellbeing of the local population served and of the quality of health services across Liverpool.

There will be continuing dialogue with Providers at Chief Executive and Non Executive Levels, realising the benefits of Quality, Innovation, Productivity and Prevention (QIPP), identifying areas that ensure efficiency and quality in provision are maximized.

The PCT will support the development of a culture of continuous improvement amongst all providers along with a culture that is blame free yet accountable. The CQUIN schemes have set high aspirations, prioritising goals for maximum benefits.

The agreed work programme for quality is fully aligned with the PCT's vision to achieve transformational improvements in health, service provision and significant reductions in inequalities, and the vision for quality supports the operational programmes for delivery such as:

- Gold Standard Hospitals and Acute Contract compliance
- Gold Standard Primary Care - Improving Standards
- Partnership
- Practice based commissioning & pathway redesign
- Neighbourhood working
- Transforming community services (TCS)
- Equality & Diversity
- Patient experience
- Quality, Innovation, Productivity and Prevention work streams
- Quality & Safety first - Key performance Indicators
- National, Regional and Local Incentivised schemes.
- Working with international and national exemplar schemes to drive through the quality improvement agenda.

The approach to quality will be delivered through 5 main goals:

- Engagement & Transparency
- Empowering patients and their families
- Aligning commissioning and incentives
- Supporting quality improvements
- Data integration and real time decision support.

These five goals will enable the PCT to benchmark providers against best practice to:

- Utilise quality and productivity measures, outcomes and prevention which will inform and improve the commissioning process.
- Commission providers to produce a quality and service improvement plan, publish their "Quality Accounts" and achieve incentive payments for quality.
- Deliver quality improvements, considering the whole patients journey across organisational boundaries and geographical locations.
- Develop a cycle of continuous quality improvements embedding a learning culture and enabling excellence.

Momentum will be maintained with the city wide Quality Forum which confirms all systems and processes drive innovation and sustain change. The aim of the forum is to encourage and support innovation, enable and engage stakeholders more effectively and to work on transformational change programmes such as "LEAN" and the Productive Ward Series. The overall direction of the Quality agenda is about collaboration, co-operation, clinical engagement and responding to the needs of our patients.

3.4 Research and Development

Modern healthcare should be firmly based upon evidence. In many cases however evidence is either unavailable, or is unused or poorly applied. In order to develop and add to the evidence base, the modern NHS must promote high quality research to support all aspects of service provision either for itself or in collaboration with other organisations. When evidence becomes available it is important that it is understood, disseminated, and appropriately used. The aims are to:

- Develop and maintain the newly established Liverpool Institute for Health Inequalities Research (LIvHR).
- To ensure that research carried out within the jurisdiction of Liverpool PCT is consistent with the Research Governance Framework.
- To ensure that staff members of and sub-contractors to the PCT have an awareness of the importance of primary care research that is consistent with their role.
- To support local PCT funded research and service evaluation.
- To develop primary care research projects consistent with the aims and objectives of the PCT, either alone or in partnership.
- To bid for and obtain funding for primary care research projects.
- To identify and participate in larger projects where appropriate, including those developed by or within Research Networks.

The outcomes to be achieved during 2010/11 will include:

- Formal launch of the Liverpool Institute for Health Inequalities Research in spring 2010. This institute will commission research in the coming year in line with gaps identified by the PCT.
- Production of a collaborative evaluation strategy and framework by December 2010 in conjunction with finance and health outcomes teams to ensure better utilisation of current and robust evidence and more evaluation is undertaken in the commissioning process.
- It is anticipated that in 2010/11 that at least 6 collaborative bids to the National Institute of Health Research (NIHR) will be produced. These bids will be

produced in partnership with various partners for example city council, universities and third sector organisations.

Priorities:

- Reflect within research programmes the areas that the PCT needs to understand better in order to improve and reduce health inequalities.
- Enable identification of new ways of preventing, diagnosing and treating disease to increase both the quality and productivity of services into the future.
- Enable commissioners to have access to clinical academic expertise to help improve Commissioning decision making, ensuring it is based on a robust evidence base.
- Support the creation a 'learning system,' which enables the timely application of evidence to support innovative practice and consistent extraction of the learning from these developments for broader dissemination.

3.5 Informatics

Informatics is recognised as a key enabler within the PCT in the delivery of World Class Commissioning and the achievement of the strategic goals. This is reflected in the recognition of Informatics as a key initiative within our delivery programme.

The key focus of the refreshed Strategic Informatics Plan is on development and implementation of information systems and technology that facilitates pathways of care, improving the quality of the patient experience through their journey through what is an often complex environment. Plans for system development are focused on the key priority pathways agreed by key stakeholders within the health economy, ensuring that information systems and processes provide intelligence to key decision makers such as:

- The health needs of the population including identification of disadvantaged groups and their specific requirements
- Insight into the lifestyles and behaviour decision making of individuals and characteristic groups so that interventions and services can be tailored to obtain best outcomes
- Best evidence and expected health outcomes
- Service provider performance in application of clinical quality standards and achievement of expected outcomes
- Intelligence on the potential for improvement within individual service providers with information used to facilitate and monitor progress on improvement

There has been a long history of collaborative working within the North Mersey LHE in relation to informatics and the North Mersey Health Informatics Service (NMHIS) was formed in 2006. Whilst the range of services delivered by the NMHIS to individual NHS organisations varies, dependent on the individual scope of services transferred, all North Mersey NHS organisations have a clear stakeholder involvement in the strategic implementation of IM&T across the community.

A Community Strategy Sub Group is in place and its objectives of this group are to:

- Develop the LHE Informatics Strategy underpinning the NHS Operating Framework;
- Support the PCTs in developing the submission of the plans to the NHS North West;
- Support and monitor the operational delivery of the LHE Strategic Informatics Plans and prioritise initiatives/projects to be delivered.

3.5.1 Governance and Management Arrangements

Liverpool PCT Commissioners will continue to provide leadership for informatics planning across the LHE and have LHE-wide governance arrangements in place for the co-ordination of informatics planning. The Chief Executive of Liverpool PCT will continue to provide overall leadership through LHE wide governance structures and processes, to support the effective management of the informatics programme as an enabler of service transformation. NMHIS is governed by the North Mersey Chief Executives. The current governance model consists of 2 boards at LHE level:

- NHHIS Management Board
- LHE National Programme for IT (NPfIT) and Strategy Board

Robust risk management procedures are in place across the LHE and individual organisations. Each organisation ensures that risks associated with Informatics are

managed and documented as part of their Informatics Risk Registers and where relevant included on the organisational Corporate Risk Register. Board Assurance Frameworks also identify the key risks to the individual organisations and the controls in place. The NMHIS has in place procedures for the systematic identification, assessment, treatment and monitoring of risks to LHE infrastructure, NPfIT and NMHIS service provision and are monitored by the NMHIS Management Boards via the Board Assurance Framework. A key element of the procedures in place within the NMHIS is the review at individual organisation level of risks affecting the organisation and its service provision.

Investment in Informatics is made at a number of different levels within the LHE. At the LHE level, administered and governed through the NMHIS Board, funding is pooled and administered to support implement of NPfIT delivery and organisational informatics plans. In addition each organisation plans its own internal investment programmes using both capital and revenue allocations to support their individual strategy implementation. As part of the North Mersey QIPP Programme, a key element will be on maximising the potential of technology to support transformational change and reduce transactional costs where relevant to support LHE Informatics investment.

All NHS Providers in the LHE have processes around benefits management, strategy and plans. A standardised process which is based on the principles of the identification, measurement and management of benefits set out in the Office of Government Commerce (OGC) *Managing Successful Programmes* has been developed by NMHIS and has been adopted across the LHC.

3.5.2 Clinical Leadership and Engagement

Liverpool has a network of Clinical IM&T Leaders. Local Providers have Clinical IM&T Leads and each Practice Based Commissioning Consortia has a GP Clinical IM&T Lead. Clinical IM&T Leads are integral to the leadership, development and implementation of informatics programmes to support service delivery and redesign.

Clinical leadership is key to ensure informatics is delivered effectively to support clinicians as an enabler to improve service delivery. Within Liverpool, informatics is embedded into clinical service redesign and pathway implementation processes. There are very strong relationships with the Professional Executive Committee, Local Medical Committee and Practice Based Commissioning who all play a key role in the development and delivery of informatics in supporting clinical care. Each NHS Provider across the LHE has clinical IM&T leads to drive informatics within Trusts.

3.5.3 Connect All Approach

Organisations within NHS Liverpool are committed to, and actively developing systems to provide the delivery of integrated electronic patient records. Plans can be broken down into a number of components:

- Enhancing organisational electronic health records
- Implementing digital technology
- Integration across organisational boundaries
- Integration with the local authorities
- Information Governance

The Department of Health's Health Informatics Review (July 2008) highlights system

requirements for secondary care in order to meet the information needs of clinicians. It identifies five key elements – termed the ‘Clinical 5’ – to ‘create a ‘tipping point’ in the acceptability and demand for strategic IT systems. Significant progress has been made on implementation of the Clinical 5 across the health economy and within individual organisations.

- **Integrated Patient Administration System:** The SHA review of NPfIT services has a large part to play in Trusts delivering the Integrated PAS component. Trusts across North Mersey have indicated their intentions regarding NPfIT.
- **Order Communications:** A Pathology Modernisation Programme is well underway across Cheshire and Merseyside to implement lab to lab communications and order communications from GPs to Trusts. The initial scope is for pathology with plans to extend to radiology. All providers are in the process of implementing internal order communications; this will be in place with local interim solutions by April 2011.
- **Discharges:** All Trusts are in the process of implementing standardised electronic discharge summaries. A North Mersey minimum discharge dataset has been approved and is being adopted by all Trusts. A programme is underway to see the implementation of electronic discharges from Trusts to GP practices. There has been significant progress in some Trusts with the majority of in-patients live with the process. It is expected that all Trusts will have a fully electronic solution in place by April 2011.
- **Electronic Prescribing:** A number of providers have commenced implementation of electronic prescribing with others planned to commence in early 2010. It is expected that all Providers will have implemented an Electronic Prescribing solution by the end of 2011.
- **Scheduling:** All Providers are working towards the implementation of scheduling. This is dependent on local decisions around the integrated PAS.

Isoft Patient Manager (IPM) software has been deployed across a significant number of community health care settings within both Liverpool and Sefton PCTs. Liverpool Community Health have implemented IPM with 35 community teams. Plans are in place to upgrade from IPM to Lorenzo Regional Care (LRC).

Key programmes are in place to implement specific initiatives using digital technology to transform service delivery. As part of a co-ordinated North Mersey approach to the QIPP agenda, an IT Transformation work stream is in place chaired by an NHS Trust Chief Executive. Key QIPP Areas including high level progress include:

- **Map of Medicine:** Implementation programme is in place with a number of pathways approved and implemented
- **Mobile Working:** A number of projects are underway including mobile working at the point of clinical care and facilitating home working.
- **Voice to Text:** A number of projects are in progress either using or in the process of procuring a system for digital dictation.
- **Collaboration Tools:** A variety of tools are in use across North Mersey including video conferencing, web conferencing, electronic whiteboards, sharepoint and information kiosks. Electronic wipeboards are being used in one major Acute to support access to real time bed states across the Trust
- **Health 2.0 Patient Services:** The LHE have plans in place to roll out Web 2.0 technology across multiple sites
- **Telehealth / Telecare:** Small pockets of telehealth pilots have been undertaken. Across the LHE, linked to QIPP Pathways and care at home, plans are underway to co-ordinate a strategy around Telehealth across health and social care.
- **Picture Archiving Communications Service (PACS):** There are plans in

place to manage and maximise benefits across the economy

3.5.4 Integration across organisational boundaries

North Mersey Electronic Patient Record - All providers across Liverpool and Sefton are committed to the development of integrated records across the North Mersey Economy. This work will support the delivery of the QIPP programme with a key focus on the delivery of shared records across health and social care settings to deliver key clinical pathways including urgent care and long term conditions. Real time decision support systems will be developed as part of priority clinical pathway implementation.

EMIS Web - Significant progress has been made throughout 2009/2011 with the roll out of EMIS Web to enable the need for information sharing as part of the New Health Service for Liverpool. This technology has been rolled out to many clinicians and services and is delivering significant clinical benefits from both clinical quality and productivity perspectives. The technology is also supporting a radical modernisation in the way in which primary care information is collected and reported to GP practices, enabling real time data reporting to primary care on key clinical priority areas.

Plans for 2010/2011 include further deployment of EMIS Web to underpin service delivery with a focus on interoperability of systems including INPS and Isoft from a primary care perspective and System C from a Secondary Care Perspective. EMIS Web will support the delivery of services on a neighbourhood level, enabling clinicians to work within integrated neighbourhood clinical teams.

Integration with Liverpool City Council - Liverpool City Council are in the process of procuring a new IT system which will support joint working across health and social care teams. A key requirement of the specification is the ability to join up health care systems with social care systems to support integrated commissioning, clinical pathways and discharge planning. The system will be fully implemented within 18 months.

There are a number of joint IM&T initiatives across the NHS and Local Authority including:

- Contact Point is a key part of the National Every Child Matters Programme. It is a national database which will enable authorised Practitioners to identify in a timely manner, other key practitioners involved in a child's care. It enables multi disciplinary working and minimises delays in dealing with urgent issues. Liverpool PCT and Local Authority are currently piloting the software to assess its capabilities and benefits.
- A joint IM&T work stream is in place to support the Aiming High for Disabled Children Programme. This aims to improve the submission of information from providers to allow commissioners to plan and monitor services for children & young people with disabilities and promote the sharing of information between care and service providers to allow better co-ordination of services and joined up care.
- A Common Client Index project is underway as part of the implementation of the Single Assessment Process to join up health and social care workers involved in individual patients
- A review of the Continuing Health Care and Brokerage functions are underway which include the delivery of an integrated IT solution. This solution will strategically align with both the NHS and Local Authority IT strategies.

3.5.5 Information Governance

A project is underway to ensure the delivery of the NHS Number Programme Implementation Guidance. Implementation plans are in place to address the delivery of key areas including corporate, provider and commissioning. The LHE Strategy Group will monitor progress across the LHE.

The Pseudonymisation Implementation Project is concerned with enabling the NHS to undertake secondary use of patient data in a legal, safe and secure manner. A high level plan has been submitted to NHS North West which outlines Liverpool PCTs commitment to achieving this by March 2011. All commissioned providers are also working towards implementation of Pseudonymisation standards.

The PCT are currently achieving level 2 in Operating Framework Requirements, and working towards compliance to level 2 and above in all standards. The PCT is looking at its commissioned services to put in place processes to regularly monitor current performance against the IGT and put in place measures to improve performance where necessary. This is being monitored by the Integrated Governance Committee and managed by the Information Governance Sub-Committee. Currently the NHS IG Training Tool is not used for all Liverpool PCT staff as it does not cover all areas deemed necessary as part of the training evaluation. Its future use will be kept under consideration as the number of modules increases to cover all required Information Governance Areas. It is being promoted with commissioned services to ensure suitable training is provided to all required staff.

Liverpool PCT has implemented the NHAIS project to level 3 during 2009. A consultation is currently underway nationally, with respect to how far proposals for Level 4 will be implemented. Following the outcome of this, a local pilot will take place in 2010 – 2011 with full rollout to be undertaken from June 2011 onwards.

3.5.6 National Expectations

The PCT is working with GP Practices to facilitate data accreditation in preparation for upload of primary care information to the NHS Spine for Summary Care Records. A public information programme is scheduled for completion in March 2010. By December 2010 the PCT plan to ensure that eligible practices have had their data uploaded to the SCR. Priority areas for use of the SCR will focus on urgent care settings. This will align with current work programmes within the PCT on record sharing.

All eligible practices have been utilising GP2GP for over 18 months. Regular usage monitoring is part of business as usual processes. Deployment to Isoft Synergy and EMIS PCS practices will commence when solutions are available to deploy.

Liverpool PCT is in an advanced state of readiness to implement Electronic Prescription Service (EPS) Release 2. As soon as GP system suppliers in use within Liverpool are approved by CfH to undertake first of type testing in 2010, the PCT will implement Release 2 with GPs and Pharmacies.

In Choose and Book, Liverpool PCT is working towards the achievement of 90% of 1st outpatient consultant appointments by the end of March 2011 by means of working closely with the local Trusts and Primary Care Providers. Action plans are in place with RLBUHT to improve slot availability and regular meetings taking place with secondary care to discuss performance.

3.5.7 Infrastructure Development and Impact Transaction Cost Programme

As part of plans/processes to ensure that the NHS's legal obligations and reputation for integrity is maintained through the implementation and maintenance of robust software license management, NMHIS undertakes assurance reviews of licensed software comparing the number of installations with the number of licences purchased and held. This process is currently being audited and all providers of healthcare will be supplied with data on licences held versus installations.

Asset Management software is in the process of being deployed across Liverpool PCT's IT infrastructure providing visibility of all installed software.

All providers within the Health economy are committed to the benchmarking assessment of its core IT Infrastructure against the NHS Infrastructure Maturity Model, (NIMM). Six providers originally participated in the initial benchmark assessment early in 2008. As a Local Health Economy, through the community wide strategy group, all providers jointly with NMHIS will continue to adopt this model to ensure that the technical infrastructure is developed and matured and that all trusts are achieving optimisation, are robust to support local and NPfIT programmes and that it is able to underpin and respond to business changes. NMHIS will facilitate a review of NIMM for all providers by May 2010.

Liverpool PCT has a 3 year technical strategy which ensures adherence to the NIMM strategy, addressing key areas such as:

- **Virtualisation** - Plans are in place for Liverpool PCT to upgrade its IT Infrastructure to support server virtualisation, providing capacity to reduce a large number of physical servers during 2010 which will result in reduction in maintenance costs and carbon footprint
- **IP Telephony** – IP Telephony is widely used across Liverpool PCT, including corporate sites, and a number of GP and community bases resulting in free telephone calls between these locations.

NMHIS manage the deployment of the LAN, WAN and Wi-Fi infrastructures across partner organisations. NHS North West Network Infrastructure Lead is supporting the NMHIS in a review of the Community of Interest Network (CoIN) to ensure the WAN infrastructure is fit for purpose and is able to support new technical innovations.

There are plan in place for the realisation of benefits from increased utilisation of products available via NHS enterprise wide agreements.

- **Microsoft Forefront Combined AV** - Two trusts within the LHE are using this combined anti-virus and anti-malware solution and the NMHIS are working with the remaining trusts to identify when the current solutions are due for renewal.
- **Intelligent Application Gateway (IAG)** – the NMHIS are proposing IAG as the NMHIS-Wide Remote Mobile Access Solution. This is a fully scalable solution, facilitates Single Sign-On integration, utilises existing VPN Tokens as well as SMS one-time codes and allows filtering of applications so staff can only see the applications which they require. A proof of concept will be implemented by end of March 2010.
- **Novell Asset Management Tool** - currently being evaluated by NMHIS and will be completed by the end of April 2010.

Liverpool PCT use Prince2 methodology to deliver local and national projects and this includes introduction of new products available via NHS enterprise wide agreements. Realisation of benefits through increased utilisation of these products will be identified during business case development and during the project lifecycle

The NMHIS are undertaking a gap analysis of NHS Mail v Microsoft Exchange and

are liaising closely with the NHS Mail team. A full evaluation is underway, and is due for completion by the end of March 2010. Unless the business case determines otherwise, it is intended that Liverpool PCT will move to NHS Mail within the next two years.

As part of the Informatics planning process in 2008/2009, North Mersey LHE are committed to looking at LISA self assessment tools. A local facilitator has been trained and a community wide session is in the process of being organised to take this forward across the local health economy.

Business Intelligence solutions are crucial to each individual organisations approach to delivery of key strategic requirements including World Class Commissioning, Joint Strategic Needs Assessment, Clinical Quality Dashboards and Performance Management Frameworks.

Whilst each organisation has their own individual approach to business intelligence, based on their clinical system infrastructure and existing solutions the LHE is committed to a collaborate approach to sharing of intelligence and where necessary skill sets. This supports the development and implementation of LHE intelligence such as Urgent Care Dashboards, Advancing Quality and Vital Signs monitoring, facilitating the delivery of near real time data, reduction of production effort and data quality management.

Metrics:

KLOE	2.2 Does the organisation produce relevant and reliable data and information to support decision making and manage performance?
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4.0 Conclusion

The achievements, improvement areas, and priorities contained in this Operational Plan identify the challenges and opportunities presented to Liverpool PCT during 20010/11, and demonstrate the actions that will be undertaken to improve the health and wellbeing of the people of Liverpool.

Appendix A – Showing the Three Tiers of the Vital Signs

National Targets and Standards (Tier 1)	
VSA01	MRSA number of infections
VSA03	Number of Clostridium difficile infections patients aged 2 or above
VSA04	Percentage of patients seen within 18 weeks for admitted and non-admitted pathways
VSA05	Supporting measures: number of diagnostic waits > 6 weeks, Percentage of patients seen within 18 weeks for direct access audiology treatment, Activity levels, Patient reported experience of 18 week pathways
VSA06	Patient reported measure of GP access
VSA07	Practises offering extended opening
VSA08	Breast symptoms – 2 week wait standard for patients referred with breast symptoms not currently covered by 2 week waits for suspected breast cancer.
VSA09	Breast screening – Extension of NHS breast screening programme to women aged 53-70
VSA10	Bowel screening – Percentage of 60-74 year old adult population screened for bowel cancer
VSA11	Cancer – 31 day subsequent treatments target (surgery and drug treatments)
VSA12	Cancer – 31 day subsequent treatment target (radiotherapy)
VSA13	Cancer – 62 days GP urgent referral to treatment (including new cancer strategy commitment).
VSA14	Patients who spend at least 90% of their time on a stroke unit and higher risk TIA cases who are scanned and treated within 24 hours
VSA15	Percentage of women who receive the results of their cervical screening tests within 2 weeks.
National Priorities for Local Delivery (Tier 2)	
VSB01	All-age all cause mortality rate per 100,000 population
VSB02	Reduction in <75 CVD mortality rate per 100,000 population.
VSB03	Reduction in <75 cancer mortality rate per 100,000 population.

VSB05	The number of 4-week smoking quitters attending NHS stop smoking services per 100,000 population.
VSB06	Percentage of women who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy.
VSB08	Teenage pregnancy – under 18 conception rate per 1,000 females aged 15-17.
VSB09	Childhood obesity – prevalence of obesity in primary school age children (reception and Year 6)
VSB10	Proportion of individuals who complete immunisation by recommended ages.
VSB11	Prevalence of breastfeeding at 6-8 weeks
VSB12	Emotional health, well being and child / adolescent health services (CAMHS)
VSB13	The percentage of the population aged 15-24 accepting a test / screen for Chlamydia
VSB14	Number of drug users recorded as being in effective treatment
VSB15	Self reported experience of patients/users
VSB16	Measure of public confidence in local NHS
VSB17	NHS staff survey based measures of job satisfaction.
VSB18	Dental services – based on assessment of local needs, ensuring year-on-year improvements in the numbers of patients
Local Priorities (Tier 3)	
VSC11	People with long-term conditions feeling independent and in control of their conditions.
VSC10	Delayed transfers of care per 100,000 population
VSC12	Timeliness of social care assessments (all adults)
VSC20	Emergency bed days per head of weighted population
VSC21	Hospital admissions for ambulatory care sensitive conditions
VSC23	Vascular risk – number of practices with validated registers of patients without symptoms of CVD but who have an absolute risk of CVD events greater than 20% over the next 10 years.
VSC24	Patients admitted with a heart attack taking appropriate medicine – percentage prescribed anti-platelet, a statin, a beta-blocker
VSC26	Rate of hospital admissions for alcohol related harm per 100,000 population
VSC27	The percentage of patients with diabetes in who the last HbA1c is 7.5 or less in the previous 15 months.
VSC29	Hospital admissions caused by unintended and deliberate injuries to children and young people

Appendix B - Local Area Agreement - Liverpool First Priority Indicators

Driver	PRIORITY OUTCOME TITLE	INDICATOR DESCRIPTION	LEAD NEGOTIATION OFFICER ORGANISATION
Competitiveness	Increased wealth creation, jobs and business, particularly in the knowledge economy	NI 151 - Overall employment rate	Liverpool Vision
		NI 171 - New business registration rate	Liverpool Vision
		NI 172 - Percentage of small businesses in an area showing employment growth	Liverpool Vision
		NI 165 - Working age population qualified to at least Level 4 or higher	Learning Skills Council
		Local Indicator – Environment for a thriving third sector - positive impact of local statutory bodies on local third sector organisations.	Liverpool Charity & Voluntary Services
		Local Indicator – Number of jobs and % in Knowledge Economy	Liverpool Vision
	A larger more skilled workforce through improved skills and qualifications.	NI 72 - Achievement of at least 78 points across the Early Years Foundation Stage with at least 6 in each of the scales in personal social and emotional development and communication, language and literacy.	LCC Children's Services
		NI 73 - Achievement at level 4 or above in both English and Maths at Key Stage 2	LCC Children's Services
		NI 74 – Achievement at level 5 or above in both English and Maths at Key Stage 3	LCC Children's Services
		NI 75 – Achievement of 5 or more A*-C grades at GCSE or equivalent including English and Maths	LCC Children's Services
		NI 80 - Achievement or Level 3 qualification at age 19	Learning Skills Council
		NI 83 - Achievement at Level 5 or above in Science at Key Stage 3.	LCC Children's Services
		NI 87- Secondary school persistent absence rate	LCC Children's Services
		NI 92 - Narrowing the gap between the lowest achieving 20% in the Early Years Foundation Stage profile and the rest	LCC Children's Services
		NI 93 - Progression by 2 levels in English between Key Stage 1 and Key Stage 2	LCC Children's Services
		NI 94 - Progression by 2 levels in Maths between Key Stage 1 and Key Stage 2	LCC Children's Services
		NI 95 - Progression by 2 levels in English between Key Stage 2 and Key Stage 3	LCC Children's Services
		NI 96 - Progression by 2 levels in Maths between Key Stage 2 and Key Stage 3	LCC Children's Services
		NI 97 - Progression by 2 levels in English between Key Stage 3 and Key Stage 4	LCC Children's Services
		NI 98 - Progression by 2 levels in Maths between Key Stage 3 and Key Stage 4	LCC Children's Services

Driver	PRIORITY OUTCOME TITLE	INDICATOR DESCRIPTION	LEAD NEGOTIATION OFFICER ORGANISATION
		NI 99 – Children in care reaching level 4 in English at Key Stage 2	LCC Children’s Services
		NI 100 – Children in care reaching level 4 in Maths at Key Stage 2	LCC Children’s Services
		NI 101 – Children in care achieving 5 A*-C GCSEs (or equivalent) at Key Stage 4 (including English and Maths)	LCC Children’s Services
		NI 116 - Proportion of children in poverty	Liverpool Vision
		NI 117 - 16 to 18 year olds who are not in education, employment or training (NEET)	Connexions
		NI 153 - Working age people claiming out of work benefits in the worst performing neighbourhoods	Liverpool Vision
		NI 163 – Working age population qualified to at least Level 2 or higher	Learning Skills Council
Connectivity	Connecting Liverpool as an international gateway for goods, people and information	Local Indicator – Increase in tonnage through port Local Indicator – Increase people through airport	Liverpool Airport Merseyside Docks & Harbour Company
	Connecting Liverpool - Improving public transport , reducing congestion and enhancing pedestrian movement	NI 167 – Congestion: average journey time per mile during the morning peak	LCC Highways Merseytravel
		NI 175 - Access to services and facilities by public transport, walking and cycling	LCC Highways Merseytravel
Distinctive Sense of Place	Cultural, tourist, business and retail destination of choice	Local Indicator – Total room nights sold in Liverpool (000)	The Mersey Partnership
		Local Indicator – LCC cash related efficiency targets	LCC - Finance
	Improved housing standards, choice and	NI 154 - Net additional homes provided	LCC Neighbourhoods

Driver	PRIORITY OUTCOME TITLE	INDICATOR DESCRIPTION	LEAD NEGOTIATION OFFICER ORGANISATION
	affordability	NI 156 - Number of households living in temporary accommodation	LCC Neighbourhoods
Thriving Neighbourhoods	A cleaner, greener environment delivered by efficient, effective and locally responsible services	NI 4 - Percentage of people who feel they can influence decisions in their locality	LCC Neighbourhoods
		NI 195 Improved street and environmental cleanliness (levels of detritus, graffiti and fly posting)	LCC Neighbourhoods
	Reduced crime, fear of crime, disorder, anti-social behaviour and substance misuse	NI 15 - Serious violent crime rate	LCC Community Safety
		NI 16 - Serious acquisitive crime rate	LCC Community Safety
		NI 19 - Rate of proven re-offending by young offenders	LCC Youth Offending
		NI 20 - Assault with injury crime rate	LCC Community Safety
		NI 29 - Gun crime rate	LCC Community Safety
		NI 30 - Re-offending rate of prolific and priority offenders	LCC Community Safety
		NI 32 - Repeat incidents of domestic violence	LCC Community Safety
		NI 115 - Substance misuse by young people	Drugs And Alcohol Team
		Local Indicator – Number of ASB incidents per 1,000 population as reported by the police	LCC Community Safety
Local Indicator – Dealing with local concerns about anti-social behaviour and crime by the local council and police	LCC Community Safety		
Cohesive communities that value diversity	NI 1 - Percentage of people who believe people from different backgrounds get on well together in their local area	LCC Neighbourhoods	
Health and Well-Being	Improved health, well-being and reduced health inequalities	NI 39 - Rate of hospital admissions per 100,000 for alcohol related harm	PCT
		NI 53 - Prevalence of breastfeeding at 6 – 8 weeks from birth	PCT
		NI 56 - Obesity among primary school age children in Year 6	PCT
		NI 62 - Stability of Placements of looked after children	LCC / PCT
		NI 120 - All-age all cause mortality rate	PCT

Driver	PRIORITY OUTCOME TITLE	INDICATOR DESCRIPTION	LEAD NEGOTIATION OFFICER ORGANISATION
		Local Indicator – Wellbeing: absenteeism / presenteeism attributed to emotional / mental distress	PCT
	Improved opportunities for independent living and for children and families to thrive	NI 124 - People with a long-term condition supported to be independent and in control of their condition	PCT
		NI 141 -Number of vulnerable people achieving independent living	LCC Social Care
		NI 130 - Social Care clients receiving self directed support per 100,000 population	LCC Social Care
	Shared action to reduce climate change and environmental sustainability	NI 187 – Tackling fuel poverty - % o people receiving income based benefits living in homes with a low energy efficiency rating	LCC Neighbourhoods
		NI 188 – Planning to adapt to climate change	LCC Regeneration
		NI 192 – Percentage of household waste sent for reuse, recycling and composting	LCC Neighbourhoods

Appendix C – Liverpool PCT Performance Metrics

Liverpool PCT Strategic Goals	Priority Areas	Metrics: World Class Commissioning Outcomes / Local Priority Outcomes / Vital Signs / Local Area Agreement
1. Delivering the things that make a big difference	2.1.1 Health Inequalities	WCC Improving Health Inequalities / Increasing Life Expectancy, LPO Spearhead Life Expectancy Target / Reduction in deaths from accidents, VS / LAA VSB01 All age all cause mortality.
	2.1.2 Prevention	LPO School education smoking prevention / Halt the rise in adult obesity / Increase numbers who are physically active / Increase access to health trainers / increase flu vaccination
	2.1.3 Childhood Obesity	LPO Increase referrals for weight management, VS / LAA VSB09 Reduction in childhood obesity
	2.1.4 Breastfeeding	LPO Increase breastfeeding initiation rates, VS / LAA VSB11 Prevalence of breastfeeding 6-8 weeks
	2.1.5 Teenage Pregnancy	LPO Increased access to health services for young people, VS VSB08 15-17 year old conception rates
	2.1.6 Healthy Child Programme	WCC Reduce infant mortality, VS VSB10 Immunisation by recommended ages / VSC29 Hospital admissions caused by unintentional and deliberate injuries to children
	2.1.7 Alcohol	WCC / VS / LAA VSC26 Reduce the rate of alcohol admissions due to alcohol misuse, LPO Reduction in harmful levels of alcohol consumption / improved effectiveness of assessment and treatment
	2.1.8 Tobacco Control	WCC / VS VSB05 Smoking quit rates, LPO Reduction in smoking prevalence
	2.1.9 Cancer Screening	WCC / VS VSB03 Reduce cancer mortality rate / VSA09 Breast cancer screening / VSA10 Bowel cancer Screening / VSA15 Cervical cancer screening test results

<p>2. A better understanding of health care and how to use it</p>	<p>2.2.1 Long Term Conditions and Self Care</p> <p>2.2.2 Patient Experience</p> <p>2.2.3 Health Literacy</p>	<p>LPO Increased uptake of self care programmes / Reduce non elective hospital utilisation / Increased treatment compliance, VS / LAA VSC11 People with LTC feeling independent / VSC12 Timeliness of social care assessment / VSC20 Reduction in emergency bed days / VSC21 Reduce hospital admissions for ambulatory care.</p> <p>VS VSB15 Self reported experience of patients / VSB16 Measure of public confidence in the NHS</p>
<p>3. Gold standard primary care and community services</p>	<p>2.3.1 Outside Hospitals (Estates-CHIAM)</p> <p>2.3.2 Neighbourhood Delivery</p> <p>2.3.3 Transforming Community Services (provider development)</p> <p>2.3.4 Primary Care Access</p> <p>2.3.5 NHS Health Checks</p> <p>2.3.6 Diabetes</p> <p>2.3.7 Respiratory Conditions</p> <p>2.3.8 Sexual Health</p> <p>2.3.9 MRSA</p>	<p>LPO Increasing primary care intervention / Improve quality in primary care / Reduce demand on secondary care</p> <p>LPO Deliver LAA targets at neighbourhood level / Improve performance on key health indicators / reduce the gap between expected and reported disease prevalence register levels</p> <p>LPO Increase quality productivity in community provided services / Increase shift of activity from secondary care to outside of hospitals provision.</p> <p>VS VSA06 Patient reported measure of GP access / VSA07 GP's offering extended opening</p> <p>LPO Reduction in variance between actual and expected CVD prevalence, VS VSC23 Vascular risk assessment</p> <p>LPO Reduce complication rates / Reduce the gap between actual and expected prevalence rates, VS VSC27 HbA1c < 7 / EC Retinopathy screening</p> <p>LPO Reduce premature respiratory deaths / decrease COPD progression / Increase school attendance for children with asthma / Reduction in hospital admissions for asthma</p> <p>LPO Increase access for contraception, VS VSB13 Chlamydia screening / EC Access to GUM services</p> <p>VS VSA01 Reduction in MRSA</p>

	2.3.10 Clostridium Difficile	WCC/VS VSC03 Reduction in Cdiff, LPO Reduce inappropriate antibiotic prescribing
4. Gold standard hospitals	2.4.1 Urgent Care	LPO Reduce demand for acute emergency services / reduce emergency admissions zero stay / Reduce demand and conveyance for ambulances / Reduce ambulance turnaround times, VS EC Ambulances response times / Total time in A&E
	2.4.2 Cancer	LPO Increase awareness of signs and symptoms, WCC / VS VSB03 reduce cancer mortality / VSA08 Breast cancer 2 week wait / VSA11 & 12 31 day subsequent treatment VSA13 62 day treatment.
	2.4.3 CVD	LPO Increase numbers identified as at risk of CVD / Increase numbers receiving optimum treatments for HF, BP and cholesterol / increase numbers completing cardiac rehab, WCC / VS VSB02 reduce CVD mortality / VSC24 POST MI medication / EC time to reperfusion following heart attack.
	2.4.4 Stroke	LPO Reduction in stroke mortality / Increase numbers receiving thrombolysis, VS VSA14 increase numbers admitted to Stroke Unit / Treatment for TIA within 24 hrs
	2.4.5 Military Personnel	LPO Zero tolerance of mixed sex accommodation in health care
	2.4.6 Delivering Same Sex Accommodation	
	2.4.7 Venous Thromboembolism	
5. End of life services	2.5.1 End of Life	LPO Reduce number of deaths occurring in hospitals / Improve pain management at end of life
6. Personalised care	2.6.1 Maternity and Neonatal Services	LPO Reduce smoking in pregnancy / Increase opportunity for Downs Syndrome testing / Continuity of midwifery care / Increase volume of home births / Reduce obesity in pregnancy / Improve maternal and neonatal care, VS VSB06 Percentage of women who have seen midwife or health care professional by 12 weeks.
	2.6.2 You're Welcome	
	2.6.3 Carers	LPO More people supported to live at home

7. An end to waiting	2.7.1 Dentistry	LPO Increase the number of children receiving fluoride varnish / Increase the number of NHS dental practices that have a dental nurse trained to provide preventive treatments, VS VSB18 Improving access to dental services
	2.7.2 18 Weeks	VS VSA04/05 18 weeks RTT
8. Joined up services	2.8.1 Older People	LPO 2% >65 yr olds accessing re-ablement services / Reduction in falls, VS VSC10 Reduce delayed transfers of care / VSC11 Timeliness of social care assessment, LAA VSC11 LTC feeling independent
	2.8.2 Children with Disabilities	LPO Improvement in QOL for disabled children/ Improvement in respiratory health
	2.8.3 Children and Adolescent Mental Health Services (CAMHS)	LPO Reduction in inappropriate referrals / Reduce DNAs / Improve mental health and well being, VS VSB12 Impact of CHAMS
	2.8.4 Safeguarding	LPO Improvement in assurance of safeguarding standards
	2.8.5 Emergency Preparedness	
	2.8.6 Emergency Preparedness Liverpool PCT	
	2.8.7 Dementia	LPO Increase early diagnosis / Increase independence / Increase numbers receiving direct payments
	2.8.8 Mental Health	WCC Improve access to psychological therapies and outcomes from treatment, LPO Increase access to settled accommodation and employment / Reduction in delayed transfers / Reduce demand on secondary care, VS EC Commissioning of early intervention in psychosis services and crisis resolution home treatment
	2.8.9 Crime and Violence	
	2.8.10 Domestic Violence	

	<p>2.8.11 People Living in Vulnerable Circumstances</p> <p>2.8.12 People with Learning Disabilities</p> <p>2.8.13 Offender health</p> <p>2.8.14 Drugs Strategy</p> <p>2.8.15 Third Sector</p> <p>2.8.16 Sustainability</p>	<p>LPO Increase the number of externally funded or unpaid employment schemes / Healthy Homes</p> <p>LPO Reduce health inequalities for people with learning disabilities / Reduce out of area placements / Increase GP annual health checks</p> <p>LPO Improve access to health and social care / Reduce re-offending / Reduce hep B and C rates / Increase vaccination for hep B / Improve mental health care delivery outcomes</p> <p>LPO Increase vaccination against hep B&C, VS VSB14 Numbers of drug users in effective treatment</p>
Enablers	<p>3.1 Managing Resources</p> <p>3.2 Developing Workforce</p> <p>3.3 Approach to Quality</p> <p>3.4 Research and Development</p> <p>3.5 Informatics</p>	<p>KLOE 1.1 Does the organisation plan its finances effectively to deliver its strategic priorities and secure sound financial health? / 1.2 Does the organisation have a sound understanding of its costs and performance and achieve efficiencies in its activities? / 1.3 Is the organisation's financial reporting timely, reliable and does it meet the needs of internal users, stakeholders and local people?</p> <p>KLOE 3.3 Does the organisation plan, organise and develop its workforce effectively to support the achievement of its strategic priorities?</p> <p>KLOE 2.2 Does the organisation produce relevant and reliable data and information to support decision making and manage performance?</p>

World Class Commissioning (WCC), Local Priority Outcomes (LPO), Vital Signs (VS), Local Area Agreement (LAA) KLOE Key Lines of Enquiry

Appendix D – NHS North West Operating Framework Schedule

Operating Framework Schedule Summary in relation to Operational Plan Section					
NHS North West Operating Framework Schedule		PCT Operational Plan Section	NHS North West Operating Framework Schedule		PCT Operational Plan Section
2.0	Planning		6.0	Experience & Satisfaction	
2.1	Planning Arrangements	1	6.1	General Public and Patient Engagement	2.2.2
2.2	Partnership Working	1.4	6.2	Staff	3.2
3.0	Cleanliness & Healthcare Associated Infections		7.0	Emergency Preparedness	
3.1	MRSA	2.3.9	7.1	Emergency Preparedness, Merseyside lead	2.8.5
3.2	CDiff	2.3.10	7.2	Emergency Preparedness, Liverpool PCT	2.8.6
4.0	Access		8.0	Areas to support local priorities	
4.1	18 Weeks	2.7.2	8.1	Prevention	2.1.2
4.2	Access to GP Services	2.3.4	8.2	Alcohol	2.1.7
4.3	Dental Services	2.7.1	8.3	Health Checks	2.3.5
5.0	Keeping adults & children well, improving their health and reducing health inequalities		8.4	Carers	2.6.3
5.1	Adults		8.5	Children with Disabilities	2.8.2
5.1.1	Health Inequalities	2.1.1	8.6	End of Life Care	2.5.1
5.1.2	Stroke	2.4.4	8.7	Mental Health	2.8.8
5.1.3	Cancer	2.4.2	8.8	Older People	2.8.1
5.1.4	Cancer Screening	2.1.9	8.9	Mixed Sex Accommodation	2.4.6
5.1.5	Tobacco Control	2.1.8	8.10	Military Personnel and their dependents	2.4.5
5.2	Children & Young People		8.11	Long term conditions and self care	2.2.1
5.2.1	Partnership Working		8.12	Venous Thromboembolism (VTE)	2.4.7
5.2.2	Health Child Programme	2.1.6	9.0	NHS North West Local Priorities	
5.2.3	CAMHS	2.8.3	9.1	Urgent Care	2.4.1
5.2.4	Childhood Obesity	2.1.3	9.2	Diabetic Retinopathy	2.3.6
5.2.5	Teenage Pregnancy	2.1.5	9.3	People Living in Vulnerable Circumstances	2.8.11
5.2.6	Sexual Health	2.3.8	9.4	Breastfeeding	2.1.4
5.2.7	Safeguarding	2.8.4	9.5	Crime & Violence	2.8.9
5.2.8	Maternity & Neonatal Services	2.6.1	9.6	Domestic Violence	2.8.10
			9.7	Dementia	2.8.7
			9.8	People with Learning Disabilities	2.8.12
			9.9	You're Welcome	2.6.2

2.0 Planning

2.1 Planning Arrangements

The PCT will

- Support the delivery of performance against the priorities in the Vital Signs.
- Realise the *Next Stage Review* visions.
- Address the productivity challenge for QIPP.

2.2 Partnership Working

The PCT will

- Deliver the programme for Liverpool City Region 2010 - Year of Health and Wellbeing. This themed year is a vehicle for strengthening partnership work across the region, with specific resonance for Liverpool.
- Develop a Joint Intelligence programme between LCC and LPCT to support JSNA work.
- Develop partnership work through the Healthy Cities programme - first year of latest five year phase.
- Review health partnership arrangements of the LSP with a view to re-energising the contribution of partners to achieving health goals for the city.

3.0 Cleanliness & Healthcare Associated Infections

3.1 MRSA

The PCT will

- Deliver on the 2010 MRSA objective striving for a sustained reduction in all avoidable infections to zero.
- Challenge all providers to continually reduce rates of MRSA using the Quality and Clinical Governance frameworks.
- Establish mechanisms to secure robust assurance on all HCAI prevention activity, with all providers including primary care and in collaboration with stakeholders such as the Local Authority, Local Medical and Dental Committees.
- Support all providers of healthcare to demonstrate full compliance with all legislation related to the prevention of infections, through use of the SHA/PCT Assurance Framework.
- Deliver on the specified infection control programme across primary care that is tailored to prevent and reduce all infections in patients and staff across the city's health and social care settings. The specification, while accommodating all health and social care providers across the city does focus on the provision of social care in care homes and private residences. It also requires links with MRSA UK to support its focus on patient and public involvement and self-care.
- Expand MRSA screening from 50% to 100% of relevant emergency admissions by 2011 at the latest.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">3.1 CDifficile</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Deliver at least a 30% reduction in the number of patients acquiring C difficile, in Liverpool, by 2011 from 2008 levels. • Continue to deliver on the PCT Strategy to reduce C difficile infections acquired in the community. • Challenge all providers to continually reduce rates of C difficile using the Quality and Clinical Governance frameworks. • Establish mechanisms to secure robust assurance on all HCAI prevention activity, with all providers including primary care and in collaboration with stakeholders such as the Local Authority, Local Medical and Dental Committees. • Support all providers of healthcare to demonstrate full compliance with all legislation related to the prevention of infections, through use of the SHA/PCT Assurance Framework. • Deliver on the specified infection control programme across primary care that is tailored to prevent and reduce all infections in patients and staff across the city's health and social care settings. The specification, while accommodating all health and social care providers across the city does focus on the provision of social care in care homes and private residences. It is underpinned by a requirement to promote self-care in infection prevention for the public and staff. • Strive for 100% uptake of the deep clean initiative in the city's care homes.
<p>4.0 Access</p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">4.1 18 Weeks</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Work with providers to ensure delivery of 18 week targets for all specialties, including audiology. Those specialties with backlog or at risk of failing have already been identified and discussions are in place with providers as to actions required to improve performance. • Support NHS Liverpool Community Health Services in participation of national pilot for Allied Health Professionals (AHP) measurement of Referral to Treatment Times (RTT). • Use the emerging outcomes from the pilot of AHP RTT monitoring to work with the other Liverpool providers to develop and implement systems to monitor AHP RTT waits. • Utilise the information gained regarding AHP waiting times to inform contracting and TCS discussions between Liverpool PCT and NHS Liverpool Community Health Services. • Work with four hosted providers to improve slot availability, each trust is working to a detailed plan to deliver this supported by the PCT Choose and Book team. • Establish a mechanism to offer patients alternative providers where current treatment is not within 18 week targets and this is not through patient choice or because of a complex pathway. • Work with the PCT Stakeholder Engagement team to identify opportunities to understand patient experience of 18 weeks as part of the wider patient and public engagement work. • Work with providers to review their policies with regard to undertaking Equality and Diversity Assessments against their policies for addressing adverse impact.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">4.2 Access to GP Services</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Improve patients experience of the accessibility and responsiveness of the General Practice. • Improve the use of the Equitable Access Centre in Everton Road, by widening the agreed area for patients to register with them and actively marketing the services they provide. • Implement the ‘balanced scorecard’ and produce practice comparable information, across all areas, to support improving performance. • In line with latest DH guidance ensure plans are in place to maximise number of practices providing extended hours DES in 2010. • Renegotiate PMS and PCTMS contracts to improve quality of services provided. • Review all enhanced services. • Work with all stakeholders to agree the optimum levels of access for the city, looking at the number of appointments available across both GPs and Practice Nurses. • Support development of a primary care ‘neighbourhood’ model for implementation across the ‘hub and spokes’ ensuring the neighbourhood population will have access to a full range of services. • Complete gap analysis of services and develop commissioning plan for the neighbourhoods which will improve patient choice and experience of primary care. • Continue to increase equality data through patient profiling and DES for ethnicity and learning disability.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">4.3 Dental Services</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Improve dental access for residents of Liverpool ensuring that by March 2011 59% of the population have access to routine dental care. • Performance manage existing contracts and recently commissioned additional activity in line with the PCT’s Oral Health Equity Audit to improve patient access to dentistry. • Develop a quality framework working in partnership with providers and with support from dental clinical governance facilitators. • Implement further outreach schemes aimed at increasing early dental attendance and increasing the provision of fluoride varnish treatments. • Continue community based fluoride toothpaste schemes. • Ensure that all dental nurses will have an ‘extended duties’ trained dental nurse by 2011. • Establish a network group for dental nurses trained in extended duties. • Monitor preventive care provision in contract performance review. • Revise the oral surgery pathway for service users in order to improve access and the patient experience. • Monitor access to language and interpreting services to address inequalities and improve access.

5.0 Keeping adults and children well, improving their health and reducing health inequalities

5.1 Adults 5.1.1 Health inequalities	<p>The PCT will</p> <ul style="list-style-type: none">• Reduce the life expectancy gap from birth, between Spearheads and the England average, by 10% by 2010.• Reduce seasonal excess deaths; establish systems with partners that ensures coordination of interventions that have greatest impact to deliver reductions in mortality in the short term through focussing on those most at risk.• Improve quality and capacity within primary care.• Optimise use of primary care registers to manage chronic disease.• Support frontline staff to make health gain everyone's business, improving stakeholder and community engagement ensuring delivery plans are in place to tackle cancer mortality, infant mortality, seasonal excess deaths and smoking prevalence.• Carry out further modelling work to predict the impact of above interventions and estimate the number of deaths that need to be averted in order to hit the 2010 target.• Ensure early detection and awareness around cancers including roll out of the Community Cancer Collaborative approach.• Target specific groups particularly BME communities using work undertaken by the cancer network to segment and understand the local population.• Ensure delivery of excellent secondary prevention and systematically assessing those at risk of CVD.• Promote and support the delivery of the newly formed Tobacco and Alcohol unit in reducing the trade in illicit/counterfeit activity which targets the most deprived with some of the worst inequalities in health.
5.1.2 Stroke	<p>The PCT will</p> <ul style="list-style-type: none">• Increase the number of people admitted to hospital following a stroke who spend 90% of their stay on a Stroke Unit from 73% to 80% in 2010/11.• For patients with higher risk TIA (ABCD2 score of 4 or more) increase the number of patients seen and treated within 24hrs from 35% to 60% in 2010/11.• Increase the numbers of patients receiving thrombolysis post stroke from 3% to 10% in 2010/11.• Reduce mortality and morbidity for people suffering stroke (links to CVD programme).• Develop stroke pathways that facilitate direct admission to a stroke unit for patients admitted with acute stroke, facilitating the achievement of VSA14 for stroke.• Monitor Race for Health key performance indicator to address higher rates of stroke within African/Caribbean/Asian communities.• Further develop stroke pathways to ensure that patients admitted with acute stroke or suspected stroke have a brain scan within 1 hour of admission.• Develop a model for the delivery of 24/7 hyperacute stroke services inline with the National Stroke Strategy and undertake an equality impact assessment of the service and feed the outcomes into the developments.• Put in place TIA pathways that ensure patients with higher risk TIA are seen and treated within 24hrs and lower risk patients are seen and treated within 2 weeks.

	<ul style="list-style-type: none"> • Further develop ESD services to support patients for 6 months post discharge who have suffered an acute stroke and ensure equity of access to services. • Develop plans for AF screening, treatment and management with appropriate anti coagulation and antiplatelet drug therapy. (Linking with CVD programme and PBC). • Identify specific areas and undertake a targeted approach to awareness raising campaigns for signs and symptoms of stroke.
5.1.3 Cancer	<p>The PCT will</p> <ul style="list-style-type: none"> • Implement Liverpool PCT Cancer Strategy. • Engage with network-wide and national work to identify key diagnostic tests and baseline current performance and access to these. • Build a number of satellite radiotherapy services serving the North Mersey population and procure additional radiotherapy services. • Use the Merseyside and Cheshire Cancer Network (MCCN) annual patient experience survey to inform commissioning. • Develop a Haematological Malignancy Diagnosis Service across MCCN. • Develop an acute oncology service in DGH. • Increase earlier presentation of the signs and symptoms of common cancers among prioritised groups. • Pilot and then apply the Merseyside and Cheshire Cancer Network Quality Performance Framework in Liverpool. • Reduce inequalities in cancer by: using staging data to identify cultural communities most at risk, working with target communities to change health seeking behaviours, use lessons learned from Healthy Community Collaborative, assess screening data by geography/practice, ethnic group, age group, disabled etc. use the results of the equity audit to determine the levels of variation in access to cancer services by GP practice.
5.1.4 Cancer Screening	<p>The PCT will</p> <ul style="list-style-type: none"> • Maintain the QARC requirements for age extension screening. • Replace mobile analogue screening machines by digital mammography machines. • Ensure women aged 47-49 and 71-73 yrs have been invited for breast screening by March 2011. • Ensure women with a family history of breast cancer are screened via the local symptomatic service, using digital mammography. • Develop a local infrastructure for the commissioning of the bowel screening programme by April 2010.
	<p>The PCT will</p> <p>Increase smoking quit rate to 1378 per 100,000 population aged 16 and over, equating to 4935 four-week quits in 2010/11 by:</p> <p>Partnership Working: Work in partnership, and as part of the local tobacco alliance, with local service providers, educational establishments, local authority, and other colleagues to ensure that the local strategy reflects the wider tobacco control agenda</p> <p>Data Collection: With partners in Smoke Free North West, commission a new, comprehensive database for stop smoking services. Strengthen the collection and analysis of local data to assess need, equity and help to plan future programmes. Commission a local prevalence survey.</p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.1.5 Tobacco Control and smoking</p>	<p>Use tobacco control to tackle inequalities: Use local analysis, including an Equality Impact Assessment (for BME communities), and associated research / evidence to target vulnerable groups. In particular, focus on areas with high prevalence, BME communities, routine and manual workers and pregnant women. Evaluate the recently introduced opt out system to stop smoking services for pregnant women. Ensure that all available sources are utilised, including non-NHS surveys, analysis and information from the Alcohol and Tobacco Unit, Healthy Homes Scheme, etc.</p> <p>Deliver consistent, coherent and coordinated communications: Commission four campaigns for tobacco control, including Smoke Free Families, No Smoking Day, Smoke Free Sports and DMyst. Ensure that all communications are linked with regional and national campaigns and use the most relevant segmentation information to help target to the right groups.</p> <p>An integrated stop smoking approach: Continue to offer brief intervention and signposting training to front line staff, within NHS and with other partners. Benchmark local services to ensure they are working to the standards in the Stop Smoking Service and Monitoring Guidance for Local Programmes.</p> <p>Build and sustain capacity in tobacco control: Link closely with other partners to ensure that tobacco control is included in their agendas e.g. Children's Centres, Hospitals and Schools – work with partners to agree a high level outcome and objectives to tackle tobacco control within their organisation.</p> <p>Tackle cheap and illicit tobacco: Work with HMRC, DH and Smoke Free North West to manage the Illicit Tobacco Campaign, including pre and post research opportunities. Monitor the LPCT-funded Alcohol and Tobacco Unit within the local authority to ensure that the targets and priorities are met.</p> <p>Influence change through advocacy: Co-ordinate communication and strategy events that will enable us to influence senior / key members of staff across a range of agencies including local councillors, so that they are able to champion tobacco control.</p> <p>Helping young people to be tobacco free: Continue to recruit and support young people to have a voice regarding tobacco control and the tobacco industry. Evaluate the Prevention Initiatives currently being piloted in four schools to assess their success; ensure that all learning from this is translated into future service specifications. Work with 20 Healthy Schools to promote and achieve Enhanced Status.</p> <p>Maintain and promote smoke free environments: Evaluate the Smoke Free Families, and ensure that 1500 homes are signed up to the programme by March 2011. Visit and assess at least 75 organisations and ensure that they are supported to develop / update a tobacco control policy as well as support for staff to stop smoking. Commission the Smoke Free Sports campaign and research and intervention programme.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.2 Children & Young People 5.2.1 Partnership Working</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Engage all key specialist sexual health services in the local <i>You're Welcome</i> quality standard initiative, to ensure the provision of accessible, young-people friendly services across the city. • Accelerate HPV catch-up programme in line with national guidance. • Support the continuation of the Liverpool First Children's Trust as a strategic partnership to deliver the Children and Young People's Plan 2009/11 'Be Healthy' sexual health targets. • Develop the Team around the school/locality based model in collaboration with the Children's Trust. • Publish a Joint Strategic Needs Assessment for children and Young People to inform future service planning and the development of the Children's Health Strategy, with an associated equality impact assessment. • Develop HCP team-working to include; antenatal programmes; health-based programmes with children's centre's ensuring that each centre has access to a named health visitor; joint working between primary care, health visiting and school health.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.2.2 Healthy Child Programme</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Develop the Children's Trust in partnership with the City Council and others. • Publish a Joint Strategic Needs Assessment for children and Young People to inform future service planning and the development of the Children's Health Strategy. • Ensure sufficient HV capacity to deliver the HCP. • Develop HCP team-working to include; ante-natal programmes; health-based programmes with children's centre's ensuring that each centre has access to a named health visitor; joint working between primary care, health visiting and school health. • Deliver the Healthy Child Programme for school-age children including development of a service standard which will set out what services will be available to all parents in all areas. • Commission a range of programmes and services to meet different levels of need and risk (progressive universalism). • Develop the Team around the school/locality based model in collaboration with the Childrens Trust. • Develop transition pathways between children's health services and adult health services. • Develop age appropriate services and environments for adolescents, incorporating the 'You're Welcome' Standard into current and future planned services. • Ensure the neonatal screening services are compliant with minimal national standards. • Monitor neonatal bloodspot and hearing screening against performance indicators and report to board percentage of screens offered, started, completed and declined. Ensure providers reach targets for percentage of blood spot cards including NHS number as per performance indicators.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.2.3 CAMHS</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Maintain delivery of a comprehensive CAMHS as measured by VSB12 – (ensure the scoring for 4 proxy measures remains at 16/16). • Improve awareness within schools and GPs of services for children's mental health and emotional wellbeing – measured through a 5% reduction in the number of inappropriate referrals within the year across specialist mental health provision. • Improve awareness and understanding of children and young peoples mental health and emotional wellbeing and services available across the public health agenda – measured through a 5% reduction in number of inappropriate referrals within the year across specialist mental health provision and 10% reduction in number of DNA's within specialist mental health provision. • Achieve full compliance with the Mental Health Act 2007 by preventing admission of children and young people under the age of 18 to adult mental health beds, unless such an admission is in accordance with their needs. • Maintain low waiting times (within 18 weeks) for specialist mental health services in line with government guidance. • Consult on, launch and implement the children and young peoples mental health and emotional well being strategy 2010/13 following recommendations outlined in local and national CAMHS review (to be achieved by 31st May 2010).

	<ul style="list-style-type: none"> • Develop a mental health and emotional well being delivery model and specification to ensure more locality based teams, in line with the recommendations outlined in the local CAMHS review and neighbourhood structures (to be achieved by 31st March 2011). • Review CORC and its potential to expand its use across non specialist provision (to be achieved by 31st March 2011). • Deliver Tackling Stigma pilot and develop mental health promotion resources (to be achieved by 31st March 2011). • Continue roll out of cultural competency training across mental health and wellbeing services and completion of an equality impact assessment by all providers (to be achieved by 31st December 2010). • Monitor and evaluate Targeted Mental Health in Schools (TAMHS) (to be achieved by 31st March 2011). • Implement transition action plan as identified in the transition strategy (to be achieved by 30th June 2010). • Commission age appropriate beds for young people aged 16-18years (to be achieved by 31st March 2010).
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.2.4 Childhood Obesity</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Continue to address childhood obesity with a focus on prevention and a committed partnership through the multi agency Obesity Task Force. The NCMP 2008/09 identified that in Liverpool 1,244 of children in reception year and year 6 are overweight and 1,557 are obese. • Ensure the effective delivery of routine feedback of NCMP results to parents of all reception and year 6 children, and a process for linking parents into local schemes and interventions. • Integrate the Change 4Life and Start 4Life brand and materials into all relevant work streams using key healthy weight strategies as drivers for this work. • Increase awareness of children, young people, parents and professionals regarding the management of, and interventions available to reduce overweight and obesity levels. • Improve the links between primary and secondary care by utilisation of the children's care pathway. Increase appropriate multi disciplinary referrals for childhood weight management. • Ensure provision of school based interventions including school and community food workers and the healthy schools programme; 84% of schools now have healthy schools status. • Increase the knowledge and understanding of food provision and nutrition within nurseries involved in the project. • Compare the findings with Caroline Walker Trust guidelines and develop a standard to reduce any deficit found. • Commission and support the implementation of a range of Weight Management programmes, including commercial, pharmacy and expert led city wide services in the community, based on impact of pilot studies and other evidence. Develop support for joint commissioning between the LA and PCT of weight management services where relevant. • Deliver a social marketing and insight plan for the development of targeted interventions to target segments of the population including BME, disabled children and their families. • Integrate data from various sources across the City using NST support to identify trends and develop an estimate of numbers of overweight and obese children in the City in 2010/11. Develop a clear reporting process from the integrated data and a systematic evaluation of the Healthy Weight, Healthy Liverpool strategy.

	<ul style="list-style-type: none"> • Complete equality impact assessments on all new and revised strategies including Taste for Health and Active City. • Build capacity in and through the multi agency weight management group. • Provide the GOALS programme for up to 210 obese children and their families depending on family size. • Provide consistent, city wide services to families with obese children, which can be extended to level two to support overweight adults and children.
5.2.5 Teenage Pregnancy	<p>The PCT will</p> <ul style="list-style-type: none"> • Pilot 5 school based health drop-ins which offer basic sexual health services including pregnancy testing, chlamydia screening, and EHC provision, and referrals to specialist sexual health provision where required. The programme will be delivered in partnership with schools and key partners, and evaluated as part of the ABG grant allocation process. • Pilot a sexual health outreach post to work in partnership with key Children’s Services agencies to provide sexual health education and basic sexual health service provision to key vulnerable groups, in non-traditional health settings. The pilot will run throughout 2010/11, and will be evaluated as part of the ABG grant allocation process. • Expand access to LARC methods, via practitioners who accessed specialist LARC training in 2009/10. • Engage all key specialist sexual health services in the local <i>You’re Welcome</i> quality standard initiative, to ensure the provision of accessible, young people friendly services across the city. • Expand the ‘<i>Bitesize Brook</i>’ holistic education programme, to ensure all secondary schools have the opportunity to offer one event during 2010/11. The programme will be delivered in partnership with Liverpool Schools, <i>Brook</i>, the Liverpool and Knowsley Chlamydia Screening Programme, School Health and Liverpool Youth Service, and will be evaluated by learners, staff, and partners. • Strengthen collaborative commissioning and delivery of services across the sexual health and alcohol agendas, following the joint sexual health and drug and alcohol event held in March 2010. • Observe teenage pregnancy rates by ethnic groups to understand and promote cultural services.
5.2.6 Sexual Health	<p>The PCT will</p> <ul style="list-style-type: none"> • Ensure that robust plans are in place to deliver the 35% chlamydia screening target, focusing on core sexual health services, primary care and embedding the programme into non-health services. Also ensure an increased uptake of Chlamydia screening programme by under 25 year olds: a 10% increase over the next year in the percentage of individuals accessing chlamydia screening. • Develop and implement a sexual health strategy and associated equality impact assessment to deliver succinct action to those that experience sexual ill health. • Maintain the delivery of the targets relating to access for GUM services. • Complete the HIV and sexual health services review and make recommendations for change that ensure that a comprehensive range of services are available that offer a quality service and are value for money. Evaluate current research programme exploring methods and tools for early diagnosis. • Support the expansion of access to long-acting reversible contraceptive (LARC) methods, via community and acute sector practitioners who accessed specialist LARC training in 2009/10 (from TP priorities).

	<ul style="list-style-type: none"> • Implement the revised Local Enhanced Service specifications for sexual health; including chlamydia which will promote equality and improve access to more community based sexual health and chlamydia screening services. • Engage all key specialist sexual health services in the local <i>You're Welcome</i> quality standard initiative, to ensure the provision of accessible, young-people friendly services across the city (from TP priorities). • Ensure improved access to sexual health services in community based health settings by increasing the numbers of GPs practices who offer sexual health services. • Implement new sexual health system to enable a fully electronic shared, paper light sexual health service.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.2.7 Safeguarding</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Review the progress by providers of the PCT Safeguarding Children Strategy Work Plan for 2010/11. • Audit compliance of safeguarding children minimum standards by independent contractors. • Receive assurance that the PCT providers review and revise their existing safeguarding children policies and procedures in line with the 2010 Working Together to Safeguard Children statutory guidance once it is published. • Develop safeguarding pathway from CAHMS to social care, embedding a Community Assessment Framework in the early referral process. • Receive assurance that independent sector providers comply with statutory guidance and DH National Minimum care standards regulations before spot purchasing services. • Maintain the non-placement of under 16's on adult mental health wards in accordance with the Mental Health Act. • Maintain the non-placement of under 18's on adult mental health wards unless their individual needs require such an admission.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">5.2.8 Maternity & Neonatal Services</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Improve ante-natal pathway and revise the choose and book process to separate out the maternity booking from ultrasound screening enabling women to receive their first appointment within 12 weeks and 6 days. • Improve women's perception of choice in the place of birth and birth plan. Ensure all women who request a home birth are able to have one (unless there are contrary clinical indications). • Improve the maternity patient pathway to support the provision of community midwifery and ensure continuity of care throughout pregnancy by reducing the numbers of midwives a woman sees. • Support the provision of first trimester screening for downs syndrome as part of the general maternity care. The preferred standard of care uses the combined test to give a risk calculation prior to 14 weeks of pregnancy. This will include an early ultrasound scan to assess gestational age as well as ultrasound nuchal translucency measurement and biochemistry testing between 11 and 13+6 weeks gestation. • Ensure the provision second trimester quadruple testing will be offered between 15 to 20 weeks gestation were women book after 14 weeks • Maintain the partnership working for the smoking cessation programme, ensuring women are provided the opportunity and support to quit smoking during and after pregnancy.

	<ul style="list-style-type: none"> • To monitor and improve the skills of staff within LWH to undertake a common assessment process (CAF). • To review and improve discharge planning and information sharing for post natal care between acute care providers and multi agency services. • To examine the current shortfall of neonatal nursing workforce against the recommendations produced in the neonatal toolkit 2009. Make recommendations to the Cheshire and Merseyside neonatal network to improve workforce via a phased incremental basis. • Develop a maternity service specification to ensure that services are culturally sensitive by staff involved in care, ensuring that maternity services are aware of beliefs, religions and backgrounds. • Observe activity re take up of ante-natal care by women from groups who may experience difficulties in accessing services including, black and ethnic minorities, single women with poor family support, women experiencing domestic violence, the homeless, travellers and asylum seekers, pregnant teenage and women not registered with a general practitioner.
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6.0 Experience & Satisfaction

6.1 General Public and Patient Engagement	<p>The PCT will</p> <ul style="list-style-type: none"> • Ensure the co-commissioning toolkit and stakeholder maps are embedded systematically into commissioning decisions and patient views are taken into account to derive evidence based service improvement. • Adopt and pilot the insight model (including customer experience journey mapping) to enable the PCT to target services and gain meaningful intelligence. • Improve patient satisfaction with GP services (monitored by the new GP survey) and ensure the results of the privacy & dignity survey for outpatient care are used to improve patient experience during forthcoming contracting round and repeated year on year to drive quality. • Support a regular schedule of PCT led independent patient surveys seeking views of patients to drive quality/establish measures for year on year improvement. • Note patient experience by equality target group. • Ensure that consultation and engagement is a systematic process of engaging with marginalised communities through Social Inclusion Team. • Establish strong mechanisms for patient, public and community engagement, to ensure that local decision-making is embedded into the structures and culture of the PCT, demonstrating openness and accountability. • Ensure that the PCT adheres to national standards and directives in relation to involving patients and the public in its work, in order to facilitate the progression of Liverpool PCT towards excellence in its delivery of stakeholder engagement. • Expand the range of engagement and communication mechanisms, to enable effective dialogue with local communities, including equality target groups. • Ensure the intelligence gained by 'grass roots' teams including Community Development Workers, Social Inclusion Team and Community Engagement Officers influence commissioning decisions. • Improve the partnership approach and process for planning and managing patient and public involvement, working closely with LINKs and other organisations. • Ensure providers implement systems that enable them to respond to the views and experiences of patients and improve patient experience.
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	<ul style="list-style-type: none"> • Initiate an insight audit across the PCT to bring together information and intelligence on patient views/experience. Use this to inform contracting processes. • Ensure that the experience of patients is at the centre of LPCT commissioning processes, systematically capturing patient experience data and use this to learn and commission improved services. • Promote and build on the X-PERT Patient Programme so that patients will be supported to become experts in their own conditions and ensure it's embedded into neighbourhood development beginning with Ellergreen Neighbourhood Centre. • Secure robust links across stakeholder engagement, health literacy, insight and patient experience in order to create a greater understanding of health issues and options in the population through effective communication and engagement strategies. • Create a PCT led Quality Health Council to strengthen the commissioning cycle and enable Liverpool PCT to address World Class Commissioning Assurance and QIPP requirements.
6.2 Staff	<p>The PCT will</p> <ul style="list-style-type: none"> • Promote the effective management of sickness absence through targeted training sessions for managers and staff and the close management of Occupational Health and Staff Support SLA's. • Improve the quality of information provided by ESR on sickness absence. • Promote mental health and wellbeing in the workplace through the targeted promotion of existing support mechanisms such as Occupational Health and Staff Support, ensuring that staff know how to access these facilities. • Launch a health and well being area on the intranet area to update staff and ensure that everyone has access to key health promotion messages. This will support the Health and Well Being events planned following feedback from staff. • Support the 2010 Year of Health and Wellbeing in the Liverpool City region by promoting the health and wellbeing agenda across the workforce. • Improvement in staff survey response rate for 2010/11 from 61% in 2009/10. • Achieve a reduction in the number of staff survey respondents for 2010/11 reporting that they are unaware of the Staff Support Service and the range of services it provides (from 25% in 2009/10). • Achieve 100% of data within data cleanse of workforce. • Ensure workforce is represented in equality targets as noted in Single Equality Scheme. • Support the development of staff networks re BME, Disability and LGBT. • Improve levels of staff satisfaction and engagement across Liverpool PCT workforce by taking forward the recommendations of the Boorman Review. • Achieve a reduction in the number of staff survey respondents for 2010/11 reporting that they have felt unwell in the last 12 months due to work related stress. • Support the staff engagement agenda through reward and recognition initiatives including the annual staff awards ceremony. • Continue promotion and development of the Liverpool PCT Staff Benefits handbook.

7.0 Emergency Preparedness

7.1 Emergency Preparedness, Lead (Merseyside)	<p>The PCT will</p> <ul style="list-style-type: none">• Develop and review existing plans and procedures to ensure an appropriate response to local emergencies from the lead PCT.• Maintain existing NHS groups to focus upon resilience issues.• Review the Merseyside Resilience Forum Pandemic Influenza Plan.• Give guidance and support to Trusts in the maintenance and development of plans and procedures, including;<ul style="list-style-type: none">○ pandemic influenza○ major incident○ severe weather○ Chemical Biological Radiological and Nuclear (CBRN)○ NHS Recovery• Development and implementation of a 5 year strategy for improving NHS Resilience in Merseyside.• Maintaining the operability of the NHS Gold Cell in anticipation of any local emergencies.• Periodic testing of the Merseyside command and control structures for local emergencies.• Develop the capability to monitor the urgent care system across Merseyside.• Implement finding from Equality Impact Assessment.
7.2 Emergency Preparedness, Liverpool PCT	<p>The PCT will</p> <ul style="list-style-type: none">• Review test and update pandemic influenza plan including vaccine delivery models.• Periodic testing of the Liverpool command and control structures for local emergencies.• Develop review and test business continuity plans.• Continue with the delivery of the role specific and induction training programme, including the development of an e-learning package.• Establish contracts with providers and third sector organisations to improve PCT business resilience.• Ensure the major incident rooms for the PCT are fully prepared for operational response.• Develop and review severe weather plans including heatwave prior to the new/updated guidance being released by the DH.• Conduct a major incident table top exercise to ensure compliance with the NHS Emergency Planning Guidance 2005.• Maintain the plans and capability to respond quickly and effectively to local emergencies, whether from malicious acts, pandemic, man-made or natural disasters.• Ensure increased PCT dialogue with other Responder organisations.

8.0 Areas to support Local Priorities

8.1 Prevention

The PCT will

- Continue to support the delivery of the 4 key lifestyles programmes.
- Increase smoking quit rate to 1378 per 100,000 population aged 16 and over, equating to 4935 four-week quits in 2010/11.
- Reduce smoking prevalence – the Integrated General Household Survey will be used from 2011/12 to measure this. Ensure that the 4 week quit target is met year on year by the Stop Smoking Service.
- Increase the numbers of young people who have access to smoking prevention education.
- Sustain the major Smoke Free Campaigns, Smoke Free Kids, DMyst and Scary Movies to reduce children and young people's exposure to tobacco and to continue to promote smoke free environments beyond the legislation.
- Develop the Tobacco and Alcohol Unit to remove illegal and counterfeit products from the local economy.
- Increase the numbers in the population who are physically active.
- Increase the numbers in the population who access a Health Trainer.
- Monitor equality data from Health Trainer programme to promote targeted recruitment into the programme.
- Develop Exercise for Health Programme and ensure systematic GP and Primary Care referral pathways in place.
- Integrate the "Lets Get Moving" model into the Active City Programme to deliver increased levels of activity in the population.
- Work with partners to increase the uptake of healthy school meals.
- Increase the proportion of individuals who have the seasonal flu vaccine.
- Accelerate HPV catch-up programme in line with national guidance.
- Continue to develop the CQINS approach for public health indicators, and to monitor progress against current stop smoking target.
- Deliver the Public Mental Health Strategy following consultation with key stakeholders.
- Further develop the neighbourhood focus for all lifestyle interventions and to target groups with most need.
- Support Health Trainers to deliver health improvements in neighbourhoods and develop closer working links with GPs and primary care.
- Make further use of social marketing techniques to engage with the hardest to reach communities in line with work around health inequalities.
- Build public health capacity within front line services through the brief interventions training programme.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.2 Alcohol</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Continue to deliver the “Liverpool Alcohol Improvement Programme’s” action plan in partnership with other alcohol stakeholders. • Reduce harmful levels of alcohol consumption and measure progress through the Alcohol Harm Reduction Programme. • Implement a comprehensive and effective alcohol treatment and support service across the city. • Introduce a primary care alcohol pathway to include a community-based detox service and Alcohol Specialist Nurses. • Establish an Alcohol Intelligence Implementation Group to analyse alcohol needs (particularly hospital admissions) data in order to provide better intelligence to support the development of new initiatives to reduce alcohol-related harm. • Deliver a programme of targeted and opportunistic alcohol screening and brief intervention activities for the early identification and prevention of alcohol problems across a range of settings. • Promote a social marketing and communications plan to contribute to the alcohol harm minimisation agenda and underpin the delivery of the Alcohol Improvement Programme. • Work with citysafe to ensure Alcohol Treatment Requirements (ATRs) address domestic violence offenders. • To undertake an Equality Impact Assessment of the Liverpool Alcohol Improvement Action Plan.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.3 Health Checks</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Deliver NHS Health Check programme to 5% of eligible cohort of population aged between 40-74 years in 2010/11, 12% delivered by 2011/12 and 20% by 2012/13. • Implement model of delivery for health checks. • Review impact of implementation on other prevention services. • Establish performance measures for health check programme. • Agree evaluation methodology with stakeholders. • Redesign and recommission cardiac rehabilitation services to meet population need and demand. • Utilise General Practice Improving Standards framework and long-term conditions locally enhanced service to support General Practice to optimise pharmacological interventions for patients with Heart Failure, Hypertension and Hypercholesterolemia. • Ensure data coherence to ensure achievement of national service framework and MINAP requirements for patients discharged from secondary and tertiary care. • Support primary care, at a neighbourhood level, to case find members of the population at risk of developing CVD, utilising the General Practice Improving Standards framework. • Implementation of Heart Failure pathway across health economy.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.4 Carers</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Produce a joint plan with LCC by June 2010, outlining how the PCT and LCC combined initiatives will support carers, including short breaks, in a personalised way in accordance with the National Carers Strategy. • Ensure that more carers have access to health services appropriate to their needs to help maintain their physical and mental wellbeing. • Support joint carers assessments in partnership with Liverpool City Council and other NHS partners. • Work with appropriate agencies to ensure the particular needs of those caring for people with dementia are addressed. • Work in partnership with LCC to ensure there is improvement in: <ul style="list-style-type: none"> ○ patients receiving clear information on the quality of each service offered by every NHS provider ○ supporting the work of clinicians to inform the public, patients and carers about health choices and choice of service providers ○ promoting NHS Choices by integrating it into local support and advice for their patients and encouraging GP practices to improve service information ○ increasing the number of people supported to live at home ○ reducing long term admission into residential care
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.5 Children with disabilities</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Deliver on priorities within the Aiming High programme assessment carried out by the NWSHA. • Deliver a comprehensive programme of work around children and family engagement across community primary and acute health care services. • Improve information collection and management of data on need differentiation working with public health and IM&T. • Develop in partnership, an integrated care pathway for children with neuro disability and complex health needs. • Undertake a review of community paediatric and community paediatric nursing as part of Transforming Community Services and the AHDC core programme development. • Review individual care packages including mobility and postural care assessment in order to assess the need for personalised health care budgets. • Evaluate the effectiveness of education and training of the Team Around the Child Carer and Citizen College (TAC college). • Implement the work programme supporting the development of a service for young people in transition including palliative care. • Develop specific information on services for children and young people including service provision and decision making process. • Develop systems to inform predictive modelling of need in relation to children and young people with continuing health care in preparation for the implementation of Continuing Health Care Guidance. • Complete Disability Audit Tool for NSF Standard 8 and AHDC, in collaboration with providers, children and families. Develop an action plan based on the audit findings including the benchmarks within the national core offer of Aiming High for Disabled Children. • Reduce waiting within Speech and Language Therapy. • Implement an action plan to deliver on the Bercow Review recommendation for speech and language and communication needs.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.6 End of Life Care</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Implement the Liverpool PCT End of Life Care strategy, which was developed with wide stakeholder engagement in 2009/10 in line with national and local end of life care guidance. • Further define and enable the provision of services that meet the end of life care requirements, and national quality standards for both general and specific priority conditions, such as dementia. • Raise public/patient awareness regarding dying matters and encourage them to discuss their preferences for end of life care with their partner/family, before the need arises. • Extend the use of the electronic supportive care register to all NHS-contracted providers of end of life care. This provides a systematic framework, in line with national end of life care tools which assist in the optimisation of service delivery. It contains prompts to enable timely conversations to be had with the patient/carer/families. • Extend care home training to enable compliance with the use of end of life care tools and standardised assessment of their needs. • Observe number of referrals and uptake from BME communities who historically are not represented in end of life or palliative care services. • Ensure that appropriate end of life care training and audit (e.g. quality markers) is mandated and delivered within provider organisations. Future plans include the sharing of records to facilitate information sharing for patients across multi agencies. • Development of a Supportive Care Register in General Practice.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.7 Mental Health</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Improve access to settled accommodation and employment for people in secondary mental health services. • Improve Access to Psychological Therapies (IAPT) services for people with mild to moderate depression or anxiety in line with national guidance. • Reduce delayed discharge for in-patients, improving the range and quality of commissioned services in the community, and at primary care level. • Maintain the yearly target of 7,500 Early Intervention cases. • Improve accessibility of preventative mental health services, including the IAPT, to vulnerable and marginalised groups, particularly people from BRM groups, people with learning disability, young carers and their parents, and offenders. • Develop a shared care protocol with primary care for ADHD. • Improve access to mental health services for people who suffer from the combination of mental health difficulties and substance abuse (dual diagnosis). • Work with partners to develop the service for refugee and asylum seeker mothers in partnership with child and maternity services. • Work with high risk groups to address suicide prevention and support the implementation of the updated suicide prevention toolkit. • Support the reform of the estate for acute in-patient services through the implementation of the TIME (Mersey Care's new hospital project). • Implement the <i>Your Well-being in Mind</i> review to build capacity and care pathways in community mental health services. • Improve the Delivering Race Equality Dashboard and apply it to areas of service and pathway reform.

	<ul style="list-style-type: none"> • Review and recommission nursing home services for people with severe mental illness. • Improve capacity to respond to crises.
	<ul style="list-style-type: none"> • Ensure the implementation of the new hub and spoke personality disorder service. • Working jointly with the City Council to prevent and reduce homelessness in people with poor mental health. • Review psychological therapies for people with gender identity. • Pilot the implementation of the <i>Think Child Think Parent Think Family</i> guidelines ensuring that innovative practice (such as joint work with children's centres) is fully supported. • Support the implementation of the DH personalisation and mental health pilot in Early Intervention in Psychosis and Community Mental Health Teams and ensure that learning is disseminated across other areas of service provision.
8.8 Older people	<p>The PCT will</p> <ul style="list-style-type: none"> • Increase the number of people being enabled to live independently at home for longer and implement and promote the Independence Strategy which focuses upon prevention and active ageing activities. • Input to the specification for domiciliary care services to ensure that a higher level of care and support is available at the neighbourhood level to support people at home. • Extend the Liveability service to North Liverpool in partnership with Leisure Services and Primary Care to encourage older people to increase participation in physical activities. • Establish new processes and pathways which will support reduction in avoidable emergency admissions into hospital and reduce length of stay. • Design and develop a new specification for domiciliary care services to ensure that a higher level of care and support is available at the neighbourhood level to support people at home. • Implement a reablement strategy and improve the capacity of the service to meet future demands and ensure robust care pathways which improve transfers from acute care to appropriate reablement facilities. • Define and agree levels of care to ensure that people are appropriately placed according to their needs, for use by the Transfer of Care Team on discharge from hospital. • Consolidate the differing acute and community services involved in falls into one service, which includes a single point of access for all referrals. • Develop a robust Integrated Care Pathway, which includes people with osteopenia/osteoporosis. • Review service provision to ensure appropriate services for older people with learning disabilities. • In response to the growing numbers of older people with alcohol and drug problems ensure services are adequate to address the needs of older people. • Support GPs and primary care teams in the detection of possible dementia through the development of a primary care dementia pathway and protocols.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.9 Mixed Sex Accommodation</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Monitor all providers on their continuous compliance status of delivering same sex accommodation through the clinical quality contract performance meetings and formal reporting bi monthly (following declaration of compliance by end of March 2010). There will be a full risk assessment and Root Cause Analysis to be undertaken in the event of mixed sex occurrence, including those with clinical justification. • Performance manage all cases of a breach. • Providers to gather intelligence from LINKs, patient engagement forums and wider stakeholder groups. • Providers to undertake patient surveys of all areas to include views of delivering same sex accommodation. • Evidence of Dignity Champions, their involvement in the area of privacy, dignity and respect. • Full participation in the Dignity Care Agenda.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.10 Military Personnel</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Ensure military personnel, their families and veterans in Liverpool will have equal access to timely health care and dental services and veterans will have priority access for service-related conditions subject to clinical need in line with national policy. All providers will be required to ensure this takes place.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.11 Long Term Conditions and self care</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Audit patient records, in line with Chronic Disease Locally Enhanced Service, to determine the number of population who have an individual self management plan. • Audit to identify number of population who have completed the X-PERT Diabetes programme, and Pulmonary Rehabilitation programme, and reported understanding of self management plan. • Ensure implementation of self management plans for all patients with COPD, Asthma and Diabetes, including implementation of individual care plans for all patients with a long term condition. • Review of X-PERT diabetes education programme. • Implement the Public Health Improvement Neighbourhood management model, supporting populations to utilise programmes to support self care. • Work with service providers and service users, re-examining the delivery models for pulmonary, cardiac and stroke rehabilitation programmes to ensure suitability and effectiveness. • Review the utilisation of telemedicine for patients with COPD.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">8.12 Venous Thromboembolism</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Establish a baseline of current activity to ensure the delivery of the 90% target via contractual routes. • Ensure clinical staff understand the goal and are able to risk assess patients, record the outcomes, prescribe and administer appropriate prophylaxis. • Plan and organise data collection on risk assessment of all adult inpatients. • Report on clinical audits or appropriate prophylaxis and root cause analysis of inpatient pulmonary embolisms (PE's) and deep vein thrombosis (DVT's).

9.0 NHS North West Local Priorities

9.1 Urgent Care	<p>The PCT will</p> <ul style="list-style-type: none">• Reduce A&E attendances and emergency admissions due to Ambulatory Care Sensitive conditions specifically COPD, heart failure, ENT and asthma.• Increase utilisation of alternative community based pathways to acute admission through the single point of access for health professionals.• Pilot of CMS Directory of Services for DVT pathway.• Implement A&E diversion scheme – RLBUHT and Alder Hey.• Continue improvement in the discharge processes through improved reconfiguration of the transfer team and community based re-ablement teams.• Control and maintain demand for ambulance services working with Nursing Homes and local health providers to reduce demand.• Implement shared GP records for out of hours doctors working for UC24. Deployment of Adastra system within Unplanned Care Direct.• Establish IT systems for sharing of data across primary care (and possibly community services), secondary care, eye screening and ophthalmology to support the patient pathway.• Agree definition of general practice diabetes care provision and performance.• Ensure services are in place in the community for more complex patients.
9.2 Diabetic Retinopathy	<p>The PCT will</p> <ul style="list-style-type: none">• Complete roll out of fixed sites for retinal screening and phase 2 of co-location of services, meeting national standards and ensuring failsafe mechanisms to reduce risk.• Agree workforce development plans for increasing population for next 5 years.• Commission education for staff across primary care, including levels of accreditation of practice provision.• Review the role of the new injectable therapies in primary care.• Performance manage provision of patient education.• Establish foot care group to investigate high rates of amputations.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">9.3 People Living in vulnerable Circumstances</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Develop a cohesive set of NHS specific externally funded or unpaid employment schemes to support local vulnerable people into work. • Create internal work placements via local or national employment schemes designed to improve work opportunities for local people (placements are funded by external schemes or unpaid). • Encouragement work opportunities for local vulnerable people across the PCT by utilising both NHS specific and externally funded or unpaid employment schemes. • Support the development of a Workplace Wellbeing Charter across Liverpool and the roll out of best practice. • Support the improvement in the living conditions of local residents in vulnerable circumstances and improve access to local health services. • Improve engagement with third sector organisations affecting the vulnerable element of the local population. • Develop third sector organisations supporting the local health economy and those individuals in vulnerable circumstances. • Through the Healthy Homes programme, improve the living conditions and access to health and other local services for vulnerable residents across the city.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">9.4 Breastfeeding</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Implement the UK Baby Friendly seven point plan by the following measures:- <ul style="list-style-type: none"> ○ To commission a peer support programme during 2010/11 ○ To train a minimum of 80% of clinical staff by September 2011 in breastfeeding management • Monitor and improve data collection systems for breastfeeding at 6-8 weeks, and by ethnicity. • Develop and launch a breastfeeding social marketing strategy in 2010. • Increase the uptake of Healthy Start vitamins for pregnant women, new mothers and children up to 4 years.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">9.5 Crime & Violence</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Ensure appropriate engagement of PCT (or commissioned health services) in the crime reduction strategies including Knife Crime / Tackling Youth Crime / Anti Social Behaviour / Violence Against Women and Children / Early Intervention / FIP (Ref: Cutting Crime – a new partnership 2008/11). • Ensure appropriate responses are developed and provided to the meet the health needs of offenders in particular those with mental health problems. • Ensure appropriate support is given to the Sexual Assault Referral Centre. • Engage in the two Domestic Violence Multi-Agency Risk Assessment Conferences (MARACs) in Liverpool (monthly meetings - one in Liverpool North and one in Liverpool South). • Engage in the Hate Crime MARAC. • Further develop joint intelligence / joint information sharing / surveys with other CDRP partners for purposes of reducing crime and disorder e.g. contribution to Partnership's Strategic Intelligence Assessment.

	<ul style="list-style-type: none"> • Investigate further development of other services to address violence e.g. services in A&E and services in Maternity. • Ensure that in the development of any new building programmes the issue of designing out crime and target hardening is considered in the planning process. • Fulfil the PCT's forthcoming duty (April 2010) to contribute to reducing re-offending.
9.6 Domestic Violence	<p>The PCT will</p> <ul style="list-style-type: none"> • Further develop links with the Maternity Services Liaison Group in line with requirements to address Domestic Violence as a priority and consider the findings of the pilot Women's Hospital Domestic Violence Service. • Identify a lead in the PCT for Domestic Violence and work with providers (NHS and Voluntary Sector) to ensure leads (including SPOC) are identified and a network is created for the purposes of workforce development including links between alcohol and violence. • Agree an overarching Domestic Violence policy for all PCT commissioned services and adapt for local use. • Develop and implement a supportive approach to NHS employees who may have been subject to Domestic Violence (Healthy Workforce). • Review published and other available literature about health services' response to national guidance including "<i>Together we can end violence against women and girls</i>". • Collaborate with partner agencies working in related fields (e.g. Safeguarding) to ensure that there is a coordinated approach. • Maintain existing health input into the following: <ul style="list-style-type: none"> ○ MARACs (Hospitals and PCT), North Liverpool Domestic Violence Pilot, representation on the Domestic and Sexual Violence Forum • Undertake Equality impact Assessments on any PCT commissioned services, and ensure our providers also undertake the assessments. • Monitor EPIT (equality performance improvement toolkit) with all providers and ensure that it is performance managed throughout NHS contracts. • Ensure appropriate support is given to the Sexual Assault Referral Centre (SARC) and health input delivered where/when required. • Support the delivery of the Alcohol Treatment Requirement (order specified by the Courts) with specific reference to perpetrators of domestic violence where alcohol has been a contributory factor.
9.7 Dementia	<p>The PCT will</p> <ul style="list-style-type: none"> • Increase the early and accurate diagnosis of dementia. • Support GPs and primary care teams in the detection of possible dementia through the development of a primary care dementia pathway and protocols. • Identify carers earlier within primary care by establishing Carers Registers. • Support people with dementia and their carers in navigating their way through dementia care, taking control and making informed decisions by developing a 'Care Navigator' model of support within the community. • Support streamlined information sharing to achieve timely assessment and care packages through the wider use of the Single Assessment Process Client held records file and any other information sharing documentation, for example 'hospital passports'.

	<ul style="list-style-type: none"> • Ensure people with a diagnosis of dementia are not excluded from rehabilitation and therapeutic services by increasing access to intermediate care, speech and language teams and falls prevention. • Increase the number of adults and older people receiving direct payments and/or individual budgets. • Undertake full needs assessment, service review and contribute to the alcohol harm minimisation agenda and the Alcohol Improvement Plan in relation to older people and alcohol.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">9.8 People with Learning Disabilities</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Involve "experts by experience" (people with a learning disability and carers) in commissioning and planning for people with learning disabilities. • Improve quality of information required to identify the learning disabled population in Liverpool and to enable a fuller understanding of their needs. • Ensure appropriate leadership and support for the full implementation of the Direct Enhanced Service for PWLD, so that the maximum number of annual health checks is achieved by GP practices and audited and reported by the PCT. • Ensure that all commissioned health services, including health promotion and improvement programmes, offer information in accessible formats, in line with Disability Discrimination Act and Single Equality Scheme requirements. • Reduce barriers to accessing in-patient care and treatment, in line with DH recommendations (<i>Healthcare for All</i>) and increase the number of people with learning disabilities (PWLD) in mainstream health services in order to reduce health inequalities. • Provide support and direction to MCT to review current health-based respite provision to ensure that investments support a personalised approach to providing short breaks and meet the needs of service users and their families. • Investigate opportunities for PWLD and their families presented by the use of individualised budgets, including health budgets. • Reduce the number of 'Out of area' placements in line with the outcomes referred to in Valuing People now. • Improve Care Pathways for patients with a Learning Disability with forensic needs in Low and Medium Secure inpatient facilities to return to Liverpool services in the Community in partnership with North West Secure Commissioning team, City Council and local Clinicians. • Develop a partnership approach with Offender Health Commissioners and Criminal Justice professionals and local community clinicians for PWLD to be more effectively identified, assessed, screened and diverted from inappropriate custodial provision in line with the Bradley Report Implementation plan.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">9.9 You're Welcome</p>	<p>The PCT will</p> <ul style="list-style-type: none"> • Implement the first full wave of You're Welcome roll out programme by May 2010. • Agree a local action plan for the implementation of You're Welcome, outlining local targets for the achievement of the quality mark within all health services that regularly see young people by 2020, and ensure that the action plan is agreed by the Children's Trust. • Nominate a multi-agency led process to provide support and guidance to local health services working towards the quality mark. • Identify both Professionals and Young People to undertake You're Welcome verifier training with a view to them being part of a number of citywide verification panels. • Agree a strategy for local verifiers to cascade the training to a wider multiagency 'panel' of verifiers, identified from across the Children's Trust, who will undertake desk-based verification and verification visits to participating services, up to four times a year.

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| | <ul style="list-style-type: none">• Develop a local model to involve young people in verification visits to participating health services.• Contribute to the Regional Steering Group for the You're Welcome initiative to share good practice and improve development and learning.• Implement a Communications Plan which ensures that all relevant organisations and young people are fully informed and involved with the development of You're Welcome.• Hold You're Welcome awareness raising events for key partners to encourage participation and identify a priority target group for the year ahead. The first of these will take place in April 2010.• Work with relevant Commissioners to ensure that the You're Welcome quality mark is built into future commissioning arrangements for all health services that are regularly seeing young people aged 11-19 years. |
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