REPORT TO:	Health Policy and Performance Board
DATE:	5 March 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults; Children, Young People and Families
SUBJECT:	The Mandate and Everyone Counts: Planning for Patients 2013/14
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To inform the Health Policy and Performance Board of the publication of *The Mandate* and *Everyone Counts: Planning for Patients 2013/14* and the response to this by Halton Clinical Commissioning Group (CCG).

2.0 RECOMMENDATION

It is recommended that the Board:

1. **Notes the publication of the *Mandate* and *Everyone Counts: Planning for Patients 2013/14* and the concomitant requirements for the CCG, particularly in regard to the production of clear and credible commissioning plans; and**

2. **Notes that a copy of the CCG's Integrated Commissioning Strategy 2013-15 and an Integrated Delivery Plan for 2013/14 will be presented for discussion at the next Health Policy and Performance Board in May.**

3.0 SUPPORTING INFORMATION

3.1 The first *Mandate* between the Government and the NHS Commissioning Board, setting out the ambitions for the health service for the next two years, was published on 13th November 2012. The Mandate reaffirms the Government's commitment to an NHS that remains comprehensive and universal – available to all, based on clinical need and not ability to pay – and that is able to meet patients' needs and expectations now and in the future.

3.2 The NHS *Mandate* is structured around five key areas where the Government expects the NHS Commissioning Board (NHS CB) to

make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

Through the *Mandate*, the NHS will be measured, for the first time, by how well it achieves the things that really matter to people.

3.3 The key objectives contained within the *Mandate* include:

- improving standards of care and not just treatment, especially for the elderly
- better diagnosis, treatment and care for people with dementia
- better care for women during pregnancy, including a named midwife responsible for ensuring personalised, one-to-one care throughout pregnancy, childbirth and the postnatal period
- every patient will be able to give feedback on the quality of their care through the Friends and Family Test starting from next April – so patients will be able to tell which wards, A&E departments, maternity units and hospitals are providing the best care
- by 2015 everyone will be able to book their GP appointments online, order a repeat prescription online and talk to their GP online
- putting mental health on an equal footing with physical health – this means everyone who needs mental health services having timely access to the best available treatment
- preventing premature deaths from the biggest killers
- by 2015, everyone should be able to find out how well their local NHS is providing the care they need, with the publication of the results it achieves for all major services.

3.4 *Everyone Counts: Planning for Patients 2013/14* sets out how the NHS Commissioning Board intends to ensure that it, and Clinical Commissioning Groups (CCGs), deliver the requirements of the Mandate and the NHS Constitution. *Everyone Counts: Planning for Patients 2013/14* was published on 17th December 2012, with further guidance following on 21st December 2012.

3.5 *Everyone Counts: Planning for Patients 2013/14* and the supplementary guidance are very detailed. The headline measures in the documents are:

Listening to patients:

- The rights of patients set out in the NHS Constitution are vital. They must be delivered.
- Customer convenience - the NHS will move to providing seven days a week access to routine healthcare services.
- Real-time experience feedback from patients and carers by 2015.
- A Friends and Family Test to identify whether patients would recommend their hospital to those with whom they are closest.

Focusing on outcomes:

- Publication of consultant-level outcome data covering mortality and quality for ten surgical and medical specialties.
- NHS Outcomes Framework will now inform NHS planning. Commissioners will be expected to prioritise and make improvements against all indicators.

Rewarding excellence:

- Continued financial and related levers and enablers for clinical commissioning groups to use when commissioning for better patient outcomes.
- A Quality Premium for clinical commissioning groups who secure quality improvement against certain measures from the *NHS Outcomes Framework*
- Support for clinical commissioning groups to define their local QIPP challenge and set milestones.
- CQUIN payments only available to providers who meet the minimum requirements concerning the high-impact innovations, as set out in *Innovation, Health and Wealth*.
- During 2013/14, a fundamental review of the incentives, rewards and sanctions available to commissioners to drive improvements in care quality.

Improving knowledge and data:

- NHS Standard Contract to require all NHS providers to submit data sets that comply with published information standards.
- *Care.data* - a modern knowledge service for the NHS will provide commissioners with timely and accurate data.

3.6 *Everyone Counts: Planning for Patients 2013/14* and associated guidance set out the measures, the *NHS Outcomes Framework*, which the CCGs will use to track progress in improving healthcare for their population. These are set out in Appendix 1 of this paper. All CCGs will be measured in four key outcome areas:

- Potential years of life lost (PYLL) from causes considered amenable to healthcare.
- Emergency admissions for acute conditions that should not usually require hospital admission.
- Friends and family test.
- Incidence of healthcare associated infection (HCAI)

3.7 Halton CCG will also have to identify an additional three local priorities from those set out in Appendix 1 against which it will make progress during the year. These priorities will be taken into account when determining if the CCG should be rewarded through the Quality Premium.

3.8 Halton CCG will be expected to deliver and uphold the rights and pledges from the NHS Constitution and the thresholds set by the NHS CB, these are set out in Appendix 2. The CCG will be required to produce a plan to demonstrate delivery in these areas. Plans should be built on the assumption that no indicator contained within the national *NHS Outcomes Framework* or the *CCG Outcome Indicator Set* deteriorates.

3.9 The NHS CB has set out a planning timetable for CCGs that requires the following:

- By 25th January 2013 CCGs to share first draft of plans with Area Team Director. This has been achieved.
- By 8th February 2013 Area Team Director to provide feedback to CCGs. This work has been completed.
- By 31st March 2013 all contracts signed off.
- By 5th April 2013 final CCG plans shared with Area Team Director.
- By 31st May 2013 final CCG plans published as prospectus for local population.

3.10 The Policy and Performance Board will be aware that the CCG has engaged with local people and member practices in order to formulate an Integrated Commissioning Strategy 2013-15 and an Integrated Delivery Plan for 2013/14. Throughout this process of engagement the CCG has been clear that the Strategy and associated Delivery Plan will need to take account of national drivers, such as the Mandate and *Everyone Counts*, as well as local requirements.

3.11 To maintain the engagement of local people in the development of the Integrated Commissioning Strategy 2013-15 and Integrated Delivery Plan 2013-14 the CCG has held three more engagement events:

- 8th February 2013, CCG Members' Forum
- 12th February 2013, Halton People's Health Forum (day event)
- 13th February 2013, Halton People's Health Forum (evening event)

The Strategy and Delivery Plan will be presented to the Health Policy and Performance Board in May for discussion.

4.0 POLICY IMPLICATIONS

4.1 The NHS Commissioning Board will require the CCG to ensure that all aspects of the Mandate and *Everyone Counts: Planning for Patients 2013/14* are addressed in our Integrated Commissioning Strategy 2013-15 and Integrated Delivery Plan for 2013/14. In particular the CCG will need to ensure that these plans are structured around the five key areas where the Government expects improvements to be made. The CCG will also need to measure progress in each of these areas using the NHS Outcomes Framework.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The financial settlement 2013/14 for the NHS was published at the same time as *Everyone Counts: Planning for Patients 2013/14*. The baseline allocation for Halton CCG excluding running costs before uplift is £172,686. After a 2.3% uplift this is £176,657. The CCG will be required to make plans for a cumulative surplus of 1% of revenue for 2013/14 and 2014/15. CCGs are also required to plan for a 2% recurrent surplus by the end of 2013/14 and hold a contingency of at least 0.5% of revenue to mitigate risks within the local health economy.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

NHS Halton CCG will work closely with the Children's Trust to commission services for children and young people and to meet statutory responsibilities in regard to safeguarding.

6.2 Employment, Learning & Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

Halton CCG is a key partner in this agenda.

6.4 A Safer Halton

None as a result of this report.

6.5 **Halton's Urban Renewal**

None as a result of this report.

7.0 RISK ANALYSIS

7.1 The CCG has strong governance arrangements in place that will enable the risks associated with the delivery of the *Mandate* and *Everyone Counts* to be transparently managed and mitigated.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no equality and diversity issues as a result of this report. Halton CCG, as a statutory organisation, will comply with the requirements of the Equality Act 2010.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Department of Health, *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, Department of Health, 13th November 2012, http://mandate.dh.gov.uk/

NHS Commissioning Board, *Everyone Counts: Planning for Patients 2013/14*, NHS Commissioning Board, 17th December 2012, http://www.commissioningboard.nhs.uk/everyonecounts/

Appendix 1 NHS Outcomes Framework

The NHS Outcomes Framework measures which the NHS Commissioning Board and Clinical Commissioning Groups will use to track progress (i.e. data can be generated at Clinical Commissioning Group level and a baseline can be determined against which progress can be considered).

1. Preventing people from dying prematurely

Potential years of life lost (PYLL) from causes considered amendable to healthcare

Under 75 mortality rate from cardiovascular disease

Under 75 mortality rate from respiratory disease

Under 75 mortality rate from liver disease

Under 75 mortality rate from cancer

2. Enhancing quality of life for people with long term conditions

Health-related quality of life for people with long-term conditions

Proportion of people feeling supported to manage their condition

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Estimated diagnosis rate for people with dementia

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

Emergency admissions for acute conditions that should not usually require hospital admission

Emergency readmissions within 30 days of discharge from hospital

Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins

Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)

4. Ensuring that people have a positive experience of care

Patient experience of primary care i) GP Services ii) GP Out of Hours services

Patient experience of hospital care

Friends and family test

5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Incidence of healthcare associated infection (HCAI)

i) MRSA ii) C. difficile

Appendix 2 **NHS Constitution Rights and Pledges and NHS CB Thresholds**

Referral To Treatment waiting times for non-urgent consultant-led treatment

Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%

Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%

Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%

Diagnostic test waiting times

Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%

A&E waits

Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%

Cancer waits – 2 week wait

Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%

Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%

Cancer waits – 31 days

Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%

Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%

Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%

Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%

Cancer waits – 62 days

Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%

Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set

Category A ambulance calls

Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately)

Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

Mixed Sex Accommodation Breaches

Minimise breaches

Cancelled Operations

All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

Mental health

Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.