NHS
Brighton and Hove

# The 2009/10 Annual Operating Plan for NHS Brighton and Hove

FINAL 27th March 2009

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## Appendices

## Executive Summary

The Annual Operating Plan for NHS Brighton and Hove (the working name for Brighton and Hove City PCT) develops the Strategic Commissioning Plan (SCP) which was published in October 2008. The SCP described our vision to keep people well and making sure 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 2009/10 to deliver these priorities and continue to develop health services that are fit for the future and seen as best practice. 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 A. We are also committed to achieving the NHS South East Coast pledges. These are referred to throughout the document and are described in Appendix D.

The five Strategic Commissioning Goals identified in the SCP are described in section 2 and expanded in section 4 into a series of initiatives for 2009/10. The five goals are:

- Adding years to life
- Maximising life chances for children and families
- Developing a healthy young city
- Promoting independence
- Commissioning nationally recognised best practice

Focusing on these goals and implementing our initiatives 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 7 and Appendix E. We are investing £11.0m in our Commissioning Goals (with off-setting savings of £7.9m), £6.2m in increased capacity and £1.6m in quality. This is in addition to ongoing funding of services and infrastructure. We have a savings target of £3.6m for the year to enable these investments to be made; specific savings plans will be developed with our partners in the local health economy.

As well as making changes during 2009/10 in the services we commission, we also have plans for the people and resources within our own organisation. These are described in section 7.

The impact of this plan on equalities will be reviewed during March 2009. 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

This Annual Operating Plan sets out the priorities of NHS Brighton and Hove and the work the organisation will do in the coming year. There are references to these objectives and to the Strategic Commissioning Plan which was published in October 2008. The Plan describes our key initiatives and outlines the plans that the PCT will implement in 2009/10.

# 2 Context

## 2.1 Our city

The city of Brighton and Hove is a vibrant place in which to live, work and visit.

In 2006 Brighton and Hove City had an estimated population of approximately 251,000. By 2018 it is estimated that this will be approximately 265,000.

Brighton and Hove City has a high proportion of young adults. We also have an unusually and increasingly diverse population compared with other areas on the South East Coast. 15% of our population was born outside England. Between 2001-2004 black and minority ethnic groups grew at a rate of 35% compared to only 13% nationally. We have a relatively high proportion of people who are from the lesbian, gay, bisexual or transgender (LGBT) groups, estimated as up to 15% of the population. The 2001 census identified 59% of the City as Christian with 5% being from another religious group. National figures are 72% and 6% respectively. This census also found that there were 21,800 carers in Brighton and Hove with 510 young carers under 18 – these figures are likely to be under stated due to under-reporting. It is estimated that 1,060 people aged over 18 in the City have a moderate or severe learning disability and 15,480 have a moderate or severe physical disability. Projections also show 6,020 people ages 65+ with mobility problems.

Brighton and Hove City faces substantial socio-economic issues. The Index of Multiple Deprivation 2007 identifies Brighton and Hove City as the 79$^{th}$ most deprived authority in England (out of 354), with 9% of all Super Output Areas (SOAs) in the City falling within the 10% most deprived SOAs in England and 8 SOAs falling in the 5% most deprived.

As we implement the initiatives included in this plan we will ensure that people are able to access services on an equitable basis, and we will work to reduce any barriers that exist.

## 2.2 Strategic objectives

NHS Brighton and Hove has set the following strategic objectives:

**Be the leading advocate for health and health care in the city**
- promote healthy living and a healthy city
- provide strong leadership to the local NHS
- develop effective relationships with social care and other organisations across the city

**Improve health and reduce health inequalities**
- deliver measurable improvements in the health of local people
- reduce the 'health gap' between different local communities

**Increase service quality and choice**
- commission high quality, evidence-based services
- use people's experiences to improve the quality of services
- offer people a choice of providers where this is realistic
- achieve and maintain an "excellent" rating in the annual health check

**Increase people's confidence in, and engagement with, the NHS**
- extend public confidence in local health services
- give people a stronger voice in the NHS
- be an excellent employer

**Manage resources effectively**
- deliver a sustainable financial position for NHS Brighton and Hove
- help the rest of the local health economy do the same
- demonstrate value for money and effective stewardship of public funds

## 2.3 Performance to date

NHS Brighton and Hove received a 'fair' rating for the quality of services rating under the Health Care Commission 2008 health-check and a rating of 'good' for use of resources. We had improved in both categories since the last Annual Health Check. Our aspiration is to continue this improvement with the aim of achieving ratings of excellent for both aspects of delivery. In October 2009 we will receive our rating for the financial year 2008/09 and we hope to improve the quality of services rating to 'good'. In 2008/09 the local health community has been successful in delivering on a range of national and local priorities as described below.

**18 weeks -** We successfully achieved the March 2008 target for referral to treatment for admitted and non-admitted patients, access to diagnostics and data completeness. We have a detailed project plan and governance structure for continuing to deliver the 18 week target and will continue to closely monitor providers' performance against target.

**Practices offering extended opening -** 32 out of 47 GP practices (68%) now offer extended hours in Brighton & Hove, with both the 2008/09 target and 2009/10 targets being achieved to date.

**Retinopathy screening -** We are achieving the vital signs target for the percentage of people with diabetes offered retinopathy screening (95%).

**Improved access to cancer treatment -** Alongside the acute trust, we feel confident in delivering the vital sign and access targets for chemotherapy and surgery given the increasing capacity for radiotherapy in 2008/09. Further work is being undertaken to extend a tracking system to monitor access and waiting times for breast and cervical screening.

**Cleanliness and healthcare associated infections -** MRSA & Clostridium difficile. We are on target to achieve the agreed trajectory for MRSA and Clostridium difficile in 2008/09.

**A&E 4 hour target -** The target of 98% continues to be exceeded by the acute provider.

**Ambulance target –** The 19 minute response time targets are being achieved and we are forecasting meeting the target for Category A 8 minute response times by the end of the year.

**Access to GUM -** We have achieved the 48 hour access target.

**Chlamydia screening -** We expect to meet this target at the end of 2008/09.

The governance structure around HealthCare Commission core standards is supported by five core standard sub-groups, which review evidence prepared by members of staff who 'own' the standard. The Head of Assurance leads on the review of criteria for assessment published annually by the HealthCare Commission, gathering and reviewing evidence provided by owners, which is then scrutinised at the core standard sub-groups. These sub-groups report to the Healthcare Standards and Service Quality Committee.

## 2.4 Our vision

NHS Brighton & Hove published a Strategic Commissioning Plan in October 2008. This described our vision to keep people well and mak sure that high quality care is provided when they are not. In order to deliver this vision, we will focus on five key strategic commissioning goals. These are:

**1. Adding years to life**
To reduce by at least 10% the gap in life expectancy between the most deprived areas and the least deprived. We aim to increase life expectancy by two years by 2013 for the most socially disadvantaged.

**2. Maximising life chances for children and families**
Our ambition is for children to grow to adulthood with the maximum life chances and best possible health.

**3. Developing a healthy young city**
To commission comprehensive well being, prevention and treatment services in partnership with the local authority to ensure targeted access to personalised services that meet the particular challenges of our young and working age populations.

**4. Promoting independence**
To improve the quality of life for older people and those living with long-term conditions; extending choice and increasing personalisation.

**5. Commissioning nationally recognised best practice**
To commission a range of services that is nationally recognised as best practice and bring the benefits of innovation and improved quality.

## 2.5 Health outcomes

We are committed to delivering against every aspect of our vision and on all of the strategic objectives above. Within this our performance will partly be assessed via progress in delivering on ten specific health outcomes. Two of these are nationally mandatory (health gain and health inequalities), the others were chosen locally taking our stakeholders' views into account and considering the following factors:

- Impact on health gain for local people
- Impact on health inequalities
- The extent to which our action can realistically have a significant impact on the outcome
- What we know of the aspirations of patients and the public
- Our current performance on the outcome and its priority in terms of national policy, SHA aspirations and targets set out in the Local Area Agreement
- The extent to which good performance depends on excellent commissioning

The Strategic Commissioning Plan provided further details as to why each particular outcome was chosen.

In 2009/10, and for the following two years, the priority outcomes will be:

**O1 -** Improve the overall Index of Multiple Deprivation (IMD7) score for the city and to reduce the scores in areas where there is a higher than average score for the city.

**O2 -** Reduce by at least 10% the gap between the fifth of the local authority areas with the lowest life expectancy at birth.

**O3 -** Exceed best practice by reducing teenage conceptions by 45% to meet the Local Area Agreement target and through improving options for over 100 teenagers.

**O4 -** Increase the recording of hypertension in general practice by more than 3% to reach a level of best practice and improving screening for over 8,000 people over the age of 35.

**O5 -** Increase to 80% the rate of breast cancer screening for women aged 53 to 64.

**O6 -** Significantly reduce the number of days delay in leaving hospital putting us within reach of excellent practice.

**O7 -** Reduce the prevalence of MRSA in the local acute hospital to exceed best practice.

**O8 -** Reduce the rate of admissions for alcohol related harm by 9.3%, exceeding the Local Area Agreement target and impacting on over 400 admissions.

**O9 -** Increase the choice of where to die including coordinating services to enable people to die at home and exceeding good practice levels nationally.

**O10 -** Halt the growth of childhood obesity through maintaining the level of obesity at no more than 16% at age 11.

While we will focus on these areas, we will invest and improve all services, as we aim to develop health services that are fit for the future and are seen as examples of best practice across the UK. We also need to ensure we deliver against national targets, vital signs and the Local Area Agreement. These are listed in full in Appendix B.

## 2.6 Local Priorities

NHS Brighton and Hove will implement specific commissioning initiatives in 2009/10 that will support the first year of working to achieve the ten priority health outcomes outlined above.

The table below aligns our commissioning initiatives to our priority health outcomes.

| Priority Outcome | Commissioning Initiative |
|---|---|
| O1,O2 | 1a, 1d |
| O5 | 1b |
| O4 | 1c |
| O3 | 2a |
| O10 | 2d |
| O8 | 3b |
| O6 | 4b |
| O9 | 4d |
| O7 | 5e |

In 2009/10 NHS Brighton and Hove intends to develop and implement a comprehensive range of initiatives that will enable us to achieve improvements in our chosen health outcomes and our commissioning goals, as well as deliver national and local standards and targets. The next section outlines these initiatives, setting out the key plans, the investment requirements and expected impact and outcomes.

Below is a table setting out the specific commissioning initiatives against each commissioning goal.

| Commissioning Goal | | |
|---|---|---|
| 1. Adding years to life | 1a | Smoking cessation |
| | 1b | Screening services |
| | 1c | Prevention of cardiovascular disease |
| | 1d | Cancer prevention and treatment |
| 2. Maximising chances for children and families | 2a | Teenage pregnancy reduction |
| | 2b | Child and Adolescent Mental Health Services |
| | 2c | Long acting reversible contraception |
| | 2d | Childhood obesity |
| | 2e | Improving maternity services |
| | 2f | Childhood immunisations |

| Commissioning Goal | | |
|---|---|---|
| 3. Developing a healthy young city | 3a | Reducing suicide |
| | 3b | Alcohol initiative |
| | 3c | Chlamydia screening |
| | 3d | Good mental health (improving access to psychological therapies) |
| | 3e | Sexual health services in primary care |
| | 3f | Substance misuse |
| 4. Promoting independence | 4a | Prevention of admission pathway including STAN (single telephone access number) |
| | 4b | Developing a new short term care pathway |
| | 4c | Long term conditions |
| | 4d | End of life care |
| | 4e | Delayed transfers of care |
| | 4f | Continuing care and funded nursing care |
| | 4g | Learning disabilities |
| 5. Nationally recognised best practice services | 5a | Development of an integrated urgent care centre |
| | 5b | Effective gateway and referral management |
| | 5c | Effective pathways |
| | 5d | Timely access and choice |
| | 5e | Healthcare acquired infections |
| | 5f | Improved/increased access to primary care services |
| | 5g | Improved quality of primary care services |
| | 5h | Medicines management |

# 3 Commissioning Goals

## 3.1 Commissioning Goal 1 – Adding years to life

<table>
<tr><th>CG1a</th><th>Smoking cessation</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">In 2009/10 we will review the effectiveness of the following recently introduced initiatives/pilots:<br>• Providing “stop smoking” groups in pubs, cafes, and clubs.<br>• Promoting the smoke free homes campaign.<br>• Piloting an intervention in teenage pregnancy.<br>• Work with employers and offer free courses in work places<br>• Increase the number of drop-in clinics<br>• Pilot a ‘call to quit’ line<br>• Send out information to all patients being referred for elective procedures<br>• Offer free vascular health-checks in workplaces</td><td><u>Outcome Measure and Targets</u><br>2030 quitters in 2009/10 compared to 2020 now (as part of existing contract).</td></tr>
<tr><td><u>Activity Impact</u><br>Already included in current contracts.</td></tr>
<tr><td><u>Workforce Impact</u><br>Minimal.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>Review of initiatives introduced during 208/09 will take place in Apr 09.</td><td><u>Cost Impact</u><br>£200k investment (in baseline budget)</td></tr>
<tr><td><u>Equalities Impact</u><br>The smoking cessation service has specialists who work exclusively with people from neighbourhood renewal areas.</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>Relates to the HPEC Pledge Staying Healthy 3 and 5, Overarching Pledge 8. Vital Signs VSB05, LAA NI123 (see appendix A 1.15 & 1.27)</td><td><u>Link to Outcome/Commissioning Goal</u><br>Outcome 1 and 2</td></tr>
</table>

<table>
<tr><th>CG 1b</th><th>Improving the performance and coverage of screening services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">In November 2008 the breast service moved to a new centre with modern digital technology and additional staff were recruited to ensure that the 36 month screening interval for women is achieved.<br><br>In 2009/10 we will continue to<br><br>• Roll out the national bowel cancer screening programme for men and women aged 60-69 years. The subsequent age extension to include people aged under 75 years will be implemented in 2011.<br>• Increase the coverage of cervical screening and the speed with which women receive their results.</td><td><u>Outcome Measure and Targets</u><br><br>Breast - No changes to existing levels.<br><br>Bowel - Anticipate 58 adenomas detected per annum by 2012 and 14 cancer cases. No national or local target for coverage. Reliable coverage information not likely to be available until mid 2009.<br><br>Cervical cancer screening tests results in 2 weeks</td></tr>
<tr><td><u>Activity Impact</u><br><br>Breast - No changes to existing activity levels<br><br>Bowel – increasing levels as programme develops.</td></tr>
<tr><td><u>Workforce Impact</u><br><br>No further increases anticipated.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br><br>• Increased uptake for screening programmes in disadvantaged groups and deprived areas (ongoing)<br><br><u>Bowel Cancer Screening</u>:<br>• Age extension to be implemented Nov 10<br><br><u>Breast cancer screening</u><br>• Achievement of 36 month screening interval Dec 09.<br><u>Cervical cancer screening</u><br>• Increased coverage and speed of results for cervical screening from Apr 09</td><td><u>Cost Impact</u><br><br>Breast cancer - No changes to value of existing contract with BSUH for the initial programme. As the age group of women treated is extended, there may be future cost implications.<br><br>Bowel cancer – no additional local investment as national funding continues.</td></tr>
<tr><td><u>Equalities Impact</u><br><br>For cervical cancer, a health promotion advisor targets BME women and those from disadvantaged areas.</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Relates to vital sign target VSA08, VSB03 (see appendix A 1.6 & 1.13). Planned Care pledge 7.</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning Goal 1 – adding years to life<br><br>Outcome O5 - Increase to at least 80% of women aged 53-64 being offered screening for breast cancer within 3 years of their last test<br><br>Outcome O2 – Reduce by at least 10% the gap between the fifth of local authority areas with the lowest life expectancy at birth.</td></tr>
</table>

<table>
<tr><th>CG 1c</th><th>Prevention of cardiovascular disease</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We are currently setting up community health check initiatives for CVD.<br><br>In 2009/10 we will<br>• Support the development of at-risk registers in general practice for patients at high risk of CVD and commission practices to deliver targeted vascular checks to 40 – 74 year olds who are indicated to be at greater than 20% risk of a CVD event in 10 years.<br>• the PBC incentive scheme to reduce lifestyle risks and offer vascular checks to patients who have not had their blood pressure recorded or who have not attended their practice in recent years – ie hard to reach groups.<br>• Set up community based vascular health checks for men over 50.<br>• Set up workplace based vascular health checks for men over 40.</td><td><u>Outcome Measure and Targets</u><br>• Increase the number of patients identified to have a risk of a CVD event of 20% or greater from 2,990 (2008 baseline) to 6,500 by 2012. (Estimated trajectory 2009/10 – 800)<br>• Increase the number of patients diagnosed with hypertension by at least 8,000 from 27,400 (2008 baseline) to more than 35,400 by 2012 (Estimated trajectory 2009/10 1,250)<br><br>Reductions in acute activity are amalgamated under the prevention of admission initiative.</td></tr>
<tr><td><u>Activity Impact</u><br>• 2,500 vascular checks delivered in primary care and funded by the revised CVD prevention LES<br>• 3,000 checks delivered in primary care through the revised PBC incentive scheme<br>• 1,500 checks delivered in community settings through the community and workplace project.</td></tr>
<tr><td><u>Workforce impact</u><br><br>Minimal.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• Launch community health checks initiatives by March 2009<br>• Launch revised LES by July 2009<br>• Launch PBC scheme by May 2009<br>• Evaluate progress to inform AOP 2010/11 by October 2009</td><td><u>Cost Impact</u><br><br>£45k investment</td></tr>
<tr><td><u>Equalities Impact</u><br><br>PBC incentive scheme prioritises hard to reach patients</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Relates to Vital Sign target VSB02 (see appendix A 1.12)</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Outcome O4 – Increase the recording of hypertension in general practice by more than 3% to reach a level of best practice and improve screening for over 8,000 people over the age of 35.<br><br>Commissioning Goal 1 – adding years to life.<br><br>Outcome O2 – Reduce by at least 10% the gap between the fifth of local authority areas with the lowest life expectancy at birth.</td></tr>
</table>

<table>
<tr><th>CG1d</th><th>Cancer prevention and care</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">In 2009/10 we will<br>• Implement a targeted programme of health promotion work including the development of a new skin cancer prevention initiative (links to Dermatology community clinic in CG5c).<br>• Improve our understanding of people's knowledge, beliefs and behaviour in relation to cancer symptoms in order to develop targeted and effective programmes of symptom awareness.<br>• We will review the recommendations of the National Radiotherapy Advisory Group and assess activity requirements to achieve national targets.<br>• Increase the number of patients diagnosed with cancer referred under the urgent 2 week wait rule<br>• Commission cancer pathways and implement new guidance as agreed by Sussex Cancer Network<br>• Palliative and supportive care initiatives are described in CG4d</td><td><u>Outcome Measure and Targets</u><br><br>48% of patients diagnosed as 'urgent' under 2 week wait rule (currently 45%)<br><br>100% of patients receive subsequent treatment (chemotherapy or surgery) within 31 days.<br><br>86% of patients wait less than 31 days for radiotherapy by Apr 10<br><br>100% of patients receive first treatment within 62 days.<br><br>Targets are being expanded as follows:<br>• The two week wait standard will benefit any patient referred with breast symptoms whether cancer is suspected or not (implemented end 2009)<br>• 31 day standard will cover subsequent treatments for all cancer patients including those diagnosed with a recurrence (already implemented for surgery and chemotherapy; end 2010 for radiotherapy and other treatments)<br>• 62 day standard has already been expanded to include patients referred from NHS cancer screening programmes or by their consultant</td></tr>
<tr><td><u>Activity Impact</u><br><br>Activity for chemotherapy and radiotherapy is included in the BSUH contract (5% increase on 2008/09 month six projected outturn)</td></tr>
<tr><td><u>Workforce Impact</u><br><br>Health trainer will be employed by SDH.</td></tr>
<tr><td colspan="2"><u>Key Milestones</u><br><br>• Agree programme of health promotion work May 09<br>• Confirm social marketing approach to symptom awareness Jun 09<br>• Review requirements of radiotherapy action plan April 09<br>• Increased no. of patients diagnosed</td><td><u>Cost Impact</u><br><br>£240,000 new investment for cancer prevention<br><br>Increases for radiotherapy, chemotherapy and cancer drugs are included in the BSUH contract (amounts tbc).<br><br>Capital requirements for Linear Accelerators (to meet radiotherapy targets) are included in the BSUH Strategic Outline Case for their 3Ts Development.</td></tr>
</table>

| | |
|---|---|
| under 2 week rule by Apr 10<br>• Commission cancer pathways and implement guidance – ongoing 2009/10 | *Equalities Impact*<br>Will be assessed during implementation of initiative |
| *Linked Pledges and Targets*<br>VSA11, VSA12, VSA13, VSB03 | *Link to Outcome/Commissioning Goal*<br>Commissioning Goal 1 – Adding Years to Life<br>Outcome 1 and 2. |

## 3.2 Commissioning Goal 2 – Maximising chances for children and families

<table>
<tr><th>CG2a</th><th>Teenage pregnancy reduction</th><th>Impact Summary 2009/10</th></tr>
<tr><td rowspan="3">In 2009/10 we will deliver the revised action plan under the headings and actions below<br>• Leadership - active engagement of CYPT and PCT board members, council members and strategic leads that demonstrate leadership and direction<br>• Culture and Behaviour – use social marketing approach to challenge acceptance culture and challenge risk taking behaviour<br>• Integrated Planning and Review across CYPT and PCT<br>• Ensuring Effective Monitoring – Groups of young women most at risk of early conception will be identified in order to target support. This targeted support will be monitored quarterly.<br>• Workforce Development: Trainer recruited and deliver specific training and action learning sets across workforce<br>• Service Provision: new and continued provisions action plan.</td><td colspan="2"><u>Outcome Measure</u><br>Reduce conceptions in 15 -17 year olds to 38.68 per 1000 in 2009</td></tr>
<tr><td colspan="2"><u>Activity Impact</u><br>144 conceptions in 2009/10 (reduction)</td></tr>
<tr><td colspan="2"><u>Workforce Impact</u><br>A more directive approach towards early identification and interventions will be expected from staff commissioned and as part of the CYPT. This will be supported by behavior change interventions, a training strategy with ongoing action learning sets and performance managed though internal supervision structures.</td></tr>
<tr><td rowspan="2"><u>Key Milestones</u><br>• New and revised contracts April 09<br>• Sexual Activity assessment process and behaviour intervention packages in place May 09<br>• Two city wide conferences for staff and council / board member may 2009.<br>• Social marketing campaign Sept 09<br>• Training review Sept 09.<br>• 2nd round of schools delivery by Oct 09<br>• Evaluate progress to inform AOP 2010/11 by October 2009</td><td colspan="2"><u>Cost Impact</u><br><table><tr><th></th><th>Additional costs of services £'000</th><th>Reduced births £'000</th><th>Reduced terminations £'000</th></tr><tr><td>2009/10</td><td>60</td><td>(18)</td><td>(7)</td></tr></table>Additionally, costs of £400k will be incurred in 2009/10 and subsequent years to implement teenage pregnancy strategic reviews.</td></tr>
<tr><td colspan="2"><u>Equalities Impact</u><br>The focus of this initiative will be on young women from disadvantaged groups/women not in employment, education or training.</td></tr>
<tr><td><u>Linked Pledges and Targets</u><br>Relates to Vital Sign and LAA targets VSB08, NI112 (see appendix A 1.17 & 1.27)</td><td colspan="2"><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 2 – Maximising life changes for children and families<br>Outcome 3 – Exceed best practice by reducing teenage conceptions by 45% to meet the LAA target and through improving options for over 100 teenagers.</td></tr>
</table>

| CG 2b | Child and Adolescent Mental Health Services | Impact Summary 2009/10 |
|---|---|---|
| The PCT has agreed a new approach to the management and funding of specialist placements for children with complex mental health needs with Sussex Partnership Trust, which will allow for a greater level of specialist input in the assessment and management of these cases. This should also strengthen the financial risk management in this high-cost area of expenditure.<br><br>In 09/10 SPFT will:<br>• Ensure waiting time targets are met for accessing the service<br>• Develop a crisis home treatment team<br>• Open a unit at Chalkhill ( Princess Royal Hospital site, Haywards Heath) for high risk/severe needs cases, hence reducing out of area placements<br>• Pilot for 12 months a joint pathway with one point of referral<br>• Care coordination – implement Care programme approach CPA for relevant cases<br>• Young people's mental health 14-25 year olds – implement new model of service<br>• Implement new care pathway for looked after children's/ children in care access to full range of CAMHS services, including increase of capacity. | | *Outcome Measure*<br><br>Admissions of young people aged 16 /17 to Millview unit or other adult provision to be 0.<br><br>Reduced out of area placements<br><br>*Activity Impact*<br><br>SPT to be penalised for any breaches of waiting times.<br><br>Crisis home treatment team estimate 1,780 face to face contacts p.a.<br><br>Young people's mental health service – estimate 2,640 contacts.<br><br>Target for specialist pathway for children n care is estimate 1800 face to face contacts.<br><br>Target for area teams is estimate 6,800 face to face contacts.<br><br>*Workforce Impact* (All with SPFT)<br><br>4.3 wte for the crisis service which includes one transfer of 1wte from the current tier 4 outreach service<br><br>5 new staff for the young people's mental health service.<br><br>Children in care – 1.8 wte band 8a clinical psychologists currently seconded to CYPT will no longer be seconded but employed by SPFT to give extra capacity for CAMHS to support children in care. |
| *Key Milestones*<br><br>Further work is required to confirm milestones. | | *Cost Impact*<br><br>Additional investment of £200k to support the crisis home treatment service and out of area risk share agreement<br><br>*Equalities Impact*<br><br>Will be assessed during implementation of initiative |
| *Linked Pledges and Targets*<br><br>NI 51 | | *Link to Outcome/Commissioning Goal*<br><br>Commissioning Goal 2 – Maximising life changes for children and families |

| CG 2c | Increasing access to long acting reversible contraception (LARC) | Impact Summary 2009/10 |
|---|---|---|
| We are making Long Acting Reversible Contraception (LARC) more widely available through the community contraception service and through primary care, facilitated by increased funding for devices and incentives through QOF from 2009. | | *Outcome Measure/Target*<br>From 354 LARC fittings in 2008/09 to 520 in 2009/10. |
| | | *Activity Impact*<br>Not applicable |
| | | *Workforce Impact*<br>Minimal. |
| *Key Milestones*<br>Quarterly monitoring to ensure target achieved from July 2009<br><br>Further action tbc Kerry Clarke (CYPT) | | *Cost Impact*<br>£50k investment in baseline budget. |
| | | *Equalities Impact*<br>Outreach in high rate teenage contraception areas, which tend to be areas with the greatest health inequalities. |
| *Linked Pledges and Targets*<br>CS Pledge 4 | | *Link to Outcome/Commissioning Goal*<br>Commissioning Goal 2 – Maximising life changes for children and families<br>Outcome O3 - Exceed best practice by reducing teenage conceptions by 45% to meet the Local Area Agreement target and through improving options for over 100 teenagers. |

<table>
<tr><th colspan="2">CG 2d Childhood obesity</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We are implementing the joint strategy “Promoting the healthy weight and healthy lives of children in Brighton and Hove” alongside the CYPT and the City Council.<br>We will:<ul><li>Access to dietary advice and cookery training, play and physical activity opportunities in, or linked to, all children’s centres (including wte dietician and active for life workers)</li><li>Establish a weight management programme for 5-8 year olds;</li><li>Provide free swimming for children;</li><li>Work to remove unhealthy food in youth settings (Healthy Choice Award co-ordinator);</li><li>Establish a model of care between primary, community and secondary care; Multi-disciplinary assessments and 1:1 weight management in community setting (Consultant, school nurse and active for life worker hours)</li><li>Develop protocols and guidelines for Health Visitors to identify children at risk.</li></ul></td><td><u>Outcome Measure/Target</u><br>To meet the Department of Health target to:<ul><li>Initially reduce the rate of increase in obesity in children under 11 years.</li><li>To set the trajectory so that by 2020 childhood obesity is at 2000 levels.</li><li>For 09/10 the target is that no more than 8.6% of Reception children with height and weight recorded will be obese; 17.6% for Year 6 children</li></ul></td></tr>
<tr><td><u>Activity Impact</u><br>92.7% (2,266) Reception children and 88% (2,003) Year 6 children to have height and weight recorded.</td></tr>
<tr><td><u>Workforce Impact</u><br>1WTE Dietitian<br>1 WTE Healthy Choice Award Co-ordinator<br>Both to be employed by the Food Partnership. This is a Social Enterprise set up by the PCT and the Council.<br>Consultant, school nurse and active for life worker hours</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>Apr 09 – Promote healthy weight via Children’s Centres<br>Apr 09 - Weight management (5-8 yrs);<br>Jul 09 - Free swimming<br>Aug 09 – Removal of unhealthy food (Healthy Choice Award)<br>Aug 09- Model of care<br>Apr 10 - HV protocols and guidelines</td><td><u>Cost Impact</u><br>Anticipated investment of £250k per annum.</td></tr>
<tr><td><u>Equalities Impact</u><br>Children’s Centres are situated in disadvantaged areas. We will specifically assess the needs of disabled children with respect to childhood obesity in 2010/11.</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>Staying Healthy Pledge 1; Overarching Pledge 5; VSB09 (see appendix A 1.18)</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 2 – Maximising life changes for children and families<br>Outcome O10 – Halt the growth of childhood obesity through maintaining the level of obesity at no more than 16% at age 11.</td></tr>
</table>

<table>
<tr><th>CG2e</th><th>Improving maternity services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">In 2009/10 we will<br>• Develop a new strategy and commissioning plan for maternity services. The key issues it will address include:<br>  ○ Maternity pathway – ensuring we meet national best practice and that the service meets the needs of vulnerable groups within the community.<br>  ○ Choice and extending care – how we can give a choice of where to give birth and ensure that we have antenatal and postnatal care that supports women and families, including fathers, both in preparation and after birth.<br>  ○ Quality and standards – setting out the quality and performance standards we need to ensure the service we commission is implemented and delivers health and well-being for mothers and children.<br>• Develop Health Promotion material to target access for vulnerable and BME groups<br>• Implement combined screening for Downs syndrome at BSUH<br>• With CYPT, contrive to increase breast feeding rates in the City.</td><td><u>Outcome Measure and Targets</u><br>Consultants on labour wards for 60 hours/week<br>84% of pregnant women to see a midwife within 12 weeks by Apr 10<br>68.4 & prevalence of breast feeding by Q4 2009/10</td></tr>
<tr><td><u>Activity Impact</u><br>Included in BSUH and SDH contracts 2009/10.</td></tr>
<tr><td><u>Workforce Impact</u><br>BSUH plans to recruit 4 additional consultants to meet 60 hour target.<br>Midwife ratios of 1:28 need to be improved for 2012 in line with national targets.<br>Workforce implications to address Pledge 4 are being assessed – this will involve looking at skills mix and different models of care working with BSUH and Maternity Service Liaison Committee (MSLC).</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• Agree Maternity Standards for 09/10 contract with BSUH Apr 09<br>• Develop and Support User engagement and feedback (Apr 09)<br>• Develop maternity service specification (Jun 09)<br>• Commissioning strategy developed (Sept 09)<br>• Health Promotion work (June 09)<br>• Combined screening (date tba)<br>• Increased breast feeding (on-going)</td><td><u>Cost Impact</u><br>BSUH costs are included within their contract.<br>£20k new investment for initial work. Further investment will be reviewed as funds become available during the year.<br>£95k additional funding from CYPT for breast feeding.<br>Investment required to address Pledge 4 is currently unknown.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
</table>

| *Linked Pledges and Targets* | *Link to Outcome/Commissioning Goal* |
|---|---|
| Maternity and Newborn Pledges 1 – 6,<br>VSB06<br>VSB011 | Commissioning Goal 2 – Maximising life changes for children and families |

<table>
<tr><th>CG2f</th><th>Childhood Immunisations</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We have an existing programme of childhood immunisations covering HPV and all routine childhood immunisations. In addition in 2009/10 we will:<br>• Complete the catch-up for the HPV vaccine for all young women under 18 years<br>• In partnership with the CYPT, develop the immunisations team for the follow-up of unvaccinated children to ensure targets are achieved<br>• Work with the CYPT, GPs and the school nursing team to review the appropriate service model for the school leaving booster</td><td><u>Outcome Measure and Targets</u><br>91% of children aged 1 to complete immunisations<br>85% of children aged 2 to complete boosters<br>84% if children aged 2 to complete MMR immunisations<br>76% of children aged 5 to complete immunisation (ex MMR)<br>69% of children aged 5 to complete MMR (2 doses)<br>85% or girls age 12-13 to complete HPV<br>58% of children age 13-18 to complete immunisation programme</td></tr>
<tr><td><u>Activity Impact</u></td></tr>
<tr><td><u>Workforce Impact</u><br>It is proposed that CYPT will employ 1 Health Visitor, 1 Nurse, part-time analyst, part-time administrator for the immunisations team.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• HPV catch-up Mar 10<br>• Develop immunisations team Sep 09<br>• Review model to deliver school leaving booster Jun 09</td><td><u>Cost Impact</u><br>HPV programme is funded by the Department of Health. Immunisation team funding is under discussion with CYPT.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>VSB10</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 2 – Maximising life changes for children and families</td></tr>
</table>

## 3.3 Commissioning Goal 3 - Developing a healthy young city

<table>
<tr><th colspan="2">CG 3a Reducing suicide</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We are currently:<br>• Commissioning an enhanced care programme, crisis resolution and home treatment teams working with people most at risk.<br>• Promoting the mental health of vulnerable groups.<br>• Identifying local risk factors for suicide via a Serious Events Audit.<br>• In 2009/10 we will:<br>• Translate learning from Serious Events Audit into action plan<br>• Implement action plans from the Brighton and Hove suicide prevention strategy – increasing awareness/reducing risks for high risk groups<br>• Roll-out training programme for professionals to assist with early identification of people at risk</td><td><u>Outcome Measure and Target</u><br>VSB04 – reduce death rate from suicide to 12.9 per 100,000 population by end 2009/10.</td></tr>
<tr><td><u>Activity Impact</u><br>Not applicable</td></tr>
<tr><td><u>Workforce Impact</u><br>Currently being assessed</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• Action plan from Serious Events Audit Apr 09<br>• Training programme rolled out: proposal ratified Apr 09, implement from Jun 09<br>• Key milestones from suicide prevention strategy Apr 09 onwards</td><td><u>Cost Impact</u><br>Investment of £100k.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>Relates to Vital Sign targets VSC29, VSB04, (see appendix A 1.14) Mental Health Pledge 1</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 3 – developing a healthy young city</td></tr>
</table>

<table>
<tr><th>CG 3b</th><th>Alcohol initiative</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">In 2008/09 we agreed a new local enhanced service for brief interventions for whole population aged 16+.<br><br>In 2009/10 we will:<br>• Implement plans to reduce alcohol related hospital admissions via community based brief interventions.<br>• Appoint Health Trainers and implement an information project.<br>• Roll out an awareness project.<br>• Establish a social marketing campaign for both the general public and specific groups.<br>• Introduce a lifestyle incentive scheme to improve recording of alcohol intake, intervening where intake is risky and outreach.<br>• Develop pathways with CYPT to ensure that young people are signposted to appropriate services</td><td><u>Outcome Measure and Targets</u><br><br>2% reduction in the increase in alcohol related hospital admissions</td></tr>
<tr><td><u>Activity Impact</u><br><br>Alcohol related admissions will increase by 15% in 2009/10 (net of the 2% targeted reduction).<br><br>Projected increases have been factored into BSUH ‘3T’s’ project.</td></tr>
<tr><td><u>Workforce Impact</u><br><br>18 wte brief intervention workers (3.6 on secondment to BSUH; the remainder in the community) – relates to the reduction in admissions initiative. Community workers will be employed by Crime Reduction Initiatives (CRI), a charity. Those on secondment to BSUH will be employed by SPFT.<br><br>Health trainer to be employed by SDH.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br><br>• Tender for community based service to be awarded Apr 09<br>• Health trainers appointed Jul 09<br>• Information project implemented Jul 09<br>• Prevention project implemented Jul 09<br>• Social marketing campaign implemented Jul 09<br>• Lifestyle incentive scheme implemented Date to be confirmed PW</td><td><u>Cost Impact</u><br><br>£ 748k Alcohol intervention; £147k for Health Promotion</td></tr>
<tr><td><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Relates to Staying Healthy Pledge 4; Children’s Services Pledge 5 and LAA target NI 39 (see appendix A 1.27)</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning Goal 3 – developing a healthy young city<br><br>Outcome O8 – reduce the rate of admissions for alcohol related harm by 9.3%, exceeding the LAA target and impacting on over 400 admissions.</td></tr>
</table>

<table>
<tr><th>GC 3c</th><th>Increasing uptake of chlamydia screening programme</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We are currently tendering for a revised Chlamydia Screening Service.<br><br>In 2009/10 we will:<br>• Complete tender in order to have a new scheme in place<br>• Develop a health promotion social marketing campaign to stimulate demand for screening.</td><td><u>Outcome Measure</u><br>Since completion of the Strategic Commissioning Plan, the Department of Health has announced significant increases in the chlamydia screening targets for 2009/10 and subsequent years. During 2009/10 25% of 15 – 24 year olds are required to be screened (from 17% in 2008/09).<br>New VSI technical guidance does permit inclusion of tests undertaken in GUM but targets remain highly challenging.</td></tr>
<tr><td><u>Activity Impact</u><br><br>9,600 screens in 2009/10.<br><br>BSUH have not re-bid for the service and their contract will terminate in May 2009.</td></tr>
<tr><td><u>Workforce Impact</u><br><br>At BSUH, 1 Band 6 nurse, 1 Band 3 Healthcare Assistant and 1 Band 4 administrator will be transferred to other posts.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br><br>• Contract awarded Feb 09<br>• New service commences Apr 09<br>• Date of campaign tba</td><td><u>Cost Impact</u><br><br><table><tr><th></th><th>New Service £000</th><th>Reduced Activity BSUH £'000</th></tr><tr><td>2009/10</td><td>270</td><td>(109)</td></tr></table></td></tr>
<tr><td><u>Equalities Impact</u><br><br>Prioritises disadvantaged areas and groups</td></tr>
<tr><td colspan="2"><u>Linked Projects and Targets</u><br><br>Related to Vital Sign target VSB13 (see appendix A 1.22)</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 3 – developing a healthy young city</td></tr>
</table>

<table>
<tr><th>CG 3d</th><th>Good mental health (Improving access to psychological therapies)</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">In 2009/10 we will commission an IAPT service that will improve access to low and high intensity interventions to reduce anxiety and depression, with a particular focus on reducing the number of people on incapacity benefit.<br>With regard to mental health in primary care, we will:<br>• Develop Support packs for GPs and others for Step Zero resources and include on Map of Medicine<br>• Develop a Mental Health Issue LES</td><td><u>Outcome Measure</u><br>We aim to improve clinical outcomes for some physical health conditions. (Specific target tbc).<br>Target to support 158 people who wish to return to work by 2010/11 (no target for 2009/10).</td></tr>
<tr><td><u>Activity Impact</u><br>3,500 in 2009/10 (528 in 2008/09)</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• Data set collection collected quarterly<br>• Additional contractual variation to reflect IAPT service Mar 09<br>• Review affordability for year 3 scale-up Mar 09<br>• Service review Mar 10<br>• GP support packs – Oct 09<br>• Mental Health Issue LES – Sep 09</td><td><u>Workforce Impact</u><br>28 additional psychological therapists (SPT)(IAPT service)</td></tr>
<tr><td><u>Cost Impact</u><br>£426k investment in IAPT from PCT and £1,046k from Department of Health.<br>£14k investment in support packs from baseline<br>£380k investment in LES</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>Related to Mental Health Pledges 1 and 2, Overarching Pledge 10, VSC02</td><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative<br><br><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 3 – developing a healthy young city</td></tr>
</table>

| CG 3e | Increasing access to level II sexual health services in primary care | Impact Summary 2009/10 |
|---|---|---|
| We will increase the level of primary care based services allowing more asymptomatic patients and those requesting sexual health screens to be seen quickly in the most appropriate and cost effective setting. | | *Outcome Measure*<br>This will support:<br>• Delivery of the 48 hour access target.<br>• Reduction in transmission of STIs and HIV.<br>• Reduction in the prevalence of undiagnosed HIV and STIs |
| | | *Activity Impact*<br>None in 2009/10 |
| | | *Workforce Impact*<br>Minimal. |
| *Key Milestones*<br>• Pilot routine HIV 'opt out' testing in primary care April 2009.<br>• Health Promotion Campaign to start in April 09<br>• Service review and specification July 09<br>• Tender process initiated for provision of service in each PBC locality Sept 09<br>• Service commences Apr 10 | | *Cost Impact*<br>Investment of £50k in baseline budget.<br>Savings from BSUH contract of £156k. (£42k for this service and £114k relating to Sexual Health services in the GP Led Health Centre ref 5f) |
| | | *Equalities Impact*<br>We do not believe there is any further work to be done in this area. |
| *Linked Projects and Targets*<br>Relates to Staying Healthy Pledge 2, | | *Link to Outcome/Commissioning Goal*<br>Commissioning Goal 3 – developing a healthy young city |

<table>
<tr><th colspan="2">CG3f Substance misuse</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">Drug misuse continues to be a significant concern. Although the Brighton and Hove Drug and Alcohol Action Team (DAAT) is well-rated by the national treatment agency, significant challenges remain to improve the proportion of people who remain drug free. In 2009/10 we will :<br>• Improve support to carers and parents to help them cope with the impact of drug misuse on their families<br>• Increase the proportion of people receiving treatment within primary care<br>• Increase the proportion of people in treatment being offered Hepatitis B vaccinations<br>• Reduce the volume of available benzodiazepines within the city</td><td><u>Outcome Measure and Targets</u><br>1% increase in drug users in effective treatment</td></tr>
<tr><td><u>Activity Impact</u><br>.</td></tr>
<tr><td><u>Workforce Impact</u><br>Minimal.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• Improve support to carers – ongoing<br>• Increase the proportion of people receiving treatment within primary care (date tbc)<br>• Increase the proportion of people in treatment being offered Hepatitis B vaccinations (date tbc)<br>• Reduce the volume of available benzodiazepines within the city (date tbc)</td><td><u>Cost Impact</u><br>£24k fye of prior year investment.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>VSB14, NI 40</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning Goal 3 – developing a healthy young city</td></tr>
</table>

## 3.4 Commissioning Goal 4 – Promoting independence

<table>
<tr><th>CG 4a</th><th>Prevention of admission pathway including STAN</th><th>Impact Summary 2009/10</th></tr>
<tr><td rowspan="3">We currently run a single telephone access number (STAN) for clinicians to refer into the Medical Assessment Unit (MASU), supported by community alternatives, and are piloting a Rapid Access Clinic for Older People.<br><br>In 2009/10 we will<br>• Re-commission STAN with extended scope to include access by other referrers including paramedics and hospital discharge teams and a single point of access to all community health services<br>• Pilot a dedicated ‘Roving’ GP service to enable rapid assessment of patients who require urgent home visits during the day.<br>• Extend the piloted daily rapid access assessment clinic (RACOP) for older people to support urgent assessment and diagnostics completed within a one stop shop<br>• Establish Paramedic practitioners assessing and treating patients at scene rather than conveying them to A&E.<br>• Develop a Directory of Services to support referral to community services<br>• Establish a Pharmacy-led Community Anticoagulation Service. This service will provide point of care testing in 16 community pharmacies.<br>• Introduce the use of the D-dimer test by GP’s in the community to prevent outpatient attendence.<br>• Develop the IV at home service for cellulitis to prevent admission.</td><td colspan="2"><u>Outcome Measure and Targets</u><br><br>Reduction in emergency admissions attendances to acute settings by 5% in 2009/10.</td></tr>
<tr><td colspan="2"><u>Activity Impact</u><br><br>Anticoagulation – 2375 patients (95%) of service to be cared for in community clinics<br><br>Paramedic Practitioners are expected to impact in 2010/11<br><br>Directory of Services is being developed as a tool for other services to use – reduced activity will be credited to those services<br><br>No direct savings in activity will be attributed to STAN – reduced activity will be credited to other community services. Date from STAN will be used to inform future commissioning plans.<br><br>
<table>
<tr><th></th><th>Reduced new/follow up appointments 2009/10</th><th>Reduction in admissions 2009/10</th></tr>
<tr><td>Anticoag</td><td>(30,198)</td><td></td></tr>
<tr><td>Roving GP</td><td></td><td>(260)</td></tr>
<tr><td>RACOP</td><td></td><td>(300)</td></tr>
<tr><td>DVT (D-dimer)</td><td>(101)</td><td></td></tr>
<tr><td>Cellulitis</td><td></td><td>(48)</td></tr>
</table></td></tr>
<tr><td colspan="2"><u>Workforce Impact</u><br><br>Roving GP service will be tendered but will include 1 GP.<br><br>RACOP service will increase by 1 nurse and 1 doctor, employed by BSUH.<br><br>At BSUH, the de-commissioning of the anti-coagulation service will impact on the Pathology establishment by a maximum of 5 posts.</td></tr>
</table>

<table>
<tr><th>CG 4a</th><th>Prevention of admission pathway including STAN</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2"><u>Key Milestones</u><br><br>Care Coordination Centre:<br>• 31 Oct permanent service in place and operational<br><br>Roving GP:<br>• 31 March commence pilot<br>• 31 Oct decision made about longer term arrangements<br>• 31 Dec permanent arrangements commence<br>RACOP:<br>• 31 March complete pilot phase and evaluation<br>• 1 April permanent service in place<br>Paramedic Practitioners Sept 09<br><br>Directory of Services date Jun 09<br><br>Community Anticoagulation Service:<br>• April 2009 Begin implementation with first pharmacy<br>• July 2009 Implementation of clinics complete<br>• August 2009 Domiciliary service complete<br>IV at Home Apr 09<br>D-dimer test Apr 09</td><td><u>Cost Impact</u> – Additional costs/savings in 2009/10<br><br><table><tr><th></th><th>Activity reduction £'000</th><th>Costs of schemes £'000</th></tr><tr><td>Anti-coag.</td><td>(1,590)</td><td>940</td></tr><tr><td>Roving GP</td><td>(462)</td><td>125</td></tr><tr><td>RACOP</td><td>(682)</td><td>233</td></tr><tr><td>Other</td><td>(189)</td><td></td></tr></table><br><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Relates to Acute Care Pledge 1; and Vital Sign target VSC10; VSSC14; VSC21</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 4 – promoting independence.</td></tr>
</table>

<table>
<tr><th>CG 4b</th><th>Developing a new short term care pathway</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We are reviewing our range of services to ensure patients can be discharged from the acute hospital setting as soon as they no longer require its specialist support The review is focusing on community domiciliary and bed based services across health and social care. Once the review has concluded a detailed commissioning plan will be developed.<br><br>The emerging findings indicate the following developments are likely:<br>• Development of flexible responsive domiciliary provision working longer core hours<br>• Greater provision of step up services within the community to be used for diagnosis and clinical assessment<br>• Service improvements and development of pathways within and between short term services<br>• Development of a larger bed based facility that provides free health care episode for full assessment of need</td><td><u>Outcome Measure</u><br><br>Delayed transfers to be maintained at a level of 3% or less.</td></tr>
<tr><td><u>Activity Impact</u><br><br>It is not possible to quantify this until the commissioning intentions have been costed and agreed</td></tr>
<tr><td><u>Workforce Impact</u><br><br>Skill mix of staff is likely to be reviewed as part of this work.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br><br>May 2009 Report signed off with commissioning Intentions agreed<br><br>Other milestones will be agreed after this point.</td><td><u>Cost Impact</u><br><br>Funding included in baseline.</td></tr>
<tr><td><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>VSC10, VSC21, Delayed Transfers of Care strategy – 4(e) below, Planned Care Pledge 5.</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning goal 4 – promoting independence.<br><br>Outcome 6 – Significantly reduce the number of days delay in leaving hospital putting us within reach of excellent practice.</td></tr>
</table>

| CG 4c | Long Term Conditions – Dementia, physical disability, diabetes, stroke/Acquired Brain Injury (ABI) Respiratory services | Impact Summary 2009/10 |
|---|---|---|

**Long Term Conditions**

In 2009/10 we will develop a long-term conditions model (4c3)and refresh our existing self care strategy (4c4). Plans for specific conditions are outlined below.

**Dementia**

The National Dementia Strategy is in consultation, we have carried out a local baseline review and are developing an Older People Mental Health Commissioning Strategy. Based on this, in 2009/10 we expect to:

- Develop a memory screening service
- Establish an Older People's Mental Health(OPMH) LES
- Commission a voluntary sector support service
- Provide training for mainstream providers

*Outcome Measure*

LES – uptake of 25% of practices assuming in place Q4.

*Activity Impact*

Assuming memory screening service established Q4 – 100 additional people diagnosed and on register.

Care support service in place Q4 - 100 additional people diagnosed and on register.

*Workforce impact*

Training for mainstream staff required.

*Key Milestones*

Until the Commissioning Strategy is ratified it is difficult to define key service milestones. These are the milestones for the strategy ratification:

- Finalise strategy and 3 year action plan Mar 09
- Establish implementation group Apr 09
- Agree 2009/10 delivery plan and key projects Apr 09

*Cost Impact*

£97k investment

*Equalities Impact*

Will be assessed during implementation of initiative

*Linked Pledges and Targets*

Long Term Conditions Pledge 1, VSC 11

*Link to outcome and commissioning goal*

Commissioning goal 4 – promoting independence.

<table>
<tr><th>CG 4c</th><th>Long Term Conditions – Dementia, physical disability, diabetes, stroke/Acquired Brain Injury (ABI) Respiratory services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">Physical disability<br><br>We will develop services to increase choice, support independent living, deliver personalised care and improve coordination of care. We will also review the commissioning strategy for disabled children taking into account the national child health strategy and ‘Aiming high for disabled children.’<br><br>In 2009/10 we will begin to deliver:<br>• A centre for independent living<br>• Extra care housing for younger adults<br>• Increased access to housing support<br>• Management of hospital stays and discharge<br>• Longer term coordination of care<br>• Review therapy services and equipment for disabled children</td><td><u>Outcome Measure and Target</u><br><br>Reduction in Delayed Transfers of Care (DTOC) for younger adults</td></tr>
<tr><td><u>Activity Impact</u><br><br>Small impact on acute admissions and readmissions – included in Prevention of Admission pathway.</td></tr>
<tr><td colspan="2" rowspan="3"><u>Key Milestones</u><br>• Finalise action plan Feb 09<br>• Develop business cases Feb 09<br>• Ratify strategy Mar 09<br>• Other milestones will be ascertained when the action plan is finalised.<br>• Disabled children review Jun 09</td><td><u>Workforce Impact</u><br><br>This will be assessed when plan complete.</td></tr>
<tr><td><u>Cost Impact</u><br><br>£210k investment</td></tr>
<tr><td><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>VSC 11, VSC 12, VSC 13, Long Term Conditions Pledge 5</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 4 – promoting independence.</td></tr>
</table>

| CG 4c | Long Term Conditions – Dementia, physical disability, diabetes, stroke/Acquired Brain Injury (ABI) Respiratory services | Impact Summary 2009/10 |
|---|---|---|

**Diabetes**

We are delivering improvements to adult and older people's diabetes care with specific focus on enhancing primary care expertise and delivery and the provision of a community based multidisciplinary team for people with type 2 diabetes.

In 2009/10 we will

- Award the contract for the community team
- Set up a LES for diabetes
- Implement insulin pumps per NICE guidelines

*Outcome Measure and Target*

The gap between expected and known diabetes prevalence will be closed (move from 2.6% of population to 4.2%).

*Activity Impact*

| | Reduced new/ follow up appointments | Increased activity in primary care (LES 1) | Increased activity in primary care (LES 2) |
|---|---|---|---|
| 2009/10 | (1,952) | 3,842 | 209 |

*Key Milestones*

Community team :

- Procurement evaluation currently halted while additional legal advice is sought
- Contract award Feb 09
- New service implemented Jun 09

LES service:

- LMC approval Mar 09
- PBC consultations/ issue LES Mar 09
- LES awarded April
- Training offered on an on-going basis

Insulin pumps

*Workforce Impact*

No further changes planned at BSUH.

*Cost Impact*

| | Reduction in new/follow up appointments £'000 | Increased activity in primary care (MDT) £'000 | Increased activity in primary care (LES 1&2) £'000 |
|---|---|---|---|
| 09/10 | (250) | 133 | 185 |

Insulin Pumps £100k

*Equalities Impact*

Will be assessed during implementation of initiative

*Linked Pledges and Targets*

Long Term Conditions Pledges 1 and 2, VSC 11

*Link to Outcome/Commissioning Goal*

Commissioning goal 4 – promoting independence.

<table>
<tr><th>CG 4c</th><th>Long Term Conditions – Dementia, physical disability, diabetes, stroke/Acquired Brain Injury (ABI) Respiratory services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">Stroke<br><br>In 2009/10 we will improve stroke services by:<br>• Improving stroke prevention through risk management, rapid access to specialist stroke TIA service and delivery of stroke thrombolysis.<br>• Strengthening health promotion initiatives to support those at risk of stroke and following a stroke to support and maintain health.<br>• Strengthening early specialist rehabilitation support to provide more within the community.<br>• Improving the longer term co-ordination of care. The model of delivery is being currently developed with the local authority to link community stroke co-ordination with the community neuro-rehabilitation team.<br><br>Exploring longer term support needs including peer support services</td><td><u>Outcome Measure and Target</u><br><br>Reduction in the number of strokes, and in the level of disability following strokes. In activity, terms this equates to 120 patients seen within the TIA/thrombolysis service per year.<br><br>More people receiving rehabilitation at home, and reduced dependency.</td></tr>
<tr><td><u>Activity Impact</u><br><br>120 admissions reduced at BSUH.</td></tr>
<tr><td colspan="2" rowspan="3"><u>Key Milestones</u><br>• Finalise model for Sussex wide 24/7 stroke thromboysis model and develop business case to support agreed model Jun 09<br>• Complete review of stroke care pathway Aug 09<br>• Implement model for longer-term coordination of care Apr 09</td><td><u>Workforce Impact</u><br><br>Minimal</td></tr>
<tr><td><u>Cost Impact</u><br><br><table><tr><th></th><th>Reduced admissions £'000</th><th>Other costs £'000</th></tr><tr><td>2009/10</td><td>(218)</td><td>180</td></tr></table></td></tr>
<tr><td><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Acute Care Pledges 2 and 4, VSC 11, VSC 14</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 4 – promoting independence.</td></tr>
</table>

<table>
<tr><th>CG 4c</th><th>Long Term Conditions – Dementia, physical disability, diabetes, stroke/Acquired Brain Injury (ABI) Respiratory services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">Respiratory Services<br><br>In 2009/10 we will improve services by:<br>• Increasing the resources within the Community Respiratory Disease Service (CRDS) to allow for oxygen and asthma services.<br>• Ensuring that the cohort of patients are offered a care-plan, jointly constructed with the specialist team.<br>• Provide a service for patients using nebulisers to gain education and review.<br>• Provide a service for patients using oxygen to gain education, exercise sessions if clinically appropriate and to have a review of their needs.</td><td><u>Outcome Measure</u><br><br>People with long-term conditions able to be independent and in control of their symptoms.</td></tr>
<tr><td><u>Activity Impact</u><br><br>Reduction in the number of emergency admissions (5%) and A&E attendances (10%) by the cohort of patients seen by the CRDS.<br><br>20% reduction in patients requiring oxygen therapy.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• New contract agreed with current CRDS team to include extension of current provision for Respitory Services to include Oxygen & Nebuliser Services and the inclusion of additional support from the team for asthma patients Feb 09<br>• Communication plan implemented Feb/Mar 09<br>• Service commences May 09</td><td><u>Workforce Impact</u><br><br>Staff already in place.</td></tr>
<tr><td><u>Cost Impact (in baseline budgets)</u><br><br><table><tr><th></th><th>Reduction in oxygen costs<br>£'000</th><th>Service costs (already budgeted and approved)<br>£'000</th></tr><tr><td>2009/10</td><td>(72)</td><td>66</td></tr></table><br><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Acute Care Pledges 2 and 4, VSC 11, VSC 14</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning goal 4 – promoting independence.</td></tr>
</table>

| CG 4d | End of life care strategy | Impact Summary 2009/10 |
|---|---|---|
| In 2009/10 we will:<br>• Develop local end of life strategy in line with national end of life strategy requirements<br>• Ensure all staff have sufficient training to deliver good quality end of life care<br>• Ensure roll-out of recognised quality tools and markers for end of life care<br>• Improve support to carers through planned respite care and night sitting services | | *Outcome Measure and Targets*<br>100% coverage of Liverpool Care Pathway and Gold Standards Framework by 2012<br>All GP practices signed up to the Gold Standards Framework by 2012.<br>Increasing number of patients dying in their preferred place of care.<br>Reducing the number of patients dying in hospital where this is not their preferred place of care. |
| | | *Activity Impact*<br>No impact on current contracts. |
| | | *Workforce Impact*<br>Minimal |
| *Key Milestones*<br>• End of life strategy Apr 09<br>• Training for staff- plan developed Aug 09<br>• Roll-out quality tools and markers (Date tba)<br>• Evaluate contracts for respite service provision Jun 09 | | *Cost Impact*<br>£95k additional investment |
| | | *Equalities Impact*<br>Will be assessed during implementation of initiative |
| *Linked Pledges and Targets*<br>End of Life Pledges 1-5, Over-arching Pledge 7, VSC 15 | | *Link to Outcome/Commissioning Goal*<br>Commissioning goal 4 – promoting independence.<br>Outcome O4 – increase the recording of hypertension in general practice by more than 3% to reach a level of best practice and improving screening for over 8,000 people over the age of 35. |

<table>
<tr><th colspan="2">CG4e Delayed Transfers of Care</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">An improvement plan to reduce the number of delayed transfers of care was agreed by the local health economy in 2007/08 and updated in 2008/09.<br>In 2009/10 we will:<ul><li>Develop improved multidisciplinary working across the local health economy</li><li>Carry out team reviews; including improving access and information; for the integrated discharge team and intermediate care service</li><li>Use individual case studies to identify key areas for service improvement</li><li>Develop of performance reporting including review of the current reporting format</li><li>Implement the transfer of care protocol for staff involved in the discharge of patients</li><li>Develop and introducing a discharge toolkit</li><li>Develop a more flexible, community based service for short term care (refer to CG4b)</li></ul></td><td><u>Outcome Measure and Targets</u><br>Delayed transfers to be maintained at a level of 3% or less.</td></tr>
<tr><td><u>Activity Impact</u><br>The Local Health Economy will work collectively to achieve this target.</td></tr>
<tr><td><u>Workforce Impact</u><br>Changes in skill mix are envisaged following the team reviews and short term care pathway review.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><ul><li>Improved multidisciplinary working - Jun 09</li><li>Team reviews - Jun 09</li><li>Individual case studies - Apr 09</li><li>Development of performance reporting - Apr 09</li><li>Implementation of the transfer of care protocol - Apr 09</li><li>Developing and introducing a discharge toolkit - Jul 09</li></ul></td><td><u>Cost Impact</u><br>Cost control initiative.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>Overarching pledges 1 and 2, Planned Care pledge 5.</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning goal 4 – promoting independence.<br><br>Outcome 6 – Significantly reduce the number of days delay in leaving hospital putting us within reach of excellent practice.</td></tr>
</table>

<table>
<tr><th>CG4f</th><th>Continuing Care and Funded Nursing Care</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">The NHS Funded Care Team manages three 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. By April 09 we will have implemented the joint contract arrangements (PCT and local authority) with Brighton and Hove nursing homes,<br>In 2009/10 we will:<br>• Ensure adherence to clinical quality assurance standards in Nursing Homes.<br>• Extend the project's remit into other key areas of commissioned care provision, e.g. residential homes, home care providers and out of city providers (to be implemented subject to cost/benefit analysis).<br>• Fully implement the Prior Approval proposal and manage the transfer of the process to BICS.</td><td><u>Outcome Measure and Targets</u><br>tbc</td></tr>
<tr><td><u>Activity Impact</u><br>.</td></tr>
<tr><td><u>Workforce Impact</u><br>Increased staffing tbc subject to assurance that can be funded via reduced costs of placements.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• Ensure adherence to clinical quality assurance standards in Nursing Homes Jan 10<br>• Extend remit (date tba)<br>• Fully implement Prior Approval (date tba).</td><td><u>Cost Impact</u><br>Projected overall cost increase of £1m included in budgets.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u></td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning goal 4 – promoting independence.</td></tr>
</table>

<table>
<tr><th colspan="2">CG4g Learning Disabilities</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We will work in partnership with members of the Learning Disability Partnership Board and local health services to improve outcomes for people with learning disabilities<br>In 0910 we will<br>• Start to implement the new national three year strategy Valuing People Now<br>• Increase the number of people with learning disabilities who are routinely offered health checks and agree health action plans with their GP<br>• Provide a specialist liaison nurse service to provide education and training, protocol development and implementation, patient admission planning, support for care pathway coordination and liaise with community services to support chronic disease management to prevent readmission<br>• Complete a self assessment for learning disabilities provision</td><td><u>Outcome Measure and Targets</u><br>The vital sign for learning disabilities is in development.</td></tr>
<tr><td><u>Activity Impact</u><br>No impact on contracts.</td></tr>
<tr><td><u>Workforce Impact</u><br>Liaison nurses are already in place – funding transfers to PCT. Health facilitator is also in place.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>Milestone dates for implementing the strategy will be specified following the results of the self assessment.<br>• Increase the number of people with learning disabilities who are routinely offered health checks and agree health action plans with their GP (date tbc)<br>• Provide a specialist liaison nurse service Apr 09</td><td><u>Cost Impact</u><br>Additional investment of £95k. Costs of health facilitator to be found within baseline funding.</td></tr>
<tr><td><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u></td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning goal 4 – promoting independence.</td></tr>
</table>

## 3.5 Commissioning Goal 5 - Nationally recognised best practice services

<table>
<tr><th>CG 5a</th><th>Development of integrated urgent care centre</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2">We are currently establishing a fully integrated primary care Urgent Care Centre for patients who have an urgent care need presenting at Royal Sussex County Hospital. This integrates walk-in urgent care services provided by BSUH and South East Health Limited with GPs.<br><br>During 2009/10 we will<br>• Fully implement this service<br>• Specify and procure the next phase of the project to optimise the case mix to ensure that all appropriate patients are treated at the Urgent Care Centre rather than in A&E<br><br>In the longer term this will integrate with the Out of Hours primary care service.</td><td><u>Outcome Measure</u><br><br>45% of total A/E attendances to be seen and treated in the UCC in phase 4<br><br>60% of total A/E attendances to be seen and treated in the UCC in phase 5<br><br><u>Activity Impact</u><br><br><table><tr><th></th><th>Reduced attendances in ED</th><th>Additional activity in UCC</th></tr><tr><td>2009/10</td><td>(24,216)</td><td>24,216</td></tr></table><br><u>Workforce Impact</u><br><br>It is expected that staff will be redeployed and retrained.</td></tr>
<tr><td colspan="2"><u>Key Milestones</u><br><br>• Phase 4 implementation 1 April 2009<br>• 12 months notice to OoH provider – September 09<br>• Phase 4 service review at six months – October 2009<br>• 6 months notice to phase 4 provider March 2010<br>• Phase 5 specification complete – April 2010<br>• Phase 5 procurement complete Sept 10 (forecast)</td><td><u>Cost Impact</u><br><br><table><tr><th></th><th>Reduced attendances £'000</th><th>Cost of UCC £'000</th></tr><tr><td>2009/10</td><td>(1,310)</td><td>1,439</td></tr></table><br><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Acute Pledges 1 and 3, VSC 20, 21 and 14</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 5 – commissioning nationally recognised best practice.</td></tr>
</table>

<table>
<tr><th>CG 5b</th><th>Effective gateway and referral management</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">Brighton Integrated Care Service, a GP led service has been established to triage referrals and direct patients to the most appropriate clinical service. BICS is also contracted to ensure that all Brighton & Hove patients who need to be referred for a consultant led opinion following triage are offered a choice of secondary care provider and that their appointment for a first outpatient attendance is made at a time and date that is convenient to them, secured through the Choose and Book system.<br><br>In 2009/10 we will strengthen the primary care market's capability, capacity and infrastructure through alignment of established gateway management service with Map of Medicine.</td><td><u>Outcome Measure</u><br><br>Patient referrals –Reduction of 5% from Year 2 (2009/10).<br><br><u>Activity Impact</u><br><br><table><tr><th></th><th>Reduced new appointments</th><th>Reduced follow up appointments</th></tr><tr><td>09/10</td><td>(3,005)</td><td>(3,468)</td></tr></table></td></tr>
<tr><td><u>Workforce Impact</u><br><br>Impact on BSUH permanent staff minimal compared to 2008 levels.<br><br>Map of Medicine becomes an integral part of GPs, clinicians and commissioner's roles in developing an agreed consistent level of referral behaviors and improve the quality of referrals.<br><br>Improved experience and local knowledge of GP triages and established relationship with primary and secondary care.</td></tr>
<tr><td colspan="2"><u>Key Milestones</u><br><br>Map of Medicine: (dates to be agreed)<br><br>1. Develop project plan and establish governance<br><br>2. Train PCT staff<br><br>3. Agree pathway roll out plan<br><br>4. Agree and implement Incentive scheme<br><br>5. Implement plan</td><td><u>Cost Impact</u><br><br><table><tr><th></th><th>Reduced appointments £'000</th><th>Costs of scheme £'000</th></tr><tr><td>09/10</td><td>(849)</td><td>167</td></tr></table><br><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Vital Sign Targets:<br><br>1. Patient –reported measure of choice of hospital.</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 5 – commissioning nationally recognised best practice.</td></tr>
</table>

<table>
<tr><th>CG 5c</th><th>Effective pathways</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">We are currently redesigning of a number of key care pathways where we have identified significant opportunities for the further development of community based planned care services.<br><br>In 2009/10 we will re-design the following pathways:<br>• musculo-skeletal,<br>• ophthalmology (Eye Academy),<br>• urology,<br>• adult hearing aids,<br>• vasectomy,<br>• restorative dentistry<br>• fertility services.<br><br>In addition we will develop community clinics or extend existing ones in the following areas:<br>• headache clinic,<br>• gynaecology clinic (including direct access to ultrasound),<br>• minor eye conditions,<br>• dermatology,<br>• ENT and urology.</td><td><u>Outcome Measure</u><br>n/a</td></tr>
<tr><td><u>Activity Impact</u><br>Proposed reduction in activity (new and follow up appointments) taking place in acute hospital settings.<br><br><u>In activity terms:</u><br><table><tr><th></th><th>Reduced new attendances</th><th>Reduced follow up attendances</th><th>Reduced other currencies</th></tr><tr><td>2009/10</td><td>(5,272)</td><td>(7,062)</td><td>(2,682)</td></tr></table><br><u>Workforce Impact</u><br>• Develop primary care capabilities and strengthen local market to manage care transferred from hospital into the community.<br>• Transfer of some secondary care clinicians into community settings.<br>• Development of GPwSI and specialist nurse roles in the community.<br>• BSUH is assessing whether the redesign of pathways for these specialties will require changes to establishment.</td></tr>
<tr><td colspan="2"><u>Key Milestones</u><br>• MSK – implement Sept 09<br>• Eye Academy – April – Jul 09<br>• Urology – Jun 09<br>• Adult Hearing Aids – Oct 09<br>• Vasectomy – Sept 09<br>• Restorative Dentistry – Bus Case Feb 09, implementation tba<br>• Fertility Services – Sept 09<br>• Community Clinics (x6) – Jun – Sept 09</td><td><u>Cost Impact</u><br><table><tr><th></th><th>Reduction £'000</th><th>Costs of scheme £'000</th></tr><tr><td>2009/10</td><td>(2,021)</td><td>1,617</td></tr></table><br><u>Equalities Impact</u><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br>Vital Sign Target –<br><br>1. Patients seen within 18 weeks for admitted and non-admitted pathways, 6 weeks diagnostics and patient reported experience of 18 weeks pathways<br><br>2. Patient – reported measure of choice of hospital.</td><td><u>Link to Outcome/Commissioning Goal</u><br>Commissioning goal 5 – commissioning nationally recognised best practice.</td></tr>
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| CG 5d | Timely access and choice | Impact Summary 2009/10 |
|---|---|---|
| In 2009/10 we will:<br><br>For Choice, Choose and Book:<br>• Expand CAB functionality to include 2WW, Diagnostics and primary care services<br>• Ensure funding for continued Project Support role at BSUH<br>• Increase awareness of choice.<br><br>For 18 weeks:<br>Moving to a sustainable 18 week health care system; including maintaining 18 week performance for orthopaedics at Sussex Orthopaedic Treatment centre.<br>Improve patient experience of health care services;<br>Maintain average waiting time of 9 weeks ongoing basis - January 09 performance was an average of 7.4 weeks.<br>Linked to effective care pathways.<br><br>For Direct Access to Diagnostics:<br>Diagnostics and primary care services; | | *Outcome Measure*<br>Increase utilisation of CAB to book consultant led first outpatient appointments.<br>Compliance on data completeness (within the defined range of 90% - 110%).<br><br>At least 90% of patients on admitted pathways will receive their first stage of treatment within 18 weeks of being referred from 1st December 2008.<br><br>At least 95% of patients on non-admitted pathways will receive their first stage of treatment within 18 weeks of being referred from 1st December 2008.<br><br>Maintain average waiting time of 9 weeks ongoing basis.<br><br>*Activity Impact*<br><br>Activity has been captured within two other initiatives: Effective gateway and referral management and effective pathways. |
| *Key Milestones*<br><br>Convert adhoc and on request clinics to permanent as appropriate Feb 09<br><br>Roll out 2WW clinics Feb 09<br><br>Develop patient choice survey and patient experience plan Mar 09<br><br>Roll out Diagnostics clinics Jul 09<br><br>Roll out Primary Care services Sept 09<br><br>Deploy hand held devices in key improvements areas Oct 09 | | *Workforce Impact*<br>• Change in consultant's rotas, job plan;<br>• Centralising administrational support services to support 18 weeks reporting and validation;<br>• Extended 24/7 working arrangements for some diagnostics testing.<br>• Some consultant capacity gaps due to rising demand.<br><br>*Cost Impact*<br><br>£42k additional investment<br><br>Increased level of funding within acute contract from 2008/09 baseline position rolled forward and increase investment of £250k for physiotherapy<br><br>*Equalities Impact*<br><br>Will be assessed during implementation of initiative. |

| *Linked Pledges and Targets* | *Link to Outcome/Commissioning Goal* |
|---|---|
| Planned Care Pledge 1, 3, 4 and 5. Vital Sign Targets:<br><br>1. Patients seen within 18 weeks for admitted and non-admitted pathways, 6 weeks diagnostics and patient reported experience of 18 weeks pathways; and an average waiting time of 9 weeks.<br><br>2. Patient –reported measure of choice of hospital. | Commissioning goal 5 – commissioning nationally recognised best practice. |

| CG 5e | Health Care Acquired Infections | Impact Summary 2009/10 |
|---|---|---|
| We are currently provide leadership across the Local Health Economy (LHE) on HCAI through working with partner organisations and participation in a LHE HCAI Action Group. There are a number of PCT led initiatives approved by the Board and outlined in the PCT HCAI Action plan.<br><br>In 2009/10 we will<br>• Continue to lead the reduction of healthcare acquired infections (HCAI) across the local health community by ensuring a local health community HCAI monitoring and action plan.<br>• Work closely with partners within the Local Health Economy group to ensure that HCAI are collectively and effectively tackled.<br>• Implement the MRSA national screening programme for all elected cases across the city ahead of the requirements for the national 2011 programme.<br>• Review all C.diff HCAI with a view to adjustments to trajectory based upon 96 hour period for defining community acquired versus hospital acquired.<br>• Take specific measures to ensure improvements in infection control in primary and community care by:<br>○ Undertaking root cause analysis of all MRSA and C.Diff community acquired cases in the LHE;<br>○ The production a report on community acquired C.Diff for presentation to the Board based on monitoring and lessons learned from RCAs;<br>○ Leading on and facilitating infection control standards and ensuring that all contractors deep clean assurance declarations are confirmed by observed practice.<br>○ Ensuring all NHS, independent and private company contracts and service level agreements have a named and trained Infection Control<br>○ Inspecting all new and existing contractors' Infection Control standards and action plans<br>○ Ensuring all independent and private contractors have a tailored cleaning regime fit for their purpose; | *Outcome Measure*<br><br>Reduction in the rate of MRSA healthcare acquired infections to 43 cases in 2008/09 (from 63 cases in 2007/08).<br><br>A three year target for C.Diff has been agreed with local providers and the SHA. The trajectory will be revised pending the review of community versus hospital acquired C.Diff infections. The trajectory will be monitored on a monthly basis with monthly reporting to the Board.<br><br>*Activity Impact*<br><br>Reductions in MRSA infections will result in reduced length of stay. Given the small number of infections currently and plans to reduce this further this is unlikely to have significant impact on activity.<br><br>Reductions in C.Diff admission and infection rates will have a significant impact in reducing length of stay, avoidable illness and preventable death.<br><br>*Workforce Impact*<br><br>The PCT has provided further primary and community support to reduce HCAI in 2007/8 by the recruitment of a HCAI –control nurse.<br><br>In addition, further resources were secured for primary and community training and development activities through SHA HCAI specific funding.<br><br>The PCT HCAI control nurse will produce a quarterly report on MRSA screening for the Primary Care Trust for the DIPC to present to the Board.<br><br>The PCT HCAI control nurse will continuously monitor Community Acquired C.Difficile |

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- Undertaking specific HCAI training for primary care and out of hours (OOH) staff.
- Ensuring all contractors participate in national clean your hands campaigns and all staff undertake annual hand hygiene training, confirmed at contract review meetings.

</td><td>infections and produce a quarterly report on RCAs for the DIPC to present to the Board.<br><br>At BSUH, all members of the workforce have a personal obligation to act to reduce HCAIs. They must attend mandatory training in infection prevention and control and be compliant with all measures required by the Trust. Post holders must be familiar with the Trust's Infection Control Policies, such as the Hand Decontamination Policy, the Dress Code and Personal Protective Equipment Policy. Staff members who have clinical responsibilities must incorporate into their clinical activities up-to-date evidence that supports safe infection control practices and procedures, for example the use of aseptic techniques and the safe disposal of sharps. No change to the establishment of the Trust's Infection Control Team is envisaged in 2009/2010.</td></tr>
<tr><td rowspan="2">*Key Milestones*<br><br>All milestones to be implemented by April 2010.<br><br>Learning event will be held by Dec 09.<br><br>Reports to the Board (every formal Board meeting) on progress with HCAI control.<br><br>Implementation of MRSA Screening by December 2009.<br><br>RCA process agreed and monitoring in place by April 1st 2009.<br><br>MRSA screening monitoring in place by August 2009.</td><td>*Cost Impact*<br><br>No additional costs.</td></tr>
<tr><td>*Equalities Impact*<br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td>*Linked Projects and Targets*<br><br>Overarching Pledges 1 and 2</td><td>*Link to Outcome/Commissioning Goal*<br><br>Commissioning goal 5 – commissioning nationally recognised best practice.<br><br>Outcome O7 – reduce the prevalence of MRSA in the local acute hospital to exceed best practice.</td></tr>
</table>

<table>
<tr><th>CG 5f</th><th>Improved/Increased access to primary care services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">We are improving access to a range of primary care services by increasing the number of convenient appointments and venues within primary care and providing services which are open at the right times, in the evenings and at weekends as well as routinely during weekdays.<br><br>In 2009/10 we will improve the number of ways patients can access medical advice within primary care e.g. speaking over the telephone, translation services and outreach clinics. It will be delivered through:<br>• A GP led health centre opening 8am-8pm 7 days per week.<br>• Increasing practices offering extended hours, late evenings, mornings, and weekends.<br>• Improving access to optometry<br>• Improving access to quality dental care</td><td><u>Outcome Measure</u><br><br>64% of GP practices offering extended opening hours.</td></tr>
<tr><td><u>Activity Impact</u><br><br>We will build up a list of 6,000 registered patients over five year period at the GP Led Health Centre. (2009/10 figure tbc)</td></tr>
<tr><td><u>Workforce Impact</u><br><br>Minimal for NHS staff.</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br>• GPLHS opens 1st July<br>• Implement robust procurement and performance management processes for optometry – Board review Feb 09.<br>• Dentistry: Robust performance management of dental contracts, strategic development of oral health<br>• Accessing Restorative Dentistry capacity(date tbc)<br>• Implementing robust performance management Jun 09<br>• Establishing an appropriate procurement process Jun 09 – Apr 10.</td><td><u>Cost Impact</u><br><br>£1.0m for the GP led health centre in 2009/10.<br><br>Other costs within baseline.</td></tr>
<tr><td><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>VSA07, Planned care pledges 2 and 6.</td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 5 – commissioning nationally recognised best practice.</td></tr>
</table>

<table>
<tr><th>CG 5g</th><th>Improved quality of primary care services</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="2">We will drive up the quality of primary care across the board through an enhanced performance management framework.<br><br>We will collate performance information from a variety of sources in the form of a balanced scorecard. From this it will draw a number of key indicators and establish minimum performance standards. These standards will inform the type of practice visit and its focus, providing a transparent basis for discussions with practices and a firm base from which to plan practice developments.</td><td><u>Outcome Measure</u><br><br>Improved QOF scores, improved performance a whole range of indicators including immunisations, cervical cytology and influenza.</td></tr>
<tr><td><u>Activity Impact</u><br><br>No activity implications are anticipated at this stage. The development of organisational development plans will identify additional, phased activity requirements.</td></tr>
<tr><td colspan="2" rowspan="3"><u>Key Milestones</u><br>• Introduction of a performance and quality framework for Primary Medical Service contracts (paper due February 09)<br>• Implement pilot summer 09</td><td><u>Workforce Requirements</u><br><br>Minimal.</td></tr>
<tr><td><u>Cost Impact</u><br><br>Existing funding</td></tr>
<tr><td><u>Equalities Impact</u><br><br>Will be assessed during implementation of initiative</td></tr>
<tr><td colspan="2"><u>Linked Projects and Targets</u></td><td><u>Link to Outcome/Commissioning Goal</u><br><br>Commissioning goal 5 – commissioning nationally recognised best practice.</td></tr>
</table>

<table>
<tr><th>CG 5h</th><th>Medicines Management</th><th>Impact Summary 2009/10</th></tr>
<tr><td colspan="2" rowspan="3">Annual primary care prescribing costs for NHS Brighton and Hove are £36m. During 2008/09 we:<br><br>Undertook intensive work with GPs to contain prescribing costs and promote best practice in prescribing. We also ran a campaign to reduce drug wastage. We are forecasting a 2% reduction in year on year prescribing costs (cf SHA average of 0.4% growth)<br><br>In 2009/10 we will:<br>• Further improve patient safety and reduce patient risk in conjunction with health care partners in relation to the use of medicines<br>• Continue to deliver improved clinical and cost effective medicines management within the local health economy<br>• 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<br>• Improve the use of information for patients in relation to medicines services and medicines management, and engage with public representatives to deliver the strategy.<br>• Ensure that medicines issues are fully addressed in emergency planning programmes.</td><td><u>Outcome Measure and Targets</u><br><br>NHS Better Care Better Value indicators measure PCT performance in five areas:<br>• Increasing low cost statin prescribing<br>• Increasing low cost prescribing for lipid modification<br>• Increasing generic prescribing<br>• Increasing low cost proton pump inhibitor prescribing<br>• Increasing low cost prescribing for drugs affecting the renin-angiotensin system<br><br>The PCT target for all indicators is to be within the top (best) quartile for PCTs for these measures.<br><br>http://www.productivity.nhs.uk/</td></tr>
<tr><td><u>Activity Impact</u></td></tr>
<tr><td><u>Workforce Impact</u><br><br>Recruiting one pharmacist and administrative support to improve the management of high cost drugs and to support the Area Prescribing Committee</td></tr>
<tr><td colspan="2" rowspan="2"><u>Key Milestones</u><br><br>Milestones are being developed as part of team objective setting</td><td><u>Cost Impact</u><br><br>Projects funded through efficiency saving. In addition 3% cash releasing efficiency savings delivered.</td></tr>
<tr><td><u>Equalities Impact</u><br><br>Projects include provision of services from community pharmacies for hard to reach groups.<br><br>Needs assessment in progress.</td></tr>
<tr><td colspan="2"><u>Linked Pledges and Targets</u><br><br>Overarching pledges 2 and 10.</td><td><u>Link to Outcome/Commissioning Goal</u></td></tr>
</table>

## 4 Workforce

The Annual Operating Plan indicates a radical shift of care from acute settings into primary care and the community and proposes to expand the range of providers of these services through.
Brighton and Hove Strategic Workforce Group has been set up to ensure that there is a co-ordinated approach to both workforce planning and commissioning education of the city. This group is newly formed and is still in the developmental stage. Currently has representation from the acute trust (Brighton and Sussex University Hospitals Trust), the community trust (South Downs Health), the mental health trust (Sussex Partnership Trust), Brighton and Hove City Council and the Children's and Young People's Trust.

Appendix F sets out the Workforce Plan in the local health economy terms. Work is still underway to assess the full workforce impact of each of our initiatives.

## 5 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 care, Sussex Partnership NHS Foundation Trust for mental health services and South Downs Health NHS Trust for community health services. Ambulance Services are provided by South East Coast Ambulance services and specialist services (mainly London based) are commissioned via the Specialist Commissioning Group based in NHS West Sussex. Contractual arrangements with these groups are described in Appendix C.

As we implement the initiatives described in this plan, where services are to be provided in the community, unless there are particularly good reasons to do otherwise, any willing provider should be free to provide the service as long as they can demonstrably meet the quality standards and criteria stipulated by NHS commissioners. The aim of this approach is to expand the range and number of service providers, and to encourage competition within the service rather than for the service. This is expected to drive up quality and standards, and to provide patients with a greater range of choices.

## 6 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) 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 has a joint legal agreement with the Children's and Young Peoples Trust to deliver children's services. Many of these services are already included in the commissioning goals in the Plan ie Teenage Pregnancy, CAMHS, Childhood Immunisations and Childhood Obesity.

In addition to this, the CYPT and PCT have agreed 6 priority areas from the Healthy Lives, Brighter Future Children's Health Strategy. These are:

- Safeguarding children and vulnerable children – including appointing 2 new consultant paediatricians with administrative support
- Review provision of equipment for disabled children and implement revised care pathway by 2010.
- Review therapist and allied nursing professionals – including service for disabled children
- Increase provision of information and advice to parents – including services for disabled children
- Review the impact of the prospective changes to the child health plan and the healthy child
- System level transformation – review commissioning and performance management arrangements

The PCT and CYPT will identify requirements for the above priorities, and review existing investments/ potential savings to ensure that investment monies are available in 0910 and beyond to fund these areas.

A number of other joint contracts or Service Level Agreements, where NHS Brighton & Hove and Brighton & Hove City Council work together to contract for services are in place. These are enhanced by the development of joint protocols or joint projects.

## 7 Enablers

This section outlines the key functions of NHS Brighton and Hove which work across all of our commissioning goals to support their delivery. From making best use of

medicines to strategic investment in information technology; these cross cutting functions enable us to implement our plans.

## 7.1 Quality and Patient Involvement

We are committed to commissioning high quality services for our population by strengthening patient and clinical involvement through the commissioning cycle. Our focus will be a shift towards ensuring patients stay healthy and are empowered to make choices about services they require. In response to this we will commission services which clearly deliver quality outcomes and patient satisfaction.

Quality is underpinned by three key principles:

- Empowering patients
- Placing staff at the heart of clinical decision-making
- Ensuring value for money

To support these principles our Professional Executive Committee (PEC) and Clinical Executive oversee the development and overview of the PCT's clinical strategy. The Strategic Clinical Advisory Forum, working with other clinical fora, is tasked with harnessing and developing clinical input into emerging service models. It, with the PEC, ensures the connection and fit with local practice based commissioning initiatives and the wider strategic change programme, it ensures that service changes do not adversely affect or impact on the health of the local population, or adversely affect health inequalities. The forum helps to assess clinical proposals against identified criteria and receives recommendations from clinical reference groups.

Patients, and other key stakeholders, are involved in the development of commissioning plans and service re-design. We continue to work with provider organisations to ensure consistency of service provision and to ensure that services are outcome focused and evidence based. Information on patient experience is gathered from individuals, key stakeholder groups and real time patient data using the Picker handheld patient device. Information is analysed and collated through the Health Care and Standards Group, a sub committee of our Quality Review Board, and is used to inform and develop services.

Our aspiration is to ensure that all commissioned services are high quality, consistently providing good access, delivering safe, clinical best practice and meeting the needs of patients. We seek continuous improvements in service quality. Patients and clinicians remain central to our programme of quality improvement. To that end we have commissioned a piece of work to further embed quality in every step of commissioning in order to ensure services are effective, safe and patient experiences are positive. Our Quality Framework will ensure that quality is the organising principle for everything we do' and is everyone's job.

We are investing a further £145k specifically on the Patient and Public Involvement service in 2009/10. Work includes:

- Addressing equalities issues for the PCT by providing additional training, ensuring equalities impact assessments are completed, and carrying out an equal pay review
- Implement mental health advocacy in the voluntary sector
- Implement Picker terminals
- Introduce carers breaks
- Ensure 'Deprivation of Liberty Safeguards' duty carried out

- Reform health and social care complaints handling

## 7.2 Practice Based Commissioning (PBC)

Practice based commissioners are working closely with Brighton Integrated Care Service to deliver a range of community clinics as detailed in commissioning goal 5c above. In addition the localities have worked with the PCT to develop further priorities to pursue in 2009/10.

The top three initiatives in the table below were the top priorities for PBC not already in progress. These will now be progressed jointly by the PCT and PBC. Other priorities listed are those already identified in the Strategic Commissioning Plan or those where the PCT had already committed to undertake scoping exercises.

PBC has resources available and will now undertake an exercise to decide which of these initiatives to allocate these resources to. This will allow work to be expanded or fast-tracked to provide improved outcomes in 2009/10.

| Priority Area | Notes/actions | Links within AOP (where applicable) |
|---|---|---|
| Electronic discharges (incorporating Docman software/EDT) | Steering group already established. Funded via existing resources. | |
| Eating disorders (local, early stage service) | Gap in service provision. Work will be scoped during 2009/10. Potential to reinvest resources currently spent in tertiary referrals. | |
| Pain clinic | Need to establish how this would interface with the redesign of the muskulo-skeletal service. Work will be scoped during 2009/10. | CG5c Effective Pathways (MSK) |
| Allergy services | Gap in service provision. PCT will scope potential for a specifically commissioned allergy service. | |
| Holistic gender migration | PCT will scope the potential to revise the service model. | |
| Patient transport | Scoping exercise during 2009/10. It is anticipated that a specific patient transport service that meets local needs will be commissioned from 2010/11. | |
| Improving mental health services | PCT focus on initiatives around suicide prevention, alcohol, IAPT and CAMHS | CG2b Child and Adolescent Mental Health Services<br>CG3a Reducing suicide<br>CG3b Alcohol<br>CG3d Improving Access to Psychological Therapies |

| Priority Area | Notes/actions | Links within AOP (where applicable) |
|---|---|---|
| Cognitive behavioural therapy | Already incorporated in the IAPT initiative | CG3d Improving Access to Psychological Therapies |
| Improving physiotherapy | Already planned in the redesign of the muskulo-skeletal service. | CG5c Effective Pathways (MSK) |
| Back pain clinic improvements | Incorporated in the redesign of the muskulo-skeletal service. | CG5c Effective Pathways (MSK) |
| Speedier access to diagnostics | Diagnostic clinics and other initiatives included under Timely Access and Choice. | CG5d Timely Access and Choice |
| Dept of medicine for the elderly | Links to the rapid access clinic for older people and Roving GP initiatives. | CG4a Prevention of admission pathway |
| Funding for palliative care | End of Life Care strategy is included in the Plan. | CG4d End of life care strategy |

## 7.3 Infrastructure and Capital planning

The infrastructure of the buildings within Brighton & Hove is mixed, with a significant part of the acute and community sectors operating from Victorian or outdated health care facilities. Over recent years the process of renewing this infrastructure has begun, with significant developments on the Royal Sussex County site including the Millenium Wing, renal unit and the Children's Hospital. BSUHT have vacated the Victorian wards at Brighton General and have reprovided those community beds in a range of community facilities in and around the city.

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, these are primarily around the replacement and upgrade of core IT and office systems in the next few years. The PCT is also mindful that the finance lease will come to an end in 2011/12 and is working with local health economy partners to ensure that this asset is utilised in the most effective way.

However, the PCT has a key role in supporting the capital programmes and projects across the local health economy. While capital projects are a matter for the individual NHS body, the PCT has an Estates Strategy (due to be refreshed April 2009) which reflects and influences the overall direction of travel for estates and major capital schemes within the Brighton and Hove area. £840k is available in the baseline budget to deliver the Estates strategy in 2009/10.

The PCT has a key role in signing off the major assumptions and supporting significant capital developments in the local health economy. The Teaching, Tertiary and Trauma Outline Business Case is currently under development, with oversight through the Local Health Economy Directors of Finance, while there is ongoing work with South Downs Health on the opportunities and risks around the Brighton General Hospital site and similar community capital issues.

The new GP Led Health centre will open in July 2009. The PCT is considering whether to apply to be part of the national Express LIFT Scheme to take forward a Polyclinic development at BGH and all future primary care developments.
The Sussex Partnership Trust have been granted permission to build their Headquarters adjacent to the Sussex Medical School. Any primary care development would therefore need to be an extension to the polyclinic building. This could also be considered as part of Express LIFT.

The PCT supports both main service providers in the development of business cases for capital investment which reflect key local priorities, and national objectives, including privacy and dignity.

## 7.4 Information Technology

The key priorities for the Health Informatics Service in 2009/10 are as follows:

**i. Summary Care Record (SCR)**

This will provide authorised staff faster easier access to reliable information about patients. The SCR will initially contain demographics, current medications, adverse reactions and allergies. The record can be enhanced with additional information in consultation with patient and at GP's discretion. Further benefits will be released for patients with long term conditions and health space users where patients can view their record. £374k has been budgeted for this project in 2009/10.

**ii. Information governance / security of patient data**

Patients and users will have a better standard of patient data security through the Statement of Compliance (IGSoC), SCR and the planned Smart card upgrade

**iii. Data quality**

Patients and users will have a better standard of quality through the IM&T DES and practices can implement improved processes to benefit efficiency and reduce problems

**iv. Capability and capacity**

Implementation of the enablers to deliver these programmes are planned as part of the Local Health Community strategy and will identify key drivers

**v. Community provider activity systems**

Community systems have undergone months of option appraisals to ensure the replacement system for community sufficiently meets the needs and can integrate with GP systems to provide shared electronic data to contribute to better patient care

**vi. National IM&T expectations**

NPfIT primary care programmes such as Summary Care Record, Electronic Prescription Service, GP2GP, Choose & Book, Prison Health IT and new community systems are planned deployments that when correctly implemented will provide immediate benefits in general practice and pharmacies

A full list of IT initiatives is included in appendix B.

## 7.5 Communications

The communication team works to develop and protect the reputation of NHS Brighton and Hove as the leader of the local NHS. That primarily means explaining our work to staff and local people and working with the engagement team to enhance patient and public involvement. Our tools include web sites, printed publications, events and briefings as well as working with the media. Key tasks for 2009/10 include campaigns around healthy eating and exercise, reducing alcohol-related harm and smoking cessation; updating emergency preparedness communications plans; developing and implementing communications plans for dental services. There is £160k in our baseline budgets for communications.

## 7.6 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.

## 7.7 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.

## 7.8 Emergency Preparedness and Winter Planning

The PCT recognises its legislative obligations to cooperate with NHS organisations, other contracted healthcare providers, local authorities and other responders and local organisations to put plans in place to enable an effective response to major incidents, such as train derailments, natural disasters, terrorist attacks, and public

health incidents. The Resilience Manager co-ordinates these activities, and ensures PCT participation in Sussex Resilience activities via the Local Resilience Forum. The PCT has produced a pandemic influenza plan for Brighton & Hove with the support of other local responders, & health and other agencies in the City. During 2009 / 10 and beyond, this plan will be further refined, developed, tested and reviewed as appropriate, to take account of lessons learned and of developments in the national arrangements for pandemic influenza preparedness. The PCT is also engaged on a 'root and branch' business impact analysis, with a view towards a complete review of Business Continuity Plans. These will be compatible with the current standard BS25999, in accordance with NHS requirements, and the review will be ongoing during 2009. The PCT is also engaged in other work related to preparedness, such as ensuring the maintenance of Heat-wave related plans, working with contracted primary care services to ensure the development and appropriateness of their individual preparedness arrangements, and developing our contractual arrangements with stakeholder NHS Trusts to ensure that their preparedness arrangements conform to current standards.

The operating framework makes clear the priority placed on PCTs and their health economies to ensure they can effectively respond to any major incident which may impact on the health of the population. We are working towards including robust and workable emergency preparedness and response clauses in their contracts and service level agreements with NHS organisations and other healthcare service providers, to ensure they be able to affect an appropriate response, in line with the requirements of the Civil Contingencies Act (2004).

We will test aspects of their pandemic flu plans during 2009/10 in conjunction with our local health economy's health care providers and partners.

All PCTs need to ensure that a review of system resilience during the 2008-09 winter takes place to inform winter planning for 2009-10. The PCT is reviewing the actions to support its winter plan in 08/09. This will identify any earlier actions needed to improve the mobilisation of the winter plan for 2009/10. This work is being led by the Whole Systems Manager

## 7.9 Workforce Strategy

We aim to develop a culture of continuous development and improvement for all staff.

We will build on existing high standards and challenge the workforce to reach new standards of excellence in what they do and how they work.

Our workforce strategy addresses two areas:
Our responsibility for workforce development within the wider health community, and developing capacity and capability of the commissioning organisation.

We aim to recruit, train and develop a workforce across the city that reflects the diverse and changing population it serves.

As the local leader of the NHS, we will ensure that our providers have high standards on equality and diversity which is maintained through their governance, workforce, user engagement and service delivery plans. This will be enforced through our contracting and tendering arrangements and monitored through the performance management framework.

We are responsible for developing a city-wide workforce development framework to support the delivery of the Annual Operating Plan by:

- Giving leadership and guidance to providers on how the city's workforce could be shaped to meet the stated commissioning intentions.
- Giving leadership to the development of the health community's workforce plan.
- Risk assessment and assurance of provider plans, general service and policy direction.
- Liaising with the SHA on behalf of the local health community.

We will ensure that providers meet the key workforce competences as part of the commissioning assurance process. The competences are:

- Workforce availability.
- Leadership and talent management.
- Staff engagement.
- Employment models.

## 7.10 World Class Commissioning Development Plan

In December 2008 the PCT underwent its first assessment as part of the nations World Class Commissioning (WCC) assurance process. The recommendation arising from the panel review have been incorporated into a revised organisational development plan which includes the actions necessary to support improvements in competencies, achieved of year priority health outcomes, strategy and governance arrangements. The development plan captures the key themes for improvement and in particular how the PCT will develop the enhanced capacity and capability to deliver excellence in commissioning and achieve its vision, goals and strategic objectives. The development plan identifies seven key programmes, these include:

- Developing our values and culture
- Developing effective communications and staff involvement
- Equality and Diversity
- Realigning structures, capacity development and business processes
- Talent management and succession planning
- Strategic workforce development

The PCT will make a number of key investments in capacity across the organisation which will support the delivery of the AOP priorities as welll as long term capability within the organisation. The improvements are detailed in the organisational development plans.

## 7.11 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.

# 8 Finance

## 8.1 Source and application of new funds

The table below outlines the new resources available to the PCT and how the PCT proposed to invest these additional funds.

### Source and Application of new funds

| | | |
|---|---|---|
| **Baseline (RRL)** | | |
| **New Resources (note 1)** | | |
| | 09/10 Recurrent Resource Increase | 21,794 |
| | Non-Recurrent Allocations | 11,029 |
| | **Total** | **32,823** |
| Application of Funds | | |
| (note 2) | Inflation | 5,709 |
| (note 3) | Prescribing | 2,003 |
| (note 4) | CQUIN | 1,552 |
| (note 5) | Additional funding for capacity growth | 6,193 |
| (note 6) | FYE's & unavoidable cost pressures | 2,602 |
| (note 7) | Earmarked Allocations | 10,951 |
| (note 8) | Commissioning goal - net new investment required | |
| | 1) Adding years to life | 285 |
| | 2) Maximising chances for children and families | 905 |
| | 3) Developing a healthy young city | 2,944 |
| | 4) Promoting Independence | (998) |
| | 5) Nationally recognised best practice services | 84 |
| (note 9) | Other enabling new investment | |
| | Improving Patient Experience & Patient Engagement | 145 |
| (note 10) | Contingency Reserve | 4,000 |
| (note 11) | Savings Target | (3,551) |
| | **Total** | **32,823** |

## 8.2 Supporting notes

1 New resources

The PCT has received its allocation for 2009/10 and whilst this is marginally different to the assumptions in the SCP it has not materially affected our investment plans.

Each year we also receive non-recurrent allocations which are ear-marked for particular initiatives with the main item being the protected allocation for Dental services.

2 Inflation

The growth allocation for the PCT was marginally lower than expected however the amount we are required to fund providers in terms of the tariff uplift for inflation is also lower and therefore this represents a modest net pressure from our original assumptions.

3 Prescribing

We have also added inflation and growth funding to prescribing in line with national guidance. However, later in the report you will see that we have also set an efficiency savings target.

4 CQUIN

For 2009/10 for the first time a specific amount of funding has been linked to quality initiatives. Being the first year for Acute this is primarily linked to the collection of PROMS data and for non-Acute to the production of a quality improvement strategy. There is more detail elsewhere in this document.

5 Capacity Growth

As well as the tariff uplift in the plans for all providers we have made an assessment of the level of activity required in 2009/10. This is to maintain the level of service re received from them in 2008/09 and a recognition of growth in demand.

6 Full Year Effects (FYE) and unavoidable cost pressures

In addition to activity plans we have a number of service areas (not driven by activity changes) where we have had to recognise service pressures that emerged during 2008/09. These include NICE drugs £500k, specialist services £600k and World Class Commissioning costs £300k.

7 Ear-Marked Allocations

Please refer to the comments above regarding non-recurrent allocations.

8 Commissioning Goals 1-5

The narrative supporting this section appears elsewhere within this document

9 Other ear-marked new investment

The narrative supporting this section appears elsewhere within this document

## 10 Contingency Reserve

The PCT set an organisation target of a £6m contingency reserve in recognition of the financial risks inherent in our 2009/10 plans. It has not been possible to produce a reserve at this level at this stage in the development of the AOP. A description of the financial risks appears elsewhere in this document.

## 11 Savings Target

The PCT plans for 2009/10 currently include a savings target of £3.55m to enable the trust to breakeven and have sufficient coverage for risk in contingency reserves.

# 9 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 |

## 9.1 Financial risk

An initial assessment of the financial risks within the plan has been made.

| Key AOP risk | Impact | Likelihood | Risk management approach | Residual risk | |
|---|---|---|---|---|---|
| | | | | Impact | Likelihood |
| Our initial assessment is that the contract with BSUH could over-perform in 2009/10. The risk is increased by the uncertainty around changes to the tariff construction and has been estimated at £4.5m. | 4 | 4 | We have established a contingency reserve of £4m. We will also continue to improve our performance and contract management arrangements with the Trust. | 4 | 2 |
| We may be unable to deliver the required savings in the plan. This risk is assessed at £1.0m. | 4 | 3 | We will work with the local health economy to identify robust savings plans. We will also review our cost base for further efficiencies. | 4 | 2 |
| Our plans for 2009/10 contain a number of initiatives that assume the reprovision of services in a new setting and have built within them an assumption of savings. This risk is assessed at £0.5m. | 3 | 3 | We will robustly project manage our plans to ensure delivery of savings. | 3 | 2 |

## 9.2 Delivery risk

| Key AOP risk | Impact | Likelihood | Risk management approach | Residual risk | |
|---|---|---|---|---|---|
| | | | | Impact | Likelihood |
| Insufficient capacity within primary and community services and/or failure to deliver new service to enable transfer of activity from acute hospital. | 4 | 4 | We have put in place robust programme and project management arrangements to ensure delivery.<br>Our plans assume a high level of mitigating costs. | 4 | 1 |
| Unanticipated growth in certain service areas, leading to increased demand. | 3 | 3 | The Director of Finance has set up a local health economy financial planning group to ensure clarity around assumptions and, critically, differences in assumptions. The Contracting Boards have developed risk registers which identify and manage key divergences in plans over time. | 3 | 2 |
| Unanticipated growth in specialist services, or a delay in moving services from London to BSUH. | 3 | 3 | We have included an assumption of 'change delay' in our commissioning plans. | 3 | 2 |
| Dependency on cross agency work and multiple organisations – adding programme complexity. | 4 | 4 | We are developing stronger partnership arrangements and improving the governance of all cross agency projects. | 4 | 2 |
| Lack of capacity and capability within the PCT to deliver on such a large agenda | 4 | 4 | The OD and workforce plans are directly targeted at addressing these issues. | 4 | 2 |

### 9.3 Workforce risk

| Key AOP risk | Impact | Likelihood | Risk management approach | Residual risk | |
|---|---|---|---|---|---|
| | | | | Impact | Likelihood |
| Workforce models are properly costed and fall within the financial envelope. | 3 | 3 | Work closely with all members of the LPG and ensure financial sign off of all provider workforce plans<br>Develop stronger links with service and finance planning colleagues. | 3 | 1 |
| Plan indicates significant changes in the delivery of healthcare which will have an impact on staffing structures within and between providers | 3 | 3 | LPG to work on improving staff transferability | 3 | 2 |
| There might be insufficient capability and capacity within primary and community services to enable the transfer of services from acute settings to more local areas | 3 | 3 | Work with other PCT colleagues to ensure that workforce is considered upfront when considering large scale changes to care settings. | 3 | 2 |
| BSUH has a plan to increase specialist training doctors by 31 between March 09 and August 09 at an additional cost of £1.6 million. The full implication is not adequately reflected in the financial plans and recruitment to the full 31 WTEs is unlikely. | 4 | 3 | Use available funds fromn the EWTD Trained Doctor funding stream to offset any resource constraints for 2009/10. Work with other PCT colleagues to ensure BSUH develops a sustainable solution for compliance. | 4 | 2 |
| Plans at BSUH envisage the expansion of services requiring highly | 3 | 3 | Current career/education pathways are being | 3 | 2 |

| Key AOP risk | Impact | Likelihood | Risk management approach | Residual risk | |
|---|---|---|---|---|---|
| | | | | Impact | Likelihood |
| specialised staff e.g. therapeutic radiographers, nuclear medicine technicians and scientists etc. Traditional training routes struggle to recruit and retain students in these fields. Community therapists and specialist LD nurses can be difficult to recruit. | | | mapped for these groups to identify key recruitment points. These are likely to include recruitment campaigns to attract senior staff and study leave and career pathways for support staff moving to more senior roles. | | |
| Plan envisages greater plurality of providers – this will cause pressure on training, quality and placements. | 3 | 3 | Ensure that contacts/SLAs specify requirements to participate in training and quality reviews and provide placements where appropriate | 3 | 2 |
| BSUH may not be compliant with the European Working Time Directive by August. | 3 | 4 | Start planning now to change working patterns or find ways of funding additional recruitment. | 3 | 2 |
| Providers have indicated a number of workforce hotspots especially in relation to an ageing workforce | 3 | 3 | Use apprenticeships to encourage and (where appropriatye) fast track new entrants into vacancies for estates and maintenance. For community nursing roles – focussing on managing succession and post-retirement employment. | 3 | 2 |
| Anecdotal evidence from all providers indicates that clinical placement provision is under pressure | 3 | 3 | Work with PLFs and Brighton University to identify pinch-points and then develp a LPG-wide strategy for alleviating these using the widest range of | 3 | 2 |

| Key AOP risk | Impact | Likelihood | Risk management approach | Residual risk | |
|---|---|---|---|---|---|
| | | | | Impact | Likelihood |
| | | | options | | |
| Providers have struggled to provide meaningful and costed workforce plans. There is a lack of corporate ownership and planning for the strategic agenda across all provider organisations. Timescales are such that providers are asked to report on financial, activity and workforce plans at the same time, often before the commissioning and demand plans are finalised. | 3 | 3 | Work with organisational decision-making structure to influence reporting timescales both at the Strategic Health Authority and at Department of Health levels. Also use the same structure to increase the profile of workforce planning and development. | 3 | 2 |
| Nurse leadership | 2 | 2 | Wide range of nurse leadership development on offer from SHA, university and within the acute trust. There is a leadership community and a leadership pathway mapped out against available courses. Competencies developed for bands 5-7 and developing in-house ward manager programme. | 2 | 1 |
| Impact on recruitment as already difficulties recruiting to the February intake. NVQ secondees will need additional qualifications to get on the course as some of these are day release this might cause a | 3 | 2 | Look in house to see if there are ways to support staff to do A levels. Discuss with university if they can provide something more flexible. However has been in place elsewhere with no | 3 | 1 |

| Key AOP risk | Impact | Likelihood | Risk management approach | Residual risk | |
|---|---|---|---|---|---|
| | | | | Impact | Likelihood |
| problem. Bursary funding needs to be sorted out at DH level before full impact can be assessed | | | reported concerns on recruitment. | | |

## 9.4 Risk Management and Assurance Processes

NHS Brighton and Hove has agreed a revised Risk Management Plan during 2008/09 and has refined its corporate governance structures to ensure that there are systematic processes and that the organisation is working towards an effective management approach to continually reviewing and mitigating risk within the organisation. Significant assurance has been provided by internal audit.

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. 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 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 and 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 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 must ensure 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 a Risk Manager within the Assurance Team.

**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. It will routinely monitor elements of the Annual Health Check assessment and compliance with the relevant core standards.

**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 register, and reviewing and monitoring the action plans in respect of the most significant risks to the delivery of the organisation's principle objectives as detailed in the corporate risk register.

**The Healthcare Standards and Service Quality Committee**
This is a sub committee of the Integrated Governance Committee and it is responsible for examining trends in incidents, complaints and audits etc to determine whether there are any areas of concern and any resultant risks. It also identifies any risks to the PCT's compliance with the core standards.

**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.