Brighton & Hove City Council

NHS Brighton and Hove

Children & Young People's Trust Board

Title:	**Children & Young People's Trust Board**
Date:	**17 May 2010**
Time:	**5.00pm**
Venue	**Council Chamber, Hove Town Hall**
Contact:	**John Peel** Democratic Services Officer 01273 291058 john.peel@brighton-hove.gov.uk

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	**An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.**
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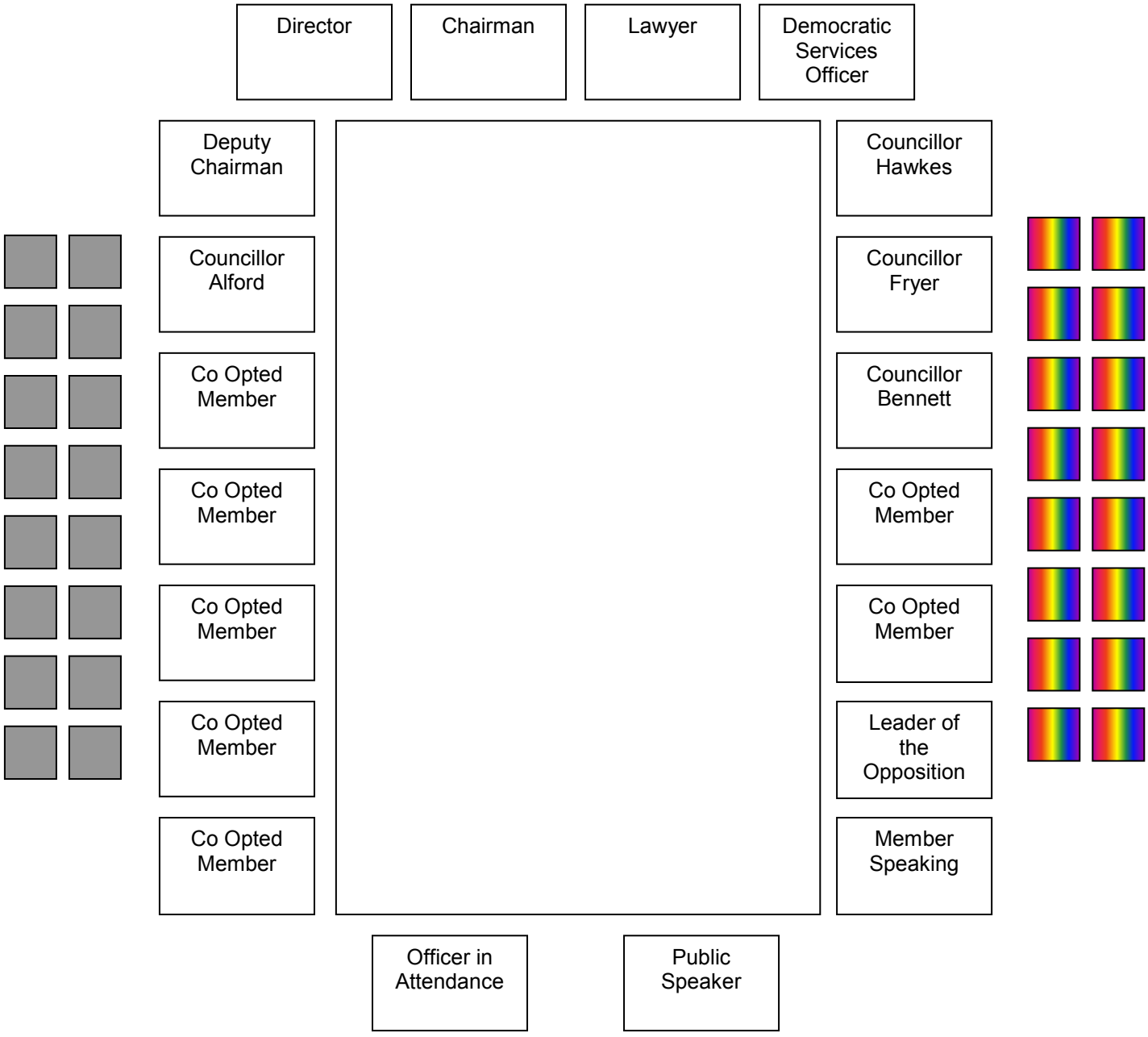
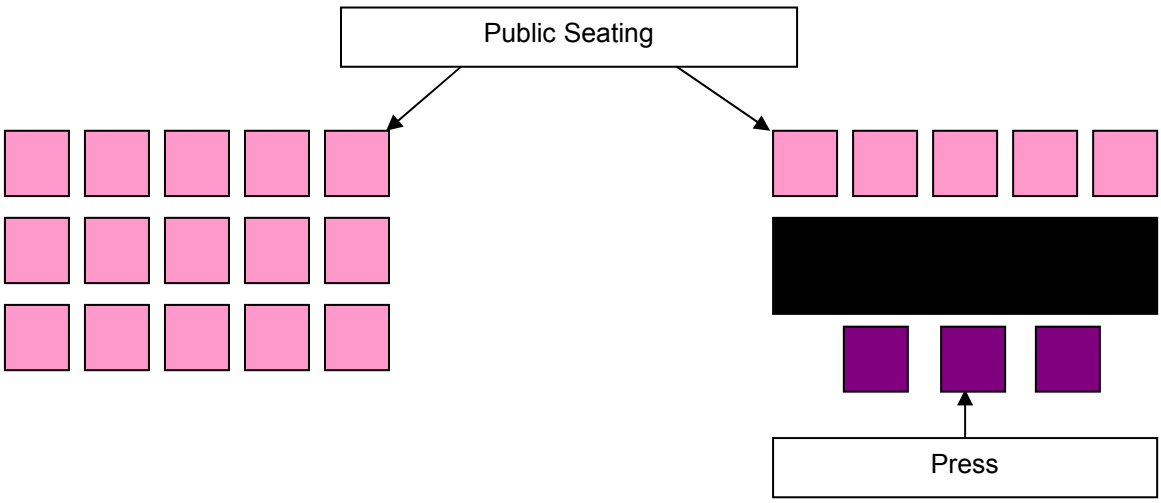
Democratic Services: Meeting Layout





CHILDREN & YOUNG PEOPLE'S TRUST BOARD

The Following are requested to attend the meeting:

Councillors: Brown (Chairman), Bennett, Fryer and Hawkes (Opposition Spokesperson)**,**

Brighton & Hove Primary Care Trust: Alan McCarthy, Darren Grayson and Dr Louise Hulton

South Downs Health: Andy Painton, Mo Marsh and Simon Turpitt

Non-Voting Co-optees:

Lynette Gwyn Jones	Brighton & Sussex University Hospitals NHS Trust
David Standing	Community & Voluntary Sector Forum
Gail Gray	Community & Voluntary Sector Forum
Andrew Jeffrey	Parent Forum
Eleanor Davies	Parent Forum
Vacancy	Surrey & Sussex Strategic Health Authority
Graham Bartlett	Sussex Police Authority
Professor Imogen Taylor	Universities of Brighton & Sussex
Priya Rogers	Youth Council
Rose Suman	Youth Council

AGENDA

Part One **Page**

50. PROCEDURAL BUSINESS

(a) Declaration of Substitutes - Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest by all Members present of any personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

(c) Exclusion of Press and Public - To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading either that it is confidential or the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

A list and description of the categories of exempt information is available for public inspection at Brighton and Hove Town Halls.

51. MINUTES OF THE PREVIOUS MEETING **1 - 6**

Minutes of the meeting held on 22 March 2010 (copy attached).

52. CHAIRMAN'S COMMUNICATIONS

53. CORPORATE PARENTING STRATEGY FRAMEWORK **7 - 30**

Contact Officer: *Dermot Anketell* *Tel: 29-5423*

54. FUTURE ARRANGEMENT FOR THE CHILDREN & YOUNG PEOPLE'S TRUST BOARD **31 - 54**

Contact Officer: *Steve Barton* *Tel: 29-6105*
Ward Affected: *All Wards;*

55. UNDERSTANDING INTERVENTION: THE TIER APPROACH FOR CHILDREN AND YOUNG PEOPLE (PRESENTATION)

Contact Officer: *James Dougan* *Tel: 295511*

56. NHS BRIGHTON & HOVE OPERATING PLAN 2010/11 **55 - 168**

CHILDREN & YOUNG PEOPLE'S TRUST BOARD

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next Cabinet Member Meeting is 12 noon on the fifth working day before the meeting.

Agendas and minutes are published on the council's website www.brighton-hove.gov.uk. Agendas are available to view five working days prior to the meeting date.

Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Caroline Banfield, (01273 291058, email john.peel@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

Date of Publication - Friday, 7 May 2010

BRIGHTON & HOVE CITY COUNCIL

CHILDREN & YOUNG PEOPLE'S TRUST BOARD

5.00pm 22 MARCH 2010

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors: Brown (Chairman), Bennett, Fryer and Hawkes (Opposition Spokesperson)

Brighton & Hove Primary Care Trust: Alan McCarthy and Dr Louise Hulton

South Downs Health: Andy Painton, Mo Marsh and Simon Turpitt

Non-Voting Co-optees:
David Standing, Community & Voluntary Sector Forum
Gail Gray, Community & Voluntary Sector Forum
Eleanor Davies, Parent Forum
Graham Bartlett, Sussex Police Authority
Priya Rogers, Youth Council
Rose Suman, Youth Council
Amanda Fadero, Primary Care Trust
Also in attendance:

Apologies:
Andrew Jeffrey, Parent Forum
Professor Imogen Taylor, Universities of Brighton & Sussex

PART ONE

45. PROCEDURAL BUSINESS

45a Declarations of Substitutes

45.1 Councillor Kemble attended as substitute for Councillor Alford.

45b Declarations of Interest

45.2 There were none.

45c In accordance with section 100A of the Local Government Act 1972 ('the Act'), the Children & Young People's Trust Board considered whether the press and public should be excluded from the meeting during an item of business on the grounds that it was

likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press or public were present during that item, there would be disclosure to them of confidential information (as defined in section 100A(3) of the Act) or exempt information (as defined in section 100I(1) of the Act).

45.3 **RESOLVED-** That the press and public not be excluded from the meeting.

46. MINUTES OF THE PREVIOUS MEETING

46.1 **RESOLVED-** That the minutes of the previous meeting held on 1 February 2010 be approved and signed as the correct record.

47. CHAIRMAN'S COMMUNICATIONS

47.1 The Cabinet Member announced that efforts in partnership with the Primary Care Trust (PCT) had seen teenage pregnancies decrease by 25 per cent. The Cabinet Member congratulated those involved and maintained all parties commitment to decreasing this level further.

48. REVIEW OF PARTNERSHIP AGREEMENTS (S75 AGREEMENT) AND IMPLICATIONS OF THE 2009 APPRENTICESHIP, CHILDREN, LEARNING & SKILLS ACT.

48.1 The Board considered a report of the Director of Children's Services concerning proposed changes to the existing Section 75 partnership arrangements between the Council, NHS Brighton and Hove (PCT) and South Downs Trust (SDH).

48.2 The Director of Children's Services highlighted the dedicated efforts of the officers involved and asked Members not to underestimate the length or complexity of the subject elaborating that each organisation has to ratify what the Trust does on a collective and individual basis.

48.3 A representative of the PCT enquired about the subject of liability noted in section 5.1.2 of the documentation.

48.4 The author of the report replied that this issue concerned the agreement to budgets by all parties.

The Principal Litigation Lawyer added that this meant unforeseen but legitimate overspend by the Trust as a whole.

48.5 Members sought clarification on the proposed review of membership. It was noted that there was no reference to University, Sixth Form or Youth Services membership under the proposed changes. However, Members did concur that too large a membership may hamper the operation of the Trust.

48.6 The Director of Children's Services noted the concerns and that further exploration of possible options was necessary.

48.7 Members indicated that the report recommended reviews and asked how these would be undertaken.

48.8 The report author clarified that a Joint Managment Board with authorised officers delegated to it would implement this work.

The Principal Litigation Lawyer reiterated that the proposals had to reflect the legislative framework.

48.9 Members raised the issue of collective responsibility and how each partner would deliver their own elements.

48.10 The Director of Children's Services iterated that she felt that there was an ambiguity in the review between Children's Services and the Children's Trust that needed to be clarified. She informed Members that the changes had most impact to Council services and that all partners would be held to account by the Local Safeguarding Children Board (LSCB) for safeguarding issues.

48.11 **RESOLVED-** That the Board accept the following recommendations:

1. That the principles of the proposed S75 agreements as outlined in paragraphs 3.6 and 3.7 and Appendices 1 and 2 of the report be approved.

2. That the new duties in relation to establishing a Children's Trust Board outlined in paragraphs 3.9 to 3.12 and in Appendix 3 of the report be noted; and the Director of Children's Services be requested to bring forward detailed proposals to meet those duties for approval at the next Board meeting.

49. CHILDREN & YOUNG PEOPLE'S PLAN: PERFORMANCE IMPROVEMENT REPORT

49.1. The Board considered a report of the Director of Children's Services concerning the Children and Young People's Plan (CYPP) Performance Report for the financial year 2009/10 to date.

49.2 Members noted the inclusion of predominantly southern towns and cities used as comparators in the report on Substance Misuse by Young People (NI 115).

49.3 The report author responded that the selection were statistical neighbours determined by similarities of profile which by chance had comprised of predominantly southern areas.

49.4 A Member commented that the report stated that responses at secondary level were strongly based from one particular school and asked if there was any intention to widen the focus.

49.5 The author of the report answered that the process was for schools to nominate themselves and although participation was encouraged, the frankness of the results could act as a deterrent in the expectancy of negative publicity.

49.6 Members asked if the results in NI115 were based on self-substance misuse or witnessing substance misuse.

49.7 The report author responded that the results were based on questions posed about self-misuse in the last four weeks.

49.8 Members enquired if the figures on Child Poverty (NI 116) included other benefits in addition to the ones noted.

49.9 The report author clarified that he believed the results to be based on the receipt of multiple benefits although child tax credit was not one of these.

49.10 Members noted that the presentation of the report had stated an issue with figures on Social Care (NI 59).

49.11 The author of the report explained that results may have been undermined by an incorrect measurement of the data but that performance would still be of a poor standard.

49.12 The Director of Children's Services commented to the Board that the report was an opportunity to clarify current performance and to help the improvement measures required.

49.13 Members agreed that negative results from the report would need to be examined.

49.14 **RESOLVED-** That the Board approve the following recommendations:

1. That the data and analysis in the CYPP Performance Report be noted and the action being taken to improve performance be agreed.

2. That the Board agrees the report provides the necessary information to allow it to fulfil its statutory duty to "monitor a strategic Children and Young People's Plan for the local area".

3. That the new format of the report be agreed.

The meeting concluded at 6.25pm

Signed Chair

Dated this day of

CHILDREN & YOUNG PEOPLE'S TRUST BOARD	Agenda Item 53 Brighton & Hove City Council

Subject:		Corporate Parenting Strategy	
Date of Meeting:		**17th May 2010**	
Report of:		***Di Smith***	
Contact Officer:	Name:	***James Dougan***	**Tel: 295511**
	E-mail:	james.dougan@brighton-hove.gov.uk	
Key Decision:	No		
Wards Affected:	All		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 To inform the Board of the work being undertaken to develop the next phase of Brighton & Hove's Corporate Parenting Strategy.

1.2 Corporate Parenting describes the collective responsibilities that members and officers of Brighton & Hove City Council and its partner organisations have towards children and young people in care of the Local Authority.

1.3 The strategy is about ensuring that these children and young people are safe, secure and healthy, are encouraged and supported to achieve their potential and aspirations, are encouraged to lead fulfilled lives and are successfully prepared for a future where they will be valued and involved citizens who are economically independent and able to contribute positively to the communities in which they live.

1.4 As Corporate Parents, members, officers and partners need to ask two questions:

"If this was my child, would this be good enough for them?"

"If I was that child or young person, would this have been good enough for me?"

1.5 Development of the Corporate Parenting Strategy is the next chapter of a longer story of the Brighton and Hove Corporate Parenting journey **(See Appendix 1 – Introduction to Corporate Parenting).** The Strategy will set out our next steps as we continue to work together to build improvement in the outcomes of Brighton and Hove looked after children and young people.

The Strategy will mark an important shift in not just how we view the issues and barriers faced by looked after children and young people, but also a shift in our emphasis on how we intend to make an impact on these outcomes.

Together as Whole system partnership we can improve life outcomes for Brighton and Hove looked after children and young people.

We want all our children and young people to have successful, productive lives and we want to provide the services and supports that will help them succeed, particularly when they have problems to overcome.

The new strategy will strengthen our corporate parenting work and it will help us to express what we are collectively trying to achieve in terms of outcomes in the overarching strategy.

As corporate parents, the overarching outcomes we are collectively aiming for are:

Children and young people who have experienced the care system to be successful learners, confident individuals, responsible citizens and effective contributors whose life outcomes mirror those of their peers.

The specific outcome relating to the function of corporate parenting is:

The Council and its partners will fully understand and accept their responsibilities as corporate parents and governance arrangements will be in place to make sure that work within councils and their partner organisations is child-centred and focused on achieving the overarching outcome.

2. RECOMMENDATIONS:

2.1 To agree the proposals for the development of the corporate parenting Strategy.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Development of Strategy

In spite of considerable attention over recent years, the gap between outcomes for looked after children and their peers has continued to widen. The Government nationally has responded over the years by having a number of initiatives to improve the outcomes of looked after children. The last major initiative was Care Matters which was designed to ensure that the State's responsibility and the role of local authorities in discharging their responsibility in being an effective corporate parent.

Brighton & Hove has been engaged for sometime in corporate parenting developments. It was a pilot area for the Who Cares Trust Equal Chances Project in 2000 and since then there has been a continuous strengthening of

work to bridge the gap between looked after children's outcomes and those of the general population of children's outcomes.

In developing the new strategy a comprehensive audit/self assessment has been undertaken using the Ofsted Framework for Inspection. This audit/self assessment highlights very good and outstanding practice as well as areas for practice development and will help shape and strengthen the next phase strategy.

The strategy will provide us with the opportunity to make a significant step change by looking more closely and in more detail at some of the factors which may impact on the outcomes for children who are looked after. It will give us an opportunity to understand the complexities of inter-relationships and to respond to them in a way that acknowledges and takes account of this complexity. The strategy is about us setting out how we will take forward positive and definitive action. We will build on both the positive work that has been undertaken and is ongoing in Brighton & Hove.

3.2 Corporate Parenting Forum

The Council has established a Corporate Parenting Forum. The Forum consists of the Lead Member for Children and Young People, an elected member from the Conservative, Labour, Green and Liberal Democrats groups, 2 children looked after and/or care leavers, representatives of Brighton & Hove Foster Carers Association, and the Director of Children's Services.

The Corporate Parenting Forum acts as the advisory consultation body to the Council to enable the effective discharge of the duty of corporate parent.

The role of the Corporate Parenting Forum is to monitor and review services and establish the objectives and priorities for looked after children by council departments and partner agencies. The central role is to achieve continuing improvements for looked after children and care leavers. The forum will oversee the implementation of the strategy.

3.3 Next Steps

The strategy will be constructed around the five Every Child Matters outcomes: Being Healthy, Staying Safe, Enjoy and Achieve, Making a Positive Contribution, Achieving Economic Wellbeing. A section on the strategy will look at each of these outcome areas and will give clear principles, good practice and commitments in each of the five outcome areas.

Being Healthy

While promoting physical and sexual health and emotional well-being are obvious priorities, preventative strategies, including education to encourage healthy lifestyle choices and leisure interests are key elements of our work. Children and young people in care may have additional health needs caused by earlier abuse or neglect and these must be taken into account under the key aim of ensuring their life chances are improved by promoting their of health and well being.

Some corporate parenting initiatives to date:

- Priority access to health services including Morley Street dental service
- 16+ Nurse providing a personalised and flexible service to increases take up of advice and support including sexual health and contraception
- Listen Up card ensures free access to swimming and other leisure activities
- Dedicated pathway for access to Children and Adolescent mental Health Services

Staying Safe

Most children and young people who come into care do so as a result of not being safe from physical and sexual harm and neglect while living at home. Robust arrangements need to be in place therefore to ensure that they live in safe, secure and nurturing placements that provide continuity and stability. As they move towards adulthood we must ensure that they have access to safe, secure and affordable permanent accommodation.

Some corporate parenting initiatives to date:

- Joint Protocol with Housing Department ensure that the corporate responsibility for meeting the diverse accommodation needs of young people who have been Looked After by B&HCC are met.
- Pan Sussex 'Missing from Care' Protocol with Sussex Police

Enjoy and Achieve

The main focus is on improving the educational attainment of children and young people in care. This is the single most important contribution those involved in corporate parenting can make because it is about investing in their future. It must be acknowledged that children and young people in care have significantly poorer educational outcomes than their peers. However, we must move away from the assumption that this is an inevitable consequence of their often disadvantaged and disadvantaged backgrounds. What it does mean is that we need to invest in specific and targeted additional support to improve these outcomes.

Some corporate parenting initiatives to date:

- Entry2Learning partnership with Sussex Central YMCA
- Partnership with Aim Higher Sussex
- Appointment of Virtual Head teacher
- Tickets for shows at B&H venues

Making a Positive Contribution

Participation and engagement of children and young people in care is key to the success of any corporate parenting strategy. This outcome area is about more than just involving them in the development of services. We must support them to: engage in law abiding and socially acceptable activity and behaviour; develop positive relationships by choosing not to bully or discriminate; develop self-confidence and learning to deal successfully with significant life changes and challenges.

The key aim is to ensure that all children and young people in care have the opportunity to be listened to and heard, are involved and participate in the planning and development of services they receive

Some corporate parenting initiatives to date:

- Development of websites for Listen Up Care Council (LUCC) and 16 Plus Advisory Group with private sector partner

Achieving Economic Wellbeing

Children and young people in Care find it more difficult than their peers to attain a good standard of living when they become adult and independent. We must promote and provide work experience, taster days, training and employment opportunities with all employers and employer organisations in the city and to continue to ensure that these care leavers are fully supported to move positively into adulthood.

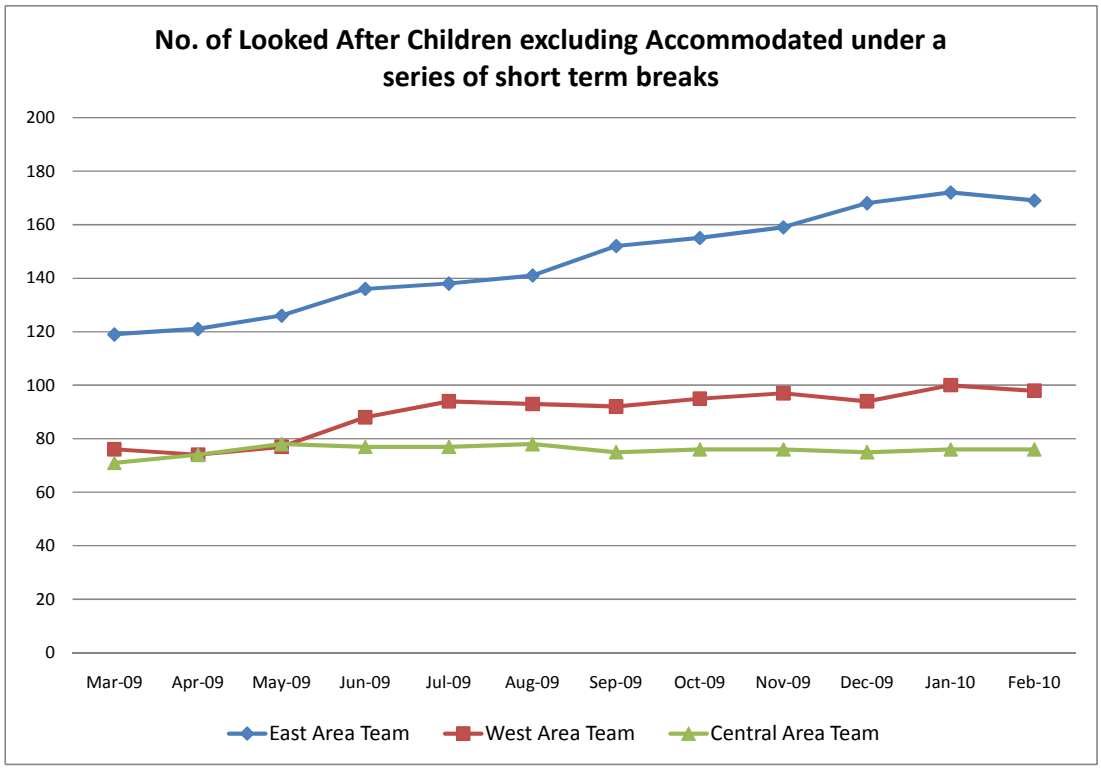
Some corporate parenting initiatives to date:

- Directorate offers of council wide opportunities from taster days to apprenticeships
- Extension of support post-18 (Supported Lodgings and Supporting People) so that care leavers move to their own accommodation when ready and able

3.4 Who **are our looked after children - Profile of Looked After Children**

Source: Monthly Monitoring Social Care Data February 2010

Figure 1: Number of Looked After Children by Area Team

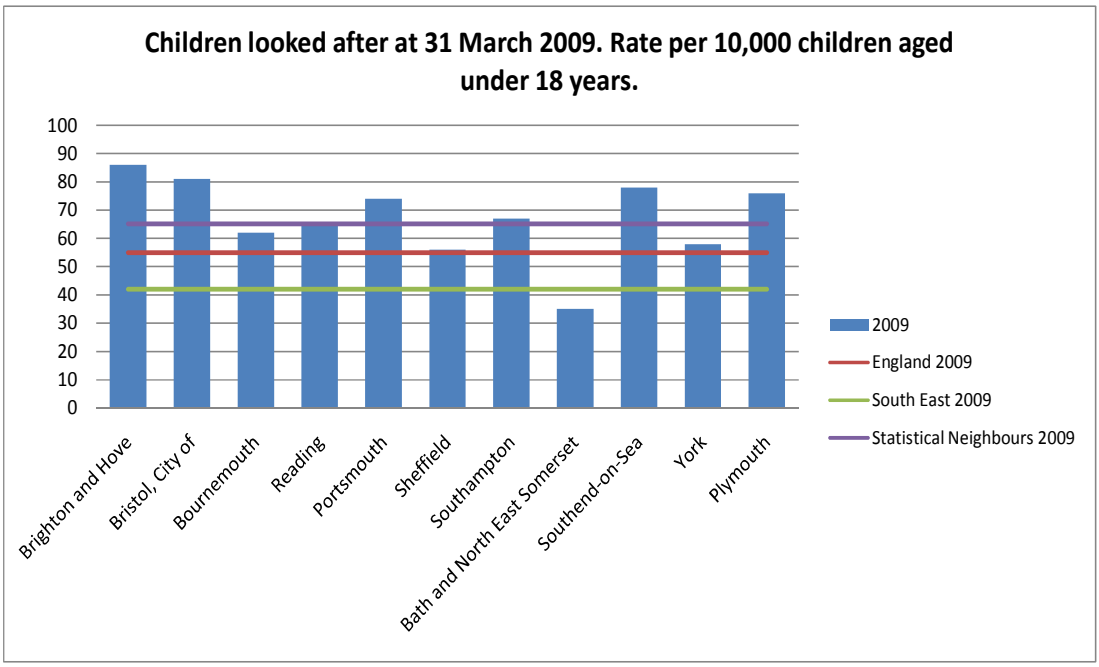


The graph shows that the CYPT Safeguarding teams in the East of the city continue to carry the majority of Looked after Children. There has been an increase in the number of Looked after Children in all of the Area Teams, with the most striking rises being located in East and West Area where the number has increased by 34% and 26% respectively.

Table 1: Percentage Increase in Looked After Children by Area Team

Team	February 2009	February 2010	Increase	Percentage Increase
All Teams	401	473	+72	18%
East Area Team	126	169	+43	34%
West Area Team	78	98	+20	26%
Central Area Team	68	76	+8	12%

Figure 2a: Children looked after at 31 March 2009. Rate per 10,000 children aged under 18 years.

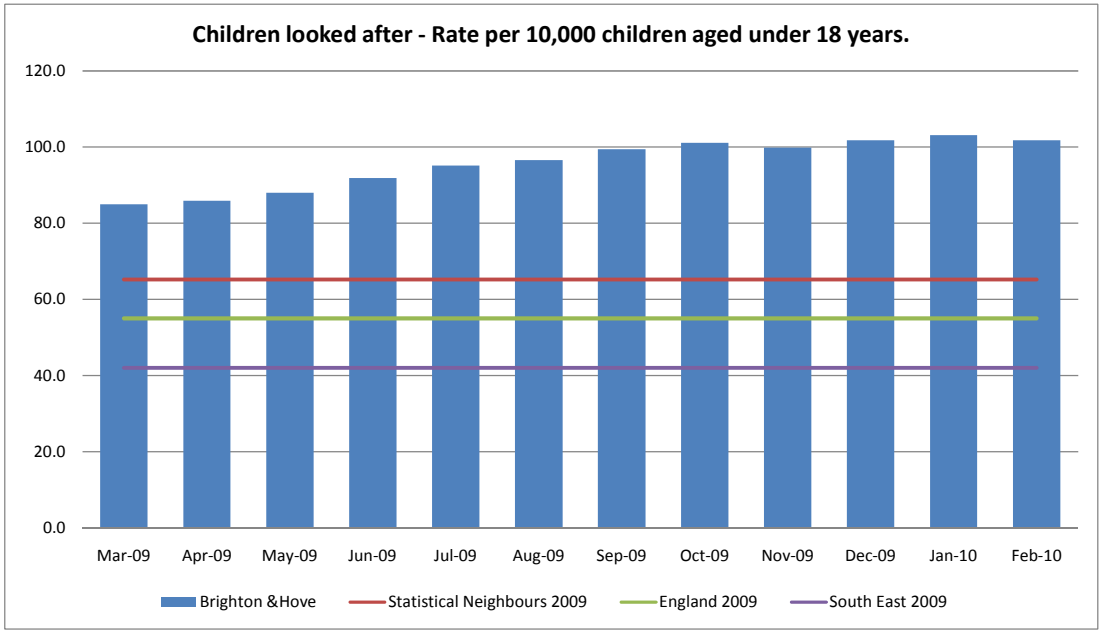


There were 473 Looked after Children as at February 2010. The city has a higher proportion of Looked after Children[1] than the national average (86 per 10,000 as at March 31st 2009 compared with 55 per 10,000 in England and 65 per 10,000 amongst benchmark authorities)[2].

[1] Number of children looked after on 31 March expressed as a rate per 10,000 children aged under 18. Source: http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml

[2] Statistical Neighbours (SN) are ranked in order of statistical closeness, with the top SN being closest: Bristol, Bournemouth, Portsmouth, Reading ,Sheffield ,Southampton, Bath and North East Somerset, Southend, York and Plymouth

Figure 2b: Children Looked After - Rate per 10,000 children aged under 18 years.



The rate of Looked after Children per 10,000 children has increased from 86 per 10,000 as at March 2009 to 102 per 10,000 as at February 2010.

Figure 3: Children Starting and Ceasing to be Looked After Each Month March 2009 to February 2010.

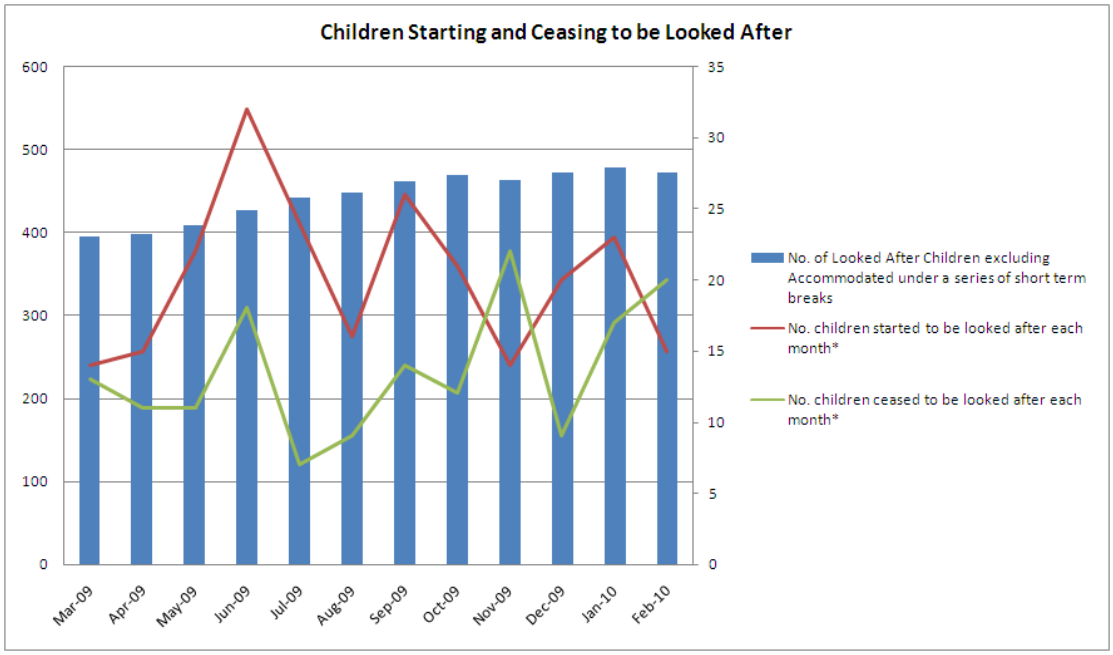


Figure 3 illustrates the number of children starting and ceasing to be looked after over the last 12 months. There has only been two occasions during that period (November 2009 and February 2010) where the number of children who have ceased to be looked after is greater than the number of children who started to be looked after.

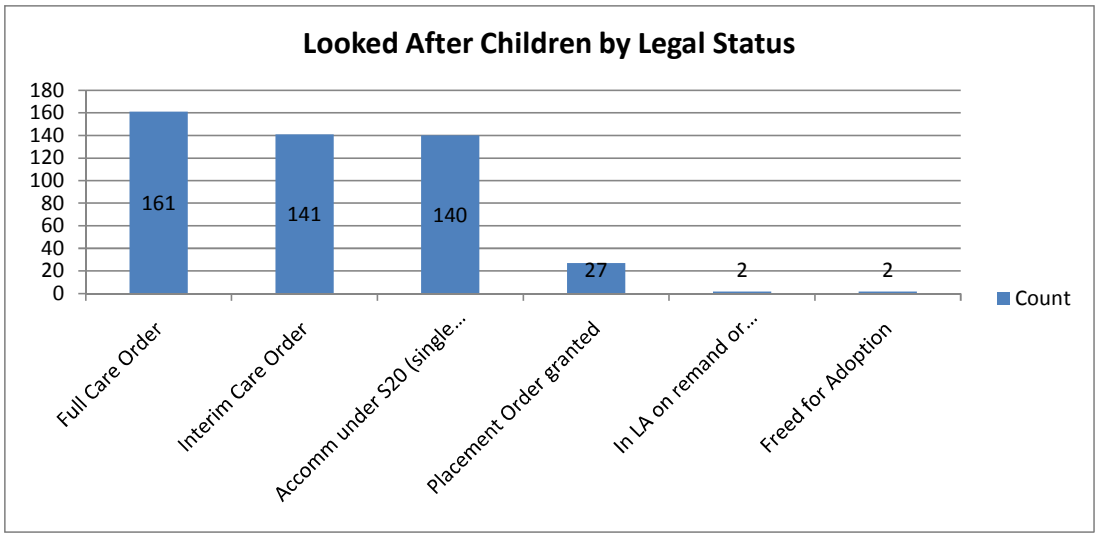
Table 2: Children Looked After by Area Team and Placement Area February 2010

	Placement Area			
	EAST	CENTRAL	WEST	Out of Area
East Area Team	69%	13%	8%	11%
Central Area Team	25%	54%	4%	17%
West Area Team	10%	15%	71%	3%

N.B 'Out of Area' includes children with post codes outside of Brighton and Hove and children whose placement address has not been disclosed.

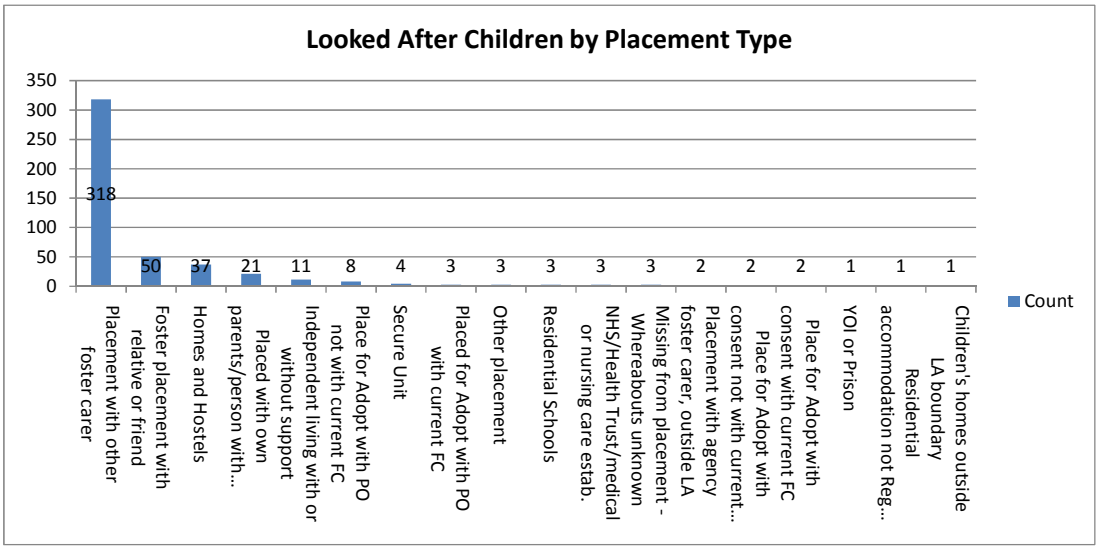
Table 2 illustrates the percentage of Looked after Children by Area Team allocation and their geographical placement area. Just over half of children allocated to the Central Area Team were placed in the Central Area, with a quarter of that cohort placed in the East Area of the city.

Figure 4: Children Looked After by Legal Status February 2010.



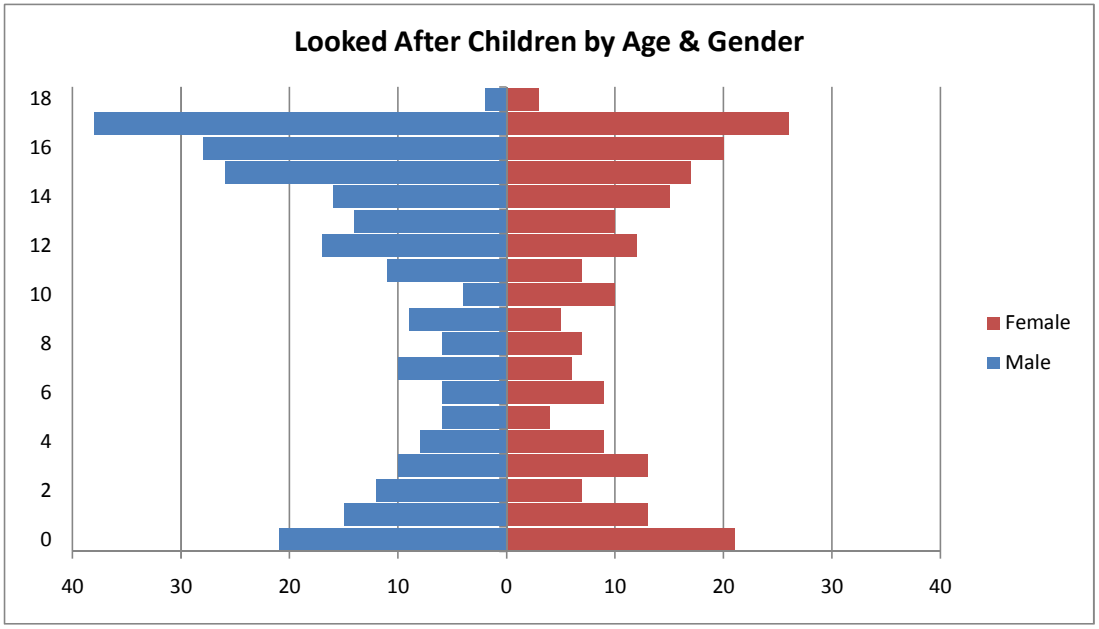
The majority of Looked after Children are on were on a Care Order (302 out of 473 children as at February 2010). However, the number of children Looked After on an Interim Care Order has increased significantly over the last twelve months, from 51 in February 2009 to 141 as at February 2010. Further analysis shows that younger children are more likely to be in court proceedings whereas older children are more likely to be voluntarily accommodated.

Figure 5: Children Looked After by Placement Type February 2010.



The majority of Looked after children were placed with 'other foster carer' (318 as at February 2010) with the next highest category being 'foster placement with relative or friend' (50 children).

Figure 6: Children Looked After by Age and Gender February 2010

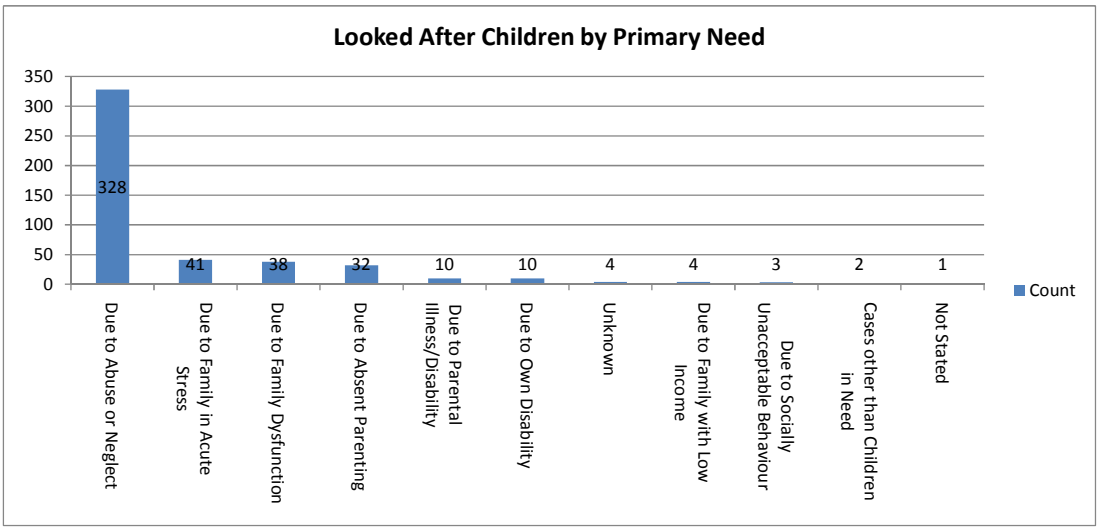


The age and gender split of Looked after Children is illustrated in Figure 6. Approximately 55% of the cohort was male as at February 2010. Around a third of Looked after Children (160 children) were aged 15 and over, with males accounting for 59% of children in this age range.

Table 3: Looked After Children by Age and Gender February 2010

Age	Male	Female
0	21	21
1	15	13
2	12	7
3	10	13
4	8	9
5	6	4
6	6	9
7	10	6
8	6	7
9	9	5
10	4	10
11	11	7
12	17	12
13	14	10
14	16	15
15	26	17
16	28	20
17	38	26
18	2	3

Figure 7: Looked After Children by Primary Need February 2010



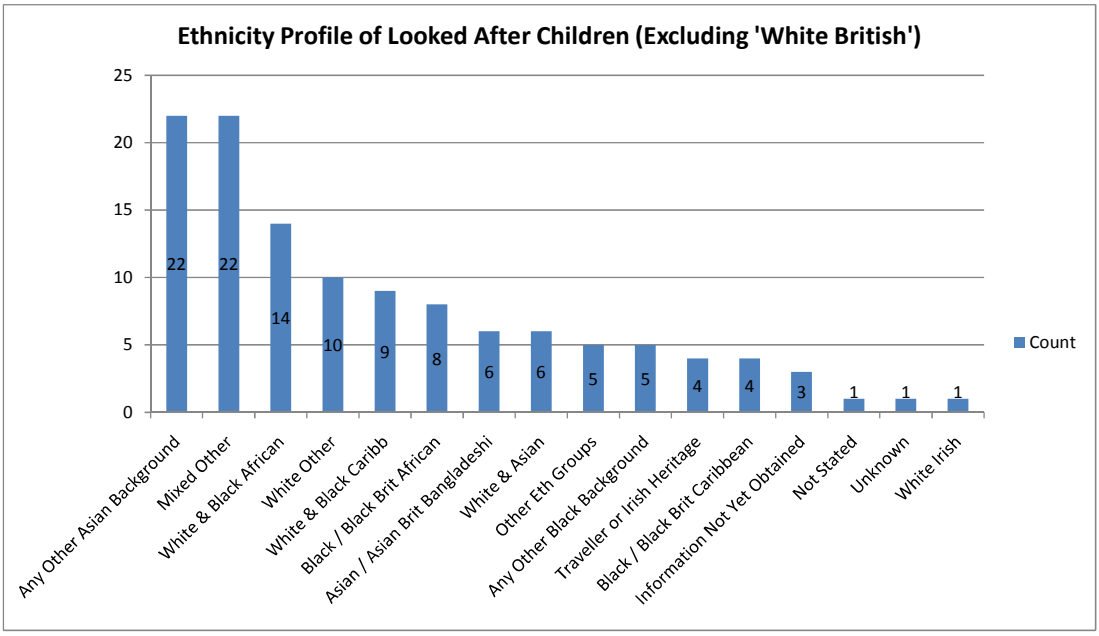
The majority of Looked after Children have a primary need[3] code of 'Due to Abuse or Neglect' (328 as at February 2010) with 'Family in Acute Stress' and 'Family Dysfunction' the next highest categories.

Table 4: Children Looked After by Primary Need Code February 2010

3 'Category of Need codes record the main reason why a child is being provided with services' and 'provides a further insight as to why a particular child is being looked after'. SSDA 903 guidance 2008-09 Version 1.3 Issued January 09 p28

Primary Need	Count
Due to Abuse or Neglect	328
Due to Family in Acute Stress	41
Due to Family Dysfunction	38
Due to Absent Parenting	32
Due to Parental Illness/Disability	10
Due to Own Disability	10
Unknown	4
Due to Family with Low Income	4
Due to Socially Unacceptable Behaviour	3
Cases other than Children in Need	2
Not Stated	1

Figure 8: Ethnicity Profile of Looked After Children February 2010



The 'White British' ethnicity Category has been removed from the Figure 8 to allow for easier comparison of other Ethnicity categories. The majority of Looked after Children in Brighton and Hove have a recorded ethnicity as 'White British' (352 as at February 2010) with 'Any Other Asian Background' and 'Mixed Other' the next highest categories (22 children in each category).

3.5 The Pledge

Within Care Matters policy guidance one of the requirements was that each local authority should have a pledge developed in conjunction with children and young people that clearly identifies what children and young people can expect from the council. **(See Appendix 2)**

3.6 Report Card

We will monitor the success of our corporate parenting strategy by the corporate parenting report card. **(See Appendix 3)**

4. CONSULTATION

4.1 We are also involving children and young people who are in care and care leavers in the development of the strategy. As a council and as a partnership we have been committed to listening to children and young people in our care and providing them with a range of opportunities to enable them to make the

decisions about how they want to get involved. These opportunities afford the children and young people the ability to effect change in services. But they also provide the young people with opportunities to develop their skills and levels of understanding in areas most relevant to their own interests and personal development. We have two formal processes within the care system. We have the 16+ Advisory Group for young people and we have the Listen Up Care Council Group for children and young people. The new strategy will advance a whole range of consultative and involvement initiatives.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are currently no direct financial implications arising from the recommendation in this report. If additional costs arise as a result of the future development of the corporate parenting strategy then it would be necessary to identify appropriate funding.

Finance Officer Consulted: Jeff Coates Date: 4th May 2010

Legal Implications:

5.2 The Corporate Parenting Strategy will assist the partners to the Children's Trust in meeting their duties to looked after children and care leavers. It mirrors the ECM agenda, and reflects the duty to promote the well being of children contained in S10 of the Children Act 2004. The Board will be aware that no child can be accommodated without either the consent of their parents, or by way of an Interim Care Order (ICO) sanctioned by the Court. An ICO can only be made where the threshold criteria that the child is suffering or is at risk of suffering significant harm is proved to the satisfaction of the court AND the court are satisfied that such an order is necessary to secure the welfare of the child.

Lawyer Consulted: Natasha Watson: 05.05.2010

5.3 Equalities Implications:

The Corporate Parenting Strategy is critical to the implementation of the council's equalities policies and to the achievement of the priorities set out in the Children and Young people's Plan.

5.4 Sustainability Implications:

There are no immediate sustainability implications.

5.5 Crime & Disorder Implications:

The Corporate Parenting Strategy aims to support young people to engage in law abiding and socially acceptable activity and behaviour.

5.6 Risk and Opportunity Management Implications:

The Corporate Parenting Strategy will assist the partners to the Children's Trust in meeting their duties to looked after children and care leavers and this includes the management of significant risks, including risk to reputation and financial risk.

Corporate / Citywide Implications:

Corporate Parenting Strategy describes the collective responsibilities that members and officers of Brighton & Hove City Council and its partner organisations have towards children and young people in care of the Local Authority.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The Corporate Parenting Strategy meets a statutory duty for the council in respect of to looked after children and care leavers.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To meet the Council's statutory duty in respect of looked after children and care leavers.

SUPPORTING DOCUMENTATION

Appendices:

None

Documents In Members' Rooms

None

Background Documents

None

The Brighton & Hove Pledge

The Government has recently put together a list of proposals to make the care system better for young people, in a document called *Care Matters: Time For Change.* One of these proposals is that each local council should put together a Pledge (a set of promises) about what children and young people in care can expect from the council.

1. We will recognise your strengths & interests

By:

- Tracking your progress
- Knowing what's going well
- Looking at your options
- Providing you with role models
- Recognising your cultural needs
- Supporting you to do the things you enjoy in your free time

2. We will encourage you to aim high

By:

- Knowing your strengths and interests
- Knowing what you do well
- Knowing what you need to improve upon
- Helping you meet your targets
- Being involved in planning your education

3. We will support you to succeed

By having access to:

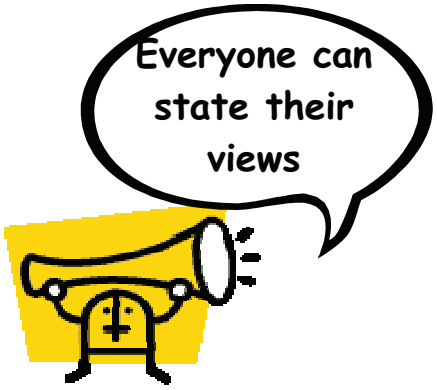
- good childcare when you are little
- help at home and school
- extra help with school work from a tutor if you need one.
- ICT
- good quality resources

4. We will recognise your achievements

By:

- Being positive and consistent
- Providing an incentive
- Helping you build on your success
- Holding an awards ceremony

5. We will make sure you can say what you want to say



By:

- **Listening carefully to your opinions, wishes and feelings**
- **Seriously considering your ideas**
- **Explaining our decisions**

6. We will make sure you are able to take part in meetings

By:

- **Helping you manage meetings about yourself**
- **Asking you what you want to say and how you want to say it.**
- **Making sure that an Independent Reviewing Officer works with you to plan your Reviews.**

7. We will make sure you have help if you want to make a formal suggestion or complaint

By:

- **Making it easy to tell the council what you think**
- **Making it easy to put forward suggestions and complaints**
- **Making it easy to ask for an Advocate to help you voice your opinions**
- **Properly investigating your suggestions and complaints and telling you what we are going to do about them.**

8. We will make sure you can tell decision makers what you think about the services you receive

By:

- **Inviting you to take part in the Brighton & Hove "Listen Up Care Council"**
- **Giving you the chance to put your ideas and opinions directly to the Big Bosses (the Director and Lead Member for Children's Services)**

9. We promise to keep you safe

By:

- **Making sure that you understand what a social worker is meant to do.**
- **Making sure you have a social worker and that you know how to contact him or her**
- **Making sure that your social worker visits you regularly and has time to listen to any worries that you might have**
- **Making sure you have an up to date Care Plan that spells out what you need**
- **Finding carers for you who will look after you if you can't live with your family**

10. We will support you to be physically fit and well

By:

- **Listening to your concerns and working with you**
- **Knowing what you need and making plans for improvements**
- **Offering advice and support**
- **Offering appointments when you need them**
- **Keeping a record of your progress.**

11. We will support your emotional health and well being

By:

- **Helping you keep in touch with people who are important to you.**
- **Helping you to understand your own life story and what has happened to you.**
- **Listening to your worries**
- **Working with you so that you have the support you need**
- **Supporting you to take part in sport, activities and outings that you enjoy**

And when you are older…….

12. We will support you into adult life

By:

- **Guaranteeing you have your own Personal Adviser who will help you move from living in care to adult life**
- **Ensuring you have high quality 16+ information, advice and guidance**
- **Helping you consider job, apprenticeships, college or university options**

13. We will help you to move on to a place that is right for you

By:

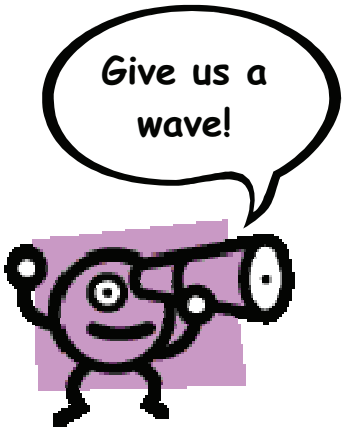
- **Helping you find a good place to live**
- **Helping you to find a place of your own when this is right for you.**

14. We promise to help you be healthy as you become older and more independent

By:

- **Helping you to use health services**
- **Providing you with information and practical help on how to keep yourself well**
- **Supporting you with sexual health needs**
- **Helping you - if you smoke - to give up when you are ready to**
- **Work with you if you use alcohol and /or drugs to find the help that you need**

15. We will continue to support you by



By:

- **Making sure you have a Pathway Plan that sets out what help and support you will get as you become an adult and move out of Care**
- **Making sure you have a named worker who will be there to support you up to 21. Contact will depend upon the level of support you need.**
- **Staying in your care or supported housing placement until you are ready and able to move on.**

Corporate Parent Report Card

Improving emotional and behavioural health

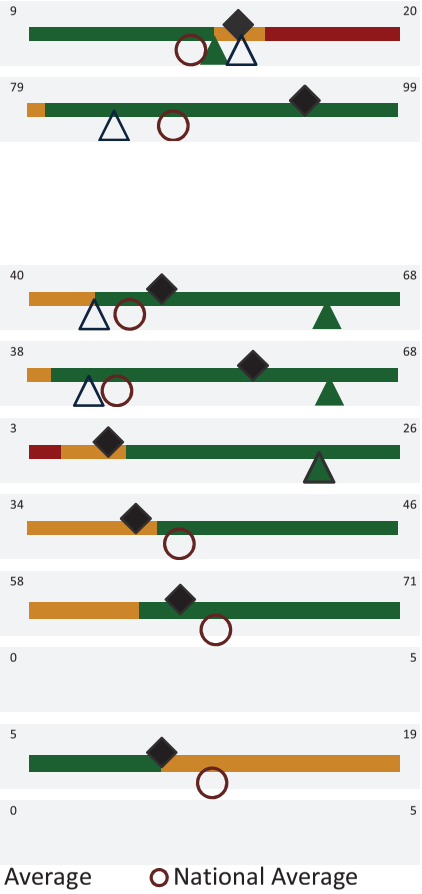
Priority: Promote health and well-being, inclusion and achievement

	Result		Target		Comparator Average		National Average	
Emotional and behavioural health of children in care	Mar-09	15.2	Mar-10	14.5	Mar-09	15.3	Mar-09	13.8
Health of Children Looked After - The average of Health and Dental checks recorded for LAC	Oct-08	94	N/A		Oct-08	83.7	Oct-08	86.9

Improving educational outcomes

Priority: Reduce child poverty and health inequality

	Result		Target		Comparator Average		National Average	
Children in care reaching level 4 in English at Key stage 2 (%)	Oct-09	50	N/A	62.5	Oct-08	44.9	Oct-08	47.6
Children in care reaching level 4 in Maths at Key stage 2 (%)	Oct-09	56.3	Oct-09	62.5	Oct-08	43	Oct-08	45.3
Children in care achieving 5 A*-C GCSEs (or equivalent) at Key Stage 4 (including English and maths)	Oct-09	7.9	N/A	21	N/A		N/A	
Children in care achieving 5 A*-G GCSEs (or equivalent) at Key Stage 4	Oct-09	39	N/A		N/A		Oct-08	41
Children in care achieving 1 A*-G GCSE (or equivalent) at Key Stage 4	Oct-09	63	N/A		N/A		Oct-08	65.6
Current Personal Education Plan in place for Children in care	N/A		N/A		N/A		N/A	
Children in care missing 25 days or more of schooling for any reason	Oct-08	10	N/A		Oct-08	13.6	Oct-08	11.9
Number of sessions missed by Children in care through fixed term exclusions	N/A		N/A		N/A		N/A	



Corporate Parent Report Card

Increasing the number of care leavers in 'settled, safe accommodation'

Priority: Promote health and well-being, inclusion and achievement

		Result		Target		Comparator Average		National Average	
Care leavers at 19 - in education, employment and training	Mar-09	67.6	Mar-10	63	Mar-09	59.3	Mar-09	65.1	54 … 73
Care leavers at 19 - Suitable accommodation	Mar-09	97.3	Mar-10	97	Mar-09	82.9	Mar-09	88.8	78 … 102
Young offenders who are LAC	Oct-08	1.8	N/A		Mar-09	2.34	Mar-09	2.1	0 … 7

Corporate Parenting Processes

Priority: Safeguarding and child protection, early intervention and prevention

		Result		Target		Comparator Average		National Average	
Looked after children cases which were reviewed within required timescales (%)	Mar-09	92.2	Mar-10	92	Mar-09	88.9	Mar-09	90.9	84 … 97
Stability of placements of looked after children: number of moves (%)	Mar-09	13.7	Mar-10	12	Mar-09	9.4	Mar-09	10.7	4 … 19

◆ Result ▲ Target △ Comparator Average ○ National Average

CHILDREN & YOUNG PEOPLE'S TRUST BOARD	Agenda Item 54 Brighton & Hove City Council

Subject:		**Children's Trust Board arrangements**		
Date of Meeting:		**17th May 2010**		
Report of:		**Director of Children's Services**		
Contact Officer:	Name:	**Steve Barton**	**Tel:**	**29-6105**
	E-mail:	Steve.barton@brighton-hove.gov.uk		
Key Decision:	No			
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out proposals to meet the requirements of:

- Statutory Guidance on co-operation arrangements, including the Children's Trust Board and the Children and Young People's Plan (2010)

- Statutory Guidance on the Roles and Responsibilities of the Lead Member for Children's Services and the Director of Children's Services (updated 2009).

1.2 The report addresses the recommendation agreed by the Board on March 22nd 2010 to note the new duties in relation to establishing a Children's Trust Board and to ask the Director of Children's Services to bring forward detailed proposals to meet those duties for approval at the next Board meeting.

2. RECOMMENDATIONS:

That the Board agrees:

2.1 (1) To re-constitute the Children and Young People's Trust Board to meet the requirements of the Statutory Guidance on co-operation arrangements (2010) and establish a new Children's Trust Board with the membership proposed by the local authority (paragraph 3.9. and Appendix 1).

2.2. (2) The Chair of the Children's Trust Board will be the Lead member for Children's Services (paragraph 3.11).

2.3. (3) To adopt the draft Terms of Reference for the new Children's Trust Board (paragraph 3.12 and attached as Appendix 2)

2.4. (4) The proposal not to establish sub groups of the Children's Trust Board at this stage (paragraph 3.14).

2.5. (5) The draft work programme for the Children's Trust Board (paragraph 3.15 and attached as Appendix 3).

2.5. (6) To receive a further report in respect of the necessary transitional arrangements to ensure that the city's Children and Young People's Plan complies with Statutory Guidance by April 2011.

2.6 (7) That this will be the final meeting of the Children's Board in its current constitution. The new Children's Board will commence business at the next meeting.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

Co-operation Arrangements:

3.1 The Statutory Guidance on co-operation arrangements states:

"The Children's Trust is the sum of co-operation arrangements and partnerships between organisations with a role in improving outcomes for children and young people. This includes the Children's Trust Board." (1.1)

The Guidance goes on the highlight that:

"The Children's Trust is not a separate organisation. Each partner within the Children's Trust retains its own functions and responsibilities within the wider partnership framework." (1.1)

What the Children's Trust Partnership (including the Children's Trust Board) does collectively:

3.2. The 2010 Statutory Guidance states:

"Children's Trust co-operation arrangements, which include the Children's Trust Board, promote co-operation through integrated working across services at each organisational level to commission or deliver services which are child (and family)centred and improve outcomes for all children and young people in the local area. These include:

- developing and promoting a local vision – set out in the CYPP – to drive improved outcomes for local children, young people and their families;
- robust arrangements for interagency governance (i.e. the Children's Trust Board);
- developing better integrated strategies such as strategic commissioning with pooled or aligned budgets, shared data and other information, and workforce development
- supporting those strategies via more integrated processes including effective joint working sustained by a shared

understanding of professional language and common systems; and

- developing and promoting better integrated front line delivery, organised around the child, young person, or their family. (1.7)

What the Children's Trust Partners do individually:

3.3. The 2020 Statutory Guidance states:

"**The partners in the Children's Trust (both statutory and those included by local agreement) are individually responsible for implementing the CYPP in the course of delivering their normal functions.** Partners will set out in the CYPP what their strategy will be to co-operate to improve children's well-being. This should include, wherever possible, the level of resource each partner intends to commit to it. They must 'have regard' to the Plan and the commitments they have made, which means if they depart from them, they must be able to show a good reason for doing so. (1.9)

Section 10 of the Children Act 2004 requires the local authority to 'make' the co-operation arrangements, (including establishing the Children's Trust Board10) and each of the statutory 'relevant partners' is required to co-operate with it in doing so. In practice this means engaging with and contributing to the various arrangements for co-operation (partnerships, tools and processes) that are put in place. The local authority has a leading role insofar as it must make sure the arrangements are in place and fit for purpose, but in all other respects it is one partner among equals within the partnership, and alone it does not have the power to direct any other Children's Trust partner on how to use its resources." (1.10)

The Children's Trust Board:

3.4. The Apprenticeship, Skills, Children and Learning Act 2009 (ASCL Act) requires each local authority to establish a Children's Trust Board as part of its arrangements to promote co-operation to improve well-being for children under section 10 of the Children Act 2004.

The Statutory guidance states:

"The statutory functions of the Children's Trust Board relate almost exclusively to the CYPP. The purpose of the Children's Trust Board is to bring all partners with a role in improving outcomes for children together to agree a common strategy on how they will co-operate to improve children's well-being and to help embed partnership working in the partners' routine delivery of their own functions. It also provides a strategic framework within which partners may agree to commission services together, with pooled or aligned budgets, but **delivering the strategy remains the responsibility of the partners, both individually and together.** This means that each partner's existing lines of accountability are unchanged, i.e. each partner of the Children's Trust Board retains its existing formal lines of accountability for delivering its own functions. This avoids any confusion or blurring of lines of accountability within the Children's Trust board." (1.4.)

3.5. The Children's Trust Board is responsible for:

- developing and publishing the CYPP, keeping it under review and revising it; and

- monitoring progress and producing a report on the extent to which the Children's Trust partners act in accordance with the CYPP." (1.8)

3.6. The Children's Trust Board will become a statutory body which will provide interagency governance of the co-operation arrangements across all organisations with a role in improving outcomes for children and young people in Brighton and Hove.

3.7. Local co-operation arrangements are dealt with in the Children and Young People's Plan (CYPP) which summarises how Brighton and Hove is delivering on the 5 essential features of a Children's Trust i.e.

- A child and family centred outcomes led vision
- Inter-agency governance
- Integrated Strategy
- Integrated Process
- Front line delivery organised around the child, young person and family (CYPP pp 6-11)

Children's Trust Board: membership and representation:

3.8. The Statutory Guidance 2010 states:

"The Children's Trust Board must include a representative of the local authority and of each of its statutory 'relevant partners'. It should also include non-statutory partners to reflect local circumstances." (4.15)

(Relevant partners are those organisations with a 'duty to co-operate under the Children Act 2004 (Section 10).

"The non-statutory partners are just as important as the statutory ones and, in the case of third sector organisations, for example, should be represented on the Children's Trust Board. The inclusion of non-statutory partners allows local partners the flexibility to shape their co-operation arrangements, including their Children's Trust Board, in a way that best suits local circumstances." (2.3)

"Representatives should be senior members of their organisation able to comment on the full range of their organisation's interests, report back to that organisation on debates with the Children's Trust Board and make decisions committing the organisation to taking action and providing resources through the CYPP." (4.17)

"To be effective, the Children's trust Board will have an optimum size: too big and meetings become unmanageable; too small and they will not cover the full range of interests." (4.19)

3.9. The table attached as Appendix 1 sets out the proposed membership and representation for the new

Children's Trust Board i.e.

- Relevant Partners required by the Children Act 2004

- Proposals for non-statutory partners. The Guidance states that 'these organisations are included in the partnership's 'co-operation arrangements' at the discretion of the local authority and may also become members of the Children's Trust Board following consultation with the other Board members

- Rationale for not including other non-statutory partners presented as options in the Statutory Guidance.

In summary the council proposes the following membership, subject to the completion of final negotiations with some partners:

- Brighton and Hove City Council : 6 (Lead Member Children's Services; 4 Elected Members; Director of Children's Services)
- NHS Brighton and Hove (PCT) : 2
- Sussex Police: 1
- Schools: 3 (to be confirmed)
- Further education and sixth form colleges: 1 (to be confirmed)
- Job Centre Plus: 1
- Youth Council: 1
- Parents Forum: 1
- Community and Voluntary Sector: 2
- Providers of Health Care: 4 - South Downs NHS Trust 1(2); Brighton and Sussex University Hospitals NHS Trust 1; Sussex Partnership NHS Foundation Trust 1 (to be confirmed)
- Lead Practice Based Commissioner (G.P.): 1
- Sure Start Children's Centres: 1

Provisional total 24.

Children's Trust Board: Chair

3.10. The Statutory Guidance (2010) states:

"As part of the duty to establish a Children's Trust Board, it is the responsibility of the local authority to appoint the Chair in consultation with the Board members. It is more important that the best person available is selected than that a particular role is prescribed. The Chair could, for example, be the Director of Children's Services, Lead Member for Children's Services, Chief Executive of the PCT, or an independent person. It is crucial that the Chair is able to speak with authority on behalf of the Children's Trust Board as a whole and ensure each of the members contributes fully to its work. Where the Chair is not appointed from within the local authority, the local authority should monitor the effectiveness of the Chair's work. (4.7)

The Chair has a vital role in making sure that the Children's Trust Board operates effectively. The Chair should be of sufficient standing and expertise

to command the respect and support of all partners. The Chair should act objectively and distinguish their role as chair from any other day-to-day job." (4.8)

3.11. The council proposes that the Lead Member for Children's Services as the Children's Trust Board chair.

Children's Trust Board: Terms of Reference

3.12 The Statutory Guidance (2010) states:

"As part of its work to establish the Children's Trust Board, the local authority should develop terms of reference and agree these with its partners. The terms of reference should cover roles and responsibilities, governance, membership, objectives and frequency of meetings (4.24).

Draft Terms of reference are attached as Appendix 2.

Children's Trust Board: Sub Groups

3.13 The Statutory Guidance (2010) states:

In order to keep the Board to a workable size and its meetings suitably focused, the local authority should set up sub-groups. These might be thematic (for example focusing on consultation), focused on a particular group of children (such as those with special educational needs and disabilities), or set up to enable effective representation on the Children's Trust Board (sub-groups of schools or third sector bodies, for example) (4.10).

The Board may also nominate one of its members to take a strategic lead on a single theme of work and report back to it on a regular basis, effectively becoming a champion. This theme could be to promote the involvement of children and young people in the Board's work, or for safeguarding for example. (4.12)

3.14 The council does not propose, at this stage, that the new Children's Trust Board should establish separate sub groups as outlined in the Guidance. Instead it proposes that the Board focus on strengthening existing relationships with other partnerships. The Statutory Guidance highlights the key partnerships in respect of services for children and young people including: the Local Strategic Partnership; the Local Safeguarding Children Board (LSCB); the Community Safety Partnership; and the Behaviour and Attendance Partnership.

Page 20 of Brighton and Hove's CYPP sets out how children's services already relate to the local planning framework for local public services.

Children's Trust Board: work programme:

3.15 The Board will wish to agree how to manage its business in the future. A draft work programme is attached as Appendix 3 based on a preliminary proposal for a structured agenda to cover the following:

- Standing Items: e.g. 6 monthly CYPP performance reports; the required annual report on the city's safeguarding from the LSCB; the annual report in respect of the S75 arrangements between the council, the PCT and South Downs Trust.

- Strategic Improvement Priorities: Appendix 3 suggests a number of possible headline reports that would address specific actions included under the CYPP 4 Strategic improvement priorities.

- Reports from Board Members/other partnerships: Each Partner agency will wish to propose and/or prepare and present reports setting out how they are delivering on their commitments/role for the CYPP. In addition the Board will wish to request reports and/or presentations from other partnerships (see paragraphs 3.13 and 3.14 above).

- CYPP Transitional Arrangements: The Board will wish to monitor transition arrangements to ensure that the new arrangements are compliant with the new Statutory Guidance for Children's Trust Boards and the CYPP.

4. CONSULTATION

4.1 This paper has been prepared in consultation with members of the Board and senior officers.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

There are no additional financial implications directly arising from the recommendations in this report. It should be noted that the statutory guidance states that the CYPP should be clear as to what resources are available, the cost of delivering priorities and how they will be met. In Brighton & Hove new Section 75 agreements with strengthened pooled budget arrangements came into effect from 1st April 2010. The statutory guidance states that pooled budget arrangements such as these are a particularly effective method of commissioning and providing joint area priorities. It also states that "detailed financial information is not required in the CYPP but it should contain sufficient information to give confidence that the actions proposed in the CYPP are realistic and affordable. When the CYPP is updated in 2011it will need to be costed and all partners commit to the budget contributions.

Finance Officer Consulted: Jeff Coates *Date:* 22nd April 2010 *February 2010*

Legal Implications:

5.8 The paper and appendices set out the legislative and regulatory framework in which these proposals are made. The proposals comply with the statutory guidance and the accompanying regulations in respect of Children's Board, and its role within the Children's Trust. The effective functioning of the Children's Board will be core in meeting the partners statutory duties to co-operate to promote the well-being of children under the Children Act 2004, and to promote the right to family life and the rights of the child under the United Nations Convention on the rights of the child.

Lawyer Consulted: Natasha Watson Date: 05.05.2010

Equalities Implications:

5.9 The proposed new arrangements for the Children's Trust Board, including wider representation from schools, 6th Form and FE Colleges, Job Centre Plus and Sure Start will strengthen the Board's capacity to deliver on the CYPP Strategic Improvement Priorities which pay particular attention to equalities issues.

Sustainability Implications:

5.10 There are no adverse sustainability implications arising from these proposals.

Crime & Disorder Implications:

5.11 The proposed new arrangements for the Children's Trust Board, including wider representation from schools, 6th Form and FE Colleges, Job Centre Plus and Sure Start will strengthen the Board's capacity to deliver on the CYPP Strategic Improvement Priorities which pay particular attention to the reduction of crime and anti-social behaviour.

Risk & Opportunity Management Implications:

5.12 The proposed new arrangements for the Children's Trust Board, including wider representation from schools, 6th Form and FE Colleges, Job Centre Plus and Sure Start will strengthen the Board's capacity to deliver on the CYPP Strategic Improvement Priorities which address risk and opportunities across partner agencies.

Corporate / Citywide Implications:

5.13 The proposed new arrangements for the Children's Trust Board will benefit the residents of Brighton and Hove by enabling all partners to work together to deliver services that improve outcomes for children and young people.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The new arrangements proposed in this report reflect statutory guidance which precludes consideration of other options.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To ensure that the Council, and its partner agencies meet their statutory duties under Statutory Guidance.

SUPPORTING DOCUMENTATION

Appendices:

1. Summary of the Statutory Guidance on co-operation arrangements, including the Children's Trust Board and the Children and Young People's Plan (2010) – to follow

2. Children's Trust Board: Draft Terms of Reference - to follow

3. Draft Work programme

Documents In Members' Rooms

1. None

Background Documents

1. None

Appendix 1: Proposed Membership of the Children's Trust Board:

Agency/Organisation	Relevant guidance (in italics) & commentary	Proposed representation
Statutory 'Relevant Partners'		
Brighton and Hove City Council: • Lead Member • Director of Children's Services • 4 Elected Members	*4.13 Both the DCS and the Lead Member should be members of the Children's Trust Board. The Lead Member should attend as a member of the political executive with a pivotal role in championing children and defining political priorities for them on the Board and to represent the local community. DCSs should attend as the senior local authority officer with responsibility for coordinating children's services within the authority and establishing the co-operation arrangements in the wider Children's Trust partnership, including setting up the Children's Trust Board.* The council will maintain current cross party representation. In addition the Lead Member will be the Chair of the Children's Trust Board.	6
NHS Brighton and Hove (PCT)	2.14 *The partnership between the local authority and the PCT is the driving relationship of the Children's Trust. Neither a PCT nor a local authority can deliver its priorities without the active co-operation of the other. The guidance document Transforming Community Services (2010), supports this position and says, ' For children, service pathways will need to cover not only the interface between hospitals and community services but also the interface with early years services and schools, as well as with children's social care.'*	2

	The PCT will be represented by the Chair of the Board and the Chief Executive	
Strategic Health Authority	*2.19 It is important that the SHA is a statutory 'relevant partner' in the Children's Trust co-operation arrangements because it provides strategic leadership to local health systems. ….They are not required to be represented on the Children's Trust Board, but this does not preclude their involvement. The local authority should decide, based on advice from the other Board members and the SHA itself, what arrangement best suits local circumstances.* The SHA will not have a representative at the Children's Trust Board, the Authority's involvement will be through the formal receipt of the minutes of all Board meetings.	0
Sussex Police	No specific details in the Statutory Guidance	1
Schools	*4.20 The addition of schools to the list of statutory 'relevant partners' is a key step to help strengthen the partnership between schools and other children's services. But their numbers make shared representation on the Children's Trust Board essential. The local authority is responsible for developing – in agreement with schools – a system for representation.* The council will present proposals at the Board meeting.	3
Further education and sixth form colleges	*2.36 Institutions within the further education sector are also statutory 'relevant partners' in the Children's Trust co-*	1

	operation arrangements covering the area in which their main site is located. This will help enable them to have a strong voice in local decisions about the use of resources and service commissioning. FE institutions also have a role to play in identifying young people who need extra support and, with appropriate advice and help from other agencies, ensure that it is provided early enough to avoid more serious problems later on. *2.37 Local authorities will have responsibilities for planning and funding 16-19 learning, which includes commissioning a range of provision from schools, FE institutions and other training providers to meet the learning needs of every young person in the local area up to the age of 19. This will be informed by the strategic commissioning priorities identified by the local strategic 14-19 partnership, which is part of the Children's Trust co-operation arrangements.* The council will present proposals at the Board meeting.	
Job Centre Plus	*2.40 Jobcentre Plus must be represented on the Children's Trust Board, but as its districts are not the same as (Children's Trust) local authority areas, Jobcentre Plus will need to agree who is best placed to represent its interests. The representative should be able to cover the full range of Jobcentre Plus services and have sufficient authority to speak for Jobcentre Plus locally and commit it, where appropriate, to the strategic*	1

	and operational aims of the Children's Trust Board, including committing resources.	
Proposed Non Statutory Partners		
Youth Council	*2.66 Listening to children and young people and taking account of their views is central to the success of policies to improve their well-being and life chances. Article 12 of the UNCRC says that children have the right to express their views and have them taken into account and given due weight, according to their age and maturity, in all matters affecting them. The Children's Trust Board should take into account the views of children, including when developing and reviewing the CYPP'.* Although not required by the Statutory Guidance the council proposes to maintain membership from the Youth Council. Following discussion with Youth Council representatives it has been agreed to reduce the number of representatives from 2 to 1 (plus support worker)	1
Parents Forum	*2.68 The Children's Trust Board should, as part of its development and monitoring of the CYPP, undertake full consultation with parents and consider innovative ways of identifying and speaking to parents who are less likely to come forward to express their views, involving neighbourhood groups and community events to support outreach work, or existing arrangements such as parent forums under the Aiming High for Disabled Children[51] programme.* Although not required by the	1

	Statutory Guidance the council proposes to maintain membership from the Parents Forum. Following discussion with Parents Forum representatives it has been agreed to reduce the number of representatives from 2 to 1 (plus advice worker).	
Community & Voluntary Sector Forum	*2.43 As the third sector has an essential contribution to make, every Children's Trust Board should include third sector representation.* *2.44. Where smaller third sector organisations do not have the capacity to engage – the local authority should take steps to engage them in the Children's Trust Board, through local third sector infrastructure organisations for example voluntary sector forums.* Following discussion with the Community and Voluntary Sector Forum the council proposes that the sector is represented by two people elected by the Forum.	2
Providers of Health Care	*2..51 Acute, foundation and specialist NHS trusts, mental health trusts and community NHS services have a major role in improving outcomes for children and young people, and should be fully involved in the development of the Children and Young People's Plan. Other services such as ambulance trusts, walk-in centres and NHS Direct also provide important services to families, especially out of hours. The Children's Trust partners should actively engage clinicians and health care providers in the development and operation of local arrangements for*	4

	multi-agency working, information sharing and joint training. Negotiations are still to be concluded and the council with present final proposals at the Board meeting to following advice from the PCT to agree representation from 3 local providers of Health Care i.e. South Downs NHS Trust 1 (2 during the transitional establishment of governance arrangements for the S75 Agreement)) Brighton and Sussex University Hospitals NHS Trust (1); Sussex Partnership NHS Foundation Trust (1).	
Options for other Non Statutory Partners		
Sussex and Brighton Universities	Sussex and Brighton Universities have been represented on the CYPT Partnership Board since 2006. The Statutory Guidance does not discuss membership from Higher Education – but that remains a local option. The council proposes to ask the Universities' representative to stand down and to focus involvement in the Workforce Development Partnership.	0
Lead General Practitioner	*2.49 The work of Children's Trusts will be improved by greater input from GPs, with their extensive experience of dealing with the health needs of children and families. It is also vital that the children's services provided in every area support the work of GP practices.* *2.50 The Director of Children's Services should consult the PCT to secure a lead GP on the Children's Trust Board to*	1

	act as professional advisor, building on existing local groupings of GPs. This would include offering advice on how to reflect the views of the wider community of GPs in developing and delivering the CYPP. On the advice of the PCT the council proposes to include a General Practitioner to represent Practice Based Commissioning in the city.	
Sure Start Children's Centres	*2.47 We expect Children's Trust partners to take into account the provision of services through local children's centres as part of their development and implementation of the Children and Young People's Plan. The Children's Trust Board must consult all Children's Centre advisory boards in the local authority's area when drawing up their Children and Young People's Plan and there should be a children's centre representative on the Children's Trust Board. Robust and fair arrangements should be developed for the selection of a representative following principles similar to those for selecting a schools representative (set out in paragraph 4.20 of this guidance).* The council proposes that one parent represents Sure Start on the Board.	1
Private Sector	*2.45 Along with the third sector, private sector organisations may provide a significant proportion of all early learning and childcare.*	

	Where this is the case, it is important they are represented on the Children's Trust Board. The council does not propose to include separate representation from private early years providers in light of existing arrangements for commissioning, supporting and involving those providers in the Children's Trust Partnership.	
Housing Sector:	*2.52 Access to decent housing is a major factor in helping to improve outcomes for children and young people. This is a local authority function, so technically the appropriate strategic bodies (the local authorities) are among the statutory members. However in practice, housing services may not be routinely included, as it might be considered an 'adult service' outside the scope of the Children's Trust. This should not be the case. Within the local authority, the Chief Executive has an important role in forging those links and ensuring that housing functions are exercised in a manner consistent with the strategies set out in the CYPP.* The council considers that effective arrangements, within the council and with other partners, are already in place and that these will be strengthened by the new proposals to create 'a council the city deserves'.	
Other Adult Services	*2.54 As with housing, adult social care is a local authority function and so should be taken into account by the local authority in setting up its*	

	Children's Trust co-operation arrangements and Board, but in practice is often regarded as outside the scope of the Children's Trust. It is, however, crucial that young people, especially those from vulnerable groups, make a smooth transition from children's to adult services. The Director of Adult Social Services (DASS) should work closely with the Director of Children's Services (DCS) to ensure that young people leaving children's services make a successful transition. The local authority Chief Executive has an important role in helping to make sure that these links are made within the authority and that all local authority functions are exercised with regard to the strategies set out in the CYPP and relevant guidance. The council considers that effective arrangements are already in place and that these will be strengthened by the new proposals to create 'a council the city deserves'.	

Appendix 2: Draft Terms of Reference for the Children's Trust Board

1. The Terms of Reference are pursuant to The Apprenticeships, Skills, Children and Learning (ASCL) Act 2009 , and the accompanying statutory guidance and regulations. Regarding co-operation arrangements.

2. The role and responsibilities of the Board

2.1 The Children's Trust Board provides the interagency governance of the Children's Trust cooperation arrangements to promote children's well being arising from Section 10 of the Children Act 2004, whereby arrangements are to be made with a view to improving the well-being of children in the authority's area so far as relating to –

(a) physical and mental health and emotional well-being;
(b) protection from harm and neglect;
(c) education, training and recreation;
(d) the contribution made by them to society;
(e) social and economic well-being.

2.2 The Children's Trust Board will bring partners together in a common strategy through the Children and Young People's Plan (CYPP). The Act transfers responsibility for preparing, publishing and revising the CYPP from the local authority alone to the Children's Trust Board.

2.3 The Children's Trust Board will prepare and monitor the implementation of the CYPP – but does not deliver it. Delivering the strategy remains the responsibility of the partners, both individually and together. Each partner within the Children's Trust retains its own functions and responsibilities within the wider partnership framework.

2.4 When preparing, reviewing and revising the CYPP the Board must have regard to the compatibility with the UN convention on the rights of the child, which includes children's rights to:

- protection from harm and violence and discrimination,
- a supportive family environment or alternative care,
- help to keep healthy;
- education, play and leisure;
- additional support for those with the most need.

3. Membership

3.1 The membership of the Board will be as set out in the attached schedule, at Appendix 1.

4. Governance

4.1 The Chair of the Board will be the Lead Member for Children's Services.

4.2 The Children's Board has no quorum.

4.3 If a member of the Board cannot attend deputies or alternative representatives with decision making powers should attend with the agreement of the Chair.

4.4 Should the need arise the Board has the power to set up sub -groups. There are no plans to do so at present

5. Objectives: The Board has responsibility for:

(i) Conducting a needs analysis to inform the CYPP

5.1.1 The Board must carry out a thorough and wide ranging analysis of children and young peoples needs mapped against existing services, to identify gaps in service provision and inform strategic commissioning.

5.1.2 The Board should review the needs analysis as an ongoing activity.

5.1.3 The Board must ensure that the needs assessment is informed by safeguarding priorities

5.1.4 The needs assessment should inform and be informed by the statutory Joint Strategic Needs Assessment (JSNA)

(ii) Developing and publishing the CYPP:

5.2.1 The Board must collectively prepare, publish, monitor and revise the CYPP in accordance with current statutory regulation and guidance.

5.2.2 The CYPP is a joint strategy which sets out how the Children's Trust partners will cooperate to improve children's well-being in the local area and sets the strategic framework for the commissioning of services for children and young people.

5.2.3 The CYPP should be consistent with the strategic vision in the Sustainable Community Strategy.

5.2.4 In preparing the CYPP the Board will set the strategic priorities for children and young people with special educational needs, disabilities and looked after children in the local area

5.2.5 Every local area must publish a joint CYPP on or before 1 April 2011

5.2.6 The Board must agree the period of the plan to be published on or before April 2011, and the period covered by each plan thereafter.

5.2.7 The Plan must be published by the partners to the Board in accordance with statutory guidance

5.2.8 The Children's Trust Board will consult widely during the preparation of the Plan per the CYPP regulations.

(iii) Monitoring the CYPP

5.3.1 Whereas individual partners to the Board are responsible for delivering the CYPP, the Board is responsible for monitoring the extent to which each Children's Trust partner acts in accordance with their commitments in the CYPP

5.3.2 The Children's Trust Board will monitor the extent to which the priorities and targets identified in the CYPP are being achieved and specifically how each partner is implementing the Plan, providing challenge if necessary.

5.3.3 The partners to the Board must provide information and relevant data to enable the Board to assess progress of the CYPP

5.3.4 The Board will review the CYPP each year in which a new Plan is not published. The emphasis of the review is to assess the effectiveness of the Plan itself. Following any review of the plan if it considers it is necessary the Board will revise the plan and publish it in accordance with regulations.

5.3.5 The Board will produce an annual report on the extent to which the Children's Trust partners act in accordance with the CYPP.

5.3.6 The annual report shall include the assessment of the Chief Executive and Leader of the Council as to the effectiveness of local governance and partnership arrangements for improving outcomes for children.

(iv) Safeguarding and promoting welfare

5.4.1 Per the statutory guidance keeping children safe is a top priority for the Children's Trust Board and each of the Children's Trust partners, statutory and non-statutory alike.

5.4.2 The Board must receive an annual report from the Local Safeguarding Children Board (LSCB)

5.4.3 In developing the CYPP the Board must have regard to the strengths and weaknesses identified by the LSCB.The LSCB is responsible for challenging the Children's Trust Board and the Children's Trust partners individually on their success in ensuring that children and young people are kept safe.

5.4.4 The CYPP must set out the arrangements to promote the welfare and safety of children and young people, and the arrangements made by Board partners for co-operating to improve safeguarding and provide early intervention and preventative action.

5.4.5 The CYPP regulations require the CYPP to set out the arrangements they will make to reduce and mitigate the effects of child poverty

5.4.6 The CYPP must include a local workforce strategy to help create a workforce which delivers improved outcomes for children.

5.4.7 The Children's Trust Board should promote consistent adoption and use of integrated processes and tools available to support integrated working through the CYPP. This includes effective information sharing and per Lord Laming's recommendation the Children's Trust Board should assure itself that partners consistently apply the Information Sharing Guidance to protect children.

Appendix 3: Draft Work programme

Board Meeting	Report
17th May 2010	Standing Items: • none Strategic Improvement Priorities: Priorty1 • Children's Trust Board Arrangements • Corporate Parenting • Safeguarding Thresholds - presentation Reports from Board members/other partnerships: • None CYPP Transitional Arrangements: • none
19th July 2010	Standing Items: • none Strategic Improvement Priorities: Priority 1: • VFM programme: prevention work stream Priority 2: • Report on School clusters/extended services • Service redesign scoping papers: children with a disability: and Child Health Programme Priority 3: • Service redesign scoping paper: Youth Services Priority 4 • Workforce development Reports from Board members/other partnerships: • Community Safety Partnership: Domestic violence-commissioning review CYPP Transitional Arrangements • none
6th September 2010	Standing Items: • LSCB Annual Report/Evaluation of Safeguarding in Brighton and Hove (and LSCB Business Plan)? Strategic Improvement Priorities: Priority 3: • Maximising life chances – children's health care • Access to education

	Reports from Board members/other partnerships: • none CYPP Transitional Arrangements • Report/work-plan
1st November 2010	Standing Items: • CYPP Performance report Strategic Improvement Priorities: Priority 2: • Child poverty: needs analysis and strategy • Young People: Outcome of Youth service Review: 14-19 Strategy; YOS Priority 4: • Update on VFM Reports from Board members/other partnerships: • none CYPP Transitional Arrangements • none
31st January 2011	Standing Items Strategic Improvement Priorities: Reports from Board members/other partnerships: CYPP Transitional Arrangements
21st March 2010	Standing Items: • Report on Section 75 partnership Arrangements Strategic Improvement Priorities: Reports from Board members/other partnerships: CYPP Transitional Arrangements

NHS
Brighton and Hove

Annual Operating Plan for NHS Brighton and Hove 2010/11

FINAL 06.04.10

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Appendices

Executive Summary

The Annual Operating Plan (AOP) for NHS Brighton and Hove (the working name for Brighton and Hove City PCT) develops the Strategic Commissioning Plan (SCP) which was first published in October 2008 and refreshed in December 2009. The SCP described our vision to keep people well and ensure that high quality care is provided to the population of Brighton and Hove. The priorities in the SCP were formulated through discussions with our staff, NHS organisations, patients, members of the public, voluntary sector organisations, City Council and other stakeholders. The Annual Operating Plan focuses on what we will do in 2010/11 to deliver these priorities. Our Annual Operating Plan has been developed in partnership with key local providers of health care and the City Council. The financial, workforce and contractual implications are reconciled to their plans. National targets, 'vital signs' and local authority targets are integrated within the document and are separately listed in Appendix C. We are also committed to achieving the NHS South East Coast pledges. These are referred to throughout the document and are described in Appendix E.

The SCP describes the PCT's strategy as 'targeted transformation' to ensure that we deliver:

- Our commissioning goals
- Our priority health outcomes
- A significant rise in quality and productivity
- Financial sustainability

It sets out a number of 'Priority Transformation Programmes' to ensure we deliver these aims covering the following areas: urgent care, primary care, long term conditions and end of life care, planned care, mental health, maternity and children's services, public health and cross cutting efficiency programmes. The Annual Operating Plan further develops these into Delivery Plans for 2010/11. These are described in detail in section 7 of this plan. Implementing these plans will help us to deliver our vision for the people of Brighton and Hove.

The financial impact of our Annual Operating Plan is set out in section 4 and Appendix F. We are investing £11.8m in our Transformational Programmes (with off-setting savings of £24.1m), £4.8m in increased capacity and £3.3m in quality. This is in addition to ongoing funding of services and infrastructure. We have a savings target of £6.4m for the year to enable these investments to be made; specific savings plans will be developed internally and with our partners in the local health economy. These will focus on systems levers, corporate efficiency and quality metrics and are further described in section 7.8.

As well as making changes during 2010/11 in the services we commission, we also have plans for the people and resources within our own organisation. These are described in section 8.

The impact of this plan on equalities has been reviewed. As each initiative is further developed the impact on minority groups will be assessed at a detailed level to ensure that services are available to all and that specific groups are not disadvantaged.

Our track record is strong and foundations are in place to deliver excellent care for the City; this plan sets out how this will be done and how we will measure success.

1 Introduction

The Annual Operating Plan (AOP) sets out the priorities of the PCT and the work the organisation will do in the coming year. It links to the Strategic Commissioning Plan (SCP) by describing year 1 key initiatives and outlining the PCT's plans, targets and financial flows in that year.

2 Context and Links to Strategic Commissioning Plan

The SCP set out the vision, values, commissioning goals and strategic objectives of the PCT. These are summarised in the table below but more detail can be found in the SCP.

Vision	NHS Brighton and Hove is passionate about keeping people well and making sure that high quality care is provided when they are not well
Values	Professional Focused on achievement Working in partnership Driving quality Promoting innovation
Commissioning goals	Adding years to life Maximising life chances for children and families Developing a healthy young city Promoting independence Commissioning nationally recognised best practice
Strategic objectives	• Be the leading advocate for health and healthcare in the city • Improve health and reduce inequalities • Increase service quality and choice • Increase confidence in and engagement with the NHS • Manage resources effectively

Healthier People, excellent care priorities

The SCP further describes the priority health outcomes which have been developed in response to the strategic context and local health outcomes. For further detail refer to the SCP sections 3 and 4. The priority health outcomes are listed below with rationales for their selection. In delivering out priority health outcomes we will assess the impact and barriers to access including socio-economic barriers, on all groups in our community.

Outcome	Rationale
Under 18 conception rate	Teenage pregnancy is a significant issue for the city and is an LAA target. Babies born to teenage mothers are more likely to have a low birth weight, to die in infancy and to suffer accidents Teenage mothers are at increased risk of postnatal depression and are less likely to be in education, employment or training The conception rate for this group is reducing but remains above the national average
Reducing childhood obesity	Childhood obesity levels are expected to rise. This is an issue in the city and halting this rising rate presents a significant challenge It is considered to be a key marker of the future health of the city as it is associated with a wide range of adverse outcomes in later life
Rate of hospital admissions per 100,000 for alcohol related harm	Alcohol misuse is a significant issue for the city and the rate of admissions for alcohol related harm is high Reducing rates is a challenge, given the reliance on changing lifestyles and behaviours and the need for social marketing. We aim to reduce the growth in the rate of admissions in the next five years through a more targeted approach
Coverage of women aged 53-70 offered screening for breast cancer	We are performing below the national average and recent coverage has fallen for operational reasons An action plan remains in place across the health economy to improve capacity which will help us to recover the recent drop in performance and move towards the national average
Delayed transfers of care (DTOCs)	Improvements are being made but performance remains below ONS cluster average performance. We have reviewed with our partners whether we should retain this as a priority health outcome and given that this is a system-wide target we will continue to focus on this. We will demonstrate leadership by increasing community capacity, improving the effectiveness of joint working and increasing personalised care outside of hospital
Proportion of all deaths that occur at home	We will better co-ordinate primary care and acute services in order to offer choice for people at the end of their life. Our performance is very good but we hope to exceed our current performance and provide a nationally excellent service
MRSA infection rate	MRSA has been a considerable concern for the local health economy and reducing MRSA remains a critical target in order to reduce the risk to patients Local rates of infection remain volatile and are the subject of an ongoing health community wide action plan
The percentage of people moving into recovery from IAPT services	Increasing access to psychological therapies has been commissioned to meet mild to moderate need, however referrals to date indicate that the intensity of interventions have been higher than expected We will work to increase access and to ensure that pathways are redesigned to improve the chances of recovery

2.1 Priority Transformation Programmes

The strategy of NHS Brighton and Hove is described by a number of Priority Transformation Programmes (PTPs). These are commissioning activities or initiatives that will help deliver the right future model of care, our strategic vision, commissioning goals and priority health outcomes and will also help us to bridge our future financial gap.

The AOP sets out how the Priority Transformation Programme will be delivered in 2010/11. Each programme has been further split into a number of plans which are listed below. These are further described in section three and Appendix A.

Priority Transformation Programme		Delivery plan
Urgent care		Urgent Care
Primary care		Transforming Primary Care
Long term conditions & end of life care		Long term conditions and case management
		Long term conditions and independence
Planned care		Moving services into the community
		Improving prevention, access and treatment for cancer
		Specialised and tertiary commissioning
		Increasing productivity and efficiency
Mental health		Promoting mental health and wellbeing
		Developing community pathways to support recovery
		Developing effective and efficient care pathways and treatment services
		Managing access to treatment
Maternity & Children's services		Strengthening partnerships
		Access and settings of care
		Children & Adolescent Mental Health Services (CAMHS)
		Improving early intervention and prevention
		youth service provision
		Improve support to children and young people with a disability or complex health needs and their families
		Childhood obesity
		Transforming maternity services
Public health		Sexual health

Priority Transformation Programme		Delivery plan
		Stop smoking
		Health care acquired infections
		Emergency Preparedness & Resilience
		Prevention of CVD and detection of AAA
Cross cutting PTPs		Targeted spend review
		Corporate efficiency
		Use of systems levers

3 A focus on quality

3.1 Commissioning for quality

As commissioners of healthcare services on behalf of our population, we are committed to ensuring that healthcare services provide high quality care which is accessible to all members of the public. We recognise that quality matters to patients, ensures good value for taxpayers and energises staff.
The NHS Operating Framework for 2010/11 confirms that the focus remains on stability and improvement of frontline services, specifically the delivery of safe, high quality services, delivery against national and local priorities and providing cost-effective services to keep people well.

3.2 The quality framework

In association with staff and stakeholder feedback, we have developed an overarching quality framework, informed by both the national and regional policy and our local plans. This framework sets outs the approach we will use to ensure that the services we commission on behalf of the local population are of the highest quality. This framework will apply to all commissioned and contracted services.
Our principles are to:

- Engage, empower and involve patients, carers and the public
- Place staff at the heart of clinical decision making
- Ensure value for money

An overview of the aspects of this framework is represented in the following diagram:

Each element is explored in greater detail below.

3.3 Quality, Innovation, Productivity and Prevention (QIPP)

High Quality for All supports the collaboration between commissioners and clinicians around the principle of quality and to focus efforts in using innovation to drive up both the quality of patient care and the productivity of healthcare services.
Specifically, the NHS Operating Framework sets out the requirement for us to improve efficiency. Specific focus is placed on releasing savings whilst driving up quality in services.

The links between QIPP and our AOP plans are shown in the following table:

Efficiencies		Our response – AOP Initiative
Provider savings	Reduced back office costs	Corporate efficiency Priority Transformation Programme – staff productivity
	Better value from procurement	Use of system levers Priority Transformation Programme - Commercial Support Unit
	Reduced estates running costs and carbon emissions	Corporate efficiency Priority Transformation Programme – estates rationalisation
Commissioners/ Providers shared savings	Releasing savings and driving up quality	Long term conditions and Independence - Self care and community based alternatives to avoid acute hospital admission and to facilitate discharge
		Urgent care - Single point of access and alternatives to acute hospital to avoid A&E attendances and admissions
		Managing Demand Differently - Review and management of planned care referrals to avoid unnecessary acute admissions
		Increasing Productivity and Efficiency - Improved efficiency and productivity of acute hospital episodes as enforced via contractual levers
		Out of hospital care Priority Transformation Programme - Community based alternative to acute services to prevent elective admissions and facilitate timely discharge
		Specialised commissioning - Repatriation of costlier, out of area placements
		Mental health Priority Managing Access to Treatment - Review and management of referrals to mental health services and early intervention to avoid unnecessary admissions where there are community based alternatives
		Children's services - Promotion of healthier lifestyles to avoid health issues in later life and provision of community based alternative to acute hospital for complex conditions
		Transforming maternity services - Reduction in elective caesarean sections where they are not clinically necessary
		Prevention of CVD and detection of AAA - Prevention and early detection to reduce dependence on acute hospital services

3.4 Clinical effectiveness, safety and patient experience

Lord Darzi (2008) defines quality of care as safe, effective and a good experience for patients. Key elements and areas of focus for each of these three dimensions of quality are as follows:
The vision set out in the Brighton & Hove Commissioning for Quality Framework and its associated action plan will support the identification and delivery of local Commissioning for Quality and Innovation (CQUIN) improvements and support the implementation of the Enhancing Quality programme within Brighton & Hove.
The CQUIN for 2010-11 also include two nationally mandated schemes for acute trusts; 'reducing the impact of Venous Thromboembolism' and 'improving responsiveness to personal needs of patients'. The 2010-11 CQUIN payment framework will also incentivise the implementation of the Enhancing Quality Programme.

3.5 Enhancing Quality Programme

To be implemented across the Southeast Coast SHA providers and commissioners, the Enhancing Quality is a PCT Alliance sponsored Programme which builds upon innovative work by North West SHA.
Enhancing Quality is a clinical change Programme which uses triangulated information to drive quality improvements in clinical interventions; patient reported outcomes and patient experience.
From 2010/11 the programme will be a significant component of the local approach towards CQUIN.

A full list of CQUINs for 2010/11 is included as Appendix C

- **HCAI prevention and control** – The 2010/11 Operating Framework sets out a new objective on MRSA infections and a new standard for C Diff will be published in 2010. This is included in the initiative template for HCAI.

- **Safeguarding** – the local health economy safeguarding arrangements will continue to be strengthened to ensure that consistent arrangements are in place to safeguard and promote the welfare of children and vulnerable adults. The PCT will work closely with colleagues within local healthcare and local authority to ensure we are informed of all incidents involving children and adults, including death or harm whilst in the care of the provider.

4 Finance

4.1 Source and application of new funds

The PCT receives 5.2% growth funding in 2010/11 (£22.8m) and has a carried forward surplus of £1m. There is no change in tariff (the prices paid under Payment by Results) and there is a 3.5% efficiency savings requirement to providers. CQUIN increases from 0.5% to 1.5% demonstrating an increased emphasis on quality issues.

Because 2010/11 is set to be a year of consolidation and constraint, it will feel financially tighter than 2009/10. We are required to increase our surplus to 1% (£4,615k), spend 2% (£9,229k) non-recurrently on transformational change and ensure that we have sufficient contingencies to cover risk. In developing the AOP we have also set a contingency reserve of 1% (£4,615k).

The plan for 2010/11 can be summarized as follows and the table below: **-**

	2010/11
Summary use of Growth	£'000's
Source of Funds	
Growth (5.2%) in 2010/11	22,823
Prior Year surplus Non Recurrent	1,000
Underlying Surplus Recurrent	0
Total	**23,823**
Inflation and Tariff	
PbR/Non-PbR	0
CQUIN (+1%=1.5% in total)	3,314
Prescribing	2,021
Capacity (@2.25%)	4,827
	10,162
Service pressures	
PbR exclusions	500
2009/10 NR savings	4,000
Continuing Care	2,000
Carers + Misc.	946
	7,446
New 'Choosing Health' investments/savings	
Investments	798
Savings	(798)
	0
Priority Transformational Programmes	
Investments	11,813
Savings	(24,057)
	(12,244)
Contingency (1%)	4,615
Non Recurrent Spend on Transformational change (2%)	9,229
Total Expenditure	**19,208**
Surplus (1%)	**4,615**
	23,823

Therefore, the AOP for 2010/11 has: -

- 1% Contingency £ 4,615k
- 2% Non Recurrent spend reserve £ 9,229k
- 1% Surplus £ 4,615k
- Total £18,459k

Although a contingency reserve has been set at 1% in the AOP within the savings figure of £24,057k are savings of £6,403k which are yet to be identified. (see Table 1).

We continue to work up initiatives to recurrently secure the full £6403k savings under the leadership of the Director of Finance. This remains the corporate aim as not to do so merely increases the financial challenge in 2011/12.

The AOP has a reserve for non-recurrent spend on transformational change of 2% (£9229k). For 2010/11 this 'Investment Fund' requirement has been agreed across SEC to be 1.25%. Therefore in the FIMS plan submitted to the SHA we have made an adjustment of £3461k reduction to the investment fund which also reduces the 'savings to be identified' figure down to £2942k. We have also identified how this can be found non-recurrently and submitted a balanced FIMS plan with no shortfall in savings.

It is seen as a high corporate priority to ensure that as we move into 2011/12 we have a 1% Surplus, 1% Contingency Reserve and 2% Investment Fund. Therefore the AOP reflects the need to meet this financial challenge in 2010/11 as will the budgets we set for the year.

Given the challenging financial environment there will be no access to any contingency reserve until all the savings are identified and even then the access will be to non-recurrent funding to deliver future savings, thereby ensuring a sustainable financial position with expenditure being contained within budget.

Table 1 **Priority Transformational Programmes**	**2010/11** **Investment**	 **Savings**
Urgent Care	**155**	**(1,540)**
Primary Care	**841**	**(350)**
Long Term Conditions & Case Management	**592**	**(857)**
Long Term Conditions & Independence	**98**	**0**
Moving services into the community	**5,669**	**(6,301)**
Improving Cancer Services	**1,329**	**(239)**
Referral Management	**0**	**(838)**
Acute Care	**0**	**(435)**
Mental Health	**832**	**(341)**
Children's Services	**0**	**(325)**
Maternity Services	**165**	**(263)**
Developing a Healthy Young City	**304**	**(261)**
Adding Years to Life	**20**	**0**
Corporate efficiencies	**0**	**(1,200)**
Use of Systems levers	**0**	**(1,600)**
Targeted spend reviews	**0**	**(1,101)**
Cost Pressures	**1,808**	**(653)**
Public Health Efficiencies	**0**	**(300)**
Dental and Prescribing underspend	**0**	**(1,050)**
Yet to be identified		**(6,403)**
Total	**11,813**	**(24,057)**

The table above as well as summarising the Delivery Plans set out in the rest of this document shows assumed efficiency savings of the Public Health budget, and the under spend in Prescribing and Dental budgets in 2010/11 reflecting the experience of previous years rather than being planned.

5 Equality and Diversity

NHS Brighton and Hove, like all public bodies, has legal duties to promote equality and tackle discrimination in everything it does as an employer and commissioner of health services.

These legal duties are laid out in the Race Relations (Amendment) Act 2000, The Disability Discrimination (Amendment) Act 2005, and the Equality Act 2006. Whilst these specific duties cover Race, Disability and Gender, there are further legislative measures both in force, and coming in the Single Equality Bill 2010 expanding our duties to cover the 'protected characteristics of – Age; Disability; Gender Reassignment; Marriage and Civil Partnerships; Race; Religion or Belief; Gender; Sexual Orientation; Pregnancy and Maternity. Our obligations also now include Socio-Economic inequalities and Carers. The Trust has a Single Equality and Human Rights Scheme (SEHRS), detailing its responsibilities and commitments to include the new 'protected characteristics'.

We assess the impact of changes to NHS services, commissioning and decision making, via our Equality Impact Assessment (EIA) process. The Trust supports staff

networks and provides training and awareness raising activities to ensure the organisation values and supports its diverse staff.

The PCT recognises that no one person can be easily categorised by just one of these definitions or identities. Therefore the organisation's work to promote equality and diversity considers all of these issues simultaneously, whilst acknowledging that some people will experience exclusion and unfair treatment because of their identity within one of these strands.

6 Clinical Commissioning

Our governance arrangements promote and encourage local clinicians to play a central role in the identification and delivery of local quality and efficiency improvement priorities. Clinicians are actively involved in supporting the adoption and development of service specific indicators for quality, ensuring local ownership for reviewing and improving quality so that the needs of the local population are best met. Through this process, commissioners work in collaboration with providers to understand quality issues and identify and implement solutions which facilitate continuous quality care improvement. The key mechanism for supporting this clinical engagement is Practice Based commissioning (PBC).

6.1 Overview of PBC

Local practices in Brighton and Hove have been actively involved in PBC since April 2006. Three active locality commissioning groups are in existence covering the East, Central and West localities population. Governance and strategic decision-making is coordinated via a City wide Joint PBC Board that meets on a monthly basis and is chaired by the PBC locality chairs.

We have committed to maintain the engagement already in place and to work jointly with PBC to develop systems and processes and to change current ways of working. An enhanced operational framework has been developed to ensure PBC collectives have greater engagement in the clinical commissioning agenda linked to our SCP. The PBC Operational Framework 2010/11 focuses on:

- PBC's link to the strategic focus of the PCT (including more clinical engagement in the strategic decision making process)
- The financial framework (including achievement of financial balance and the implications of poor performance)
- The context and outcomes expected through the effective management of PBC across NHS Brighton and Hove by both the PCT and GP Practices (including aligned resources internally within the PCT to support PBC)

The main priorities identified for PBC

- Developing a more cohesive collective structure that manages practices in a more operational way linked to performance management and clinical engagement. The development of collective agreements is being suggested as a practical way forward for ensuring this process is achieved.
- Managing demand, linked to a more cohesive structure. This level of operational management is seen as the minimum level of PBC engagement.
- Clinical Leadership and engagement. The future leaders of PBC should be GPs, supported by operational managers and these GPs will be supported financially to invest the time needed to deliver a more cohesive structure.

- Service redesigns linked to the strategic focus of the PCT. Clinicians should be involved in the whole process of developing the strategy, and should be involved in a way that allows them to take ownership.
- Defining a revised financial framework and budget setting methodology that support PBC and is delivered through high quality data management processes and tools.
- The PCT delivering dedicated resources allocated to support PBC.
- PCT Teams created internally to cover:
    - Service redesign support functions
    - Finance and Data dedicated functions linked to PBC
    - Management Support dedicated function linked to PBC

7 Delivery Plans

7.1 Urgent Care

7.1.1 Urgent Care

Summary

We will transform urgent care services in the city so that they are simple to access, responsive, – consistent and appropriate.

Projects within the initiative

In 2009/10 we

- Implemented Phase 4 of the Urgent Care Centre (UCC)
- Implemented a pilot Roving GP service
- Implemented a pilot RACOP (Rapid Access Clinic for Older People) service
- Re-commissioned STAN (single telephone access number), now known as 'HERMES'.
- Worked with SECAMB to establish 5 paramedic practitioners

In 2010/11 we will:

- Develop the service model for a fully integrated urgent care centre and decide on procurement options
- Work to reduce avoidable admissions and Delayed Transfers of Care across pathways from self-care to hospital discharge including the following:
    - Develop the service model for the rapid assessment and response services.
    - Test acute admission criteria for key pathways.
    - Review and extend where appropriate the RACOP, Roving GP and HERMES services
    - Review and refocus the Integrated Discharge Team
    - Develop and extend community IV clinic supported by IV team
- Ensure people are seen at the right place and time with the right clinician including the following:
    - Develop a targeted communication strategy to influence patient behaviour and use of urgent care
    - Simplify access to all short term services - one referral and one assessment
    - Minimise opportunities for bypassing care pathways by ringing 999/NHSDirect
    - Develop the role of paramedic practitioners
- Develop service model for short term services.

Key Milestones

- Urgent Care Centre service model defined and decision made re procurement options April 2011)
- Work to reduce avoidable admissions and Delayed Transfers of Care across pathways from self-care to hospital discharge (March 2011)
- Ensure people are seen at the right place and time with the right clinician (March 2011)
- Service model for the Rapid Access and Assessment Model defined. (March 2011)
- Test acute admission criteria. (March 2011)
- Service model for short term services (March 2011)

Outcome measures

Measure	Target
Rate of emergency admission per 100000 population by 2013/14	National average
Ambulatory care sensitive conditions 2013	Upper quartile
Shift balance between use of short term services	60% for prevention of admission and 40% for hospital discharge

Quality metrics

Measure	Target
CQUIN measure for SECAMB 1. To complete the piloting of the training programme and develop a roll-out plan to cover all relevant SECAMB staff across all PCT areas.	Pilot training programme completed
2. To work towards improving the communication of palliative care handover notes/DNAR orders from the central database to ambulance crews.	Quarterly progress reports.
South CQUINS relevant to urgent care Reducing variability in patterns of admissions to short term services across the week. Reduce the number of patients readmitted to hospital within 28 days of discharge from a community short term service	
BSUH CQUINS relevant to urgent care: Reducing variability in pattern of discharges across the week Reduction in Avoidable readmissions with 14 days by 10% Reduction of patients falls in hospital by 20% Ensure 95% of patients have an agreed discharge plan within 24 hours of on all elective and emergency admissions	

Principal changes in activity

NEL Admissions	10/11
Roving GP	177
RACOP	142
Reduction in admissions	496
Total	**815**

10/11 shows additional over and above 09/10

Implications for workforce

The potential procurement of a fully integrated urgent care centre could involve contracting with a new provider for this service with implications for TUPE of staff and change of staffing focus. This will be evaluated as part of the procurement process.
A revised rapid access model could involve TUPE of staff from existing services as well as the development of new roles. It may also require staff to work in different locations i.e. on a locality basis and much closely to primary care. We may also seek to change the operating times of services to match patient need eg some service may need to function on a 24/7 basis.

The implementation of acute admission criteria will be dependent on the development of a senior clinician role at the front door of the hospital to stream patients to the most appropriate service to meet their need

The development of a new model for short term services is likely to involve an increase in the

provision of services delivered in the community, reducing reliance on bed based services. We will expect services to be delivered in delivered in different locations, all within the city and from few sites. Developing a single model for short term care may mean staff working under new management arrangements or even for a new provider.

We will need to develop roles such as GPwSI or middle grade doctors with a special interest in elderly medicine to ensure the right medical input to community services that support prevention of admission.

Commentary on financial requirements

	10/11		
	Cost	**Savings**	**Net Savings**
Roving GP	76	377	301
RACOP	79	281	202
Out of hours GP		310	310
Short Term Services		72	72
Reduction in admissions		500	500
Total	**155**	**1,540**	**1,385**

Procurement and market management implications

Procurement options for Integrated Urgent Care will be reviewed this year

Related Vital Signs Measures/ Existing Commitments	CQC EC8 (VSC10) VSC20 VSC11 CQC EC2,3 & 4 CQC EC13 CQC EC14
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Acute Care pledges 1,2 &3

Equalities Impact

High quality care for all will deliver better and fairer outcomes for all patients. We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.

7.2 Primary care

7.2.1 Transforming Primary Care

Summary

The overall aim of this initiative is to develop and improve Primary Care services and in particular to reduce the variation in quality and performance between individual contractors. There needs to be a strong foundation in order to enable the strategic shift of services from secondary to primary care.

Projects within the initiative

In 2009/10 we

- Opened a GP led health centre in central Brighton
- Developed a new quality and performance management framework for general practice using a balanced scorecard
- Supported practices to improve patient access and responsiveness through one to one facilitation and support. Improved access to NHS dentistry through additional investment and marketing and communications.
- Continued to invest in primary care estates
- Started to implement the NHS Health Check programme – focusing on the hard to reach and most at risk populations
- Published a new Pharmaceutical Needs Assessment
- Develop new community pharmacy enhanced services and revised several existing services

In 2010/11 we will

- Continue to improve and develop the primary care infrastructure
- Roll out the General Practice quality and performance framework to all practice
- Introduced a quality and performance framework for NHS dentistry
- Develop plans for a quality and performance framework for optometry
- Improve access and responsiveness by continuing to provide individual support to practices and investing in the “Access and Responsiveness” LES
- Ensure 100% of our population in General Practice
- Maximise value from primary care contracts by:
    - Encouraging quality improvements through the balanced scorecard approach
    - Specifically incentivising quality in all new contracts
- Targeting resources and refocusing commissioning activity to focus on:
    - Reducing health inequalities
    - Promoting health and prevention
    - Long term conditions
- Invest further in NHS dentistry to improve access and meet the Vital Signs target set for 31 March 2011
- Review orthodontics services
- Review the PCT’s contract for special care dentistry
- Prepare to procure a more local Emergency Dental Service
- Develop a new quality and performance framework for community pharmacy.
- Target community pharmacy advance services to:
    - Long term conditions
    - Discharge
    - And raise the profile of ‘medicines check ups’ with the general public.

Key Milestones

- Implement new contracts to improve access to NHS dentistry with more focus on prevention and quality incentives - implement September 10
- Full implementation of Quality & Performance frameworks for General Practice and NHS dentistry Apr 10 – Mar 11
- Implement Estates strategy phased 10/11 and beyond
- Implement Restorative Dentistry service – New local emergency dental service procured – by 1 April 2011
- Outcome review orthodontics September 10
- New contract for special care dentistry agreed by 1 July 2010
- Launch new primary care sexual health service – April 2010
- Launch medicines check ups at BSUH and to the general public – Sept 2010
- Implement ETP Release 2 (Electronic Transmission of Prescriptions) – Winter 2010/11
- Emergency Dental service from April 11

Outcome measures

Measure	Measure
Ensure patients can choose a GP practice officering extended access to evening and weekend appointments.	100%
VSC06 Patient reported measure of GP access	91%
No. of patients receiving NHS primary dental services in previous 24 months	60%
QOF exception reporting	6.5%

Quality Metrics

Measure	Target
QOF scores – against maximum points available	94.5%
GP Contractors scoring 'A' in quality scorecard	35%
Dental Contractors scoring 'A' in quality scorecard	35%
Overall satisfaction with GP services	96.5%

Principal changes in activity

n/a

Implications for workforce

Implications for workforce

PCT: Increased access to dentistry will be achieved through contractual arrangements. Skills mix of dental staff will change to emphasise prevention eg additional hygienists. Movement of work from acute to primary care will require increasing clinical specialisation eg GPSis (GP's with Special Interests). We expect this to equate to five new dentists.
Increased focus on health promotion and prevention will change the skills mix towards practice

nurses and healthcare assistants.

Encourage pharmacists to use their teams more effectively in offering and promoting pharmacy based services.

Commentary on financial requirements

	cost	savings
Fye GP Led Health Centre	£429k	
QOF	£78k	
Premises rental increase	£259k	
Premises non-recurrent costs	£75k	
Re contract special care dentistry		£350k
Total	£841k	£350k

Procurement and market management implications

Emergency dental service and dental access procurement will be progressed this year

Related Vital Signs Measures/ Existing Commitments	VSA06 VSA07 VSB18
Related World Class Commissioning outcome measures	Under 18 conception rate
Related *Healthier People Excellent Care* Pledges	Long Term Conditions Pledge 4 Staying Healthy Pledge 2

Equalities Impact

The Access and Responsiveness LES ensures practices take account of patient satisfaction and inequalities of service provision within their practice and take action to ensure access is improved where required. With regard to dental services, social marketing is underway to improve our understanding of barriers to access. We will then target particular groups where access rates are lower. When contracting pharmacy LESs, we ensure coverage across the whole City to meet patient demand.

7.3 Long term conditions & end of life care

7.3.1 Long term conditions and case management

Summary

To provide systematic and integrated primary and community care for patients with a long term condition (LTC) across all levels of care from self care to end of life.

Projects within the initiative

In 2009/10 we

- Agreed a local dementia strategy and action plan
- Improved provision of respiratory services
- Implemented End of Life strategy including LES to ensure GPs sign up to Gold Standards Framework.
- Re provided the anticoagulation service in the community

In 2010/11 we will

- Implement LTC network
- Develop and agree locality based model of care for LTC ,care planning case management , information provision
- Test out the LTC model for 1year
- Identify key priority conditions (patient groups) within LTC where elective activity can transfer into primary and community care e.g. LTC OPAs (cross reference elective care PTP)
- Review current provision of Diabetes, COPD, Dementia and Heart Failure against national best practice to identify opportunities to improve quality and productivity
- Implement insulin pumps as per NICE guidance
- Implement local Carers Strategy
- Explore opportunities for Community tariffs and currency.
- Continue local End of Life Care Strategy roll out
- Continue roll out of Gold Standards Framework across Primary Care
- Implement an electronic End of Life Care Register
- Continue to pilot a dementia demonstrator site including the involvement of learning disabilities, BME and LGBT groups.

Key Milestones

- LTC network operational April 2010
- LTC resource envelope confirmed May 2010
- LTC model developed for each locality Aug 2010
- Testing of model Aug 2010
- Review and explore opportunities for elective activity to be managed within primary / community care
  Jan2011
- Agreement to progress Insulin pumps business case Feb 2010
- Resource allocated for End of Life Care Registers project Feb 2010
- Explore opportunities for Community tariffs and currency March2011
- GSF roll out March 2011
- Electronic end of life care registrar roll out complete March 2011

- Carers Strategy - Ongoing

Outcome measures

Measure	Measure
All patients with a LTC will be offered a personalised care plan	March 2010
Improved hypoglycaemic control by setting target HbA1c at 7, target level to be confirmed (HbA1c was previously 7.5 now 7 target now requires re adjusting? 85%)	March 2011
90% practices signed up and participating within the GSF	March 2011
Patients supported to die at home where this in their preference 23%	March 2011
Number of identified carers referred for a carers assessment	To be developed

Quality Metrics

Measure	Target
Care planning and assessment: • Total number of new referrals. • Total number of new referrals with a personalised care plan in place • Total number of new referrals with a care co-ordinator identified	
Carers • Total number of new referrals • Total number of new referrals who are asked whether they have a informal carer • Total number of new referrals for whom an informal carer is identified and whether carer is under 18, 18-65, or over 65 • Number of the above referred for carers assessments • Number of carers assessments completed by South Downs Staff	
End of Life • Increase patients being managed through Liverpool Care Pathway • Increase number of patients with recorded preferred place of care	

Principal changes in activity

Need to confirm activity for OPD and FU for Diabetes following revisions in year 09/10

Specialty Name	**Localities Reductions (phased)**
Anti Coagulant Service	**-39,840**

Implications for workforce

Provider: With the reconfiguration of existing teams and focus and shift to generic team based models of care the existing community workforce is likely to experience the most change.

Teams will move from nursing only to multi disciplinary teams working across a number of organisational boundaries.

Aspiration to train non-qualified staff to take on a range of roles including assessing for and prescribing equipment and therapy support.

Commentary on financial requirements

Service	Investment £000	Savings £000
Diabetes	122	122
Insulin Pumps	111	
Anticoag	258	735
Carers	101	
Total	**592**	**857**

Procurement and market management implications

Clarification of procurement route for Insulin Pumps required

Related Vital Signs Measures/ Existing Commitments	Vital Signs VSC 11, 12, 13, 14, 15, 20, 21
Related World Class Commissioning outcome measures	Proportion of all deaths that occur at home
Related *Healthier People Excellent Care* Pledges	Long term Condition Pledges 1,2,3,4,5 End of Life Pledges 1-5 Overarching Pledge 7

Equalities Impact

Significant inequalities of provision, access and quality of provision exist within the current services which will be addressed within the longer term commissioning plan
Improve overall performance within primary care for management of LTC
Equity of provision of services for mobile and housebound patients
Reduction in variability of quality of LTC services
Equalities impact assessment will be completed as part of the overall Primary and Community Care Strategy Development

7.3.2 Long term care and independence

Summary
To support people to live independently at home for as long as possible

Projects within the initiative

In 2009/10 we

- Implemented 24/7 provision of thrombolysis therapy for stroke

In 2010/11 we will

- Develop and agree a clear commissioning plan for acute/post acute neuro rehabilitation pathway
- In line with the commissioning plan develop procurement process to deliver plan
- Undertake feasibility study of the national retail model for provision of equipment to determine if savings expected would be achieved locally.
- Review Integrated Community Equipment Store (ICES) service
- Procure future ICES service

Key Milestones

- Development of joint CQUIN measure for improved transfer of care for neuro rehabilitation pathway March 2010
- Commissioning plan developed and agreed for future neuro rehab pathway Apr 2010
- Procurement plan (if required)for neuro rehab implemented Jul 10
- Complete feasibility study of National retail model Jul 2010
- Complete review ICES provision Jul 2010
- Commissioning and procurement of future ICES model completed March 2011

Outcome measures

Measure	Measure
VSA 14 People with a stroke will spend at least 90% of their time on a stroke unit	80% By end of 2010/11
Higher risk TIA cases are treated within 24hrs	60% By 2010/11
VSC 11 Proportion of people with LTC supported to be independent and in control of their condition	Target under review
VCS12 Timeliness of social care assessments VCS13 Timeliness of social care packages	72% By 2010/11 82% by 2010/11
Simple aids to daily living provided by local retailers	100%

Quality Metrics

Measure	Target

Principal changes in activity
Dependent on final neuro rehabilitation model, shift of activity from bed based services to community teams. Likely activity reduction equating to 8 beds BUT this will be re provided within the community with increase in activity for Community Neuro Rehab Intermediate Care BHCC
Implications for workforce
PCT: **Provider:** With the focus on increasing the shift of rehabilitation from a hospital bed setting to the home there are a number of implications for the current workforce. Increased acuity and complexity of patients will require an increase in capacity and skilled multi disciplinary community teams to care for and support these patients within their own home . Increased capacity within home care provision will also be required to manage the 24/7 nature of this level of care Stronger focus on independence and re enablement aligned with BHCC
Commentary on financial requirements
Stroke Thrombolysis £98k investment
Procurement and market management implications
Procurement of ICES services starts December 2010

Related Vital Signs Measures/ Existing Commitments	VSC 11,12 ,13,14,15
Related World Class Commissioning outcome measures	Proportion of all deaths that occur at home
Related *Healthier People Excellent Care* Pledges	LTC pledges 1,2,4 and 5.

Equalities Impact
Equalities' Impact assessment will be completed as part of the Primary and Community Strategy development

7.4 Planned Care

7.4.1 Moving Services into the Community

Summary

These schemes will make services more accessible to patients, in some instances increasing choice and deliver savings for the local economy.

In 2010/11 we have plans to reduce demand by 6% in 2010/11 and move 46% of outpatient activity to primary and community settings.

The services will be re-provided at a reduced cost (target is 20% lower than current cost).

In addition the PCT will increase the level of physiotherapy commissioned, by 20%, to enable the MSK service to be developed.

Projects within the initiative

In 2009/10 we

- Implemented the community eye clinic
- Implemented the ENT pilot
- Tendered for a community gynaecology service

In 2010/11 we will implement the following services:

- Adult Hearing Aids service
- MSK ICATS (Muscular Skeletal Integrated Clinical Assessment and Treatment Service)
- Increase capacity for Physiotherapy
- Community Dermatology
- Other Community services: ENT, neurology and opthalmology

Key Milestones

Phase 1

- Adult Hearing Aids Service is being reviewed to ensure cost effectiveness from April 10
- MSK ICATS commences from April 10
- Increase capacity for Physiotherapy April 10
- Community Dermatology commences from June 10

Phase 2

- Community ENT service commences from September 10
- Community Neurology service commences from September 10
- Community Ophthalmology service November 10

Outcome measures

Measure	Measure
Patient satisfaction	Measure to be developed
Improved access for advice and treatment	Measure to be developed

Reduction in secondary care referrals	Refer to activity section

Principal changes in activity

Principal changes in activity

	Specialty Name	Out-patient Reduction
MSK	TRAUMA & ORTHOPAEDICS	-25,881
	PAIN MANAGEMENT	-1,817
	RHEUMATOLOGY	-6,833
	PODIATRY	-591
Subtotal MSK		**-35,122**
Dermatology	DERMATOLOGY	**-11,805**
Other community clinics	UROLOGY	-129
	ENT	-3,080
	GASTROENTEROLOGY	-173
	CARDIOLOGY	-339
	NEUROLOGY	-574
	GYNAECOLOGY	-1,335
	COLORECTAL SURGERY	-317
	OPHTHALMOLOGY	-3,685
Subtotal other community		**-9,632**
	Total	**-56,559**

*Please note that the PCT will be increasing the commissioned capacity for physiotherapy by 20% in 2010/11 as an enabler for the MSK services.

Implications for workforce

Provider: In general there should be a reduction in the need for consultants and a growth in non-consultants workforce including specialist nurses, extended scope practitioners, skilled GPs and skilled primary care practitioners.

Commentary on financial requirements

	Cost	**Savings**	**Net**
MSK at BSUH	1,866	(4,106)	(2,240)
MSK – Community	1,4,19		1,419
MSK – Phasing allowance	410		410
MSK – Physiotherapy	218		218
Subtotal MSK	**3,913**	**(4,106)**	**(193)**
Dermatology	919	(1,149)	(230)
Other community	837	(1,046)	(209)
Total	**5,669**	**(6,301)**	**(632)**

Procurement and market management implications

Develop the primary care market to manage increased elective care and utilising the following different approaches:

- NHS preferred provider;
- Integrated care services;
- Any willing provider;
- Market testing for primary and community care services.

Related Vital Signs Measures/ Existing Commitments	Supports the sustainability of 18 weeks, 13 weeks and 26 weeks targets. VSA04, CQCEC12
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Planned Care – Pledge 1 and 3 (part of three year plan) Overarching Pledge 4 (part of three year plan) Planned Care – Pledge 5
Equalities Impact	
In general the initiative reduces inequalities by improving accessibility	

7.4.2 Improving prevention, access and treatment for cancer

Summary

The PCT is committed to delivering the vision for cancer services set out in our Cancer Reform Strategy Action Plan and to reducing the mortality rate from cancer in people under 75 years by 20% by 2010 (from 2005/06 baseline). This will be achieved by:

1. Minimising people's risk of developing cancer in the first place;
2. Encouraging early presentation, detection and diagnosis;
3. Providing the very best cancer treatment including faster access;
4. Improving people's experience of cancer care throughout the pathway.

Projects within the initiative

1. **Minimising people's risk of developing cancer in the first place:**
   - Continue to commission health promotion services that encourage: smoking cessation, healthy diet, physical activity, weight management, sexual health and alcohol awareness
   - Raise awareness of the causes of skin cancer
   - Deliver the HPV vaccination programme to girls in school year 8
   - Links with 6.6.5 Early intervention and prevention in Section 6.6 of Maternity and Children's services; and also 6.7.1 sexual health, 6.7.2 stop smoking, 6.7.3 prevention of cardiovascular disease in Section 6.7 of Public Health

2. **Encouraging early presentation, detection and diagnosis:**
   - Improve local understanding of the population's awareness of cancer and develop a targeted programme of work to improve symptom awareness and promote early diagnosis
   - Introduce the age extension for bowel cancer screening up to 75 years
   - Achieve and maintain the 36 month screening-round-length and age extension for breast screening for local women
   - Achieve the two week turnaround for cervical screening results

3. **Providing the very best cancer treatment including faster access:**
   - Develop an acute oncology service
   - Introduce enhanced recovery programme
   - Develop effective treatment locally e.g. Radio Frequency Ablations
   - Implement outstanding Improving Outcomes Guidance (IOG) measures
   - Increase radiotherapy capacity and deliver waiting time targets
   - Increase chemotherapy capacity by 10% and develop new model of care for chemotherapy
   - Increase capacity for Positron Emission Tomography (PET) scans by 2.5%
   - Undertake peer review for key tumour groups including: rehabilitation and radiotherapy

4. **Improving people's experience of cancer care throughout the pathway:**
   - Establish a community clinic to increase access to treatment for lymphoedema
   - Increase access to psychological support for people living with cancer

Key milestones for each project

1. Minimising people's risk of developing cancer in the first place:
   - HPV programme - complete first round of school visits October 2010, second round December 2010, and third round by April 2011
   - Skin cancer awareness launch May 2010

2. Encouraging early presentation, detection and diagnosis of cancer:
   - NAEDI funded initiative - conduct population survey using CAM March 2010; and awareness campaign August 2010
   - Ahead of the Game (promote awareness of lung, prostate and colorectal cancer in men over 55 yrs) - Project end date June 2010
   - Promote early referral - Pilot Primary care audit (LES) prior to possible roll out - dates TBC
   - Bowel screening - age extension November 2010
   - Breast screening - deliver 36 month target September 2010 and commence age extension November 2010
   - Cervical screening - Achieve two week turnaround for screening results December 2010

3. Providing the very best cancer treatment including faster access:
   - Increased chemotherapy capacity - model and tariff process agreed October 2010
   - Acute oncology - service open 24hours 5 days a week in A&E Oct 2010
   - Increased radiotherapy capacity - CT Simulator operational December 2010; Extended days and Saturdays operational October 2010
   - Radio frequency ablations (RFA) - service established October 2010
   - IOG measures - fully met and activity contracted October 2010
   - Enhanced recovery programme - gynaecology, colorectal and urology pathways completed October 2010; roll out methodology to all cancer pathways March 2011
   - Peer review - self assessment completed October 2010; external validation completed November 2010
   - PET scans - SLA signed off and capacity in place April 2010

4. Improving people's experience of cancer care throughout the pathway:
   - Lymphoedema treatment - access increased October 2010
   - Psychological therapy - capacity and pathway in place October 2010

Outcome measures

Project area	Measures
Improve cancer awareness and early diagnosis	Baseline for population awareness in Brighton and Hove Identify the population groups and types of cancer to be prioritised Increase the number of urgent 2 week referrals Increase the proportion of new cancer cases diagnosed through urgent two week referral Increase the number of new cancer cases with no spread at diagnosis or diagnosed at an earlier stage
Bowel cancer screening	Increase rate of bowel cancers diagnosed through this route Reduce mortality rate for cancer in under 75 yrs in line with national target

Breast screening	Increase breast screening coverage to 72% by end of 2010/11 Achieve 2 week wait for breast symptomatic
Cervical screening	Increase cervical screening coverage to 77% by end of 2010/11
HPV vaccination programme	High coverage of screening programme
Chemotherapy service	Improved survival rate for cancer Continue to meet access targets in line with national guidance
Oncology response times	Reduce emergency admission rate and length of stay for oncology patients
Radiotherapy capacity	Achieve 31 day standard for subsequent radiotherapy Continue to meet access targets in line with national guidance
Effective treatment eg RFA	Reduce length of stay in hospital
Enhanced recovery programme	Reduce length of stay in hospital

Quality Metrics

Measure	Target
IOG measures	100% Compliance for IOG Peer Review
Lymphoedema	Improve experience of people living with cancer
Access to psychological support	Improve experience of people living with cancer

Principal changes in activity

10% growth for chemotherapy against 09/10 outturn;
19% growth for radiotherapy against 09/10 outturn, to achieve 40,000 fractions per 1M population;
10% growth for PET scans against 09/10 outturn;
3.25% uplift on breast screening programme;
30 MRIs for Breast Family History

Implications for workforce

Provider:

- Recruit radiographers for breast screening programme and for radiotherapy service
- Recruit radiologist for breast service
- Review medical physics services
- Recruit increase in oncologist and oncology specialist nurses to meet National Cancer Action Group's acute oncology recommendations

Commentary on financial requirements

The PCT is investing in: minimising the risk of developing cancer; encouraging early presentation, detection and diagnosis; improving the quality of local services (ensuring IOG compliance) and meeting the increase in demand for radiotherapy and chemotherapy.

Minimising people's risk of developing cancer in the first place/
Encouraging early presentation, detection and diagnosis of cancer:

- Additional £105k - Continuation of NAEDI work, promoting screening up-take and skin cancer prevention work
- Current funding £182k – Continuation of Ahead of the Game, health promotion post and Primary care audit (Local Enhanced Service)
- Bowel cancer screening age extension £275k
- Bowel cancer hub £140k
- Breast screening £70k

Providing the very best cancer treatment including faster access;

- PET scans cost uplift - 10% increase on plan
- 10% uplift for chemotherapy
- 19% uplift for radiotherapy
- Improved treatments – reprovision of activity and costs – cost neutral
- IOG Compliant Services £200k (to include lymphoedema)
- CQUINs to fund acute oncology and palliative care measures
- Estimate for horizon scanning £300k (high cost drugs)

Improving people's experience of cancer care throughout the pathway.

- Existing budget - funding Psychological support

Procurement and market management implications

Develop our local NHS services to meet national standards.

Related Vital Signs Measures/ Existing Commitments	Cancer mortality target: reducing mortality by 20% in under 75 year olds by 2010 (from 1995/96 baseline) Cancer waiting times including: Radiotherapy waiting time, 2 WW for breast symptomatic services Breast screening – age extension Bowel screening – age extension Cervical screening – 2 week reporting
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	End of Life Care – Pledge 1, 2, 3, 4 and 5

Equalities Impact

- Work to prevent cancer is targeted at the more deprived populations where lifestyle risk factors are generally higher
- A particular focus is given to promoting the up-take of cancer screening in ethnic minority groups, lesbian and bi-sexual women, and people with learning disabilities.
- The population survey using the Cancer Awareness Measure is looking particularly at the more deprived population
- Cancer early awareness work is focusing on those who are most at risk of late presentation and diagnosis

7.4.3 Managing Demand Differently

Summary

To align need, demand and capacity and ensure that a patient is assessed treated by the right person first time. Utilise the incentives in the PbC Operating Framework with:

1. Develop gateway management;
2. Develop evidence based primary care management guidelines;
3. Increasing capacity in primary care to diver referrals from secondary care;
4. Increase collaboration of practices to treat patient in primary care.

This programme aims to strengthen the primary care system, in terms of aligning incentives, building collaboration, capacity and capability, and improve performance of acute outpatients against national comparators levels.

Projects within the initiative

In 2009/10 we

- Completed one year of BICS operations
- Developed and implement the Map of Medicine

In 2010/11 we will

- Increase self care and empower patient informed decisions with appropriate information tools to manage their own care and make informed choices;
- Improved access to lifestyle advice and support throughout the care pathway;
- Support people to make an informed decision about the choice of diagnostics, treatment and therapy offered across the city from a range of providers;
- Develop gateway and referral management, integrated into the PbC Operating Framework;
- Develop evidence based primary care management guidelines for a number of key pathways
- Increase capabilities and collaboration of practices to treat patient in primary care;
- Transfer pre and post operative assessment and follow up into primary care instead of in the hospital;
- Enable more patient care to be maintained and monitored in primary care through establishing formal support, advise and guidance from consultants to reduce unnecessary visits to the hospital;
- Streamline booking systems that offer choice of provider of healthcare;
- Simple community based access to diagnostics across the city

Key Milestones

- PbC Operating Framework agreed and rolled out – March 10
- Work with BICS to identify opportunities by practices and locality – April 10
- Activity and financial reports by practice implemented, agreed referral thresholds and reviews by peer groups established – April 10
- Development of pathway guidelines – June 10
- Development of gateway process and workforce – June 10
- Establish partnership working arrangements between GPs and practices – June 10
- Sign off service improvement plan and investment – July 10
- Development of advice and guidance with consultants – August 10
- Implement service changes, including direct access to diagnostics – September 10

*Please note that this programme is linked to the out of hospital transformational programme as it

increasing the capacity of alternative clinics in the community for GPs to redirect referrals to.

Outcome measures

Measure	Measure
Delivery of activity reduction	Refer to activity section
Access targets met.	6 wks, 18 wks, 13 wks and 26 wks
Numbers of conditions for which best practice is clarified and communicated	Target being developed

Quality Metrics

Measure	Target
Patient experience feedback	Upper quartile

Principal changes in activity

Reduction in outpatient episodes of 6,784 in 2010/11 on 2009/10 figures

	Benchmarking	
Specialty Name	Reduction	Reductions £
GENERAL SURGERY	-141	-£18,762
UROLOGY	-757	-£99,488
ENT	-1,914	-£161,871
ORAL SURGERY	-493	-£48,774
GASTROENTEROLOGY	-1,219	-£199,539
CARDIOLOGY	-1,136	-£137,582
NEUROLOGY	-290	-£76,694
GYNAECOLOGY	-836	-£95,506
Total	**-6,784**	**-£838,216**

Implications for workforce

Provider:

- Primary care clinicians leadership training
- Numbers of practitioners accredited as PwSI (target: national average per 100k popn)

Commentary on financial requirements

Reduction in outpatients £838,216 saving by delivering bottom of top quartile for outpatient threshold.

Procurement and market management implications

Development of primary care market to manage increase capacity and establish inter-practice working arrangements.
Develop local enhance services following the scoping of referrals rates by speciality.

Related Vital Signs Measures/ Existing Commitments	Supports the sustainability of 18, 13 and 26 week targets. **NHS Constitution** : • To make the transition between services as smooth as possible • To provide services in a clean and safe environment which is fit for purpose
Related World Class Commissioning outcome measures	Commissioning goal 5 – commissioning nationally recognized best practice.
Related *Healthier People Excellent Care* Pledges	**SHA Pledge**: You will be able to have medical tests to help diagnose and manage your illness on your local high street or at home
Equalities Impact	
In general the initiative reduces inequalities by improving accessibility	

7.4.4 Specialised and Tertiary Commissioning

Summary

To improve the management of specialised and tertiary services.

Projects within the initiative

In 2010/11 we will

- Move the management of specific Tertiary contracts from Specialised commissioning to the Sussex Acute Commissioning Service (SACS) with a specific remit to improve the rigour of the key performance indicators and other contract management regimes

- Cardiology and Cardiac Surgery – develop pooled budgets for TAVI procedures and Pulmonary Hypertension. Commission increasing capacity in current treatments and support local provider to innovate with new technologies, to meet growth in demand for cardiac surgery

- Cystic Fibrosis – Work with Specialised Commissioning Group (SCG) to development of a new national tariff and 5 year Cystic Fibrosis strategy to respond to increased demand and change in complexity of care due to increased life expectancy of patient group.

- Haemophilia Services – engage with SCG on the national blood product tendering exercise, development of formal networks and strengthen consortium risk sharing arrangements.

- HIV services – work with SCG to ensure alignment commissioning arrangements to maximise on health outcomes and value for money. Explore the opportunity of central procurement of drugs to reduce spend and review the care pathway.

- Neurosciences – support the relocating services from Hurstwood Park in line with strategic development of BSUH as a specialist centre. Develop robust clinical pathway for head injuries and neurosurgical trauma. Improve the co-ordination of care across all patient pathways for muscular dystrophy.

- Paediatrics - action recommendations from the impact of National safe and sustainable review of paediatric cardiac surgery and neurosurgery. Work with SCG to review the configuration of paediatric surgery across SEC.

- Renal - Increasing local capacity to meet growth in demand for dialysis treatment and develop a satellite unit in Brighton. Commission increase transplant surgery in line with national guidelines and repatriate 1 month transplant follow-ups locally.

Improve the interface between primary, secondary and tertiary care in line with the CKD national framework and look to develop safer and more cost effective prescribing methods. Re-design of transport models for dialysis patients required.

- Specialised Mental Health Services – work with SCG to ensure that services will need to meet enhance standards following designation and increase capacity to meet 5% growth in demand. Develop enhanced local personality disorder services at tiers 1 – 3 to enable people to be maintained at lowest level.

- Spinal Cord Injury – work with SCH and national team to develop a national PbR tariff, review service configuration and designation to ensure timely and appropriate access to services. Reduce the number of patient treatment outside the specialist centres and improve the discharge arrangement from specialist centres.

- Ambulance services - Improve interface of local urgent care pathways with ambulance services and improve response times performance level.

- Gender re-assignment – strategy group established to review this pathway.

Key Milestones

Cardiac Surgery & Cardiology Milestones:
- SEC Strategic Group in place and process for managing new technologies being developed
- GUCH review being undertaken
- Planning assumptions for surgery being developed
- Pooled budgets planned over next 3 years

Cystic Fibrosis Milestones:
- Service specifications for paediatrics, transitional care and adult services completed and ready for ratification
- Pooled budgets planned over next 18 months
- Care pathways being developed
- 5-10 year strategy completed

Haemophilia Services Milestones:
- London leading a strategic review of London haemophilia providers to ensure continuity of care for the future
- A formal network of haemophilia centre's to be developed across SEC with Canterbury at the hub.

HIV service Milestones:
- Review of commissioning arrangements being undertaken
- Clinical network approach for inpatient services

Neurosciences Milestones:
- Develop relocation plans
- Pooled budgets for DBS and SRS being refined
- Head injuries/Trauma pathways being reviewed

Paediatrics Milestones:
- Designation of Neonatal services to take place in 2010
- Review of prices for neonatology to ensure value for money and consistency
- Re-examination of PICU arrangements for SEC
- Development of SEC specialised paediatric strategy
- Develop maternity and newborn pledges with SHA as lead

Renal Milestones
- Transplantation strategy developed, including pooled budget
- Community dialysis unit opens
- Prescribing review completed
- Transport working group established

Specialised Mental Health Services Milestones:

- Refresh the SECSCG Secure Services plan incl. needs assessment
- All units visited and aware of actions required to meet standards; continue to performance manage implementation.
- Need to consider alternative treatment locations, enhancing prison in-reach etc.
- Tier 4 PD - Work with EoE, London & South Central SCG to agree work programme and timetable to implement the Joint PCT Committee decision including commissioning a full equality impact assessment & mapping of all local services

Spinal Cord Injury Milestones

- National PbR tariff developed
- Review treatment pathways and develop options appraisal on outreach services
- Agreeing comprehensive service specification with integrated referral processes

Ambulance services Milestones:

- Interface with urgent care providers improved
- Scoped potential for single digit number & NHS pathways
- Increased skills and better pathways across system including self management

Outcome measures

Measure	Measure
Reduce in mortality rates for cardiovascular diseases	Measure to be advised by Specialist commissioning group
Increase life expectancy and improved quality of live for people with Cystic Fibrosis	Measure to be advised by Specialist commissioning group
Improved quality of life and life expectancy for people living with HIV.	Measure to be advised by Specialist commissioning group
Increase life expectancy and improved quality of live for people with Chronic Kidney Disease.	Measure to be advised by Specialist commissioning group
Improved quality of life and health outcomes for people who have had a spinal cord injury.	Measure to be advised by Specialist commissioning group

Quality Metrics

Measure	Target
Cardiac Surgery & Cardiology Metrics	• Rates of interventions such as TAVI, CABG surgery, Valve surgery • Quality metrics being developed
Haemophilia Services Metrics	Blood product usage information by pct by provider
Neurosciences Metrics	• Rates of intervention for DBS/SRS • Transfer times for head injuries/trauma

Paediatrics Metrics	• 95% of babies to remain within NICU networks Implementation of maternity and newborn dashboards
Renal Metrics:	• % increase in transplantation rates (national target) • Dialysis take-on rates • % of people on home dialysis • Renal NSF standards, including Quality metrics for vascular access, choice of modality and Transport travel times
Specialised Mental Health Services	• Benchmarking across other SCGs re: capacity and price, PbR development work
Ambulance services Metrics	• Response and handover times and clinical performance indicators. Patient experience measures/PROMS

Principal changes in activity

Principal changes in activity

Cardiac Surgery & Cardiology:
- % increase in demand
- Increase interventions such as TAVI, CABG surgery, Valve surgery

Cystic Fibrosis
- % increase in demand

Haemophilia Services:
- Blood product usage information by pct by provider

HIV service
- 10-15% increase in demand

Neurosciences:
- significant increases in demand expected
- Rates of intervention for DBS/SRS

Paediatrics:
- % increasing demand in neonatal activity as birth rate increases
- % increasing prevalence of paediatric diabetes

Renal:
- 75% increase in transplantation rates (national target)
- % increase in demand for dialysis
- % of people on home dialysis

Specialised Mental Health Services
- 5% increase in demand

Ambulance services:
- Greater than 5% increase in demand for service

Implications for workforce

Commentary on financial requirements

The activity implications noted above are the estimates provided by the Specialist Commissioning Group. We will work throughout the year to review the specialist portfolio and ensure that costs are managed within the financial envelope, which includes an additional £1m.

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Over-arching Pledges – Pledge 8

Equalities Impact

7.4.5 Increasing productivity and efficiency

Summary

We aim to reduce spend in secondary elective care by identifying realistic opportunities and systematically implementing efficiency projects via joint PCT, primary care and secondary care working.

Projects within the initiative

In 2009/10 we have

- Reviewed data, agreed measures, agreed process, rolled out to Clinical Reference Groups, reviewed productivity and worked out pilot schemes.

In 2010/11 we will implement the following pilot schemes in partnership with BSUH

- Did not attend (DNA) rates to be reduced by identifying poor performing clinics and trial reminders scheme for the three specialties
- Achieve contracted levels of new to follow up ratios for two specialties
- Reduce pre operative bed days in two specialties
- Increase day case rate for laparoscopic cholecystectomy (gall bladder removal)
- Reduce surgical variation for lumbar spine procedures.

We will also

- Work with SACS to benchmark nurse led outpatient services across the SHA prior to contract negotiations to reduce costs
- Use pharmacy support to lead on the managed entry of new drugs, medicines in commissioning, prioritisation and PBR excluded drugs with a view to managing the risks associated with non PBR costs
- Work with BSUH to develop a joint strategy for the modernization of outpatients looking at 'one stop shop clinics' for long term condition patients and centralizing/streamlining patient booking processes.

Key Milestones

• Implement schemes	June 10
• Implement pilot schemes	Q1 10/11
• Review pilots	Q4 10/11
• Roll out across specialties	2011/11

Outcome measures

Measure	Measure

Reduced DNA rate	2%
Reduced New to Follow up ratio	0.1
Reduced number of pre op bed days	40%
Increased day case rate	10%

Quality Metrics

Measure	Target
Improved satisfaction on patient survey	Measure to be developed
Improved surgical outcomes for cholecystectomy.	Measure to be developed

Principal changes in activity

Reduction in excess bed days of 512 across 2010/11

Reduction in follow up appointments of 1849 in year 1

Reduction of elective ordinary admissions of 68

Implications for workforce

PCT: None

Provider: See provider workforce plans and PWC PODS.

Commentary on financial requirements

Productivity and efficiency savings £435k.
Pharmacist costs will be funded by savings on non PBR drugs costs.

Procurement and market management implications

N/a

Related Vital Signs Measures/ Existing Commitments	18 weeks referral to treatment times. VSA04 – NHS reported waits for elective care.
Related World Class Commissioning outcome measures	N/a
Related *Healthier People Excellent Care* Pledges	Planned Care - Pledges 4,5 and 6

Equalities Impact

Will be assessed if any service changes are proposed.

7.5 Mental health

7.5.1 Promoting Mental Health and Wellbeing

Summary

Improving outcomes and reducing unnecessary demand on treatment services through focusing on well-being and prevention services.

Projects within the initiative

A. Alcohol harm prevention
In 2009/10 we
- Implemented community based brief interventions
- Rolled out an awareness project.
- Established a social marketing campaign for both the general public and specific groups.
- Developed pathways with CYPT to ensure that young people are signposted to appropriate services

In 2010/11 we will
- Commence year 2 alcohol harm prevention initiatives:-
- Rollout of 65+ work identified in findings from social marketing campaign
- Workforce development – skilling key staff
- Continuation of Safe Space project
- Improve LGBT Outreach

B. Suicide prevention
In 2009/10 we
- Implemented the action plan from the Brighton and Hove suicide prevention strategy, focusing on health promotion with at risk groups and training of key workforce.

In 2010/11 we will
- Continue with this work, with future initiatives targeting prisoners, young ex-servicemen, unemployed, victims and survivors of abuse.
- Review the impact of increased demand on services following awareness raising/staff training
- Build capacity within services to meet increased demand

C. Mental Health promotion
In 2009/10 we are currently funding a number of initiatives through Choosing Health. These will be reviewed and prioritised during 10/11 to agree future funding.
Additionally in 2010/11 we will
- Scope and develop a mental health promotion social marketing campaign
- Develop and build capacity of existing domestic abuse initiatives. Implement awareness training for staff to improve mental health services response to domestic abuse.
- Build capacity for LGBT engagement into key mental health promotion functions, e.g. planning process, meetings etc.

D. Substance misuse
We will continue to develop evidence based prevention and health promotion work including training of key workforce, running campaigns and strengthening networks.

Key Milestones

- Commencement of Year 2 alcohol harm prevention initiatives May 10
- Further rollout of suicide prevention specialist training to key workforce commences May/Jun 10

- Expansion of suicide prevention health promotion work to take forward the full remit of activity around at risk/vulnerable groups – Apr 10 – Mar 11
- Review of increased demand on services following awareness raising / training Apr 10 – Mar 11
- Scope and develop a mental health promotion social marketing campaign Apr/May 10
- Improve MH services response to domestic abuse; explore training for staff Apr 10
- Commence LGBT engagement in key functions Apr 10
- Continue rollout of substance misuse training for key staff On-going

Outcome measures

Measure	Measure
Numbers reporting better understanding of alcohol levels and report a reduction in consumption as a result of alcohol campaigns.	
Increase in numbers diverted from A&E and prevented from ambulance use or police intervention as a result of accessing Safe Space	
Numbers of recorded suicides reduced	by 20% by 2010 (from a baseline 3-year average rate in 1995/6/7)

Quality Metrics

Measure	Target
Range and reach of public information	n/a
Individual mental health promotion measures set for each of the 23 work streams	n/a

Principal changes in activity

Reduce the prevalence of hazardous and harmful alcohol consumption.
Reduce alcohol related hospital admissions.
Raise general awareness of suicide particularly among those most at risk. Skill key staff, improve working practices and reduce suicide numbers

The alcohol brief intervention service to deliver 12,000 opportunitistic interventions per year in a wide variety of community settings.

Implications for workforce

Provider: Recruit domestic violence worker
Numbers of key staff trained in suicide awareness and intervention techniques:- 48 participants from un/employment projects
48 participants from housing projects
48 participants from older people's services

Commentary on financial requirements

Alcohol – £106k additional investment
Suicide - £55k additional investment
Domestic violence worker - £70k additional investment

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSC26 Hospital admissions for alcohol related harm VSB04 Suicide and injury of undetermined intent VSB14 Number of drug users recorded as being in effective treatment.
Related World Class Commissioning outcome measures	Hospital admissions for alcohol related harm.
Related *Healthier People Excellent Care* Pledges	Mental Health Pledges 1,2,4 and 5

Equalities Impact

Individual initiatives target a range of at risk groups as well as raising awareness amongst the general public.
Target groups include:-

- 25-35 age group
- Older people 65+
- LGBT communities
- Unemployed
- Homeless
- Engaging with domestic violence services

7.5.2 Developing community pathways to support recovery

Summary

Develop primary and community services that maintain people in recovery, supporting individuals to manage their on-going mental health needs.

Projects within the initiative

In 09/10 we

- Increased the provision of treatment places for people with substance misuse issues in primary care (Shared Care NES).
- Scoped the development of a LES for patients with a serious mental illness.

In 10/11 we will

- Introduce a Serious Mental Illness LES that will support the discharge from the mental health services back into the community under primary care-based services
- Develop increased capacity and knowledge within primary care for the management of mental health issues with the introduction of a GPwSI in Mental Health
- Develop a range of community initiatives to support recovery, choice, self directed support and personalisation
- Review and realign the range of aftercare and support services including day and homecare support and support to carers
- Scope services to provide better information, support and early interventions to people with dementia
- Scope the short and long term housing options available for people with both mental health and substance misuse issues.
- Implement the dual diagnosis strategy

Key Milestones

- Implement the serious mental illness LES Apr 10
- Develop a model for a GP with Special Interests (GPwSI) in Mental Health during 10/11; service to start Apr 11
- Develop market management structure for the 3rd sector Sept 10
- Develop dementia management LES Mar 11
- Develop and implement Recovery and Re-integration plans for substance misusers including a peer-support buddying model for aftercare support.

Outcome measures

Measure	Measure
More people with a SMI managed in general practice	12 month trajectory to be agreed – final target 150 patients.
Reduced re-admissions rates for discharged patients (under the SMI LES) into in-patient beds.	Baseline to be established and improvement trajectory to be agreed
More people using direct payments	VSC17 – Adults and older people receiving direct payments and/or individual budgets
More people using self directed support	Construction and information flows to be agreed during Q1 through the Data Quality

	Improvement Plan. Target to apply from Q2.
More carers assessments and services in place	This has been included in the service development and improvement plan An increase in the % of carers receiving an assessment to ensure top quartile performance against NI135. 08/09 Top quartile threshold @ 26.4%.
More people off benefits	IAPT KPI7- the number of people moving off sick pay and benefits 10/11 target: 91
More people with a serious mental illness in work	NI 150 Adults in contact with secondary mental health services in employment (also VSC08) – over 8.94% by the end of Q4
More people who have accessed IAPT moving to recovery	10/11 – 28% of total completions
People with dementia better supported, and have more choice and control	N/A
Planned discharges from substance misuse services	45%
Reduced re-referral rates for substance misuse services	Baseline to be established and then improvement trajectory to be agreed.
Quality Metrics	
Measure	**Target**
Improve patient experience – rate of return for postcard survey scheme	25% increase above baseline
Improve patient experience – response from postcard surveys	80% choose 'agree' or 'strongly agree'
Principal changes in activity	
SMI LES: 150 treatment places in primary care; **Substance Misuse:** Planned discharges from substance misuse services (45% - 10/11) Reduced re-referral rates for substance misuse services	
Implications for workforce	

PCT:
1.0 WTE Project Management support currently allocated to Mental Health and Substance Misuse Commissioning Team will be required for 12 months to assist in delivery of above projects.

Provider:
All contracts to include staff skills and requirements.
Support for general practice to implement LES.
Workforce conditions and skill mix in 3rd sector contracts to be reviewed.

Commentary on financial requirements
Serious Mental health issue LES will be financed from existing budgets

Procurement and market management implications
Market management strategy for 3rd sector to be developed (10/11) and implemented (11/12).

Related Vital Signs Measures/ Existing Commitments	VCS 26, VSC02, VSB04
Related World Class Commissioning outcome measures	Hospital admissions for alcohol related harm. The percentage of people moving into recovery from IAPT services.
Related *Healthier People Excellent Care* Pledges	Mental Health pledges 2and 3

Equalities Impact
Review issues during 10/11 to ensure these are addressed by the GPwSI in 11/12.

7.5.3 Developing Effective and Efficient Care Pathways and Treatment Services

Summary

The development of care pathways and appropriate, evidenced-based treatment services for people who require a structured treatment intervention.

Projects within the initiative

In 10/11 we will

- Complete the ABC contract analysis to achieve costed contract with SPFT
- Agree joint commissioning plan based on need, value for money and outcomes
- Scope need, best practice/evidence base, benchmark costings for complex/specialist psychological therapies (Eating Disorders, Personality Disorders, Apsergers etc)
- Devise specifications and market management strategy for any new pathways and services
- Review alcohol brief intervention LES and volunteer alcohol counselling service and develop plan for ongoing provision.
- Review the inpatient and community services for adults and older people and for people who have dementia
- Establish incentivised elements in the main provider (SPFT) substance misuse contract in relation to key structured interventions (waiting times, planned discharges, retention) and outcome measurement reporting (TOPs)

Key Milestones

- Joint Commissioning Plan agreed by JCB in January 10 with work programmes agreed by April 10
- IAPT funding agreed by Apr 10.
- Complex/specialist psychological therapies reviewed by Sept 10
- Services for market testing to be agreed by Sept 10
- Alcohol brief intervention LES and volunteer alcohol counselling reviewed and tendered agreed by Sept 10

Inpatient and community services as commissioned through SPFT redesign agreed by Sept 10.

Outcome measures

Measure	Measure
Mental health: - commence treatment for complex psychological therapies -reduced length of stay for adult and older people in-patient stay including inpatient detox.	Referral to treatment:<70 working days Adults: <28 days Older people: Organic: <60 days Functional:<50 days
Alcohol: - waiting times for structured psychosocial interventions	90% < 21 days
Substance misuse (including alcohol): - waiting times for structured interventions - planned discharges - outcome data collection (TOPs)	90% < 21 days 45% 90%

Quality Metrics

Measure	Target
Improve patient experience – rate of return for postcard survey	25% increase above baseline

scheme	
Improve patient experience – response from postcard surveys	80% choose 'agree' or 'strongly agree'
GP experience measure	80% approval rating
Carer experience measure	80% approval rating

Principal changes in activity

Implications for workforce

PCT:
1.0 WTE Project Management support currently allocated to Mental Health and Substance Misuse Commissioning Team will be required for 12 months to assist in delivery of above projects. Additional capacity allocated for Programme Management of specialist mental health provider will be required for 12 month period to support transformation agenda.

Provider:
Service redesign to include appropriate skill mix and workforce requirements

Commentary on financial requirements

No new investment

SPT savings £341k assumed

Procurement and market management implications

Market management strategies will be developed for IAPTs and any new pathways/services.

Related Vital Signs Measures/ Existing Commitments	VSC26, VSC02, VSB04
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Mental Health – Pledge 3 Staying Healthy – Pledges 4 and 5

Equalities Impact

All changes to services will undergo an equalities impact assessment

7.5.4 Managing access to treatment

Summary
To provide an efficient and effective gateway and triage system into services.

Projects within the initiative

In 09/10 we have

- Commissioned psychological services for mild to moderate need (IAPT - Improving Access to Psychological Therapies) service with Sussex Partnership NHS Foundation Trust.
- Extended the hospital-based brief interventions alcohol service and established a community based brief intervention alcohol service to reduce alcohol related hospital admissions
- Increased support to carers of people with drug misuse problems

In 10/11 we will

- Re-commission access services (including IAPT)
- Pilot a new referral management gateway into mental health services for all routine referrals to working age mental health services
- Improve access to/response from emergency and priority treatment services
- Introduce a single assessment process for substance misuse
- Scope development of a memory assessment service to increase diagnosis and ensure improved access to services for dementia.
- Expand IAPT in-line with previous plans
- Develop additional referral pathways (including self-referral) for IAPT.

Key Milestones

- 12 month pilot of new referral management gateway completed April 11
- New access contracts to be effective 11/12
- Review gateway pilot Apr 11
- Scope memory assessment service Sept 10
- Single assessment for Substance Misuse (drugs and alcohol) Sept 10

Outcome measures

Measure	Measure
Mental Health access: - Priority assessments to be completed within 5 days of referral - Routine assessments to be completed within 20 days - Emergency referrals to be responded to within 4 hours	95% 100% 100%
WAMHS Gateway – 95% compliance with standardised referral information - <10% DNA/declines assessment (tbc)	95% <10%
Substance misuse access and engagement – problem drug users recorded as in effective treatment: 1%	

increase on 0910 – waiting times to first intervention: target 90%<21 days - engagement: % of problem drug users to be retained in treatment for 12 weeks	1% increase on figure in 09/10 90% waiting <21 days 90% retained for 12 weeks
Improved dementia diagnosis rates	Trajectory to be agreed once memory assessment service scoped

Quality Metrics

Measure	Target
Improve patient experience – rate of return for postcard survey scheme	25% increase above baseline
Improve patient experience – response from postcard surveys	80% choose 'agree' or 'strongly agree'
GP experience measure	80% approval rating
Carer experience measure	80% approval rating
IAPT completed treatments, moving to recovery, off benefits	**28%**

Principal changes in activity

Implications for workforce

PCT:
1.0 WTE Project Management support currently allocated to Mental Health and Substance Misuse Commissioning Team will be required for 12 months to assist in delivery of above projects.

Provider:
Referral management gateway pilot may involve the transfer of 1 wte from SPFT to BICS.
IAPT expansion Staff attrition will have to be offset (trained therapists) 12 staff left in 09/10.

Commentary on financial requirements

IAPTs £601k

Referral management gateway £168k (from Freed up Resources)

Procurement and market management implications

Access services including IAPT likely to be re-commissioned for 11/12 following gateway pilot

Related Vital Signs Measures/ Existing Commitments	VSC26 VSC02 VSB14
Related World Class Commissioning outcome measures	Hospital admissions for alcohol related harm. The percentage of people moving into recovery from IAPT services.

Related *Healthier People Excellent Care* Pledges	Planned Care – Pledge 4 Mental Health – Pledge 3
Equalities Impact	
Equalities Impact Assessments will be carried out on all initiatives. We will aim to improve access for minority communities via a self referral pathway, especially for IAPTs.	

7.6 Maternity & Children's services

7.6.1 Strengthening Partnerships

Summary

To ensure that working arrangements with the CYPT (Children and Young People's Trust) are effective.

Projects within the initiative

In 2010/11 we will

- Strengthen safeguarding arrangements by service level agreements with clear roles of accountability and responsibility and regular reporting to NHS Brighton & Hove Board
- Complete the review of current section 75 arrangements with support from the national commissioning support programme of the DCSF (Department for Children, Schools and Families)
- Ensure that a performance management framework is in place to monitor provider functions

Key Milestones

- New section 75 agreements in place by April 2010
- Commissioning framework agreed and implemented
- Joint commissioning group set up and dates programmed for the year
- Commissioning plans for 2011/12 agreed by winter 2010

Outcome measures

Measure	Measure

Quality Metrics

Measure	Target

Principal changes in activity

N/A

Implications for workforce

PCT:

Provider: Workforce development plan for commissioning implemented during 2010

Commentary on financial requirements

Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	Commissioning Goal 2 - Maximising life chances for children and families Commissioning Goal 4 – promoting independence
Related *Healthier People Excellent Care* Pledges	HPEC Pledge on urgent care
Equalities Impact	

7.6.2 Access and settings of care

Summary
To provide care in the most appropriate setting and improve access for children and young people in the city.

Projects within the initiative

- Ensure that high volume conditions such as head injury, gastroenteritis and respiratory illness are managed in the most appropriate environment
- Link in with urgent care strategy communications to ensure that families have clear knowledge of services available
- Empower families and carers to be able to self care for children with long term conditions through the dissemination of advice and information
- Develop training programmes for health professionals who support children and young people outside of hospital
- Review out of area referrals to determine if services can be provided locally
- Review current pathways for children with long term conditions to determine how community capacity can be strengthened

Key Milestones

- Ensure high volume conditions are managed in the right setting - ongoing
- Provide training to health visitors and community staff - Jan 2010
- Develop leaflets and information fro parents and carers – Jan/Feb 2010
- Develop information for primary care – Jan /Feb 2010
- Establish activity levels for other high volume conditions – March 2010
- Implement strategies for enabling parents/carers and families to self care for high volume conditions – April- Sept 2010

Outcome measures

Measure	Measure
Reduction in emergency attendances and admissions realised through urgent care workstream	

Quality Metrics

Measure	Target
Social Marketing initiated to obtain users views	

Principal changes in activity

Reduction of 10% paediatric emergency attendance in 2011 as a result of initiatives

Implications for workforce

PCT:

Provider: Train community workforce (Health Visitors) to support families

Commentary on financial requirements

No new investments/costs	
Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Health – Pledges 1 and 3
Equalities Impact	
Equalities Impact Assessments will be completed as new services are commissioned.	

7.6.3 Children & Adolescent Mental Health Services (CAMHS)

Summary

To ensure that a comprehensive CAMHS service continues to be provided for children and young people.

Projects within the initiative

In 2009/10 we

- Ensured waiting time targets met for accessing the service
- Developed an Urgent help team
- Opened a unit at Chalkhill for high risk/severe needs cases
- Began a 12 month pilot of a joint pathway with one point of referral
- Implemented a new model of service for 14-25 year olds
- Implemented new care pathway for looked after children/children in care access to CAMHS

In 2010/11 we will

- Continue to improve support to children and young people with emotional or mental health and their families focusing on:
    - Reviewing the tier 1 & 2 Pathway for school aged children and young people taking account of the Targeted Mental Health in Schools pathfinder
    - Increase psychological support for children with long-term conditions including chronic fatigue syndrome.
    - Palliative care psychological support for children and families

Key Milestones

New pathway developed over the next year in consultation with schools in the light of the targeted mental health in schools project for implementation phased approach starting in Sept 2010 and then in academic year 2011/12

Outcome measures

Measure	Measure
My class my feelings measurement to be offered to all schools	
Sociogram measurement to be offered to all schools	

Quality Metrics

Measure	Target
Evidence based approaches to be offered to schools building on the outcomes from the TaMHS project	
Feedback from pupils teachers parent carers re outcomes/satisfaction	

Principal changes in activity

Provision of more group work and more consultation and training support from area schools and community teams

Implications for workforce

Provider: Workforce development plan for school based staff	
Commentary on financial requirements	
Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Services – Pledges 1,2 and 3
Equalities Impact	
We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.	

7.6.5 Early intervention and prevention

Summary
To improve early intervention and prevention in community based health care services for children and young people and their families.

Projects within the initiative

- The implementation of the Healthy Child Programme including the health of looked after children and the key public health priorities of uptake of immunisations, reducing childhood obesity and uptake and maintenance of breastfeeding.
- Reviewing engagement between integrated front line services provided and primary health care services and acute services for children and young people
- Breastfeeding
- Immunisation
    - Complete the HPV catch up
        - Work with CYPT, GPs and school nursing team to review the appropriate service model for the school leaving booster
        - Work with CYPT specialist immunisation team when operational to reduce the differences in immunisations uptake.

Key Milestones

- To set up a healthy child programme steering group in Jan 2010 to plan programme of work to monitor and oversee implementation of recommendations.
- To recruit breastfeeding support worker for disadvantaged areas.
- Complete HPV catch up – Sept 10
- Develop appropriate service model of school leaving booster – Jun 10

Outcome measures

Measure	Measure
Increase in breastfeeding coverage and prevalence rates at 6-8 weeks in line with national targets	Prevalence 69.7% Coverage 95%
Increased uptake of immunisations: One year old completed immunisation for baby imms	92%
Two year old completing booster	87%
Two year old completing MMR	87%
5 year old completing imms excl MMR	80%
MMR 2	76%
12-13 year old girls completing HPV	90%
13-18 year olds completing school leaving booster	75%

Quality Metrics

Measure	Target

Target re increasing breastfeeding rates in more disadvantaged areas	
Increase immunisation coverage	

Principal changes in activity

As outcome measures

Implications for workforce

PCT:

Provider: Additional 0.4 WTE post

Immunisations: Posts to be recruited to in CYPT to include:1 etw Band 7, 1 wte Band 4, 0.6 wte Band 3 clerk, 1 wte Band 2 clerk

Commentary on financial requirements

Breastfeeding £62k investment via choosing health funding

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	Reducing childhood obesity
Related *Healthier People Excellent Care* Pledges	Children's Health – Pledges 1, 2 and 3 Maternity and Newborn – Pledge 6 Staying Healthy – Pledge 1

Equalities Impact

We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.

7.6.6 Youth service provision

Summary

To review and enhance the design of youth service provision across the partnership

Projects within the initiative

- Building on the work that has already taken place to date including the development of the Integrated Youth Support Services, the Teenage Pregnancy Action Plan 2009, the Alcohol and Substance Misuse Strategies and the development of 14-19 provision; and
- Including as appropriate a service redesign process with stakeholders and service users

Key Milestones

- To scope the redesign piece of work and develop a project plan by April 2010
- To achieve key milestones in the teenage pregnancy action plan
- To develop a joined up action plan across NI II5 (related) reduction of alcohol and drugs use in year 10 young people.
- To achieve key milestones in the NI 115 joined up plan

Outcome measures

Measure	Measure
To reduce the conception rate	by 45 percent from baseline year of 1998 to 2010 within 15 to 17 /1000 age group
Increase in young parents EET (education, employment and training status)	
Reduction in young people self reporting frequent substance use (including legal highs).	
Targeted teenage pregnancy interventions	demonstrating a intervention outcome profile of 50% by end of 2010 and increasing to 80% by 2011
Young people's substance misuse service	achievement of the 80% treatment outcomes profile.

Quality Metrics

Measure	Target
Evidence based approaches applied to services / actions delivered under the action plans.	
Annual Service user questionnaires	
Auditing process for teenage pregnancy and substance misuse agenda.	

Principal changes in activity

Implications for workforce
PCT: **Provider**: Effective intervention packages reviewed and updates attached to teenage pregnancy and substance misuse annually. Workforce development plan (or training strategy) for teenage pregnancy and substance misuse across wider CYPT partnership

Commentary on financial requirements
Sustained commitment from PCT budgets and Area Based Grant. New Choosing Health Budget £55k

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSB08 Teenage pregnancy
Related World Class Commissioning outcome measures	Under 18 conception rate
Related *Healthier People Excellent Care* Pledges	Children's Health, Pledges 2,4 and 5

Equalities Impact

7.6.7 Improve support to children and young people with a disability or complex health needs and their families

Summary

Deliver improved outcomes for children with disabilities and complex needs.

Projects within the initiative

- The implementation of the Every Disabled Child Matters programme
- The review the 2005 Joint Commissioning Strategy for children with a disability and/or special educational needs, including as appropriate a service redesign process with stakeholders and service users

Key Milestones

- A project plan to take forward this piece of work will be produced in the new financial year when strategic commissioner is back from maternity leave
- Produce action plan – May 2010
- Implement actions – May 10 – Apr 2011

Outcome measures

Measure	Measure
Fulfilling obligations within EDCM charter	

Quality Metrics

Measure	Target

Principal changes in activity

Not known

Implications for workforce

Provider: Reviewing skill mix within disability service

Commentary on financial requirements

£325k savings from Chailey contract
Funding for disabled children's therapies will be reviewed on an on-going basis

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	

Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Services – Pledge 1
Equalities Impact	
We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.	

7.6.8 Childhood Obesity

Summary

A combination of diet/nutrition and physical activity initiatives are being developed to support children and young people remain fit and active and maintain a healthy weight. Weight management services will target those most in need.

Projects within the initiative

In 2009/10 we have developed a range of diet/nutrition and physical activity initiatives to support children and young people to remain fit and active and maintain a healthy weight. These include:

- Free swimming (with the Local Authority)
- Access to food growing, dietary advice, play and physical activities in areas of inequalities
- Courses in schools for 5-7 and 13-18 year olds in areas of inequalities
- Healthy Choice Award: engaged businesses and food outlets, youth settings, parks etc to offer healthy food choices.
- Implemented protocol and management guidelines for health visitors

In 2010/11 we will:

- Evaluate the impact of existing schemes using the National Obesity Observatory (NOO)
- Deliver weight management training for health visitors, school nurses and youth workers
- Implement weight management clinics with multi-disciplinary teams providing assessment and 1 to 1 weight management in community settings
- Implement Year 2 actions from Childhood Obesity Action Plan taking into account any actions required from the N.O.O evaluation

Key Milestones

- Evaluate the impact of existing schemes using the National Obesity Observatory (NOO) Feb 10 and amend schemes as appropriate.
- Deliver weight management training for health visitors, school nurses and youth workers Feb 10
- Implement weight management clinics with multi-disciplinary teams providing assessment and 1 to 1 weight management in community settings Feb 10
- Implement Year 2 actions from Childhood Obesity Action Plan (to be expanded) from Apr 10 (these are the continuation of year 1 actions as noted above).

Outcome measures

Measure	Measure
Prevalence of obesity	year 6 (10-11 y.o.) 17.5%, reception 8.5%

Quality Metrics

Measure	Target
NOO measures will be implemented with providers.	
Customer satisfaction measure to be developed as part of weight management.	

Principal changes in activity

No. of year 6 recorded = 2,004 (90%)
No. of reception recorded = 2,273 (93.7%)

Implications for workforce

Provider: Weight management training for health visitors, school nurses and youth workers.

Commentary on financial requirements

£50k to re-instate MEND funding

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSB09 (Year 6 + reception) LAA (Year 6 only)
Related World Class Commissioning outcome measures	Reducing childhood obesity
Related *Healthier People Excellent Care* Pledges	Staying Healthy Pledge 1 Overarching Pledge 5.

Equalities Impact

Equalities Impact Assessment has been completed.

7.6.9 Transforming Maternity Services

Summary

To support women and their partners prior to conception, throughout the pregnancy and post delivery to optimise a healthy, normal birth. To support the family in those early years to maximise life chances and address inequalities.

Projects within the initiative

In 2009/10 we have

- Developed the maternity pathway to ensure that we meet national best practice and the needs of vulnerable groups
- Worked towards meeting targets on consultants on labour wards (met), support for women by a midwife through labour and birth, informed choice about place of birth and high quality postnatal care.
- Implemented combined screening for Downs syndrome at BSUH.

In 2010/11 we will

- Ensure that pre-conception and pre-natal education is available to maximize healthy foetal development and normal childbirth. We will focus in particular on making contact with women from vulnerable groups.
- We will aim to reduce elective caesarean sections by education and improved midwifery support, promoting normal birth.
- Improving personalised care and support of women during labour and birth.
- We will review access to specialist mental health services with a view to informing commissioning intentions from 2011/12.

Breastfeeding initiatives are covered under the Children transformational initiatives.

Key Milestones

- Establish an enhanced service for GPs to provide pre-conceptual care 1/04/11
- Set up services with providers to provide specialist pre-conceptual advice for specific groups eg teenagers, LGBT community, people with learning or physical disabilities 1/04/11
- Review and agree a service specification for antenatal education 1/09/10
- Procure a new antenatal education service 1/04/11
- Evaluate the options to establish a midwifery led unit within the City 1/04/11
- Complete needs assessment and service review for specialist mental health services 1/04/11
- Implement action plan (already agreed) to reduce caesarean section rate 1/04/11

Outcome measures

Measure	Measure
Reduce c-section rate	from 30% 0910 to 29% 1011.
12 week referral rate to a midwife	90%.
Ratios of births to midwives	1:30.

Quality Metrics

Measure	Target

Principal changes in activity

Caesarean sections reduced by 10 (1%)
Downs screening impact activity 3,182 from specialised contract to BSUH

Implications for workforce

PCT:

Provider: Midwife working arrangements and shift patterns to be examined.
Target ratios of midwifes to births to be achieved.

Commentary on financial requirements

No new investment.
Full year effect of Downs syndrome screening is £106k cost and £238k saving in 10/11.
Reduction in c section – savings £21k

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	Department of Health ' Maternity Matters: Choice, Access and Continuity of Care in a Safe Service' Key principles: • By the end of 2009, the national choice guarantees will be available to all women and their partners. This will ensure women and their partners are given the opportunity to make well- informed choices throughout pregnancy • Modernisation of maternity services : Antenatal and postnatal care is personalised to adapt to individual needs • Reduction inequalities and reaching out to vulnerable groups
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Maternity and Newborn – Pledges 1,2,3,4,5,6

Equalities Impact

Focus on improving access amongst vulnerable groups. Ensure specialist pre-conceptual care and parenting advice is available for specific groups.

7.7 Public health

7.7.1 Sexual Health

Summary

To increase early detection and treatment of infections including Chlamydia and HIV. To improve access to services in community settings and support victims of serious sexual assault.

Projects within the initiative

In 09/10 we

- Increased access to Long Acting Reversible Contraception (LARC) through the community contraception service and primary care
- Started process to reprovide sexual health services to Brighton Station Health Centre
- Explored options for the development of a local Sexual Assault Referral Centre (SARC)

In 10/11 we will

- Ensure that the proportion of young people screened for chlamydia will double from 2008/9 levels to achieve 35%
- Increase the capacity of Level 2 sexual health services in the community
- Ensure that victims of rape and sexual assault have timely and supported access to a local sexual assault referral centre (SARC)

Key Milestones

- Level 2 service commences at Brighton Station Health Centre Apr/May 10
- SARC service procured and commenced Apr 2010
- Tender for a revised Chlamydia screening service date to start April 11

Outcome measures

Measure	Measure
VS NI 113 – Chlamydia prevalence screening	35% 15-24 year olds
Patients requiring an appointment at GUM to be seen within 48 hours	100%
Requirement that residents have access to SARC	

Quality Metrics

Measure	Target

Principal changes in activity

10% reduction in activity which amounts to 2,154 appointments

	10% reduction (GP led health centre)
First	-1,419
Follow up	-735
Grand Total	-2,154

Implications for workforce

Provider: Chlamydia – dependent on retendering of SDH contract (impacts 3 wte band 5/6)
Impact of GUM services at BSUH to be assessed

Commentary on financial requirements

Reprovide level II sexual health service costs £238k, savings BSUH £261k,

Sexual Assault Referral Centre £66k

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSB13 Chlamydia prevalence (screening) CQC target – Access to GUM clinics
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Health – Pledge 4 Staying Healthy – Pledge 2

Equalities Impact

Addressed in the JSNA for Sexual Health completed Dec 09.

7.7.2 Stop Smoking

Summary

To improve life expectancy by developing and increasing the capacity of our smoking cessation service.

Projects within the initiative

In 2009/10 we have:

- Reviewed our stop smoking services with the South East Tobacco Control Team.
- As a result of this review, restructured the specialist service to ensure focus on targets.
- Expanded the intermediate service provided by GP practices to 90% of practices.
- Trained staff in five more pharmacies to provide an intermediate service

In 2010/11 we will:

- Train nurses in SPFT to run an intermediate service
- Run the specialist and intermediate services to meet specific outcomes.

Key Milestones

- Appoint to a new Tobacco Control Coordinator post, jointly with the local authority, to be responsible for the Tobacco Control Alliance, young people and smoke free homes. Advertise January 2010 and appoint 01 April 2010
- Train nurses in SPFT to run an intermediate service from April to July initially, then provide quarterly updates and further training when needed
- Maintain an intermediate service in 90% of GP practices and increase numbers of pharmacies offering an intermediate service. From April 2010.
- Provide additional evening groups to suit commuters and all those unable to attend during the working day. From April 2010.

Outcome measures

Measure	Measure
4 week Quitters	2029

Quality Metrics

Measure	Target
Specialist services achieving a 60% quit rate:	62%
Intermediate services achieving a 50% quit rate:	52%

Changes to	Net £k*	
Principal changes in activity		
As a result of restructure from April 2010 the specialist team will be able to work more flexibly, offering more evenings and group sessions. The restructure will also be double admin capacity allowing the specialist team to concentrate on helping people quit rather than monitoring and paperwork.		
Implications for workforce		
Provider: New Tobacco Control Coordinator Post (joint with council). Training will be undertaken with SPFT nurses.		
Commentary on financial requirements		
£25k investment from Public Health budgets.		
Procurement and market management implications		
Related Vital Signs Measures/ Existing Commitments	LAA : N1.115 Young People's Substance Misuse VSB05 - Stopping Smoking	
Related World Class Commissioning outcome measures		
Related *Healthier People Excellent Care* Pledges	Staying Healthy – Pledges 3 and 4	
Equalities Impact		
The service will continue to target areas of inequalities, manual and routine workers and pregnant women.		

7.7.3 Health Care Acquired Infections

Summary

NHS Brighton and Hove currently provide leadership across the local health economy on Healthcare Acquired Infections (HCAI) through the work with partner organisations and the healthcare Infections action group.
This on going work is monitored through the local health economy healthcare acquired infection prevention and control plan and aims to reduce the incidence of Clostridium Difficile (C Diff) and Incidence of methicillin resistant Staphyloccus aureaus (MRSA) in the local health economy (LHE)

Projects within the initiative

In 2010/2011 we will continue to :

Lead the local health community in the reduction of healthcare acquired infections (HCAI) health by ensuring a local health community HCAI monitoring and action plan.

To do this we will:

- Ensure that HCAI penalties in contracts work is on going through the commissioned organisations providing information and evidence through monthly performance monitoring;
- Continue actions on root cause analyses (RCAs) through the established processes across the LHE led by the PCT;
- Continue RCAs for all community acquired C Diff patients if they live in a care home/nursing home.
- Grant ward which looks after C.Diff patients will be continued;
- Do antibiotic review in all RCAs, and antibiotic point prevalence surveys to ensure adherence to the BSUH antibiotic prescribing policy;
- Continue Trust hand hygiene audits with reporting to the weekly action group;
- Continue (RCAs) of all MRSA bacteraemia and all significant hospital acquired and community acquired C.Diff infections.
- E discharge form to be developed and implemented, and to include information on HCAI
- Infection Control Champion Training to expand to cover other practitioners
- Infection Control Nurse Specialist employed by the PCT, who has been in post for just over a year who supports ongoing work.

Key Milestones

- Community RCA summary to be presented monthly to the HCAI action group.
- Monthly reports of hand hygiene audits to the weekly HCAI action group.
- E Discharge Form to be in place by Summer 2010
- Other actions ongoing

Outcome measures

Measure	Measure
Reduction in the rate of MRSA healthcare acquired infections (VSA01)	**NHS Brighton & Hove PCT target (LHE) April 2010 – March 2011 is 11 (Proposed submission to**

	SHA January 2010)
C. Diff three year local target agreed (VSA03)	**NHS Brighton & Hove PCT target (LHE) April 2010 – March 2011 is 193 (Proposed submission to SHA January 2010)**

Quality Metrics	
Measure	**Target**

Principal changes in activity

Implications for workforce
Staff are in place to provide leadership, commissioning expertise, training and analytical skills for the continuing reduction of healthcare acquired infections (HCAI). These roles are clearly defined and are accountable to the Director of Infection Prevention and Control (DIPC) Each organisation across the local health economy has a clinical lead for nursing, an infection control nurse and infection control champions. These roles are supported by administrative support, analytical expertise, pharmacy and microbiology. There are specific responsibilities for liaising with commissioning services and completion of root cause analysis. Contractual arrangements are in place which include organisations having measures in place to ensure that the local health economy workforce have mandatory training arrangements, awareness of infection control policies such as hand washing and dress code. The local health economy infection control group meet weekly to monitor weekly information, share lessons leant, and ensure robust processes in place to manage reviewing of C Diff and MRSA related deaths.

Commentary on financial requirements

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	A healthcare outcome target – MRSA Infection rate Vital Sign Tier 1 VSA 01Incidence of Clostridium Difficile (C Diff) Number of C Diff infections for patients aged 2 or more VSA 03 Incidence of methicillin resistant Staphyloccus aureaus (MRSA)

	Number of MRSA infections
Related World Class Commissioning outcome measures	MRSA infection rate
Related *Healthier People Excellent Care* Pledges	Overarching HPEC pledges 1 and 2 By 2011 there will be no avoidable cases of hospital acquired MRSA By 2011 there will be less than 2,000 cases of C Diff per annum across South East Coast.
Equalities Impact	

7.7.4 Prevention of cardiovascular disease and detection of abdominal aortic aneurysms

Summary

Includes initiatives contributing to improving life expectancy: NHS health checks, adult obesity, CVD prevention and AAA screening.

Projects within the initiative

In 2009/10 we have:

- Launched community based and workplace based NHS Health Checks
- Launched NHS Health Checks in general practices (PBC lifestyle incentive scheme and a LES)
- Submitted a bid for funding to established AAA screening (with East Sussex PCTs and BSUH)
- Developed an Adult Obesity Framework and reviewed commissioning intentions

In 2010/11 we will:

- Increase the number of Health Checks
- Introduce Abdominal Aortic Aneurysm (AAA) screening for men over 65.
- Pilot a Bariatric Surgery Lifestyle Programme
- Improve the Healthy Weight Referral Scheme (including community weight management services) and exercise referral services

Key Milestones

- Launch revised CVD prevention LES Apr 10
- Establish regular data collection to support monitoring of Vital Sign VSC23 Apr 10 (dependent on agreement of national dataset)
- Review commissioning of community and workplace based NHS health checks Oct 10
- With BSUH, begin AAA screening programme (timescale dependent on bid approval)
- Retender adult obesity contracts as appropriate.

Outcome measures

Measure	Measure
NHS Health Checks (VSC23 from Apr 10)	4,300
Uptake of AAA screening :	60%
Adults supported per year Shape Up	900
Referrals to exercise referral scheme	1,000
Healthy Weight Referral Scheme referrals	1,500

Quality Metrics

Measure	Target
Weight management % measured at 6 months	
KPIs for NHS Health Checks are expected to be issued by 2010/11	

% of currently inactive patients referred to the Exercise Referral Scheme demonstrating an increase in physical activity levels	
Uptake and coverage of AAA screening programme	

Principal changes in activity

Implications for workforce

PCT:

Provider: We will deliver more training to support delivery of NHS Health Checks.
We will need to plan for the workforce impact of fully implementing Health Checks by 2012/13

Commentary on financial requirements

AAA screening £20k cost
Adult obesity initiatives £61k from Choosing Health budgets

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	NHS Health Checks in 2010/11 NHS Operating Framework and NHS Constitution (consultation underway) AAA screening is a national programme Links to: VSB09 – Childhood obesity VSB01 – All age all cause mortality VSB02 CVD mortality rate VSC23 Vascular risk/NHS Health Checks
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Staying Healthy – Pledge 1 Overarching Pledges – Pledge 8

Equalities Impact

Commissioning will reflect unequal burden of CVD across population groups
Equalities Impact Assessments to be conducted where appropriate
Uptake of services to be monitored by demographic and other groups

7.7.5 PCT Emergency Preparedness & Resilience

Summary

The NHS Annual Operating Framework for 2010 – 2011 lists Emergency Preparedness as one of its main priorities, and provides detail as to how and why this must be addressed by NHS organisations. This involves being prepared for and properly able to respond to Major Incidents and Emergencies, and also being resilient to threats to PCT processes and operations in terms of Business continuity.

The PCT recognises the significance and responsibility of its duty to be proficient in these areas as a 'Category 1 Responder' as defined in the Civil Contingencies Act 2004 (CCA).

The projects listed in this initiative are work-streams determined by the National Operating Framework, the CCA, NHS Business Continuity and Emergency Planning guidance, & SHA Audit.

Projects within the initiative

1. Leading the PCT's Business Continuity (BC) review, so as to implement an updated BC plan and systems conforming to BS25999 by March 2011, to ensure resilience to threats such as severe weather.
2. Further linking of Business Continuity to PCT Risk Management systems so as to ensure that related risks are identified to risk registers and managed appropriately.
3. Participate in suitable training and exercises to improve staff awareness and plan appropriately.
4. Develop and review of other PCT Plans including Emergency, Heatwave, Pandemic Influenza and Winter Surge / Escalation Plans and Mass Vaccination strategies to ensure relevance and appropriateness.
5. (Following the 1st & 2nd waves of Pandemic Influenza), a detailed city-wide review will be led by the PCT.
6. Linking the PCT's preparedness and resilience to emerging work on Climate Change & PCT sustainability, including local multi-agency response to flood-planning.
7. Participate in the SEC SHA Mutual Aid Plan which is due for review.
8. Develop a more detailed understanding of issues such as Radiological Biological Radiological and Nuclear (CBRN), Terrorism, Fuel or Supply Disruption threats to the community, and involvement in a local multi-agency response to these threats.
9. Ensure that Providers and contractors are similarly prepared and resilient.

Key Milestones

1. Business Continuity Review (31/3/11)
2. Linking of Business Continuity to PCT Risk Management systems (31/3/11)
3. training & exercises. (Ongoing – annual)
4. Plan development and review of PCT Plans. (Ongoing – annual)
5. City Flu Plan review (31/12/10
6. Link resilience to Climate Change & sustainability issues. (31/3/11)
7. SEC SHA Mutual Aid review. (31.12.10)
8. CBRN, Terrorism, Fuel or Supply Disruption threats. (Ongoing – annual)
9. Provider / contractors resilience. (ongoing contract reviews)

Outcome measures

Measure	Measure

BC Plan	BS25999 Compliance
SHA EP Audit	SHA Compliance

Quality Metrics	
Measure	**Target**

Principal changes in activity

Implications for workforce
PCT: **Provider:** Dependant on their current level of resilience awareness, training and implementation.

Commentary on financial requirements
Implementation of this initiative has minimal cost impact on the PCT. However the cost implication of not conforming to legislation, not being resilient to business threats, or not ensuring that providers & contractors are similarly resilient could be catastrophically high.

Procurement and market management implications
Business Continuity includes the concept that an organisations level of preparedness & resilience depends partly on that of its supplying organisations and stakeholders. The PCT must ensure that commissioned services and supply contracts require the provider to engage in and practice business continuity.

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact

7.8 Cost saving programmes

7.8.1 Use of System Levers

Summary

We will review contractual and other system levers which will help us identify savings and efficiencies with our provider organisations. This will include a review of the timescale for discussions with providers and implementation of contract changes.

This work will be informed by reviews of service quality, performance and benchmarked cost. We will review performance in areas such bed and theatre utilisation, levels of referrals, admissions and attendances, bed days and length of stay.

Adherence to contract rules and use of the Commercial Support Unit (CSU) will also be key features of this programme and will be managed through Quality and Delivery Boards.

The work will identify 'quick wins' in terms of savings. It will also produce longer term savings supported by implementation/delivery plans which will feed into procurement, contracting and market management processes, organisational development and workforce plans, and enabling strategies such as estates and IM&T.

Projects within the initiative

Initiate discussions with South Downs Health regarding economies of scale and corporate overheads

Collation and analysis of data on provider service performance and service benchmarking

Discussions to start with BSUH regarding plans for capacity reduction supported by redesign proposals

Review of provider performance against contracts and identification of challenges

Review of non PbR agreements to identify potential areas of cost reduction

Continued review of provider contracts

Key Milestones
(dates required)

- Initiate discussions with South Downs Health regarding economies of scale and corporate overheads – March - April 2010
- Collation and analysis of data on provider service performance Q1-2 2010
- Discussions to start with BSUH regarding plans for capacity reduction supported by redesign proposals – April 10 and ongoing
- Review of provider performance against contracts and identification of challenges – All quarters
- Review of non PbR agreements to identify potential areas of cost reduction – All quarters

Outcome measures

Measure	Measure
Achievement of productivity metrics	Range of measures to be implemented under Enhancing Quality

Quality Metrics	
Measure	**Target**
Implementation of phased savings from better care, better value metrics including new to follow up ratios, reduced length of stay, increased day surgery rates and pre-operated bed delays	To achieve top quartile performance in key areas

Principal changes in activity
Not yet known

Implications for workforce
Internal provider efficiencies to be generated

Commentary on financial requirements
£1.6m from SDH already identified. Other savings to be scoped for 2011/12 onwards

Procurement and market management implications
No specific procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	Current contract standards include a range of measures to contract for improved performance, improved coding/data management/CQUIN measures for improvement
Related World Class Commissioning outcome measures	No specific link to priority health outcome measures
Related *Healthier People Excellent Care* Pledges	Use of system levers will cut across all aspects of provider activity but not specifically

Equalities Impact
No direct impact on equalities

7.8.2 Corporate efficiency

Summary

We will undertake a systematic review of our back office, support functions, management costs and accommodation to identify where efficiency savings can be made. The PCT will develop and implement a revised organisational structure in line with national and regional targets for management cost reductions.

The work will identify 'quick wins' in terms of savings. It will also produce longer term savings supported by implementation/delivery plans which will feed into procurement, contracting and market management processes, organisational development and workforce plans, and enabling strategies such as estates and IM&T.

Projects within the initiative

Collation and analysis of financial data, including in year non-recurrent planned and generated savings.

Implementation of Sussex Commissioning Support Unit (SCSU) in line with Sussex wide plans

Discussions to start with partner organisations regarding potential for shared services and facilities.

Review in year non-recurrent savings to identify which can be made recurrent.

Review current and future accommodation requirements and new ways of working to identify opportunities for rationalising accommodation and sharing with local authority and other partner organisations.

Scope opportunities, implement and develop options for reduced management costs inline with locally set SHA targets.

Key Milestones
(dates required)

- Collation and analysis of financial data, including in year non-recurrent planned and generated savings. – Q1-2
- Implementation of Sussex Commissioning Support Unit (CSU) in line with Sussex wide plans – Dates April – September 2010.
- Discussions to start with partner organisations regarding potential for shared services and facilities. – Q1 and ongoing
- Review in year non-recurrent savings to identify which can be made recurrent. - Q1
- Review current and future accommodation requirements and new ways of working to identify opportunities for rationalising accommodation and sharing with local authority and other partner organisations. Q2
- Review overall management costs and agree revised management cost profile Q1, Q2 benchmark back office functions including staffing mix and costs
- Implement revised management structure Q3/Q4 inline with phased reductions.

Outcome measures	
Measure	**Measure**
More efficient and effective use of corporate resources to support commissioning	
Quality Metrics	
Measure	**Target**
To reduce management costs in line with national operating plan guidance	30% management and agency cost reduction by 2013/14
Principal changes in activity	
No specific activity related changes	
Implications for workforce	
The PCT will re-align its workforce in-line with the required reduction in management cost profile	
Commentary on financial requirements	
Indicative £1.2m target identified, including CSU saving. Final target to be agreed following agreement across SHA.	
Procurement and market management implications	
No specific impact identified	
Related Vital Signs Measures/ Existing Commitments	To reduce our management costs to the agreed national standard
Related World Class Commissioning outcome measures	No specific priority outcome measure
Related *Healthier People Excellent Care* Pledges	None
Equalities Impact	
No direct impact	

7.8.3 Targeted Spend Review

Summary

We will undertake a structured, phased review targeting the areas of highest spend identified in our programme budgeting analysis

The review will focus on existing spend in these areas rather than on new investment.

The work will produce a strategic response for reducing spend in each of our high spend areas, specifically improved cost effectiveness and demand management. This response will be supported by implementation/delivery plans which will feed into procurement, contracting and market management processes, organisational development and workforce plans, and enabling strategies such as estates and IM&T.

Projects within the initiative

Further analysis of programme budgeting data and triangulation with other benchmarking data sources

Scoping of overall programme and project initiation

First phase of reviews and implementation plans mental health disorders and infectious diseases

Key Milestones

- Further analysis of programme budgeting data and triangulation with other benchmarking data sources – Q1 and ongoing
- Scoping of overall programme and project initiation – Q1 and ongoing
- First phase of reviews and implementation plans (mental health disorders and infectious diseases) Q1 and ongoing
- Specific Care Pathway review

Outcome measures

Measure	Measure
To reduce areas of highest spend and improve outcomes in key areas	Reduced spend in Infectious Diseases by £500k

Quality Metrics

Measure	Target
To improve overall outcomes for reduced investment	

Principal changes in activity

Not yet known

Implications for workforce

- Potential reduced provider workforce

Commentary on financial requirements

Our plans for 2010/11 are focused on two areas.

Infectious Diseases (Sexual Health Services). This will clarify the actual spend and facilitate benchmarking from clarification to hosting arrangements and identify further opportunities for improving VfM.

Working with SPFT in the redesign of services initially to enable the IAPTS funding (£601k) to be absorbed within the existing funding of Mental Health Services. The PCT is preparing for a further drop in IAPTS funding in 2011/12. The joint working will lead to further benchmarking to ensure VfM.

Procurement and market management implications

Implications

Related Vital Signs Measures/ Existing Commitments	Implications to be assessed following individual reviews
Related World Class Commissioning outcome measures	No specific measures identified
Related *Healthier People Excellent Care* Pledges	None identified

Equalities Impact

No direct impact

8 Enablers

8.1 Working with patients, public, clinicians and local partners

Summary

NHS Brighton & Hove has a well established, innovative programme of patient, carer and public engagement and involvement. This programme supports service commissioning and development by:

- capturing feedback on the quality of healthcare services; and
- helping the organisation listen to a wide range of public views when assessing need, agreeing priorities, designing health services, and reviewing service quality.

Projects within the initiative

In 2009/10 we have:

- established the 'Talking with parents' project to develop a vision of how maternity services could be in Brighton and Hove
- established (or expanded) contracts (or agreements) with third sector 'Gateway' organisations to provide two-way dialogue and engagement mechanisms between the PCT and the following communities: Black & Minority Ethnic people, Lesbian, Gay, Bisexual & Transgender people, Disabled people, Older people, Carers, People experiencing Mental ill Health, Parents of Disabled Children, People of Faith and People with learning disabilities
- signed the PCT up to the Community Engagement Framework via the Stronger Communities Partnership which underpins how multi-sector partners will work together
- piloted 'Picker' hand-held devices to do digital questionnaires in hospital departments
- piloted the use of a 'pink camper van' with a video camera inside to go around the City and record people's views on a variety of health subjects.
- Joined with the City Council and Police in successfully tendering the City Citizens' Panel 'Exchange'
- held a 'healthy living day' open to the public with NHS organisations and key Community and Voluntary sector
- implemented the new national complaints legislation and guidance, and merged the PALS and complaints teams and function;
- 18 Week Patient group identified how best to communicate 18 weeks to Brighton and Hove patients. It engaged clinicians and managers in improving the quality of patient experience and enabled vulnerable groups to understand and benefit from faster patient journeys;
- piloted 'Information Prescriptions' in 4 GP surgeries, plus a number of other sites/services with joint NHS & City Council funding;
- piloted volunteer run 'PALS information Centres' in two GP surgeries;
- continued to develop the Expert Patients Programme (EPP) including mental health and a carer specific course

In 2010/11 we will:

- evaluate 'information prescriptions' and consider rolling the process out to further GP practices;
- evaluate 'PALS information centres' and consider rolling them out to further GP practices;
- engage and communicate around the future shape of mental health services;
- the commissioners and contracting team will develop contracting arrangements to ensure that

every provider has appropriate systems for gathering patient opinion and responding to issues and concerns;

- develop the current Health User Bank ('HUB') to ensure it is representative of the wider community, and provide robust training and familiarisation for members ;
- develop and use PCT website online mechanisms to stimulate and enhance engagement;
- develop more robust systems for learning from complaints, comments and queries; and
- building on the successful 2009 'healthy living day' by holding another in 2010;
- Develop the capacity of the 'Gateway' engagement organisations and possibly tender them;
- hire a community engagement 'bus' to build on and continue the 'Pink camper van' work in 2009;
- fully evaluate and (where possible) continue to expand the Expert Patient Programme (EPP) including considering running tutor training courses which would be an income generator for the PCT.

Key Milestones
Dates required

- evaluate 'information prescriptions' and consider expansion by end of March 2010;
- evaluate 'PALS information centres' by August 2010. If worth expanding write business plan by end of September 2010. Dependent on outcome of business plan, roll out further centres from Jan 2011;
- Enhance engagement website by July 2010;
- engagement and communications around the future shape of mental health services 8 Feb – 2 May 2010;
- developing contracting arrangements to ensure that every provider has appropriate systems for gathering patient opinion and responding to issues and concerns by October 2010;
- developing the current Health User Bank to throughout 2010;
- developing and using participation mechanisms to stimulate and enhance engagement throughout 2010;
- develop more robust systems for learning from complaints and PALS, throughout 2010; and
- 'healthy living day' to be held in approx. May 2010.
- Develop the capacity of the 'Gateway' engagement organisations by August 2010 and possible tender them in September 2010;
- hire a community engagement 'bus' by March 2010 and use throughout 2010-11;
- fully evaluate the Expert Patient Programme (EPP) by March 2010. If worth expanding write business plan by end of September 2010. Dependent on outcome of business plan, roll out further centres from Jan 2011;
- consider running EPP tutor training courses which would be an income generator for the PCT by March 2010. Set up pilot course and evaluate by August 2010. If worth expanding write business plan by end of September 2010. Dependent on outcome of business plan, roll out further centres from Jan 2011;

Outcome measures

Measure	Measure

Quality Metrics

Measure	Target

Principal changes in activity
n/a

Implications for workforce
PCT: **Provider**:

Commentary on financial requirements
All initiatives will be funded from existing budgets

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact
The following proposals need to have a full equalities impact assessment (EIA): ✓ mental health services consultation ✓ the engagement 'bus' ✓ the 'healthy living day' ✓ 'Gateway' engagement organisations tender The other proposals have either had historically EIAs or are not changing significantly enough to require an EIA. **Patient & Public Involvement Impact:**

8.2 Building the capacity of the third sector
Summary NHS Brighton & Hove has a long-standing well established relationship with the third sector in

contractual and partnership terms. As a whole NHS Brighton & Hove invests over £5m in services provided by the third sector. It is, therefore, important that NHS Brighton & Hove helps to develop the capacity of third sector organisations both to continue innovation within the sector but also to encourage them to consider taking on other services NHS Brighton & Hove may consider commissioning from them.

Projects within the initiative

In 2009/10 we have:

- invested £10k in one-off research into the value for money and social impact of 6 not-for-profit organisations in Brighton & Hove. The results will be published in 2010/11
- worked with the 'ChangeUp' Consortium to ensure that national money for sharing of 'back-room' costs and potential mergers/consortium working in the third sector is well spent;
- held two workshops to inform the third sector about how NHS Brighton & Hove will procure and commission from 2010 onwards;
- assessed and wrote to all third sector organisations to notify them of NHS Brighton & Hove's intentions regarding any agreements/contracts we had with them for 2010 onwards;
- worked with the engagement 'Gateway' organisations to develop an agreed service specification against which they may be tendered in 2010;
- attended the Dialogue 50:50 partnership meetings to ensure on-going dialogue between the statutory and third sectors;
- signed the updated Compact and Codes of Conduct between the statutory and third sectors including a new code of conduct around funding and commissioning;

In 2010/11 we will:

- Review, close, continue or tender contracts with existing third sector contractors as set out in the letters sent out in 2009;
- Identify third sector organisations who could provide NHS services and assess whether they need specific capacity building support from NHS Brighton & Hove or the support services listed above;
- Market manage third sector organisations in the same manner that other sets of providers are market managed.

Key Milestones
Dates required

- Review, close, continue or tender contracts with existing third sector contractors by 31 March 2011;
- Identify third sector organisations as above - by June 2010;
- Market manage third sector organisations – on-going

Outcome measures

Measure	Measure
All third sector organisations to be included in market management processes	Throughout 2010- 2011
More third sector organisations commissioned to provide services	by 31st March 2011

All existing third sector providers to have had their contract reviewed, tendered, continued or discontinued within agreed contractual terms	by 31st March 2011

Quality Metrics

Measure	Target

Principal changes in activity

n/a

Implications for workforce

PCT:

Provider: Tendering of some third sector organisations may have implications for some of the existing providers depending on whether they are successful or not in the tender process

Commentary on financial requirements

Procurement and market management implications

The PCT will need to support the PCT engagement team and other commissioners in the market management and tendering of third sector organisations

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact

The following closure or tendering of any third sector organisations would require a full equalities impact assessment (EIA).

Patient & Public Involvement Impact:

8.3 IM&T

Summary

Local IT initiatives that support the priority transformation programmes (PTPs) in the strategic commissioning plans 2009 -2014. Funding locally
National IT programmes - some which support the priority transformation programmes. Centrally funded and locally funded

Projects within the initiative

Local IT initiatives

- Sussex Health Hub - a service to support access to and exchange of clinical information between NHS organisations and social services in Sussex. Built upon an IT infrastructure that ensures security and ease of access to information, it will enable clinicians to:
- view a client/ patient record consolidated from multiple organisations;
- access the detailed information in clinical / social services systems if they have the appropriate permission;
- support the exchange of clinical information between systems (e.g. discharge summaries between acute hospitals and GP practice systems that can receive them).
- Practice Based Commissioning Data Warehouse - a service to enable information analysts to support PBC localities.
- Predictive risk analysis - a service that will identify patients at risk so that pre-emptive action can be taken to avoid unnecessary acute episodes and maintain the patient's ability to live at home.
- Service Portal - a service that will enable clinicians and service users to understand the content of, and order, locally available services.
- Contact Centre / unified communications - a service to support the functioning of a telephone and electronic communications contact centre.
- **COIN extension** - extension of the Sussex COIN to general practices, hospices and interconnection with local authorities.

National IT programmes

- **Integrated Care Summary Care Record (SCR)**

This will provide authorised clinicians faster and easier access to reliable information about patients. The SCR will provide a key method of joined up working across multiple care settings and patient will be able to access their own records

The SCR will initially contain basic information derived from electronic patient records held on GP clinical information systems including demographics, current medications, adverse reactions and allergies

Further benefits will be released for patients with long term conditions and HealthSpace users where patients can view their record

- **Electronic Prescription Service (EPS)**

This will enable prescriptions to be generated and processed electronically.

- **GP2GP Electronic Patient Record Transfer (GP2GP)**

This is used to transfer a patient's electronic record when they register at a new GP practice. This system is faster, more reliable and more secure than the current paper-based and the new practice often has the benefit of the patient's medical history when they attend their first consultation.

- **GP Systems of Choice (GPSoC)**

This is a clinical information computer systems provided by suppliers contracted to deliver National Programme for IT functionality. The PCT is responsible for supporting GP practices who migrate to GPSoC systems, contract implementation, managing deployment of NPfIT functionality and training (e.g. the programmes detailed above) and managing any additional services.

Key Milestones

SCR Key Milestones

- Wave 2 SCR Upload (4 practices) – 30/04/10
- Wave 3 SCR Upload (2 practices) – 30/04/10
- Wave 4 SCR Upload (1 practices) – 31/07/10
- Wave 5 SCR Upload (9 practices) – 31/08/10
- Wave 6 SCR Upload (11 practices) – 31/10/10
- Wave 7 SCR Upload (3 practices) – 31/12/10
- Wave 8 SCR Upload (7 practices) – 31/01/11
- Wave 9 SCR Upload (7 practices) – 30/03/11

EPS R2 Key Milestones

- Initial Project Board Meeting – 28/02/10
- Submission of Application SoS Dictation Approval – 17/04/10
- Initial EPS R2 Pilot between 1 GP and Pharmacy – 31/12/10

Milestones for other projects to be defined

Outcome measures

Measure	Measure
Cost Reduction in prescriptions, tests and procedures Commissioning Competence 6: Prioritise investment	Reduce the number of unnecessary prescriptions, tests and procedures
Results in fewer hospital emergency admissions, and so increased capacity of elective care leading to quicker elective treatment for patients and so better performance against the 18 week target Commissioning Competence 6: Work with Community Partners	Enables Clinicians to provide appropriate treatment to patients in emergencies and out of our hour care settings Improved incidence, speed and appropriateness of patient assessment and treatment in urgent care settings
Improvements in Care Commissioning Competence 3: Engage with public and patients	Patients care will no longer be delayed as the summary care records can be accessed by right staff at the right time and patients will not be required to repeat information to different healthcare staff

Quality Metrics

Measure	Target

Principal changes in activity

Implications for workforce
As part of regional PIP, It is specified that Data Manipulation has to be carried out by PCT staff as data will be extracted by NHAIS Training resources are required to provide concept awareness training to 42 practices, which haven't received it so far. Change facilitator support is required to identify benefits related to various SCR projects. Various service leads has to assume Benefit Lead role to measure those identify benefits.

Commentary on financial requirements
EPS R2 approximately £90,000 (excluding workforce costs like PM etc.,) SCR approximately £150,000 (excluding workforce costs like PM etc.,)

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	LAA (Local Area Agreement) NI 119 - Self reported measures of people's overall health & well being Patient reported unmet care needs; self reported experience of patient and users • PCT as leader of the local health system; • Evidence based practice and effective care pathways; • GP led commissioning; • Improving the patient's experience Management of Information in accordance with best practices and legislation standards including, Data Protection, Caldicott, Freedom of Information, and Records Management
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact

8.4 Continuing and funded nursing care

Summary

The NHS funded care team manages 3 statutory functions on behalf of the PCT – NHS Funded Continuing Healthcare (CHC), Funded Nursing Care (FNC) for individuals resident in a care home with nursing and the process for managing exceptional cases on behalf of individuals. We have joint contractual arrangements with the local authority for Brighton and Hove nursing homes.

Projects within the initiative

In 2009/10 we have

- Ensured adherence to Clinical Quality assurance standards in Nursing Homes
- Fully implemented the Prior Approval proposal and managed the transfer of the process to BICS

In 2010/11 we will
Extend the Clinical Quality Review project into other key areas of commissioned care provision. Specifically:

- Domiciliary sector
- Residential care homes

Adhere to CHC National Framework Guidance including;

- Performance monitor referral pathways
- Performance monitor completion of CHC assessment stages
- Performance monitor reviewing arrangements

Develop the Case Management function within the CHC Assessment Team

Engage with the Care Quality Commission to ensure developments in the City are informed by the National Regulatory Framework and that emerging good practice in Brighton is shared at Regional and National level.

Contribute to Regional and National Data collection on CHC Performance

Deliver Training across the Health and Social Care Community to promote the roll out of the National CHC Guidance

Implement the revised 'Best Practice' policy and process for Individual Funding Requests (IFR), based on the National Prescribing Centre's requirements for the management of IFR's

Key Milestones

- Extension of Clinical Quality Review activity into the Domiciliary sector – Subject to budget being identified June 2010
- Extension of Clinical Quality Review activity into the Residential Home sector – subject to budget being identified, September 2010
- Published Performance Data on adherence to CHC processes – Quarterly
- Training on Case Management function – May 2010
- Implementation of Case Management arrangements – Scoping of Training needs April 2010
- Implementation of Case Management arrangements - June 2010
- Revised Supervisory arrangements – April 2010 and ongoing

- Published Programme of 2010/11CHC Training events across the Health and Social Care economy – April 2010

Outcome measures

Measure	Measure
Annual audit process of all Brighton & Hove Nursing Homes to be extended into named areas of care and linked into contract framework agreement.	
IFR policy and process fully implemented	
Annual audit process of all Brighton & Hove Nursing Homes to be extended into named areas of care and linked into contract framework agreement.	
IFR policy and process fully implemented	

Quality Metrics

Measure	Target
All CHC activity is governed by expectations set out in the revised Continuing Healthcare Framework (DH Oct 2009) Clinical Quality Review audit process endorsed by the Research & Development Unit at Brighton & Sussex University Hospitals Trust.	

Principal changes in activity

All CHC Performance data is collated at a National and Regional level and provides the PCT with data on activity and performance locally that can be benchmarked against comparator PCT's

Implications for workforce

PCT:

Provider: Extending the work into new areas of care will require additional resource, already identified in 2009/10 AOP process, to enable the work to run in parallel with the existing programme.
Introduce revised supervisory arrangements

Address any skill development deficits that are identified through focused training, supervisory and peer support arrangements

Meeting the IFR Best Practice guidelines and timescales will require redefinition of existing roles and recruitment to the existing 0.6 Placement & Referrals Officer vacancy.

Commentary on financial requirements

Additional resource has been recognised as required to deliver an extended Clinical audit process but has not yet been identified within current budget setting exercises
Changes to current supervisory arrangements will be absorbed within budget
The seconded post of the CHC Trainer needs to be financially supported throughout 2010/11.

Training and support to introduce Case Management arrangements will be scoped to identify whether costs can be contained within budget.	
Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	
Equalities Impact	
The extension of the Clinical quality auditing activity is critical to ensuring the PCT can be assured that NHS funded clients benefit from consistent standard setting and monitoring of the quality of care being procured for them. The revised IFR policy and process has been equality impact assessed,	

8.5 Medicines Management

Summary

The overall aim of this initiative is to improve the clinical and cost effectiveness of medicines management within all sectors of healthcare provision within Brighton and Hove, maximising patient safety and improved health outcomes.

The PCT's medicines management team will draw on the professional input from local primary care contractors and colleagues in health and social care to deliver these aims.

Projects within the initiative

- Work with health and social care partners to improve patient safety and reduce patient risk in relation to the use of medicines
- Deliver improved clinical and cost effective medicines management within the local health economy
- Promote action to reduce inequalities in people's health and to improve their experiences of healthcare and access to services in relation to medicines and self care
- Improve the use of information for patients in relation to medicines services and medicines management, and engage with public representatives to deliver the strategy
- Ensure that medicines issues are fully addressed in emergency planning programmes
- Provide training for pharmacists, and contribute to the development of further staff training programmes

Key Milestones

- Implementation of process to provide assurance that primary care contractors are taking appropriate action on all relevant safety alerts (including NPSA and MHRA) by June 2010
- Completion of Controlled Drug self assessment by all GP practices by September 2010
- Policy for improving provision of appropriate medicines to patients and information to GPs following outpatient consultations agreed with (BSUHT) by July 2010
- Audit of PbR excluded prescribing and associated charges at BSUHT to be completed by July 2010
- Process agreed for documenting use of PbR excluded medicines within BSUHT by July 2010
- Horizon scanning and work programme for 2010/11 in place for policy making decisions on the managed entry of new drugs into the local health economy by May 2010
- Scoping exercise undertaken for alternative methods of dressings procurement within primary and community care by December 2010

Outcome measures

Measure	Measure
• Better care better value indicator for lipid modification	Maintain above 79%
• Better care better value indicator for proton pump inhibitors	Achieve 92% target
• Better care better value indicator for renin angiotensin drugs	Increase to 71%
• Reduced prescribing of high risk antibiotics in primary care	Measure being developed
• Reduced benzodiazepine prescribing in primary care	PCT prescribing below 3.5 ADQ per STAR PU (ePACT

	Toolkit figures Jan – Mar 2011)
• Increase generic prescribing for selected drugs to release cost savings	Reduction of 50% in the value of potential savings from increased generic prescribing (ePACT Toolkit figures for Dec 2010 compared with Dec 2009)
• Stop all generic prescribing of drugs where branded prescribing is recommended for clinical patient safety reasons	100% branded prescribing for these drugs
• Improved process in place within BSUHT for recording and charging for PbR excluded drugs.	KPI in contract

Quality Metrics

Measure	Target
• CQUIN for reduction of significant events relating to medication errors in BSUHT	Reduction of 20% in number of reported significant events relating to medication errors

Principal changes in activity

- Undertaking work on improvement of medicines usage and error reduction in Care Homes
- Increased monitoring of implementation of NPSA safety guidance in primary care
- Increased involvement in IFR panel and in management of expenditure on PbR excluded drugs
- Increased activity on horizon scanning and local policy making on drug use
- Increased involvement in development of care pathways to ensure appropriate level of medicines management input
- Increased monitoring of community pharmacy expenditure following devolution of the Global Sum in April 2010
- Develop role of Pharmacist with Special Interest (PwSI) for sexual health in primary care
- Increased training role within local health economy

Implications for workforce

- Assessment of current roles of the Medicines Management Team, with reconfiguration as necessary to ensure delivery of plans for 2010/11 within existing resources.

Commentary on financial requirements

Recent years of cost containment and negative growth in the primary care prescribing bill has left us starting from a lower and more efficient position. There is now scope for continued reductions in drugs bill, and the measures in place for 2010/11 will be used to contain the level of growth in expenditure.

Procurement and market management implications

Opportunities for a change in the procurement method for dressings in primary care will be investigated, but this is unlikely to result in a change of procurement within 2010/11.

Related Vital Signs Measures/ Existing Commitments	

Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	• Children's services – reduction in teenage pregnancy • Staying healthy – tobacco control programmes • Planned care – diagnostic tests on the high st • Long term conditions - ongoing support, education and training to help patients and carers better manage their own condition • End of life care – improved access to palliative care medicines • Over-arching pledges – improved antibiotic prescribing to reduce rates of MRSA and C difficile
Equalities Impact	

9 Infrastructure and Capital planning

The infrastructure used to deliver acute, community, primary and social care within Brighton & Hove is mixed and a significant part of the acute and community sectors operate from Victorian or outdated facilities. Over recent years the process of renewing this infrastructure has begun, with significant developments on the Royal Sussex County site and the cessation of inpatient care on the Brighton General Hospital site

As a commissioning only PCT, NHS Brighton and Hove has only a limited asset base, comprising office fixtures and computer equipment. The PCT also holds on its books the Sussex Orthopaedic Treatment Centre, an asset which is leased by finance lease from Care UK. In terms of the PCT's own capital plans, a baseline £250k has been identified to fund schemes in 2010/11. These primarily involve the replacement and upgrade of core IT and office systems. In addition it is anticipated that the Trust will facilitate the transfer of £2.6m Learning Disability assets from South Downs Health to Brighton and Hove City Council as part of the Valuing People Now initiative.

The PCT also has a key role in supporting capital programmes and projects across the local health economy and in doing so, influencing the strategic direction of estates and major capital projects within the Brighton and Hove area and ensuring that key local priorities and national objectives such as privacy and dignity are addressed.

The Teaching, Tertiary and Trauma Outline Business Case (OBC), which will drive the modernisation of the Royal Sussex County site, has been approved by the South East Coast Strategic Health Authority. The OBC was developed by Brighton and Sussex University Hospital Trust with oversight by the Local Health Economy Directors of Finance. The final step in the approval process for the scheme involves negotiations with the Department of Health and HM Treasury regarding securing the source of funding for the planned £420m development.

In terms of developing non acute infrastructure, the PCT is participating in developing a proposal for an Express LIFT (Local Improvement Finance Trust) in conjunction with other Health and Social Care organisations in Brighton and Hove and East Sussex. The objective of a consortium approach to the Express LIFT application is to provide the vehicle to ensure a coherent approach to transforming the delivery of services which is underpinned by modernising and maximising utilization of existing estate and developing new facilities where appropriate.

10 Chief Executive's Office

The Chief Executive's Office comprises the Chief Executive, Chair and PEC Chair, the Business Manager, Business Assistant and Executive Assistant.

The Board and the Chief Executive set the organisation's priorities (for example through the Strategic Commissioning Plan and Annual Operating Plan) and oversees corporate governance and risk. Delivery of these strategies, plans and processes are through the directorates on behalf of the Board and Chief Executive's.

The Chief Executive's Office provides administrative support for the Chief Executive, Chair and PEC Chair and runs projects on their behalf; manages Board, PEC and ET meetings; handles MP letters, Freedom of Information Act requests and access to legal advice.

11 Human Resources and Training

The HR and Training & Development teams work to provide PCT management and staff with support, guidance and expert knowledge in the areas of people management and training & development. The HR team deals with a wide variety of issues around the employment of staff, including recruitment, workforce planning, sickness management, performance management, equality and diversity, conflict resolution, pay and reward, and job satisfaction. The Training & Development team support managers and employees with their training and development needs, including the identification and achievement of key competencies and skills. Staff are provided with a range of training and development opportunities advertised in the Corporate Training Programme including the provision of core training. In addition to this staff are supported in other development activities specific to individuals or groups of staff. The team also gives support to our colleagues in Primary Care, providing development and learning opportunities for practice staff within the city. There is £700k in our baseline budgets for training.

12 Communications

NHS Brighton and Hove is supported by a communications function which works to enhance and protect the reputation of NHS Brighton and Hove as the leader of the local NHS. We work in partnership with patients, clinicians, the public and other agencies to promote the best opportunities for healthy living.

Our tools include web sites, printed publications, events and activities as well as working with the media.

Key tasks for 2010/11 include:

- campaigns around early recognition of cancer symptoms, smoking cessation focused on manual and outdoor workers, alcohol intake in older people, public awareness of the range of urgent care services, and uptake of vaccination and immunisation.
- develop our online mechanisms to stimulate and enhance engagement
- work with HR to create an employee awards scheme
- improving our intelligence about the communications' needs in primary care to support practice based commissioning and more effective partnership working

13 Workforce Strategy

The Strategic Workforce Plan for Brighton & Hove outlines the vision and plan for the future health workforce across the Brighton & Hove Local Health Community (LHC)

aligned with NHS Brighton & Hove City's Strategic Commissioning Plan and Annual Operating Plan.

Explicitly linked to the successful delivery of high quality healthcare services is the workforce. Over the past decade, significant improvements in both access and quality have been accomplished, these were enabled by investment and reform but they were delivered by staff working at the frontline.

This Strategic Workforce Plan seeks to identify the workforce implications for the next five years by identifying workforce risks, determining demands, and forecasting capability in aligning the workforce with Strategic Commissioning plans. In collaboration with healthcare providers, local health education institutions and the local authority this workforce development strategy assesses the quality, sustainability and deliverability of the local health economy workforce and identify key strategic health and social care workforce implications of our commissioning (and decommissioning) strategies.

14 World Class Commissioning (WCC) Development Plan

The PCT has developed a clear revised organisational development plan (OD) which sets out the key development interventions to support the Implementation of the Year 2 SCP and operating plan for 2010/11. The OD plans sets out the PCT's organisational strengths to enable delivery, the identification of gaps to delivery of plans and proposed organisational development solutions which will form the basis of revised priorities for the coming year. The focus of the plan includes supportive WCC development plans which include:

- Programme management capacity and capability development
- Developing targeted disinvestment reviews linked to robust continued prioritisation processes
- Capacity and capability enhancement to deliver new models of care and pathway development
- Collaborative commissioning development including maximising the role of the Commissioning Support Unit (CSU)
- Maximising knowledge management resources and evidence to support commissioning

The PCT will be developing a detailed WCC Development plan based on its updated OD plan and the outputs of the year 2 assurance process.

15 Delivering Our Plans

A culture of programme management and accountability is embedded within the organisation. This enables our plans to be delivered in a structured and disciplined way under the PCT's integrated planning and delivery function (IPDF). The PCT's Delivery Board oversees the delivery of the Annual Operating Plan, focusing on critical and high risk elements and also where a coordinated Local Health Economy (LHE) approach is required. The PCT Board has responsibility for the delivery of all plans and will review on an exceptional basis.

As we go through the year an on-going programme of service reviews and savings identification will be implemented. Any new investment requirements will be prioritised and money released to fund these as it becomes available.

16 Providers

Our provider landscape and strategy was described in detail in the Strategic Commissioning Plan. Our key providers are Brighton and Sussex University Hospitals NHS Trust for acute services; Sussex Partnership NHS Foundation Trust for mental health services; South Downs Health NHS Trust for community health services and the Children and Young Peoples Trust for our children's services. Ambulance services are provided by South East Coast Ambulance Services and specialist services are commissioned via the South East Coast Specialist Commissioning Group hosted by NHS West Kent.

As we implement the transformational change identified in this plan our priority will be real quality and value for money. As services are reviewed and redesigned the NHS will be our preferred provider, where quality and value are high, with clinicians leading change and service improvement. Where quality and value does not meet the standards required the current NHS provider will be given the opportunity to improve before we open the market to new potential providers. We are committed to the participation of independent and third sector providers where appropriate, in order to deliver our over-riding principle - to provide high quality care for patients delivered by providers who offer the best care. This approach is expected to drive up quality and standards and to provide patients choice, high quality care and value for money.

17 Partner organisations

NHS Brighton & Hove has a range of different but effective arrangements in place to work with statutory, voluntary sector and private sector providers to deliver high quality health and health care services for the City.

The city's key partnership is the 2020 partnership Local Strategic Partnership (LSP) and the Public Sector Board (acts as the engine room for the LSP), where many of the key issues, including health and associated wellbeing strategies are debated. The LSP is the umbrella for a range of associated partnerships including the Healthy City Partnership (the key cross sector group addressing health inequalities issues), the City Inclusion Partnership (which addresses equality and diversity issues), and the Stronger Communities Partnership (responsible for ensuring that partners work together on engagement issues) the Crime and Disorder Reduction Partnership. As part of the LSP NHS Brighton & Hove has also agreed to a city wide community engagement framework and a Compact with the third sector.

As leader of the local NHS, NHS Brighton & Hove has set up a local health economy wide Strategic Commissioning Board where representatives of the city's key health and social care partners shape commissioning. The Healthcare Standards and Service Quality Committee ensure that commissioned services are of a high quality.

Some commissioning arrangements for adults are carried out through formal (legal) Section 75 agreements with Brighton & Hove City Council including commissioning arrangements for working age adults with mental health issues where NHS Brighton & Hove are the lead commissioner through a pooled budget. For older people, commissioning services is done jointly across Brighton & Hove City Council (Adult Social Care) and NHS Brighton & Hove. This delivers a joint work plan, the commissioning lead sits with NHS Brighton & Hove and the budgets remain totally separate. These arrangements are jointly scrutinised by the Joint Commissioning Board made up of executives from NHS Brighton & Hove and the City Council.

The PCT also has a Section 75 agreement with the Children's and Young Peoples Trust to deliver children's services and these arrangements are currently being reviewed. Revisions should be finalised by April 2010.

18 Risk

As part of the PCT programme management approach, each initiative has its own risk register and its own risk management plan. These identify risks in relation to finance activity and resources. Below we have identified the key corporate risks.

	Impact :	Likelihood
5	Catastrophic	Almost certain
4	Major	Likely
3	Moderate	Possible
2	Minor	Unlikely
1	Negligible	Rare

18.1 Corporate and financial risks

An initial assessment of the high levels risks within the plan has been made. Risks relating to each of the Delivery Plans will be identified as part of the PCTs on-going risk management process

Key AOP risk	Impact	Likelihood	Mitigation	Residual risk	
				Impact	Likelihood
The PCT fails to deliver the savings within its direct control or finds that costs are understated or that cost pressures cannot be contained	5	4	AOP finances have been thoroughly reviewed. We will establish close in-year monitoring and any non-recurrent access to reserves will result in clear actions to find alternative savings	3	2
Focus on delivery of financial savings may compromise ability to deliver key targets	5	3	We will establish close in year monitoring of key targets and associated programmes of work to enable actions to be taken to address any issues.	3	2
Provider resistance to loss of income	5	5	We will ensure we have robust and agreed implementation plans for all PTPs, and work jointly to ensure a	3	2

Key AOP risk	Impact	Likelihood	Mitigation	Residual risk	
				Impact	Likelihood
			LHE approach.		
Reputational risk to the PCT as leader of the local health economy if we do not achieve financial balance and key financial targets	4	3	The Board will continue to provide a leadership role to LHE and ensure that communications are effectively managed with provider and partner organisations and the public`	2	2
The provider market across the community may not be developed sufficiently to deliver our plans	4	3	We will ensure robust and agreed implementation plans are in place and that relationships are effectively managed with providers.	2	2
Plans are unable to be delivered as the workforce and continuing Professional Development implications have not been identified, planned and implemented	4	4	Commissioners to review workforce implications of their plans with providers to identify impact and agree actons to manage. Link to strategic workforce development plan. Regularly monitor delivery of savings and workforce metrics	2	2
The PCT fails to deliver the demand management plans underpinning the financial savings	5	4	We will ensure that plans are robust and agreed with providers and that strong performance monitoring controls are in place to enable any corrective actions to be taken in a timely fashion.	3	2
The further £6.4m required savings are unable to be identified	5	3	The risk in 10/11 is considered low as non-recurrent savings can be readily identified. A programme of work	3	2

Key AOP risk	Impact	Likelihood	Mitigation	Residual risk	
				Impact	Likelihood
			will be established in order to identify recurrent savings for 11/12 and beyond.		

18.2 Risk Management and Assurance Processes

NHS Brighton and Hove has an agreed Risk Management Plan, incorporating the Risk Management Strategy and Policy. It has refined its corporate governance structures during 2009/10 to ensure that there are systematic processes in place and that the organisation is working towards an effective management approach to continually reviewing and mitigating risk within the organisation. Significant assurance has consistently been provided by internal audit relating to the PCT's risk management processes.

The Risk Management Plan describes clearly the arrangements for the escalation of risks to the PCT's Integrated Governance Committee, a formal Board Sub Committee, through risk registers at departmental/team, Directorate and Corporate levels. The highest level risks which impact on the delivery of the organisation's principal objectives are routinely assessed and monitored at a level that should sufficiently alleviate not only financial and operational pressures within the organisation but also identify opportunities to improve reputation, patient safety and equalities across the city.

The Board is responsible for the identification of top down corporate risks through Board level workshops. It is also the Board's task to identify and evaluate key controls intended to manage these risks. Following this the Board receives assurance reports, using the Assurance Map as its key tool, from its Executive Directors on the effectiveness of these controls across their areas of principal responsibility. Any gaps in the control or assurance process are agreed and addressed and plans put in place to mitigate these.

As a key part of the Trust's assurance framework the Board ensures that we maintain a dynamic risk management process including a well-founded risk register. The Board also receives reports from the Integrated Governance Committee to ensure effective working practices.

The PCT has developed an integrated governance structure in order to put in place a comprehensive structure of controls to co-ordinate and manage risks of all types within the organisation. The structure has been approved by the Board and the Professional Executive Committee. The PCT has appointed the Assistant Director of Assurance to lead on risk management, supported by a Risk Management and Incident Reporting Co-ordinator.

Specific roles and responsibilities for risk management are as follows:

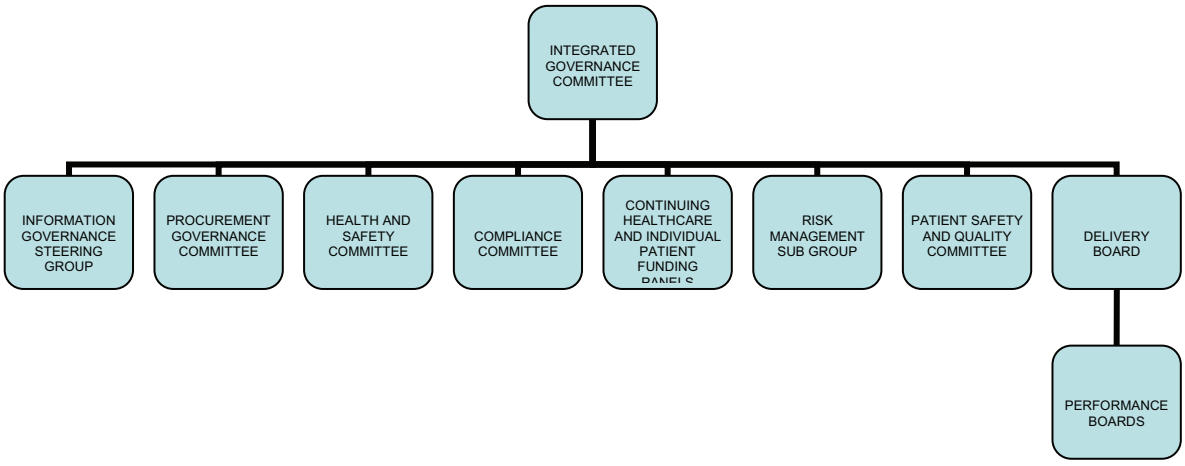
The Board
The Board is responsible for the PCT's system of internal control, including risk management. To discharge this responsibility the Integrated Governance and Audit

Committees have been established. The Board requires appropriate policies on risk management and internal controls to be in place, and to receive regular assurances on whether the system is functioning properly.

The PEC
The PEC is responsible for ensuring that the Board maintains effective control over clinical governance, strategic fit with clinical policies, clinical leadership and scrutiny and development of Practice Based Commissioning.

The Audit Committee
The Audit Committee is a formal sub committee of the Board and the minutes of all meetings are reported regularly at Board meetings. The role of the Audit Committee is to provide scrutiny and an objective view on internal control to the Board that is independent of the PCT's executive. It provides verification and assurance to the Board on internal financial controls based on reports, both written and verbal, from internal and external auditors.

The Integrated Governance Committee
The Integrated Governance Committee is a sub committee of the Board and has been constituted in this way to ensure that the clinical members of the Professional Executive Committee undertake the function of managing clinical risk. The Integrated Governance Committee oversees the management of risks through agreeing and prioritising the Trust risk registers, and reviewing and monitoring the action plans in respect of the most significant risks to the delivery of the organisation's principal objectives as detailed in the corporate risk register. It has a number of sub Committees, as shown in Figure XX below:



The Compliance Committee
This committee is responsible for monitoring compliance with expected standards and performance measures and for reviewing all performance information submitted to external bodies and regulators.

The Patient Safety and Quality Committee
This committee is responsible for reviewing and monitoring all issues concerned with the safety of patients and the quality of services provided by the PCT's commissioned services. This includes monitoring serious untoward incidents, incidents, complaints and audit data and the lessons learned.

The Risk Management Sub Group
This group reviews and challenges all risk registers to ensure that they contain appropriate risks which are consistently evaluated and which have effective action plans to mitigate the risks.

Professional Performance & Support
The General Medical Council (GMC) regulates the medical profession in England and is governed by statute. The GMC and the NHS have ensured that local procedures are in place to detect and act on concerns about doctors. The same applies to dentists, pharmacists, opticians and nurses, and the PCT has a responsibility within the NHS Clinical Governance Framework to have systems in place to register and action concerns about the performance of registered professionals.

The local PCT Professional Performance and Support Group ensures systems are in place to identify concerns about clinicians and that appropriate actions are taken. The PCT has appointed a GP as the Professional Performance Lead, and the work is supported by the Professional Performance Co-ordinator and the Head of Assurance. Systems for approving professionals onto the Brighton and Hove lists are also undertaken within this work area.

Shipman monitoring is a statutory requirement also administered in the Assurance Team, reporting to the Professional Performance & Support Group.

Appeals Panel
The Appeals Panel considers all appeals received by the PCT against the decisions of the Continuing Care and Exceptions Panels. The Appeals Panel is established as a Sub Committee of the Board.

The Panel has delegated authority from the Board to consider all appeals in respect of continuing care and acute exceptions cases. The Panel is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

The Panel may:

- ✓ Confirm the original decision taken
- ✓ Refer the case back to the original decision making panel to reconsider the case
- ✓ *Make a different decision if (a) the Appeals Panel considers that the PCT failed to follow its own procedures or failed to reach a reasonable decision and (b) that there was only one other reasonable decision that the Panel could have reached. In all other cases where (a) is satisfied the Appeals Panel will refer the case back to the originating Panel for further consideration.*

The minutes of the Appeals Panel are formally recorded and submitted in anonymised form to the Board. This work is supported by an Appeals Co-ordinator within the Assurance Team.