



Primary Care Contracting

Primary Care Service Framework: Management of Adolescent Health in Primary Care

- This 'enhanced service' framework should be read in conjunction with the **supportive statements for commissioning** on the Primary Care Contracting website – 29Hwww.pcc.nhs.uk – and the **additional supportive notes** at the end of this document to help commissioners, providers and other stakeholders with contextual planning and local service design and development. They offer further implementation pointers and have been developed with the help of those currently commissioning or providing primary care services.
- The document demonstrates good practice in adolescent health in primary care and can be adapted and used as a basis for an enhanced service via a primary care contract or Service Level Agreement. This will hopefully avoid duplication of effort and speed up the commissioning process. It would be appropriate to adapt or include local information in the relevant sections. Legal advice or support for local contractual arrangements may need to be considered.
- Adapted locally, local commissioners and providers should ensure this Framework is tightly linked to the local Children & Young People's Plan.
- NHS Primary Care Contracting kindly requests feedback from PCTs or Practice Based Commissioners following implementation of this Framework via the brief feedback questionnaire on their website – 30Hwww.pcc.nhs.uk. This will assist in its on-going development and sharing of good practice across the NHS.
- The Department of Health and NHS Primary Care Contracting would like to thank all those individuals, departments and organisations who have contributed to the development of this Primary Care Service Framework as well as Steering Group members. Thanks also go to Dr Jeff Anderson of Primary Care Unlimited – 31Hwww.primarycareunlimited.com – for coordinating the development of each Framework.

Primary Care Service Framework: Management of Adolescent Health in Primary Care

- 1. Purpose of this Primary Care Service Framework**

The purpose of this Primary Care Service Framework is

 - to equip commissioners, providers and practitioners with the necessary background knowledge, service and implementation details to deliver a safe, high quality, integrated adolescent health service in primary care.
 - as a means of improving patient's health and quality of life by providing patient-centred, systematic and integrated support.

- 2. Period of Service**

This service will run for a period of twelve months from 1st April 2009 until 31st March 2010 (with extensions subject to satisfactory annual review).

- 3. Scope and Definition of service**

The service is open to 10-19 year old male and female patients and can be provided either at individual practice level, or on a locality or PCT basis. It is open to all types of providers for example, GP practices, Community Pharmacists, community and specialist nurse-led services, voluntary sector, Local Authority, including education, the independent sector or other alternative providers. **However, this Framework is likely to achieve more success through an integrated and community based model, making best use of joint commissioning approaches and managed networks of provision.** This primary care service should not be confused with (and sits outside of) essential and additional GMS or PMS, PCTMS or APMS services already provided, current Quality and Outcomes (QOF) indicators, and other nationally agreed Directed Enhanced Services.

- 4. Parties to the agreement**

Insert names of any accountable individuals and organisation details.

- 5. Background**

 - The *Every Child Matters: Change for Children* (DfES, 2004) implementation programme set out the delivery of high quality services and improving outcomes for children and young people. The *National Service Framework for Children, Young People and Maternity Services* (DH, 2004, revised 2007) set out the standards for the NHS, Local Authorities and partner agencies to stimulate long-term and sustained improvement in children and young people's health. These standards include promoting healthy behaviours, safeguarding children, providing better access to services and offering more information and choice about the services that children, young people, parents and families receive. The areas which the NSF standards cover are listed for completeness:
 - Standard 1: Promoting Health and Well-being, Identifying Needs and Intervening Early*
 - Standard 2: Supporting Parenting*

Standard 3: Child, Young Person and Family-Centred Services

Standard 4: Growing Up into Adulthood

Standard 5: Safeguarding and Promoting the Welfare of Children and Young People

Standard 6: Children and Young People who are Ill

Standard 7: Children and Young People in Hospital

Standard 8: Disabled Children and Young People and Those with Complex Health Needs

Standard 9: The Mental Health and Psychological Well-being of Children and Young People

Standard 10: Medicines for Children and Young People

Standard 11: Maternity Services

- The White Paper *Our health, Our care, Our say: a new direction for community services* (2006) also emphasises active participation of service users in how local services are planned and developed and their views must be taken into account. Children's Centres, Extended Schools or voluntary and third sector programmes, and the development of the 'any willing provider' context provide a means of delivering the White Paper commitment to make services more accessible in the community. Furthermore, PCTs have a statutory duty to develop plans for the delivery of services to children and young people working with their partner agencies.
- Key public health indicators in priority areas such as obesity, smoking, taking drugs and sexually transmitted infections and teenage pregnancy are still important to address. Nine per cent of 11-15 year olds report that they are regular smokers. The average weekly consumption of alcohol has doubled to 10.4 units in 2000 despite a slight drop in prevalence of drinking among secondary school pupils. However, there is evidence of a drop in under 18's conception rates since 1998 and a slight decrease in the amount and prevalence of drug taking. At the same time, prevalence of long term chronic illnesses such as asthma and diabetes in young people has increased. In 2003, 57% of total deaths of 15-19 year olds resulted from injury and suicide.
- As part of the current NHS Operating Framework (2008-2011) a number of 'vital signs' indicators related to children and young people are stressed which, as a national priority, require local action to achieve. The outcomes of these achievements will improve health and reduce health inequalities that exist locally. The focus of these indicators include:

Under 18 conception rate per 1000 females aged 15-17

Obesity among primary school age children

Proportion of children who complete immunisation programmes by the recommended age

Percentage of infants breastfed at 6-8 weeks

The effectiveness of the local Child and Adolescent Mental Health Service (CAMHS)

- Trends in adolescent health are strongly linked with health and social inequalities with increasing risk behaviours during the transition from adolescence to adulthood. Adolescence is a critical period for engaging the population in health as this is the age when health related behaviours begin to set and young people begin to explore more 'adult' behaviours including drinking, smoking, drug use, violence and sexual intimacy. These also co-exist such that those who smoke are more likely to drink or have serious psychological distress.
- Variations exist in access and suitability of health services for young people across different communities. Nearly three-quarters of young people attend their GP each year. However, young people are often reluctant to use services where their needs have not been taken into account. Acceptable and accessible services for young people can help foster their sense of valuing health (not just lack of disease) and promote healthy choices that will become part of their everyday lives. Research with young people consistently shows that they are reluctant to access health advice unless services are trusted to be confidential, in the right locations, open at the right times and staffed by professionals with non-judgmental attitudes. Removing the barriers to seeking advice is particularly important in relation to sexual and reproductive health (including teenage pregnancy), where teenagers reported heightened anxieties about confidentiality and staff disapproval.
- One of the key priorities of the NHS Operating Framework 2008-2009 is to improve children and young people's physical and mental health and wellbeing, with a focus on stemming the rising tide in childhood obesity to 2000 levels by 2020. PCTs are asked to work with local authorities and other partners, in the context of Every Child Matters and the Children's Plan, to ensure that children's and young people's health and wellbeing needs are assessed and that actions are planned and contracted for. PCTs are asked to focus on evidence-based prevention, early intervention, and access, designed around the needs of the individual.

6. Summary of Local Need

Commissioners should outline or reinforce a summary of health and social care or service need drawn from the local Joint Strategic Needs Assessment. The needs assessment should be carried out jointly by the Director of Children's Services with partner agencies, and the basis for the priorities set out in the Children and Young People's Plan, together with the improvement in outcomes that are being aimed at, should support local JSNAs.

7. Service Objectives and

Local commissioners and providers should consider what a local service should and can deliver within

Intended Health Outcomes

resources available. Specific service objectives and intended health outcomes will be determined by local need and joint working between adolescent health service providers is critical to achieving this success. The following list of aims could be used to target services objectives and ensure the delivery of particular health outcomes. Dedicated adolescent health care could:

- Improve emotional and physical health and well-being outcomes for young people (10-19 year olds)
- Ensure services reach the most marginalised within this group
- Improve access to advice, information and treatment for all young people
- Improve engagement with young people in the range, delivery and quality of health services
- Create an environment for health service provision that is young person centred
- Provide more integrated services across health, social care, and education and community organisations.

8. Service Outline

Within a primary care service of this nature, commissioners may wish providers to:

1. Develop an integrated service strategy for the advice and treatment of patients within this age group in line with national guidance. This also includes working with schools and youth services through extended schools and local Children's Centres.
2. Nominate a lead clinician for health service delivery and a nominated holistic young person's health worker as one point of contact.
3. Offer outreach service to vulnerable groups such as adolescents in prisons and secure accommodation, minority ethnic groups, unaccompanied asylum seekers, travelling population. Outreach may also be needed for those that will not voluntarily come to the service such as teenage parents.
4. Identify patients whose needs are not currently well met including children with disabilities and complex needs, more vulnerable groups, those with chronic conditions, and those undertaking high risk behaviours.
5. Develop a systematic register and recall system to enable the provision of an annual health check for children and young people. The focus of these registers may be on those in particular high risk groups.
6. Ensure active engagement of young people in this service delivery by, at least, an annual survey of young people and to produce an action plan to address issues raised
7. Offer open access and a clinic/appointment system for young people to discuss health issues, considering different approaches to tele-consultation and wider use of technology generally.
8. Offer age-specific health promotion advice through a clinic/appointment system and open access on a

range of issues appropriate to the individual.

Note: All practices providing GMS or PMS are expected to deliver age-specific health promotion advice to young people who are registered with the practice. It may therefore be necessary to consider extending this to the unregistered population.

9. Engage formally with, and refer to (where appropriate), more specialist children's services, working across localities where necessary such as CAHMS for those with mental health disorders, Acute Trust and Community Paediatrics, Drug and Alcohol services, Counselling services, Child Development and Special Needs, Youth Worker services and Out of Hours primary care services.
10. Provide contraception services and advice and information tailored to adolescents.
11. Provide systematic and on-going support to individuals and their parents/carers, including follow up procedures.

9. Support for Self Care

Providers should be in a position to identify those individuals who would benefit from additional support for self care and enable these individuals to access the four main areas of self care - Skills and Education; Information; Tools and Devices; Self Care support networks. Additional detail around support for self care can be found at www.pcc.nhs.uk/204.php in a parallel Primary Care Service Framework, and also www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_4128529 on the Department of Health website. Further details of the 'Staying Positive' Expert Patient Programme workshops for children and young people can be found at www.expertpatients.co.uk/public/default.aspx

10. Location of Service

Commissioners will need to re-assure themselves that the service is provided from locations that are fit for purpose in a safe, modern way and address issues of service uptake, particularly in communities with poor health outcomes. Details should be included here.

11. Integrated Governance

Any commissioned service must meet all national standards of service quality and clinical governance including those set out in Standards for Better Health (updated April 2006 www.dh.gov.uk). These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health. Compliance with NICE guidance www.nice.org.uk is also required.

Clinical Governance arrangements must be proportionate to the service provided and comply with any local expectations or requirements of the commissioner.

Professional competency, education and training – All healthcare professions delivering the service will be required to demonstrate their professional eligibility, competence, and continuing professional

development in order to remain up-to-date and deliver an effective service which is culturally appropriate. Staff appraisal on an annual basis and at an appropriate level will also be required.

Providers should demonstrate their adherence to statutory guidance described in *Working Together to Safeguard Children (2006)* and practitioners should satisfy current CRB checks. All staff who are likely to come into contact with young people should receive basic training on communicating easily with young people and on promoting young people friendly attitudes and values. Appropriate staff members should be trained to ensure that they are competent to discuss with young people the health issues that they present with, and other relevant health issues, and to make appropriate referrals where necessary. Commissioners will need to be reassured that practitioners have the required competencies at an appropriate level such as:

- Royal College of Paediatrics and Child Health accredited training course
- GP with Special Interest in Child Protection – see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006629 and also further guidance for other Practitioners with Special Interest at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074429
- Nurse practitioner for young people
- Trained health care assistants

In engaging with young people, healthy lifestyle factors will inevitably emerge through the service provider's ability to risk assess, in partnership with the young person, identifying wider health problems often relating to other mental, social, physical and emotional health problems, drugs and alcohol use, suicide and self harm, diet and nutrition, smoking etc.

Providers should ensure safe staffing capacity at all times. Staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example infection control, manual handling, risk assessment as required.

Patient, public and staff safety – Providers will be required to demonstrate that evidence based clinical guidelines are being used. Providers should have in place appropriate health and safety and risk management systems and that premises are safe and young person friendly. They should also ensure that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented. Services should comply with national requirements for recording, reporting, investigation and implementation of learning from incidents. Further details can be found on the National Patient Safety Agency website www.npsa.nhs.uk.

Clinical audit and review – Providers will be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service.

Information management – Any communications strategy or provision should be coherent with and follow local policies and the Department of Health Code of Confidentiality, local child and adult protection procedures, and should outline the mechanisms to safeguard patient information when shared within an integrated service. Providers should be aware of the Department of Health policy around handling and disclosing patient information. ‘Confidentiality – NHS Code of Practice’ can be found at www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf. There is also a specific confidentiality code of practice for GMS, PMS and APMS providers at www.dh.gov.uk/assetRoot/04/10/73/04/04107304.pdf.

Patient and public involvement – Providers will be required to demonstrate active engagement with young people and local communities in developing services, self care plans or in supporting patients to utilise self care opportunities. This should either be undertaken by the providers themselves or demonstrate that specific community and engagement information has been considered. Providers should demonstrate how systematic patient feedback is being used to shape and improve services such as laid out within Hear by Right and health – www.nya.org.uk/hearbyright

Equality and human rights - Delivering good quality care will require organisations to demonstrate competence in identifying and taking action on inequality; and also needing to engage with communities that have not found accessing public services easy. Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation, and conducting EQIAs and using the evidence to create a meaningful dialogue with communities (especially seldom heard from groups) is central to effective commissioning and service provision. This will create an evidence-based approach. As a minimum, core standard C7e of *Standards for Better Health* stipulates “healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably”.

Managing complaints – Responsive protocols and procedures should be in place for managing patient complaints. Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.

Continuous quality improvement – a set of indicators should be selected or developed and then agreed which defines the key quality requirements of the service. The service should also identify how it uses these measures and others to ensure that the quality of the service is continuously improved.

12. Information management/requirements

Providers will need to analyse their data in order to help demonstrate service quality, effectiveness and provider performance. Information needs may be different depending on the scale of service provision (PCT-wide or at individual practice level) or if provision is focused in targeted populations. Any information management system should have the capacity to record patient episodes, track patient pathways, monitor outcomes and continuity of care, and should underpin local communication and referral networks. A selection of relevant information areas, from which key quality and performance indicators could be drawn, are offered

for consideration below.

Note - Outcomes measures and subsequent health, service and commissioning outcomes will be locally specific in line with local Children and Young People's Plans.

- *You're Welcome* quality criteria for making health services young people friendly (2007) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586 should be used as a basis for measuring overall service quality, effectiveness and performance. The ten topics covered by the service standards are: accessibility; publicity; confidentiality and consent; environment; staff training, skills, attitudes and values; monitoring and evaluation and involvement of young people; health issues for young people; sexual and reproductive health services; child and adolescent mental health services.
- Local Area Agreement outcome measures
- A&E attendances for risky behaviours
- Immunisation and vaccination rates, including HPV uptake
- Sexual and reproductive health – teenage conception rates, contraception, Chlamydia screening and other Sexual Health service attendances
- Other community services – referral rates to CAMHS, minor illness services, Out of Hours services
- Diet/lifestyle – BMI, change in physical activity level, Smoking status and quit rates, Alcohol consumption
- Social exclusion – school exclusion numbers, literacy rates, employment
- A local basket of indicators also exists for Health Inequalities and can be found at the London Health Observatory www.lho.org.uk
- Further local indicators around 'vital signs' outcomes will also be applicable.

13. Service Monitoring and Evaluation

Service providers will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting. The process by which this evaluation is achieved can also be used to show the outcomes of the service to other key stakeholders such as patients. Service evaluation should cover, as a minimum, the following areas:

Service Activity – Volume of work against any agreed activity levels and distance from profile, capacity, needs and demand analyses, workforce arrangements, real time referral data to other care pathways or appropriate agencies

Clinical Outcomes – Regular analysis and interpretation of clinical outcomes data as well as regular

analysis and interpretation of PPA data for prescribing

Quality and Governance – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year. EQIA data should be used to underpin local integrated service provision.

Patient Experience – Patients views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with patients in a way that supports them. This process should be stratified where possible to show any differential impact on disadvantaged groups (e.g. Black and Minority Ethnic groups, deprived groups, males, females etc) and any resultant service changes (planned or achieved) should be highlighted.

Value for Money – Cost effectiveness or ‘best value’ analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care. Such measures could include attendance rates, waiting times, length of stay. Other possible analyses include: - Prescribing costs; Quality Adjusted Life Years (QALYs); Savings due to reductions in days off work; benefits of increase in social capital and active citizenship; Staff and non-staff costs of running the service; Capital costs; Potential supplementary costs to patients eg time off work, travel and transport or other in-direct costs such as cost of loss of production to society

14. Funding

There will be no fixed or nationally agreed price for this service. Commissioners and providers may wish to access alternative funding mechanisms, such as local programme budgeting along the whole patient pathway, and should agree funding which is reflective of the level of service to be delivered locally and could include:

- Basic funding for achieving minimum requirements within the service specification
- Additional funding or financial incentive for delivering specific local patient outcomes
- Indication of national benchmark prices if available

15. Contract Management

The name and contact point of the contract manager of both the commissioner and provider should be given here. Any specific local arrangements for contract management should also be stated.

16. Review, variation and re-commissioning process

A number of important contractual design and management issues will be followed throughout the period of the contract. In particular:

- Formal review of the service will be on-going and will inform the end of year service review process which will be used to determine if service is to be extended or de-commissioned.

- Any in-year contract variations will be discussed and agreed by both parties and will be included as additions to this Primary Care Service Framework.
- Following the review the commissioner will decide whether the service has been effective, including whether it is addressing the needs of disadvantaged groups with high needs. If not, the commissioner will discuss with the provider any formal escalation or recovery plan with realistic timeframes for delivery.
- Appropriate notice periods and termination procedures will be agreed by both parties.

Both parties may wish to seek legal advice before agreeing any formal contractual arrangements resulting from this Primary Care Service Framework.

17. Signatories

Signatures from all parties as those accountable for the agreement

Additional supportive notes to assist the implementation of the Primary Care Service Framework: Management of Adolescent Health in Primary Care

Commissioning 'business case' and Value for Money

- Commissioning this Enhanced Service will have a significant impact on the availability of commissioning resources locally.
- For every pregnancy the average cost to the NHS is around £1500. Approximately £165 million a year is spent on treating STIs. Despite affecting a small number of individuals HIV imposes a significant burden on healthcare resources at around £580 million a year, with a lifetime cost per case of £300,000. These figures do not include preventing onward transmission of infection. Further, a wide choice of contraceptive services and abortion services provided with minimal delay is cost saving. For every £1 spent on contraceptive services, £11 is saved. Commissioners can find out more about developing local sexual health services in the Primary Care Service Framework: Management of Sexual Health in Primary Care found at www.pcc.nhs.uk/204.php
- About a third of NHS expenditure and bed occupancy for children are attributable to those who need palliative care, costing £536 million each year.
- For an indication of the costs of obesity treatment and potential impact on commissioning resources, see Primary Care Service Framework: Management of Obesity in Primary Care (p11) at www.pcc.nhs.uk/204.php
- There is a significant societal and economic cost as a consequence of youth unemployment, youth crime and educational underachievement. The Prince's Trust report (2007) estimates that over £2 million could be saved in youth crime if youth unemployment was reduced by 1%. The savings link between these problems and health outcomes is also highlighted, particularly educational underachievement.
- Commissioners should also be aware of the wider savings which would be realised through support for self care as described in a complementary Primary Care Service Framework. This can be also be found on the NHS Primary Care Contracting website www.pcc.nhs.uk/204.php

Practice Based Commissioning (PBC) sign off

- PCTs and Practice Based Commissioners should be aware that business case proposals for the provision of this Primary Care Service will need to meet the full requirements of any local service delivery plan and authorisation process. This may well be at PCT Board level or any delegated panel. For proposals that pertain to the provision of services for a wider population, consideration as to further engagement and sign off with the SHA may be necessary.
- The Commissioning Framework (Department of Health, July 2006) highlights how commissioners should follow EU best practice principles when considering competitive procurement of local services. This does not necessarily mean open tendering processes should be adopted in every case. The Department of Health would not normally expect tendering where practices currently under GMS/PMS contracts could provide services as a means of extending patient choice.
- The Commissioning Framework for Health and Well Being consultation document (Department of Health, March 2007) emphasises the key role practice based commissioners play in more effective commissioning by shifting to more personalised services, promoting health

as well as preventing the causes of ill health and working with key partners to achieve improved health outcomes overall. For more information visit www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

- PBC resources can also be obtained from the Department of Health www.dh.gov.uk and NHS Primary Care Contracting www.pcc.nhs.uk. The recent PBC guidance can be found at www.dh.gov.uk/assetRoot/04/14/15/64/04141564.pdf

Contracting for the service

- This service should be considered as a 'locally enhanced service'. As such, the full range of providers and primary care contracting flexibilities should be considered, including GMS, PMS, PCTMS, APMS, and community and voluntary organisations. Once an appropriate provider has been selected, the appropriate contracting route should be adopted. Additionally, providers may wish to sub-contract part or all of the service provision. This should be made clear throughout the contract implementation process.
- NHS Primary Care Contracting has developed a simple guide for potential providers of services such as this Primary Care Service www.pcc.nhs.uk/3.php

Incentivising provision

- The recent Commissioning Framework publication www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf emphasised the options open to commissioners to support new local providers of services by offering additional quality incentives or use of local primary care premises or pump-priming loans. However, the Kings Fund has described some of the considerations when developing local incentives. For instance, introducing new providers into the local health economy may improve service quality and efficiency but this may be at the expense of service responsiveness, provider collaboration and sustainability of services. Also care must be taken to develop better access to services whilst considering extra demand within the local health system because it will have to attract young people who have previously stayed away from accessing the health system. Some of them will also have needs identified which otherwise not have been.

Summary of local need

- Local demographic information along with a broad public health profile may need to be considered and made explicit. Specific details of morbidity and mortality levels, other health and well being data and condition-specific data, health inequality data and ethnicity profile are also important and should be included if available. It is essential to clarify that this service is a priority identified in the Local Delivery Plan for either the PCT or the local PBC group.
- Additional relevant information should also be considered for inclusion such as recent service user feedback, current service staffing levels and competencies, local partnership arrangements, and any planned changes to local need.
- Commissioners should consider carefully whether primary care, or the health sector in general, would satisfy this local need and therefore be the lead provider or partner in this service provision. Other sectors, such as education or the third sector, may be a more appropriate and effective choice to lead and deliver on local service objectives, with primary care service providers playing a smaller but nonetheless important role in delivering care for young people around immunisations/vaccinations, sexual health and contractive services, and minor illness or skin conditions.

Involving patients and the public

- The White Paper 'Our Health, Our Care, Our Say' made it clear that patients and the public would be firmly placed at the centre of NHS and social care services, with a stronger local voice. Following this, the Department of Health has published a framework for creating stronger public engagement in the development of health and social care services www.dh.gov.uk/assetRoot/04/13/70/41/04137041.pdf. This will develop with patients and the public having more involvement in service planning processes where possible including design of individualised care plans and choice of services as well as involvement in decision-making processes and service evaluation mechanisms at both provider and commissioner level.

Skill mix and partnership opportunities

- Where there is a need to develop the GP with Special Interest role, it is important to be aware of new guidance and regulation procedures due to be published by the Department of Health. This will mean greater adherence to any new special interest competency framework and more formal special interest accreditation of new practitioners. www.dh.gov.uk
- Developing a close relationship with the Local Authority, primarily education and social services departments and other sectors will be essential to ensure joint planning and commissioning for integrated care. This is reinforced in the joint commissioning framework published by the Department of Health in 2007.
- Indeed, more effective service provision may be generated through *locally managed networks* of care rather than individually linked services. The specific aim of managed local networks is to encourage all those responsible for delivering care across all agencies, whether private, public or voluntary, or providing health, social care or education services, to work together across agencies to ensure that they deliver more than the individual parts can working alone. Guidance on setting up and using local managed networks can be found at www.dh.gov.uk/assetRoot/04/11/43/68/04114368.pdf.

Health Inequalities

- Reducing the gap in infant mortality across social groups, and raising life expectancy in the most disadvantaged areas (the Spearhead areas) faster than elsewhere are the focus for the 2010 health inequalities Public Service Agreement target. Effective, pro-active action to tackle health inequalities at local level by commissioners, providers, practitioners and other stakeholders will be key to meeting the target. To understand more about the Equalities and Human Rights agenda in the NHS, the Department of Health has recently published a useful guide for NHS Boards – www.dh.gov.uk/assetRoot/04/14/13/71/04141371.pdf.
- With any provision of service, consideration must be given up front to the impact on inequalities in health which may result from service outcomes. This Primary Care Service provides an opportunity to narrow the inequalities gap by providing services not only to the mainstream population but also those in disadvantaged groups with poor health outcomes. Provision of this Primary Care Service should consider, where possible, outreach services by practitioners which offer a more flexible approach to ensure all groups in the population have good access to services. Twenty-two local pilot examples which reinforce this approach have recently been published by the Department of Health in 'Communities for Health: Learning from the Pilots' (February, 2007) – www.dh.gov.uk/assetRoot/0414/32/25/04143225.pdf.

- The first Local Authority Health Profiles covering the whole of England have been produced by Public Health Observatories and will be updated every year. These profiles, which can be used by both local authorities and the health service, are designed to show where there are important problems with health or health inequalities to help target action to improve the health of local people. The profiles can be accessed at www.communityhealthprofiles.info/
 - Commissioners may also wish to consider looking at the profile of their local population against the Health Poverty Index www.hpi-org or the inequalities reports compiled by the London Health Observatory www.lho.org to help them understand the impact this service may have on local population health.
 - Further help in this area can be obtained from the National Support Team for Health Inequalities at the Department of Health.
 - Links to Health Literacy through support for self care and using health as a useful means of educating local people.
-