NHS
Brighton and Hove

Annual Operating Plan for NHS Brighton and Hove 2010/11

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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:

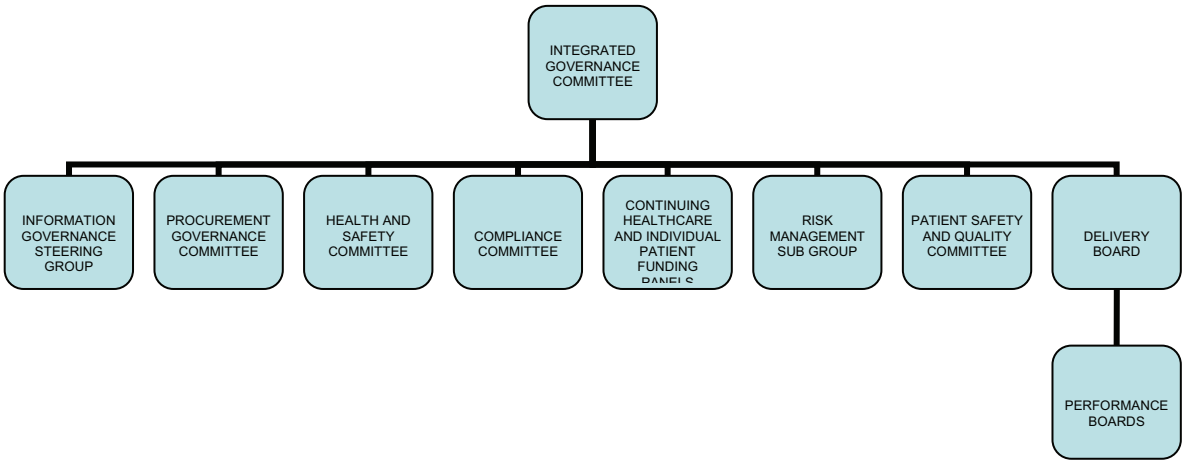
The Board
The Board is responsible for the PCT's system of internal control, including risk management. To discharge this responsibility the Integrated Governance and Audit

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.