

Agenda item: 11b

Operating Plan - 2010 - 2011

Purpose of Paper:

Attached is NHS Portsmouth's Final Cut Operating Plan 2010-2011, which is being presented to the PCT Board for formal sign-off and approval. This will then be sent to the South Central Strategic Health Authority (SHA) on the 22nd March 2010 for sign-off by the SHA on the 25th March 2010. The Operating Plan attached is the main planning document that has been produced for 2010-11 setting out how NHS Portsmouth will deliver its priorities and objectives throughout the period. In addition to this there is a suite of documents, that will also be submitted to the SHA and form part of the overall Operating Plan, that have been produced as part of the process. These are:

Vital Signs Refresh
Financial Plans (Including DM and CIPs)
Workforce Plans

Although the Operating Plan is being presented to the PCT Board for sign-off, it needs to be highlighted that there are still ongoing negotiations with regard to contracts for 2010-11 and major work continuing with the SE Hants Sustainability Programme. The end result of these negotiations and discussions will potentially have an impact on some of the areas within the plan, in particular the financial aspects.

List the corporate / annual objective that this paper relates to:

- 1 Improve the **quality of life** along with an increase in **life expectancy** raising the lowest to the best to ensure equity and equality of access for all
- 2 Investment in health services and ill-health prevention advice **focused on the young** recognising the long term benefits this brings to them and future generations in both health and social attainment
- 3 Improve the **quality and safety of services** ensuring dignity, control and choice to service users
- 4 Improve access to services for those **most vulnerable** (such as those with mental health problems, learning disabilities), and those from the most deprived populations.
- 5 Investment in **health promotion and social marketing** in partnership with the local authority to help people stay healthy and to take greater responsibility for their own health and well being
- 6 Focus on **cost and clinically-effective ill-health prevention** to allow greater independence and avoid the unnecessary use of hospital services
- 7 Achieve sustained financial stability ensuring **good use of all resources** of the PCT (financial, workforce, buildings, information, IT etc)

S4BH	<input type="checkbox"/> SAFETY C1-C4e <input type="checkbox"/> CLINICAL AND COST EFFECTIVENESS : C5a - C6 <input type="checkbox"/> GOVERNANCE C7a - C12 <input type="checkbox"/> PATIENT FOCUS C13a - C16 <input type="checkbox"/> ACCESSIBLE AND RESPONSIVE CARE C17 - C19 <input type="checkbox"/> CARE ENVIRONMENT AND AMENITIES C20-C21 <input type="checkbox"/> PUBLIC HEALTH C22a - C24	
INRA:	<input type="checkbox"/>	Please type filepath for location of INRA if applicable
UoR	<input type="checkbox"/>	Please select principal Use of Resources ref
Confirm that you have ensured that any financial and legal implications contained in this paper have been considered by:		
The Director of Finance (financial issues): The Director of Corporate Affairs (legal issues):		<input type="checkbox"/> <input type="checkbox"/>
Author: Michael Drake - Associate Director (Strategy)		Date: 10th March 2010
Sponsoring Director: Director of Strategy and System Management		
Actions requested of: PCT Board Recommendation: Approve The PCT Board is asked to approve the 2010-11 Operating Plan.		

Operating Plan



2010 – 2011

Final Cut – Board Meeting 19th March 2010

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1. Overview

The NHS Portsmouth Strategic Plan 2010-2014 defines the PCT vision and direction for delivering the PCTs strategic aims over the next 5 years. The NHS Portsmouth Operating Plan 2010-2011 sets out the detailed initiatives and actions that are to take place over the year to ensure the delivery of the 5 year strategy. The Operating Plan sets out how the PCT will deliver the requirements laid out in the NHS Operating Framework; the *NHS 2010-2015: from Good to Great*; and aligns with, and delivers the requirements of, High Quality Care for All and the SHA's response to it – Towards a Healthier Future.

The key objective of the plan is to set out actions to be undertaken by the PCT during 2010/11 to deliver change against our strategic commissioning priorities. It is a 'living' document and consequently the actions set out under each of the key strategic programme areas are not an exhaustive list, and will be added to as the PCT engages with its partner organisations to deliver service changes.

This plan is underpinned by detailed activity, financial, workforce, informatics and other infrastructure plans and trajectories and actions to ensure delivery will be performance managed by the PCTs internal programme management office (PMO), performance management systems and via the appropriate sub committees of the PCT.

The PCT is committed to working in partnership with local people, the Local Authority and other partner organisations such as NHS Providers, Independent Sector Providers and the Voluntary Sector. The PCT is fortunate to be co-terminus with the Local Authority and jointly works across a number of areas, such as Housing, Education, Social Services and Environmental Health.

Health improvement and a reduction in health inequalities cannot be achieved without partnership working between the PCT, local authority and other key partners. Now that the PCT's Operating Plan and the Local Area Agreement are closely aligned, there is wide stakeholder buy in to key priorities. NHS Portsmouth works with both Portsmouth City Council and the Local Strategic Partnership to deliver agreed priorities.

No service changes can be bought about without the commitment of the clinicians involved or the confidence of the patients receiving the care. Continued involvement of both these key groups will be essential if any of the actions listed in this plan are to become a reality. One of the PCTs key aspirations over the forthcoming year is to further develop its involvement mechanisms for clinicians and members of the public in all aspects of our work – not just in giving feedback but also in helping to develop new models of care and setting priorities.

In summary, the PCT will be regularly communicating and engaging with a wide range of stakeholders to ensure that the joint expertise of the local area is used to maximum effect to improve the health of the local population.

1.1 Focus Areas for 1011

NHS Portsmouth's Strategic Plan 2010-2014 maintains a focus on the hospital/community interface in our local health system (e.g. avoiding unnecessary hospital admissions) and on improving the long-term health of the City's population. As a consequence of this the Operating Plan will focus on how these key areas will be delivered and primarily focus on areas of investment and disinvestment in these areas that have been agreed for 1011 in order to ensure delivery and PCT aims are met. Figure 1 below outlines the main areas of focus for 1011 and beyond.

Figure 1 – 1011 Focus Areas

Prevention and Staying Healthy	<p>Alcohol: reduce harm and avoid hospital admissions</p> <p>Obesity: reduce adult and child obesity levels</p> <p>Smoking: reduce prevalence and increase the number of people quitting</p> <p>Screening: increase uptake and efficiency of local screening programmes</p>
Long Term Conditions	<p>Reduce emergency care</p> <p>Improve self-management</p> <p>Improve care options in primary and community settings</p>
Unscheduled Care	<p>Reduce emergency admissions to expected levels for the population</p> <p>Improve community services to support people in their community/home and improve the hospital/community interface</p> <p>Integrate health and social care community services, particularly to support discharge from hospital</p>
Planned Care	<p>Reduce planned admissions to hospital to expected levels for the population and then to best in class</p> <p>Focus initially on 4 care pathways with greatest gain: Orthopaedics, ENT, Ophthalmology, Oral Surgery</p>
Children and Young People	<p>Reduce paediatric hospital admissions to expected levels for the population</p> <p>Focus on prevention and early intervention</p> <p>Specific focus on improving care for children with disabilities</p>
Clinical Leadership	<p>Increase clinical leaders involved NHS Portsmouth commissioning and planning</p> <p>Reduce inappropriate referrals from primary care to hospitals to levels similar to comparator PCTs</p>
Transformation & Sustainability	<p>Develop capacity and capability within community NHS services to respond to the challenges</p> <p>Develop a community healthcare campus for Portsmouth City to ensure capacity for delivery of healthcare in non-acute settings</p>
Productivity & Collaborative Commissioning	<p>Collaborate with the four southern PCTs and Portsmouth City Council to make best use of limited commissioning resources and align delivery</p>

1.2 Strategic Programme Areas

The main body of the Operating Plan details the plans, targets, milestones and measures associated with the initiatives that have either had additional investment or disinvestment programmes approved by the PCT for 1011 in order to ensure the long term strategic targets of the PCT are achieved. Within the Operating Plan these are divided amongst the PCTs 9 Strategic Programmes, based on broad segments of health and healthcare. These are:

- Staying Healthy
- Planned Care
- Unscheduled Care
- Long Term Conditions
- Children and Families
- Maternity and Newborn
- Mental Health
- Learning Disabilities
- End of Life

Each of the 9 programmes not only contains the detailed plans as described above around investment/disinvestment areas, but also includes a comprehensive listing of all other programmes of work that make up each strategic programmes totality of work for 1011. Each strategic programmes totality of work will incorporate delivery of the following areas as appropriate to each programme:

- National targets (VSAs and VSBs)
- QIPP (SHA McKinsey)

- SHIP/COM Work Programmes
- Local Work Programmes (+ including VSCs)
- Recovery Programmes
- WCC Outcome Measures

As stated above the 1011 Operating Plan maintains focus on plans for the delivery of agreed areas of investment/disinvestment for 1011 to deliver PCT strategic aims. As a consequence detailed plans for delivery of national targets and other areas listed above are only provided where it has been deemed that the PCT is currently not achieving target levels and therefore detailed 'recovery' plans are required. For areas where the PCT is on target, work will continue to ensure that these targets are maintained, but detailed plans for these areas are not provided within this Operating Plan. The list of national targets to be delivered by each strategic programme area can be found in the PCT's Strategic Plan.

In addition there are a number of programmes that enable the delivery of the 9 Strategic Programmes and are cross-cutting themes in all of the commissioning business of NHS Portsmouth. These are:

- Clinical Leadership and Primary Care
- Quality and Safety
- Transforming Primary & Community Services
- Finance
- Medicines Management
- Estates and Infrastructure
- Information Management
- Informatics
- Workforce
- Organisational Development
- Communications and Stakeholder Engagement
- Collaborative Commissioning (SHIP)

Further detail on these enabling programmes and how they will support delivery of the 1011 Operating Plan can be found in the second half of the Plan.

2. Planning Principles and Process

The Operating Plan cannot be developed in isolation, and is informed by a range of national and local documents, including:

- The strategic priorities and direction within NHS Portsmouth's Strategic Plan
- The vision of South Central SHA detailed within 'Towards a Healthier Future'
- The World Class Commissioning Assurance Framework
- The National and Local Operating Framework and *NHS 2010-2015: from Good to Great*
- Local Commissioning Strategies

The planning process itself interlinks the overarching strategic vision of the PCT, the corresponding PCT strategic plan, national planning guidance and the subsequent supporting commissioning strategies. This in turn feeds the production of the commissioning intentions and priorities which are shared and agreed with providers.

This approach ensures that all future service developments are aligned to the agreed overall vision and strategic direction of the PCT. As part of this planning process, NHS Portsmouth

prioritises delivery of the initiatives within its 9 Strategic Programmes (and supporting programmes) based on their ability to deliver our 11 strategic outcomes and aims.

The prioritisation process also focuses on improving quality, innovation, productivity and prevention of ill health (QIPP), in line with the strategic direction set out by the NHS Management Board (May 2009) and the Secretary of State for Health (June 2009). Quality will be a fundamental principle in all that we do. As a foundation to our Strategic Plan, NHS Portsmouth has adopted the national principles of QIPP and these have shaped all of our strategic and enabling programmes and are therefore embedded within this Operating Plan.

The Department of Health (DH) has defined four key principles to underpin the change process at every level of the NHS. These include; co-production, subsidiarity, system alignment and clinical engagement. These principles have also been included in our prioritisation criteria.

The prioritisation phase is the final element of the planning process. This ensures that all aspects of each commissioning disinvestment and investment are considered and that the final decision making process is transparent. The PCT has developed a weighted scoring system to prioritise plans. A full list of criteria has been agreed which include contributions to delivering PCT strategic aims and priorities; contribution to the delivery of national targets; value for money; risk associated with non-implementation; and evidence of stakeholder involvement.

3. Operating Framework Overview

3.1 NHS Operating Framework 2010/11

The operating framework for 2010/11 was published in December 2009. This year is the final year in the current planning round and the first in which the NHS needs to be properly prepared to meet the challenges set out in the 'NHS 2010-2015: from good to great'. The focus remains one of stability and improvement to deliver safe, high quality services, to deliver on those priorities that matter both nationally and locally, and to provide cost effective services.

The vision previously set out in 'High Quality Care for All' remains as do the priority areas to be tackled. The framework identifies a number of mechanisms that are in place to support the NHS whilst it radically changes service delivery to meet the challenges. These include the NHS constitution, the role of the Care Quality Commission (CQC), the role of Monitor and the proposed National Care Services.

The operating framework is a national framework to be delivered locally and the four key principles previously set out in 'High Quality Care for All' of Clinical ownership and leadership; Co-production; Subsidiarity; and System alignment should be embraced. The framework sets out the expectations for local, regional and national organisations in taking the requirements forward.

The operating framework for 2010/11 sets out three key areas:

It sets out our **key priorities areas** for 2010/11. The framework sets out two sets of priorities:

- National priority areas against which NHS organisations will be required to improve
- Areas outside the national priorities on which PCTs and their providers can decide whether they support the delivery of locally agreed priorities

The five national priority areas remain the same. In addition the framework sets out a range of areas where national developments can support local prioritisation focusing on the two overarching ambition of the NHS:

- improving the health and well being of the population and reduce health inequalities
- provide better care to those receiving treatment

The framework sets out a range of **system levers and enablers** to deliver the priorities set out above. These are summarised over five groupings – financial framework; incentives and business rules; workforce; commissioning and system reform; informatics. These are fundamental to delivery of the national operating framework and the PCT operating plan.

It sets out the **planning framework** and timetables for the coming year, with particular emphasis on planning arrangements and partnership working, especially with local authorities, which is crucial to achieving many of the goals laid out. It also sets out the system requirements and performance monitoring and assessment.

3.2 NHS 2010-2015: From Good to Great

In December 2009 the Secretary of State for Health published its strategy for the next five years entitled 'NHS 2010-2015: from good to great. Preventative, people centred, productive'. This strategy was published to set out the route map to build upon and implement Lord Darzi's vision as set out in the NHS Next Stage Review into and through a new challenging period for the NHS to ensure patients and the public have certainty that the NHS will be there for them when they need it.

It recognises that standing still is not an option and in order to face the challenges ahead that quality improvement needs to be accelerated across all areas, recognising that improved quality also offers greater cost effectiveness with a move to a more preventative and people centred and productive approach.

The strategy sets out six challenges the NHS as a modern healthcare system needs to face:

- Ever higher patient expectations
- An ageing society
- The dawn of the information age
- The changing nature of disease
- Advances in treatments
- A changing workforce

Funding in the NHS has risen considerably in recent years and the strategy sets out how the NHS needs to deliver £15-20bn in efficiency savings over the three years from April 2011. Three areas of potential have been identified:

- Creating an empowered, flexible, healthy and productive NHS workforce
- Drive down costs of management, back office support functions and procurement across the NHS and public service generally
- Significant transformation of the way care is delivered in future.

All funding identified by these savings will be kept within the NHS and allow the NHS to meet the demands of the six challenges outlined above.

The commitment remains to implement the vision set out in 'High Quality Care for all' and to put quality at the heart of the NHS. To do this will require complex actions from every part of the system including:

- Using the NHS Constitution to build on the improvements already made, setting out the values and principles of the NHS and giving individuals legally binding entitlements
- Using information technologies to help design and support new models of care as well as improving existing services
- Research and innovation playing a key role in delivering the vision particularly in identifying new ways of preventing, diagnosing and treating diseases
- Ensuring a more productive health services

The document sets out the vision for the future of the NHS, how the NHS can be supported to implement and meet the unprecedented challenge of accelerating quality improvement and drive at efficiencies. Improving quality will continue to be at the heart of everything the NHS does with improvements led locally with no top down reorganisations imposed on local areas. The key to success will be mobilising the whole NHS workforce.

NHS 2010-2015: from good to great sets out the five year strategy and the PCT operating plan responds to the first year of this strategy as well as the NHS operating framework itself.

4. Commissioning Programme Areas

This section details within the templates below the plans, targets, milestones and measures associated with the initiatives that have either had additional investment or disinvestment programmes approved by the PCT for 1011 in order to ensure the long term strategic targets of the PCT are achieved. It also provides a comprehensive listing of all other programmes of work that make up each strategic programmes totality of work for 1011. For areas where the PCT is on target, work will continue to ensure that these targets are maintained, but detailed plans for these areas are not provided within this Operating Plan. The list of national targets to be delivered by each strategic programme area can be found in the PCT's Strategic Plan.

4.1 Staying Healthy

4.1.1 Alcohol

Staying Healthy - Alcohol
Name of Initiatives: <ol style="list-style-type: none"> 1. Improve alcohol education and awareness 2. Increase access to improved treatment and support services 3. Tackle alcohol related crime and anti-social behaviour
Name of National, Regional, Sub-Regional or Local Priority supported:
PCT Strategic Goal <ul style="list-style-type: none"> • Rate of alcohol related admissions per 100,000 population to reduce to the levels seen in 2007/08 WCC Outcome Measure <ul style="list-style-type: none"> • Rate of hospital admissions per 100,000 for alcohol related harm National Target and Local LAA Target <ul style="list-style-type: none"> • VSC26 /NI39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm

a. Executive Lead
<ul style="list-style-type: none"> • Paul Edmondson-Jones
b. Current Position
<p>1. Overall Position</p> <p>Portsmouth has the highest rate of hospital admissions per 100,000 for alcohol related harm (NI39/VSC26) in the South East of England, 1899 per 100,000 population, up from 1794 in 2007/8 (a 5.9% increase). This equates to 3912 people in 2008/9, at an estimated cost of £9,553,104 (hospital admissions only). Based on the trends of the past 7 years it is expected that the level of alcohol related hospital admissions will rise to a rate of 2521 per 100,000 by 2014/15 without significant action. This would increase the cost of these admissions to an estimated £12,681,306 per annum by 2015.</p> <p>In 2008/9 Portsmouth residents accounted for 40,772 A&E attendances, at an average cost of £86.83 per attendance. With approximately 40% of A&E attendances alcohol related this would equate to 16309 attendances, at a cost of £1,416,110.</p> <p>It is estimated that life expectancy in Portsmouth would be increased, by 9.5 months for males and 4.2 months for females, if all alcohol attributable deaths were prevented.</p> <p>The Portsmouth Alcohol Strategy 2009/2013 estimates that the cost of alcohol misuse to society in Portsmouth is £74 million. This includes health costs, costs of crime, crime prevention, criminal justice services, employee absenteeism and performance at work.</p> <p>The Alcohol Strategy provides the following initiatives:</p> <p>Prevent – Improve alcohol education and awareness</p> <ul style="list-style-type: none"> • Improve alcohol education and advice for children • Improve alcohol awareness and support services for families • Promote sensible drinking <p>Treat – Increase access to improved treatment and support services</p> <ul style="list-style-type: none"> • Provide identification and brief advice (IBA) across a range of health and social care settings • Increase the capacity of our treatment services to see more people • Improve our treatment system so that it meets the needs of our residents <p>Enforce – Tackle alcohol related crime and anti-social behaviour</p> <ul style="list-style-type: none"> • Prevent children from obtaining alcohol • Manage alcohol related crime and anti-social behaviour • Increase alcohol interventions for victims and offenders of alcohol related crime <p>1.1 Alcohol education and awareness</p> <p>Currently to support this, the PCT invests in a HIDS (Adolescent Health) Alcohol Project Worker who in 2008/09 delivered alcohol education and prevention work to 2830 children in a range of settings including infant, junior and secondary schools as well as informal settings such as youth clubs. The post holder has also developed lesson plans for schools which will allow teachers to continue developing alcohol education themselves. The PCT also invests in Community Health Practitioners (CHP), a project that is run by South Central Ambulance Service. The role is split in</p>

to two key functions, firstly they provide a rapid response to issues in the night time economy and the second function of the CHPs is health promotion which involves a considerable focus on alcohol. In addition the CHPs also co-facilitate the conditional cautioning clinics with the Drug Interventions Programme, providing alcohol conditional cautions to those the police refer. In addition the CHPs provide general alcohol health promotion advice in various settings.

1.2 Access to improved treatment and support services

Existing services are in place to deliver prevention/harm reduction, engagement and treatment for alcohol dependency. These services contribute to the overall objective of reducing alcohol related hospital admissions through assisting “at risk” individuals to alter their alcohol use and thus prevent escalating to dependency with the associated acute and chronic health issues. Treatment services are also contributing by enabling current dependant drinkers to access the community and in-patient detoxification, rehabilitation and relapse prevention services necessary to ensure sustained recovery and associated health-improvement. The current services available are:

An **outreach service** purchased from Cranstoun Drug Services (voluntary sector provider) delivering outreach service to engage individuals into treatment, including conducting initial assessments and onward referrals into structured and open access services.

Alcohol Interventions Team - The practitioners currently work across Probation, Primary Care and Portsmouth Hospitals Trust.

Community Drug & Alcohol Team provides assessment, community detoxification, psycho-social interventions, key-working and case management for alcohol users, including referral to in-patient detoxification and residential rehabilitation services.

Baytrees provide in-patient detoxification to approximately 140 alcohol patients per annum from Portsmouth City. In addition to medically supervised pharmacological detoxification supported by complimentary therapies, the service provides psycho-social interventions to help patients achieve more lasting behavioural change and sustainable recovery.

The above services work in close collaboration and partnership to deliver a coherent pathway of care for patients, linking in with City Council and SPP funded services delivering residential rehabilitation and aftercare, including reintegration into employment, training and voluntary work.

1.3 Tackle alcohol related crime and anti-social behaviour

Portsmouth residents suffer disproportionately from alcohol related crime and anti-social behaviour. Alcohol, along with drugs, is one of the few areas in which health investment can have a positive impact in terms of crime and safety. Alcohol incidents in the night time economy also place a significant burden on health service costs, including accidents that happen whilst people are drunk. A significant number of ambulance calls relate to alcohol misuse, particularly during peak periods on Friday and Saturday nights. It is estimated that 70% of A&E attendances on Friday and Saturday nights are alcohol related. The PCT currently invests in an **Alcohol Arrest Referral** service. This provides alcohol interventions to offenders at a range of locations. This is a partnership project between the Drug Intervention Programme and South Central Ambulance Service. In addition the alcohol arrest referral service provides alcohol advice sessions as part of Alcohol Conditional Cautions. This is an example of the police and health services working in partnership to achieve both their aims.

2. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

WCC Outcome Measures:

- Rate of Hospital Admissions per 100,000 for Alcohol Related Harm
- Health inequalities
- Life expectancy – Males / Females
- Cancer mortality
- CVD Mortality

PCT Strategic Objectives:

- Improve people’s quality of life, along with an increase in life expectancy, raising the lowest to the best to ensure equality of access for all
- Invest in health services and ill-health prevention advice, focusing on the young and recognising the long term benefits this brings to them, and future generations, in both health and social attainment
- Improve the quality and safety of services ensuring dignity, control and choice for those who use our services
- Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and wellbeing
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services

Local Area Agreement:

- Local Area Agreement Priority 7, ‘Encourage and enable healthy choices for all and provide appropriate access to health care and support’. (7.1 is Rate of hospital admissions per 100,000 for alcohol related harm – NI39)
- Local Area Agreement Priority 4, ‘Make Portsmouth a city where everyone feels safe and is safe’, particularly 4.2 Perceptions of anti-social behaviour – NI 17, Assaults with less serious injury – NI20, 4.5 Repeat incidents of domestic violence – NI 32, 4.7 People killed or seriously injured in road traffic accidents – NI47

Joint Strategic Needs Assessment:

- Revised JSNA 09/10 reconfirmed alcohol as a key health issue for the city.

Safer Portsmouth Partnership:

- Safer Portsmouth Partnership priority ‘Reduce the harm caused by drugs and alcohol’. Key priority in the Community Safety Plan 2008-11. Alcohol has been highlighted as a key issue in the Safer Portsmouth Partnership’s Strategic Assessment 2009.

Portsmouth Alcohol Strategy:

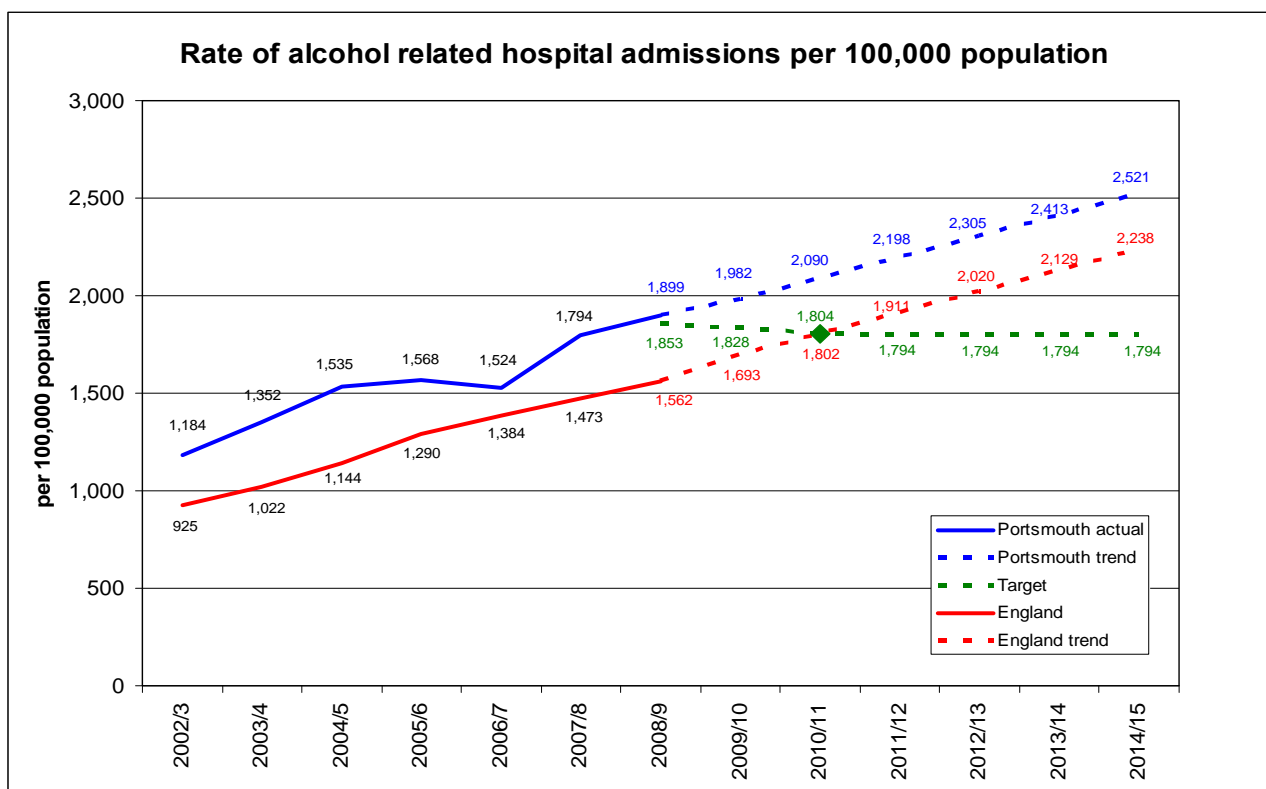
- Portsmouth Alcohol Strategy 2009-2013 – LSP approved document. Lead partnership is the Safer Portsmouth Partnership.

c. Planned Change

The target set out in the Local Area Agreement (LAA) is to achieve a rate of 1804 per 100,000 population by 2010/11. The target following on from that is to reduce this further to 1794 by 2011/12 and then maintain this rate. This will be against a backdrop of a likely rise in admissions in England as a whole.

Whilst in 2010/11 we still expect the Portsmouth rate to be marginally higher than the England average (projected) we hope that by 2011/12 the Portsmouth rate will be lower than the England rate, with the gap growing larger each year until 2014/15 when the Portsmouth rate will be 19.8% lower than the England rate. If we achieve this target the rate will also be 28.8% lower than the current projection for Portsmouth by 2014/15 (2521 per 100,000) – for Portsmouth this would

equate to 1427 less hospital admissions.



In order to deliver this planned change in 1011, the PCT will prioritise and deliver the following programmes of work in order to deliver the 3 initiatives.

1. Improve alcohol education and awareness

1.1 Alcohol Advisory School Nurse - This will provide young people attending A&E whose presentation may be related to alcohol with follow up support. These sessions will provide good quality information and advice to a target group of young people. In addition the generic work of the school nurse service will benefit from the support of a specialist alcohol school nurse.

1.2 Social Marketing (High Impact Change) - To continue to run alcohol awareness campaigns targeted at high risk groups, building on the work of the local 'Save Dave' campaign. To complete market analysis and undertake research to develop effective marketing campaigns. The aim of the campaigns will be to encourage high-risk drinkers to moderate their drinking to low-risk levels either by taking action themselves, or by accessing support services. These campaigns will run for 2 years from 2010 – 2012

Initiative: Improve alcohol education and awareness				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce the number of young people misusing substances from 14.2% in 0910 to 13.85% in 1011 (12.8% by 1314)	Alcohol Advisory School Nurse	Recruit Alcohol Specialist School Nurse	Apr-10	Failure to recruit appropriate member of staff - 6
Increase the number of children that feel the advice and information they receive about alcohol is good enough from 57% in 0910 to 59.5% in 1011 (67% by 1314)	Social Marketing	Social Marketing campaign commences	Sep-10	

2. Increase access to improved treatment and support services

The projects below which have **HIC** next to them have been identified as high impact changes by the Department for Health. These are changes which will be required if we are to reduce our rate of alcohol-related hospital admissions. Without these projects progress will not be sufficient to alter the upward trend.

2.1 Alcohol Local Enhanced Service (HIC) - This service would see high-risk patients being offered alcohol screening and brief advice in primary care. Research cited in the Portsmouth Alcohol Strategy highlighted that 42% of men with hypertension regularly drink above low risk levels (3-4 units per day), 42% of men and 16% of women with depression also drink above these levels. Figures for Portsmouth show that on the 31st January 2009 there were 24,148 people with hypertension and 12993 with depression.

2.2 Alcohol Psychosocial Treatment Service (HIC) - This project will provide an expansion to our alcohol treatment services. This would be an alcohol only service designed to meet the needs of alcohol misusers who are not currently accessing services, for example those working. This service will provide a mix of one to one and group therapy, using psychosocial interventions which have been recognised as effective by NICE. The service will also provide out of hours provision.

2.3 Alcohol Specialist Nurse Service (HIC) - This service is key to the improvement in hospital admissions. The aim of this service is to provide a comprehensive alcohol treatment support service at Queen Alexandra Hospital. The service will employ specialist alcohol nurses to provide a range of alcohol services from the provision of brief advice to overseeing the detoxification of patients who are admitted (planned or unplanned). The service will target patients that have been admitted and show withdrawal symptoms.

2.4 Alcohol Intervention Team - This service will enhance the Alcohol Interventions Team, with a particular focus on working with offenders and increasing capacity to support and receive referrals from GPs and Pharmacists, who form part of the Alcohol LES project. This service provides ill-health prevention advice, which is clinically and cost-effective.

Initiative: Increase access to improved treatment and support services				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Increase the number of alcohol users who are not drinking / drinking at sensible levels after receiving treatment (baseline to be set)	Alcohol Local Enhanced Service	Alcohol LES established and commences	Jul-10	Lack of interest from GPs / Pharmacists in signing up to the project - 9
Increase the number of people accessing alcohol treatment from 604 in 0910 to 717 in 1011 (1057 by 1314)	Alcohol Psychosocial Treatment Service	Alcohol psychosocial treatment service tendered and contract agreed	Jul-10	Lack of appropriate supplier interest in specification -3
		Service Commenced	Sep-10	Commencement of contract on time - 6
	Alcohol Specialist Nurse Service	Recruit Alcohol Specialist Nurse Service	May-10	Recruitment of appropriate staff - 9
		Alcohol Specialist Nurse service established	Jun-10	
	Alcohol Intervention Team	Enhanced service commences	Apr-10	Failure to recruit suitable applicants - 6

3. Tackle alcohol related crime and anti-social behaviour

3.1 Street Pastors - The project is a community project which was developed by local churches in

response to the growing problems related to drunkenness and drug taking in the city centre on Friday and Saturday nights. The project aims to reduce incidents of violence and anti-social behaviour by placing volunteers into the environment who can deflect and calm down situations. The pastors also support and care for people who have made themselves vulnerable to accidents or illness. The pastors currently have about 40 volunteers providing at least 3 volunteers on each Friday and Saturday night from 10pm to 3am.

3.2 Pilot Multi-agency one-stop shop - The Guildhall Walk is the most violent street in Portsmouth. The aim of this project is to set up a pilot multi-agency one-stop shop using the existing Guildhall Walk Health Care Centre, opening it up on Friday and Saturday nights from 10pm to 3am offering treatment for minor injuries and illnesses, deflecting activity from the Emergency Department. Alongside this the premises would be used as a hub by the police, Street Pastors, Community Health Practitioners.

Initiative: Tackle alcohol related crime and anti-social behaviour				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce the perception of drunk and rowdy behaviour as a problem from 42.3% in 0910 to 41.2% in 1011 (38% by 13/14)	Street Pastors	Training for new volunteers completed	Mar-10	
Reduce the number of violent crimes in the night-time economy from 766 in 0910 to 747 in 1011 (690 by 1314)		New volunteers commence patrols	Apr-10	Failure to train and retain sufficient volunteers - 2
	Pilot Multi-agency one-stop shop	Develop project model & implementation timetable	Jun-10	No premises agreed - 12
		Commencement of pilot project	Oct-10	Obtaining agency buy-in / stakeholder engagement - 6

d. Key Enablers and Links

1. Market Implications

Assertive approaches to reaching people with alcohol problems will be required as well as a stronger presence and partnerships with primary care and NHS acute services (in particular Emergency Departments).

Providers of NHS community services will be expected to be able to give brief interventions for alcohol to all users.

Providers who can offer specific services or initiatives targeting young people – both awareness and behaviours – will be required.

2. Workforce

NHS Portsmouth will expect all providers of NHS services to assess all users for smoking, alcohol and weight status, providing brief opportunistic intervention and referring onwards to specialist services. This will require basic brief intervention competencies and an awareness of promoting health in all staff and as part of ongoing professional development.

3. Estates and Facilities

NHS Portsmouth aims to develop the St Mary's Hospital site as a City Health Campus. This will

have a strong focus on acting as a local hub for prevention, community and primary care services. As such the St Mary's Community Health Campus is critical to the delivery of this Strategy.

e. Organisational Support Required

These initiatives rely on cross-organisational working. Many of the alcohol projects are interdependent and will combine to achieve the overall aims. The collaborative working within these schemes is essential to ensure delivery, but current practice demonstrates that this is possible and delivers the required benefits. The initiatives themselves includes partnership working with amongst others, the Safer Portsmouth Partnership, Portsmouth Hospital Trust, the police, schools, substance misuse agencies, Portsmouth Community and Mental Health Services, Portsmouth City Council, community alcohol treatment services, Hampshire Probation Service, GPs, Local Pharmacy Committee, Pharmacists, Alcohol Interventions Team, Alcohol Treatment Services, Care UK, Hampshire Constabulary, South Central Ambulance Service, Portsmouth City Pubwatch and the University of Portsmouth.

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Improve alcohol education and awareness	
Key Performance Indicators	Link
Reduce the number of young people misusing substances from 14.2% in 0910 to 13.85% in 1011 (12.8% by 1314)	LAA
Increase the number of children that feel the advice and information they receive about alcohol is good enough from 57% in 0910 to 59.5% in 1011 (67% by 1314)	LAA
Outcome Measures	
Redction in the rate of Hospital Admissions per 100,000 for Alcohol Related Harm (NI39)	NIS, VSC, WCC

Measures of Achievement	
Initiative: Increase access to improved treatment and support services	
Key Performance Indicators	Link
Increase the number of alcohol users who are not drinking / drinking at sensible levels after receiving treatment (baseline to be set)	LAA
Increase the number of people accessing alcohol treatment from 604 in 0910 to 717 in 1011 (1057 by 1314)	LAA
Outcome Measures	
Redction in the rate of Hospital Admissions per 100,000 for Alcohol Related Harm (NI39)	NIS, VSC, WCC

Measures of Achievement	
Initiative: Tackle alcohol related crime and anti-social behaviour	
Key Performance Indicators	Link
Reduce the perception of drunk and rowdy behaviour as a problem from 42.3% in 0910 to 41.2% in 1011 (38% by 13/14)	LAA
Reduce the number of violent crimes in the night-time economy from 766 in 0910 to 747 in 1011 (690 by 1314)	LAA
Number of contacts for street pastors and one stop shop (baselines to be set).	Local KPI
Number of patients where an A&E visit or ambulance call has been averted.	Local KPI
Outcome Measures	
Reduction in A&E attendances on Friday and Saturday nights	Local KPI
Redction in the rate of Hospital Admissions per 100,000 for Alcohol Related Harm (NI39)	NIS, VSC, WCC

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Alcohol Advisory School Nurse	50	(4)	46
Alcohol LES	49	(124)	(75)
Alcohol Psychosocial Treatment	138	(131)	7
Alcohol Specialist Nurse Service	306	(413)	(107)
Alcohol Intervention Team	77	(68)	9
Street Pastors	16	(11)	5
One Stop Shop	44	(8)	36
Total	680	(759)	(79)

4.1.2 Screening

Staying Health - Screening	
Name of Initiative:	<ol style="list-style-type: none"> 1. Breast Screening (Age Extension) 2. Bowel Cancer Screening (Age Extension) 3. Cervical Cancer Screening 4. AAA Screening Programme 5. Chlamydia Screening 6. National Health Checks Programme 7. CVD LES
Name of National, Regional, Sub-Regional or Local Priority supported:	
PCT Strategic Goal:	<ul style="list-style-type: none"> • Improve peoples quality of life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all • Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and well being

- Invest in health services and ill-health prevention advice, focusing on the young and recognising the long term benefits this brings to them, and future generations, in both health and social attainment

WCC Outcome Measure:

- Life Expectancy
- CVD Mortality
- Cancer Mortality Rate

National Target and Local LAA Target:

- Tier 1 Vital Sign (VSA09) NHS Breast Screening programmes to be extended to all women aged 47- 73 by 2012 (Updated in the operating framework 2010/11: start the extension of breast screening from April 2010 so that breast screening programmes are routinely inviting women aged 47 - 73 by 2016)
- Tier 1 Vital Sign (VSA10) NHS Bowel Cancer Screening Programme will be extended from 2010 to invite men and women aged 70–75 to take part
- Tier 1 Vital Sign (VSA15) All women should receive the results of their cervical screening tests within 2 weeks by 2010

a. Executive Lead

- Paul Edmondson-Jones

b. Current Position

1. The focus of Staying Health Screening covers the following areas.

1.1 Breast Screening (Age Extension)

The extension of breast screening to women aged 47-49 and 71-73 by 2010 was a commitment in the Cancer Reform Strategy (2007). It was decided to extend the age range downwards by one round - round 8 (age 47-49) and upwards by one round - round 9 (age 71-73) with a guaranteed invitation before the age of 50. As women are screened every three years this means that women will get 2 more screens within their lifetime.

The CRS said that phasing in of the expansion should be carefully considered to ensure that the most useful epidemiological data be gathered to inform future decisions about the programme. A pilot of the feasibility and acceptability of the randomising the phasing in of the age extension of the breast screening programme in England has just reported no major problems. Ethical approval has now been applied for randomisation (of the first round) of the roll out of breast screening in England.

The current status (09/10 Refresh V1.2) is that all local screening programmes should begin inviting women aged 47-49 (round 8) in 2010/11. However once ethical approval of the randomisation is agreed the programmes should immediately move to randomisation of 47-49 and 71-73. For 2010/11, 8% of women eligible should be invited.

1.2 Bowel Cancer Screening (Age Extension)

The Cancer Reform Strategy announced that the bowel cancer screening programme will be extended from 2010 to invite men and women aged 70-75 to take part. The current guidelines (09/10 Refresh V1.2) states that for programmes that have completed the first 2 years screening round should invite at least 30% of the population aged 70 - 75 by Q4 of 2010/11.

1.3 Cervical Cancer Screening - 2 week turn around

In Sept 2007 the government announced that was not acceptable in a modern NHS for women to wait for weeks for their cervical screening test result and that their intensions were to speed up the

results of the cervical screening. The Cancer Reform Strategy confirmed that women should receive their cervical screening result within 14 days of it being taken. The vital sign VSA15 requires that by Dec 2010 100% of women should receive the cervical screening result within 14 days (09/10 Refresh V1.2).

1.4 Abdominal Aortic Aneurysm (AAA) Screening

The local health economy has elected to become a phase 2 site for the national roll out of the AAA screening programme.

1.5 Chlamydia Screening

The National Chlamydia Screening Programme target for PCT's is 35% for 10/11, and will include all screens performed via the Chlamydia screening programme but exclude those screens undertaken via GUM. This percentage has been set in order to realise costs benefits in reducing infertility treatment. At this stage any further targets are yet to be finalised, however all the related documentation suggests that PCT's should be aspiring to achieve up to 50% screening.

1.6 National Health Checks Programme

Identifying patients at high risk of vascular disease, and offering support to manage this high risk, is a particularly high priority in Portsmouth. The purpose of the National Health Check is to:-

- identify an individual's risk of coronary heart disease, stroke, diabetes and kidney disease
- for this risk to be communicated in a way that the individual understands
- for that risk to be managed by appropriate follow-up, including being recalled every five years for reassessment.

1.7 Cardio Vascular Disease (CVD) Locally Enhanced Service (LES)

This objective sits alongside the national requirement to roll out Health Checks to those aged between 40 and 74 who are not currently on a GP register relating to cardiovascular disease.

As part of the SHA vascular prevention programme the PCT has been commissioning a CVD LES from GP practices. This involves GPs identifying and managing patients who are known to be at high risk of CVD but who do not currently have established disease, and proactively undertaking a full risk assessment and agreeing a comprehensive management plan. This includes large numbers of hypertensive patients who would be excluded from the NHS Health Check.

2. PCT Priorities and Strategic Goals

These initiatives align to many of the PCT's priorities and strategic goals:

WCC Outcome Measures

- Health Inequalities
- Life Expectancy (National Measure)
- Health Inequalities (National Measure)
- CVD Mortality
- Cancer mortality
- Proportion of women screened for cervical cancer

PCT Strategic Objectives

- Improve people's quality of life, along with an increase in life expectancy, raising the lowest to

the best to ensure equity and equality of access for all

- Invest in health services and ill-health prevention advice, focusing on the young and recognising the long term benefits this brings to them, and future generations, in both health and social attainment
- Improve access to services for the most vulnerable people amongst our local population (such as those with mental health problems or learning disabilities) and those from the most deprived populations
- Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and well-being
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)

c. Planned Change

1.1 Breast Screening (Age Extension)

The CRS requires that certain criteria are fulfilled before local programmes can start the breast extension. These are:

- Achieving a 36 month round length
- At least 1 digital mammography machine by 2010

The CRS also recommends that a number of the national standards are fully met before breast extension is implemented. These are screening to assessment in 3 wks / screen to results within 2 wks / technical recall less than 3% / film reader status.

The Portsmouth Breast Screening Unit fulfils the minimum criteria for round length and digital mammography but is currently below minimum standards for screening to assessment in 3 wks. Although this was initially thought to be caused by a temporary staffing problem, staffing appears to be becoming an ongoing concern.

There is a business case into PHT regarding breast extension which includes the recruitment of further staff and costs for delivery of the programme with an option for full digital mammography (DM) and a second with no further DM. However the business case panels are currently not going ahead at PHT and it is unclear when the breast screening unit will be ready for age extension.

The current planned programme (assuming that the breast screening unit is able to get resources for roll out) is that they will start inviting women in the extended age range by Nov 2010. However as the current screening programme screens women in locations on a rotation basis Portsmouth women are not due to be screened for the age extension till 2013.

Initiative: Breast Screening (Age Extension)				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Tier 1 Vital Sign (VSA09) Proportion of women aged 47-49 and 71-73 offered screening for breast cancer - Planned trajectory of 8% of the eligible population randomised in by Quarter 4	Clarification of guidelines for delivery of VSA09 from DH and SHA and setting of trajectory for breast extension	Trajectory set	Apr-10	No feedback from DH on definitional issues - 12
	Action plan to overcome local barriers to implementation including (a) resourcing (b) possible redesign of current service structure	Action plan to overcome local barriers	Jun-10	Limited feedback from PHT re: resources / difficulties with redesigning delivery structure - 10
	Programme plan for extension implementation	Programme implementation plan	Aug-10	Limited resources - 10

1.2 Bowel Cancer Screening (Age Extension)

Solent and West Sussex Bowel Screening Programme started in bowel screening in March 2007 and consequently fulfil the criteria of 2 years operation in order to be invited to start the age extension and is the first programme in South Central. Other criteria for starting the extension programme that will need to be complied with include particularly the 14 day minimum waiting time for colonoscopy referral.

A recent South Central Screening Quality Assurance Reference Centre visit to the Solent and West Sussex programme recommended that before extension can take place a 4th specialist screening practitioner should be recruited and a 5th should be recruited when the extension programme is fully implemented

Initiative: Bowel Screening (Age Extension)				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Tier 1 Vital Sign (VSA10) Proportion of men and women aged 70 – 75 taking part in bowel screening programme - Planned trajectory 30% of eligible population by Quarter 4)	Setting of trajectories for bowel extension	Trajectory Set	Apr-10	
	Action plan to overcome local barriers to implementation including (a) resourcing (b) complying with programme criteria for extension	Action plan to overcome barriers	May-10	Funding issues with regards to staffing - 10
	Programme plan for extension and implementation	Programme implementation plan	Aug-10	Funding issues with regards to staffing - 10

1.3 Cervical Cancer Screening - 2 week turn around

One of the issues with achieving the 2 week turn around is that currently the indicator is not measured in any organised way and is therefore difficult to monitor. This is currently being addressed by the Quality assurance reference centre and local requirements for reporting. At best estimates the 2 week turnaround time for cervical screening (TAT) was low in 2009/10 at approximately 4%. This was due to the huge increase in uptake of the service cause by the death of Jade Goodie. There were also issues around staffing which are currently settled and the current TATs are improving to approximately 98%and prospects of achieving the 100% level by Dec 2010 are on tract. Actions that might be included and are currently being investigated include the use of first class post instead of 2nd class.

Initiative: Cervical Cancer Screening - 2 week turnaround				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Tier 1 Vital Sign (VSA15) Proportion of women receiving their cervical screening result within 14 days of the screen date - 100% by Dec 2010	Setting of trajectories for 2 week turnaround	Trajectory Set	Apr-10	Capacity issues - 4
	Action plan to overcome local barriers to implementation	Action plan to overcome barriers	Apr-10	
	Programme Plan	Programme implementation plan	Apr-10	

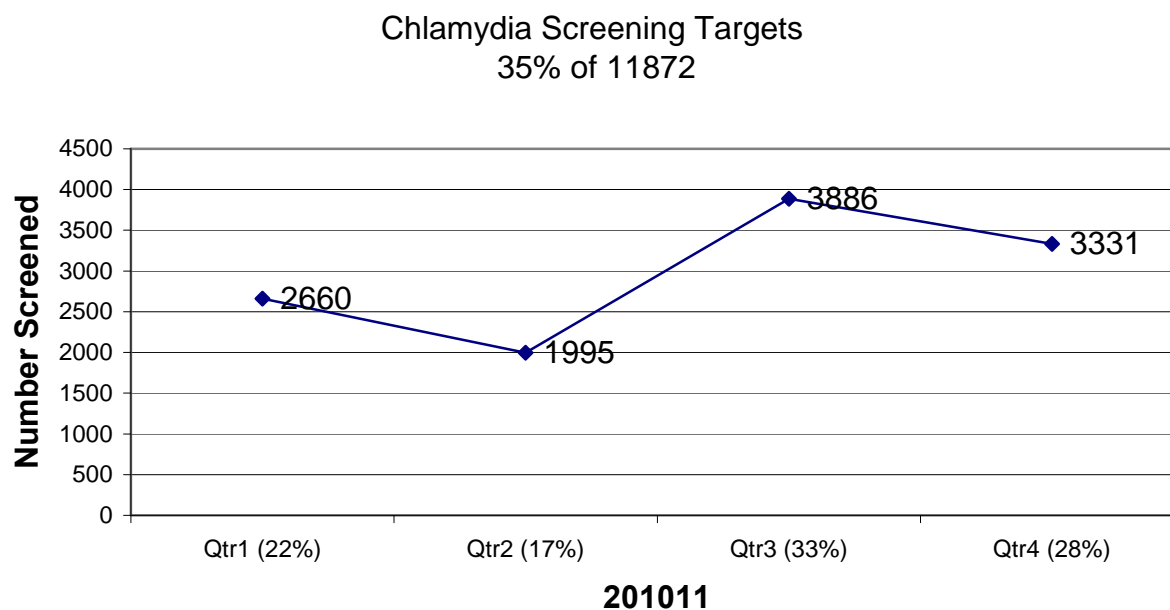
1.4 Abdominal Aortic Aneurysm (AAA) Screening

It is proposed that Southampton University Hospitals Trusts (SUHT) will manage the screening programme, which will cover Portsmouth City, Isle of Wight, Southampton City and Hampshire. Elective surgery on Portsmouth residents to repair any detected aneurysms will be undertaken in Portsmouth Hospitals NHS Trust.

Initiative: Abdominal Aortic Aneurysm (AAA) Screening				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Implementation of the national abdominal aortic aneurysm screening programme by October 2010	This programme will be provided across Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP). It will be implemented by the Strategic Health Authority (SHA).	To be agreed by the SHA following acceptance of business case	TBC	

1.5 Chlamydia Screening

Targets for the National Chlamydia screening programme have been confirmed to be 35% for 2010/2011, however this will not include GUM screens as had been originally suggested. To date targets for future years have been suggested but have yet to be confirmed, however year on year increases are expected, and therefore extra funding will need to be sourced if we are to achieve the vital sign target, year on year.



Initiative: Chlamydia Screening				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Phased approach to implementing a National Screening Programme where 35% of 15-24yr old population will be screened.	The National Chlamydia screening programme for PCT's is 35% for 10/11, and will include all screens performed via the Chlamydia screening programme but exclude those screens undertaken via GUM. This percentage has been set in order to realise costs benefits in reducing infertility treatment	Hold discussion with provider services to ensure extra screening activity can be achieved, within budget allocation.	Jan-10	Lack of increased funding will lead to under achievement of Vital Sign target - Score 15
		Confirm extra screening activity can be achieved from April 2010	Feb-10	Provider unable to perform extra screens due to lack of resources eg staff - Score 12
		Discussion with contracts and performance re change of contract information and possible need for SAVO.	Mar-10	Young people do not want to be tested - Score 12
		Commencement of Service providing extra screening capacity	Mar-10	Primary care unable to increase number of screening tests offered - Score 9

1.6 National Health Checks Programme

Rolling out the National Health Checks programme in 2010/11 within Portsmouth offers a real opportunity to make significant inroads in tackling health inequalities, including socio-economic, ethnic and gender inequalities, providing the PCT ensures that the approach is focused on reducing these inequalities. A small scale pilot of NHS Health Checks started in early 2010. Roll out will be informed by this pilot and is expected to commence in Summer 2010, using a variety of providers including Community Pharmacies (including supermarket based), GP Practices and third sector / voluntary organisations

Initiative: Health Checks				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Roll out of National Health Checks programme and continue to specifically target patients known to be at high risk within GP practices	A small scale pilot is being undertaken during 2009/10 to assess the feasibility of conducting these health checks outside of GP practices and the evaluation of this pilot will then inform the development of the programme going forward into 2010/11.	Appoint Development Manager	29-Mar-10	Lack of capacity within PCT to commission NHS Health checks - Score 8
		Agree Project plan for roll out	26-Apr-10	Lack of GP engagement - Score 12
		Agree outcomes from NHS Health Checks pilot phase	07-Jun-10	Information governance practices - Score 9
		Confirm service providers	19-Jul-10	Patient confidentiality - Score 12
		Re-Launch service / training event	06-Sep-10	Poor patient uptake - Score 9

1.7 Cardio Vascular Disease (CVD) Locally Enhanced Service (LES)

Most GP practices have identified the number of known high risk patients (>20% CVD risk over 10 years) and have included them on a register. The total number is approximately 10,500. It's anticipated that approximately 2250 patients underwent risk assessment by the end of 2009/10 leaving a potential additional 8250 high risk patients who could be seen in GP practices if the LES were to continue. This equates to 1650 per year over the next 5 years.

Initiative: CVD LES				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
GP practices to continue to undertake full CVD risk assessment and management of known high risk patients.	This involves GPs identifying and managing patients who known to be at high risk of CVD but who do not currently have established disease, and proactively undertaking a full risk assessment and agreeing a comprehensive management plan.	• Revise LES to include targets and provision of data to PCT	June 2010	Lack of capacity in GP practices - Score 12 Failure to prevent CVD related events in high risk patients - Score 16
		• Devise system for collection of data on outcomes of assessment	June 2010	
		• Visit all practices to provide support and encouragement engagement with CVD LES	June 2010	
		• Plan provision of additional training and support	July 2010	
		• Deliver additional training if required	June 2010 and at least annually thereafter	

d. Key Enablers and Links

1. Market Implications

1.1 Screening

NHS Portsmouth is seeking to work with providers who can deliver innovative social marketing solutions to support our aim to increase uptake across all screening programmes.

2. Estates and Facilities

NHS Portsmouth aims to develop the St Mary's Hospital site as a City Health Campus. This will have a strong focus on acting as a local hub for prevention, community and primary care services. As such the St Mary's Community Health Campus is critical to the delivery of this Strategy.

The rationalisation of estates required as part of the St Mary's Community Health Campus development will give a specific opportunity to review the current configuration of sexual health services; Genito-urinary Medicine and Contraception & Sexual Health Services are currently provided separately on the St Mary's Hospital site.

3. Other Key Enablers

- Informatics
- Information management
- Knowledge management
- Service improvement / Pathway re-design

4. Links to other workstreams

Chlamydia Screening - This initiative has interdependencies with Staying Healthy, Children and families, and Planned care Darzi Groups.

National Health Checks - This initiative has links with the CVD LES initiative delivered within GP Practices.

e. Organisational Support Required

Much of the Screening developments are wider than just the PCT. The AAA screening will be provided across SHIP and implemented by the SHA. The Breast Screening (Age Extension) will also be developed at a SHA level. Therefore, key organisational support for these areas will be needed from:

- South Central Quality Assurance Reference Centre
- South Central Screening Group
- Breast steering group
- SHIP

With regard to Health Checks, support to deliver the requirements will be needed from organisations such as:

- LMC/ LPC
- GP Practices
- Local Community pharmacies

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Breast Screening (Age Extension)	
Key Performance Indicators	Link
Uptake rates of women aged 47-49	Local KPI
Uptake rates of women aged 71-73	Local KPI
Breast cancer rates	Local KPI
Tier 1 Vital Sign (VSA9) Proportion of women aged 47-49 and 71-73 offered screening for breast cancer	VSA
Outcome Measures	
Reduction in breast cancer rates	Local KPI

Measures of Achievement	
Initiative: Bowel Screening (Age Extension)	
Key Performance Indicators	Link
Uptake rates men and women aged 70-75	Local KPI
Bowel cancer rates	Local KPI
VSA10 Proportion of men and women aged 70 – 75 taking part in bowel screening programme	VSA
Outcome Measures	
Reduction in bowel cancer rates	Local KPI
Bowel screening will be offered to men and women aged 70-75	Local KPI

Measures of Achievement	
Initiative: Abdominal Aortic Aneurysm (AAA) Screening	
Outcome Measures	
Successful implementation of the AAA screening programme that meets the National Quality Standards.	Local KPI

Measures of Achievement	
Initiative: CVD LES	
Key Performance Indicators	Link
400 risk assessments per month of potentially high risk patients on register	VSC23
Qtrly return of data on assessments undertaken and interventions made	Local KPI
Outcome Measures	Link
Increased prescribing of statins	Local KPI
Increased referral to smoking cessation services	Local KPI
Reduction in CVD related major events	Local KPI
Reductions in CVD related events and mortality	PSA18 / WCC

Measures of Achievement	
Initiative: Health Checks	
Key Performance Indicators	Link
1,000 health checks completed by June 2010	Local KPI
2,500 health checks complete by March 2011	Local KPI
4,000 Health Checks by March 2012	Local KPI
6,000 Health Checks by March 2013	Local KPI
8,500 Health Checks per annum by March 2014	Local KPI
Outcome Measures	Link
Increase in number of people accessing smoking cessation services	LAA
Increase in number of high risk patients prescribed statins	Local KPI
Reduction in number of cardiovascular related events (long term)	Local KPI
Reductions in health inequalities (long term)	LAA / WCC
Reductions in CVD related events and mortality	PSA18 / WCC

Measures of Achievement	
Initiative: Chlamydia Screening	
Key Performance Indicators	Link
Indirect contribution to reducing infertility	
Indirect contribution to reducing Pelvis Inflammatory Disease	
Percentage of 15-24yr olds being screened for Chlamydia	VSB13/ LAA
Outcome Measures	Link
Improving patient experience and access to services	
Number of valid screens undertaken confirmed via the National Chlamydia screening programme and the Health Protection agency.	
Targeted activity to ensure no more than 10% of screens undertaken fall outside screening criteria.	Local KPI
Notification of positives within agreed timescales	Local KPI
Notification of negatives within agreed timescales	Local KPI
Notification of positive partners within agreed timescales	Local KPI
Treatment of positives within agreed guidelines and protocols	Local KPI
Establishment of Steering group and action plan	Local KPI
Patient survey and evaluation	Local KPI
Improve the health and wellbeing of children and young people	PSA12
Promote better health and wellbeing for all	PSA18
Ensure better care for all	PSA19

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Breast Screening (Age Extension)	60	-	60
Bowel Cancer Screening (Age Extension)	293	-	293
AAA Screening	-	-	-
Chlamydia Screening	51	-	51
National Health Checks	126	-	126
CVD LES	50	(54)	(4)
Total	580	(54)	526

4.1.3 Obesity

Staying Healthy - Obesity
Name of Initiative: 1. Physical Activity Care Pathway - Lets Get Moving (LGM)
Name of National, Regional, Sub-Regional or Local Priority supported:
<p>PCT Strategic Aims</p> <ul style="list-style-type: none"> • Improving life expectancy and people's quality of life • Helping people stay healthy and take greater responsibility for their own health and well-being • Easing the burden of chronic disease • Providing clinically and cost-effective ill-health prevention • Reducing the demand for acute care <p>World Class Commissioning Outcomes</p> <ul style="list-style-type: none"> • Reduction in health inequalities • Increased life expectancy • Reduction in childhood obesity • Decrease cancer mortality rates • Decrease CVD mortality rates <p>LAA Targets:</p> <ul style="list-style-type: none"> • Increased cycle • Per capita reduction in CO • Reducing childhood obesity • All age, all cause mortality • Adult participation in sport and active recreation
a. Executive Lead
<ul style="list-style-type: none"> • Paul Edmondson-Jones
b. Current Position
<p>1. Overview</p> <p>Lets Get Moving (LGM) is a behavioural change intervention that has been designed to provide a systematic approach to identifying and supporting adults who are not meeting national guidance on physical activity levels. This programme has strong links with the Portsmouth Healthy Weight Strategy. The programme will in particular be used as a solution to meet the needs of the NHS Health Checks.</p> <p>The LGM physical activity care pathway is informed by NICE (2006) guidance on 'Four commonly used methods to increase physical activity'. The Physical Activity Care Pathway involves four key steps:</p> <ul style="list-style-type: none"> • Assessment of patients' physical activity levels • Brief intervention • Signposting to local physical activity opportunities • Follow-up consultations <p>2. PCT Priorities and Strategic Goals</p> <p>This initiative aligns to many of the PCTs priorities and strategic goals:</p>

WCC Outcome Measures

- Health inequalities
- Life expectancy – Males/ Females
- Infant Mortality
- Cancer Mortality
- CVD Mortality
- Reduction in Childhood Obesity

PCT Strategic Objectives

This programme will provide a significant contribution to a number of the PCT Strategic Objectives, reducing all-cause mortality, improving life expectancy and easing the burden of chronic disease. In addition it will provide clinically and cost-effective ill-health prevention, potentially reducing the demand for acute care.

c. Planned Change

Patients are recruited via new patient registers, disease registers and existing care pathways. They are screened using a validated, GP physical activity questionnaire.

Patients activity levels are classified and 'read codes' can be inputted into patient records. Patients are then given motivational interviewing to set goals, provided with a patient pack and signposted to local activity opportunities. They are then reviewed at 3, 6 and 12 months.

This programme can be used to prevent and manage over 20 conditions and diseases including CHD, stroke, Type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions and can provide an intervention solution for a range of programmes/ care pathways e.g. Vascular Checks, COPD management, weight management, falls prevention and mental health management.

There is a national mandate for this project through The Secretary of State for Health who is encouraging PCTs to include this programme in their 2010/11 commissioning intentions. A feasibility study on the project has been run in London and was used to inform 'Lets Get Moving' - guidance on commissioning physical activity care pathways (DH 2009). If this project is not undertaken, a number of care pathways will put at risk in that they will lack a referral option for a physical activity intervention.

At a broader level, if this project is not delivered, Portsmouth will see increased morbidity and mortality resulting from physical inactivity and an increasing financial burden on the NHS due to associated conditions. This is evidenced by the fact that physical inactivity nationally causes 3.1% of morbidity and mortality in the UK and 35,000 deaths per year, costing Portsmouth NHS approx £2,634,760 per year.

Activity will contribute to delivery of the LAA target for increasing adult participation in sport and active recreation. Participation under this LAA target is defined as taking part on at least 3 days a week in moderate intensity sport and active recreation (at least 12 days in the last 4 weeks) for at least 30 minutes continuously in any one session. Participation includes recreational walking and cycling. The LAA target for October 2010 is 28% (reported annually) against a baseline of 23.5% (Dec 06).

Initiative: Physical Activity Pathway				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To have a robust physical activity care pathway in use across primary care and community settings	Patients are recruited via new patient registers, disease registers and existing care pathways. They are screened using a validated, GP physical activity questionnaire. Patients are then given motivational interviewing to set goals, provided with a patient pack and signposted to local activity opportunities. They are then reviewed at 3, 6 and 12 months.	Agree contract format and draft service specification	08-Feb-10	A lower number of patients than the targets set are recruited onto and complete the pathway - Score 9
		Consult on service specification with stakeholders (including relevant committees e.g. LPC, GMC)	15-Feb-10	
		Invite initial primary care sites to sign-up	17-May-10	
		Scheme starts	06-Sep-10	Primary care and community sites do not sign up to the scheme - Score 4
		Recruitment of service users (via disease registers and opportunistically)	11-Oct-10	

d. Key Enablers and Links

1. Market Implications

There is currently a small provider market for both adult and childhood obesity services and thus NHS Portsmouth will be innovative in testing new models of service provision. We are currently testing the market through tendering for adult weight management providers and will be tendering for family weight management providers following the evaluation of a number of feasibility and pilot programmes. As the adult and childhood obesity care pathways are new, there is uncertainty about future demand for services.

Over the next 5 years NHS Portsmouth will continue to expand the number of interventions being delivered in the City, from prevention through to treatment and will in particular, commission new obesity treatment services for both adults and children.

2. Workforce

NHS Portsmouth will expect all providers of NHS services to assess all users for smoking, alcohol, physical activity and weight status, providing brief opportunistic intervention and referring onwards to specialist services. This will require basic brief intervention competencies and an awareness of promoting health in all staff and as part of ongoing professional development. This initiative will, in particular, skill-up the primary care workforce in motivational interviewing and encouraging behaviour change among patients through increasing levels of physical activity.

3. Estates and Facilities

NHS Portsmouth aims to develop the St Mary's Hospital site as a City Health Campus. This will have a strong focus on acting as a local hub for prevention, community and primary care services. As such the St Mary's Community Health Campus is critical to the delivery of this Strategy.

4. Other Key Enablers

- LAA flagship and target
- NICE guidance
- NHS Health Check
- South Central programmes – Prevention into pathways project and the Sixty Seconds Project

5. Links to other workstreams

- Darzi work-streams - Long Term Conditions, Planned Care, Children & Young People & Maternity
- Social marketing
- NHS Life-check (40-70)
- Health Trainers
- Healthy Living Pharmacy Model
- Healthy Pompey
- Vascular Prevention Programme
- Portsmouth Healthy Weight Strategy
- Forthcoming COPD national clinical strategy
- Cancer prevention and survivorship
- Learning disabilities Health Check
- GP Education
- Staying Healthy
- Change4life

e. Organisational Support Required

- Clinical engagement via PBC
- Obesity SHIP
- CES
- Regional Healthy Weight Leads
- Solent Supplies with procurement
- Informatics
- GP Education
- Knowledge Management & Information Management

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Physical Activity Pathway	
Key Performance Indicators	Link
Number of adults who achieve incremental increases towards Chief Medical Officer's (CMOs) recommendations on physical activity	Local KPI
Number of individuals who meet CMOs recommendations on physical activity	Local KPI
Number of people provided with a brief intervention	Local KPI
Follow-ups at 3, 6 and 12 months	Local KPI
GPPAQ (Physical Activity Index Score)	Local KPI
Outcome Measures	Link
PSA 12: Improve the health and well-being of children and young people – Indicator 3, levels of childhood obesity	PSA
PSA 18: Promote better health and well-being for all – Indicator 1, All age, all cause mortality rate	PSA
PSA 27: Lead the global effort to avoid dangerous climate change – Indicators 1-6	PSA
LAA 2.3: Increased cycle use	LAA
LAA 5.1: Per capita reduction in CO ² emissions in the LA area	LAA
LAA 7.2: Obesity in primary school age children in Reception	LAA
LAA: 7.4.1: All age, all cause mortality (Males) Rate per 100,000 (DSR)	LAA
LAA 7.4.2: All age, all cause mortality (Females) Rate per 100,000 (DSR)	LAA
LAA 7.3: Obesity in primary school age children in Year 6	LAA
LAA 8.1: Adult participation in sport and active recreation	LAA

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)

Physical Activity Care Pathway	138	-	138
Total	138	-	138

4.1.4 Smoking Cessation

Staying Healthy – Smoking Cessation			
<p>Name of Initiative: 1. VSBO5 – Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services whilst achieving value for money 2.Reduction in smoking prevalence amongst pregnant women (This is a separate objective which supports delivery of the overall vital sign in relation to smoking (see Objective 1)) 3. Increase referral of a patients with established health conditions to smoking cessation services, by improving referral arrangements within acute services (This is a separate objective which supports delivery of the overall vital sign in relation to smoking (see Objective 1)) 4. To ensure provision of work based smoking cessation services, particularly to support routine and manual workers 5. To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy to ensure its aims are met</p>			
<p>Name of National, Regional, Sub-Regional or Local Priority supported: National Target</p> <ul style="list-style-type: none"> VSBO5 – Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services PSA SR07 - “tackle the underlying determinants of ill health and health inequalities by reducing adults smoking rates to 21% or less by 2010 with a reduction in prevalence among routine and manual groups to 25% or less. <p>LAA Target</p> <ul style="list-style-type: none"> LAA 7.5 Stopping Smoking 			
a. Executive Lead			
<ul style="list-style-type: none"> Paul Edmondson-Jones 			
b. Current Position			
1. Overview			
1.1 Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services whilst achieving value for money			
The vital sign for 4 week quitters for 20089 through to 2010/11 is as follows			
2007/8	2008/9	2009/10	2010/11
1906	2218	2388	2668
<p>As described above this is a very high number for quits per 1000 smokers. As the prevalence of smoking falls within the city, the target number of quitters should level of to reflect this. The PCT will be required to set new vital sign target for the period 2011/12 through to 2014/15; there is no indication as to how these targets will be calculated. However, it is proposed that for 2011/12 onwards the target number of quitters should be increased by only 1.5% per annum for the next 5 years, in view of the fall in prevalence now being reported. This trajectory is indicated on the graph below</p>			
Quit targets will be increasingly difficult to achieve. In particular providers will have to invest more in			

developing services to reach the required number of routine and manual workers. It will also be necessary to invest in data management and monitoring systems as the PCT takes a more strategic approach to commissioning.

1.2 Reduction in smoking prevalence amongst pregnant women

NHS Portsmouth was unable to meet its vital sign target in 2008/2009 as the reporting of maternity figures was withdrawn part way through the year by the Strategic Health Authority, as they were assessed not to fit the stringent data monitoring guidelines. As a consequence the PCT has worked hard to ensure maternity figures are more accurately recorded and adhere to the NICE Guidance 2009/2010. During 2009, a pilot to test out a referral pathway has been established within the maternity service at PHT. This involves a referral for all pregnant women to the specialist smoking cessation services who smoke when they attend for their nuchal scan on an “opt-out” basis

1.3 Increase referral of a patients with established health conditions to smoking cessation services

In Portsmouth the number of people who smoke with selected conditions is above the national average and similarly the number of people with select conditions who have been offered smoking cessation advice is slightly below the national average(2007/8 QOF data)
During 2009/10 pilots have been established within 3 out patient departments within the local acute trust which provide an “opt- out” referral to smoking cessation services.

1.4 To ensure provision of work based smoking cessation services, particularly to support routine and manual workers

The PCT is currently commissioning additional smoking cessation services from an independent company to provide additional capacity and services more suited to the needs of a proportion of people living and working in the city. Whilst only recently launched this short term pilot has given us some insight into potential providers and the costs of providing this service

In addition the PCT has commissioned some social marketing research which is focussed on female routine and manual workers in the City. The outcomes of this work will not be known for some months but are likely to highlight issues of access to services and support.

1.5 To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy

The aims of the Smoke free Portsmouth strategy are to:

- Support local communities to create a smoke free culture for Portsmouth
- To reduce smoking prevalence in Portsmouth, both overall and in identified target groups.

And 6 more specific objectives:

- To reduce tobacco use, especially in young people;
- To promote smoke-free environments across Portsmouth;
- To reduce smoking-related health inequalities;
- To increase public support for smokefree workplaces and public places
- To work in partnership and influence regional and local policies and decision-making;
- To use local evidence to inform the development of smokefree and smoking cessation programmes.

Key to achieving these aims is to use local evidence and intelligence to inform the development of

local smoke free programmes.

2. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

WCC Outcome Measures:

- 4 week Quitters (included within top 10 world class commissioning outcomes from 2010/11
- Life Expectancy
- Health Inequalities
- CVD Mortality
- Cancer Mortality
- Infant Mortality

PCT Strategic Objectives:

- Improve people's quality of life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all
- Invest in health services and ill-health prevention advice, focusing on the young and recognising the long term benefits this brings to them, and future generations, in both health and social attainment
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services

c. Planned Change

1.1 Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services whilst achieving value for money

Initiative: VSB05 – Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services whilst achieving value for money				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To deliver 2668 4-week smoking quitters for 1011	Ensure delivery of vital sign (VSB05) for 1011	Establishment of commissioner led smoking data management system	01-Apr-10	Lack of engagement / desire from public to quit - Score 6
	Ensure service delivers value for money	Redesign of Primary care provided smoking cessation services	01-Jun-10	Competition between variety of providers, distracting form achieving overall target - Score 6
		Re- assessment of current smoking cessation service model and performance	01-Jun-10	Failure to achieve vital sign and impact on overall Health Check assessment - Score 9
		Development of tender specification and market testing if appropriate	01-Sep-10	
		Re-commissioning of specialist smoking cessation services	Dec 2010	

1.2 Reduction in smoking prevalence amongst pregnant women

During 2010 the plan will be to embed 'opt out' within Nuchal scan appointments and to develop additional referral pathways within maternity and health visiting to increase the reach to pregnant women and new mums. This will need to be done in partnership with NHS Hampshire as the maternity services are provided to both PCTs.

Initiative: Reduction in smoking prevalence amongst pregnant women				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
1% year on year decrease in smoking rates during pregnancy. Baseline to be taken as outturn for 2009/10 taken from Omnibus return – Smoking at time of delivery. (At quarter 2 this is 19.5%)	Embed 'opt out' within Nuchal scan appointments and to develop additional referral pathways within maternity and health visiting.	Identification with maternity services of additional referral points	May 2010	Lack of capacity within maternity services - Score 6
		Development of roll out plan in conjunction with maternity and NHS Hampshire including arrangements for training	May 2010	Failure to achieve vital sign and subsequent impact on overall Health Check assessment - Score 9
		System in place whereby all pregnant women who smoke are referred to smoking cessation services	Dec 2010	Failure to reduce smoking prevalence in pregnancy - Score 9
				Failure to impact on infant mortality (vital sign) - Score 9

1.3 Increase referral of a patients with established health conditions to smoking cessation services

The aim for 2010/11 is to gradually rollout the “opt- out” referral to smoking cessation services to all outpatient departments and eventually to inpatients.

Initiative: Increase referral of a patients with established health conditions to smoking cessation services				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To support the delivery of 2668 4-week smoking quitters for 1011	Improve referral arrangements to smoking cessation services within acute services	Identification of additional champions within PHT	June 2010	Lack of engagement and capacity to make referrals within secondary care - Score 12
		Development of roll out plan for referral of Hospital outpatients to smoking cessation services in conjunction with PHT champions and NHS Hampshire including arrangements for training	Sept 2010	Failure to achieve vital sign and to impact on smoking prevalence - Score 9
		Development of prescribing protocols within PHT to allow for provision of NRT and other smoking cessation products	Sept 2010	Failure to reduce smoking related admissions - Score 9

1.4 To ensure provision of work based smoking cessation services, particularly to support routine and manual workers

The aim is to support the delivery of the 2010/11 increased vital sign of 2688 4 week quitters.

Initiative: To ensure provision of work based smoking cessation services, particularly to support routine and manual workers				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To support the delivery of the 2010/11 increased vital sign, of 2688 4 week quitters	To provide services specifically focussed on reaching the required target Group	Review achievement of current additional commissioned service.	April 2010	Failure to co-ordinate activity of range of providers across the city - Score 9
		Prepare options and service specifications for commissioned services targeted at routine and manual workers	June 2010	Failure to meet vital sign (4 week quit) - Score 9
		Let 3 year tender for additional activity	Sept 2010	Failure to reduce gap in health inequalities - Score 9
		Memorandum of Understanding between core smoking cessation service and any new provider	Sept 2010	

1.5 To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy

During 2009/10 the PCT commissioned two phases of a social marketing smoking initiative in conjunction with the National Social Marketing Centre, in order to support these aims. This has involved gaining insights into beliefs and attitudes of female routine and manual workers who currently smoke and then the development of interventions to increase their uptake and retention in smoking cessation services.

These two phases are due to be complete by the end of March 2010, at which time the PCT will then need to implement the interventions which have been developed. This forms part of a tried and tested social marketing methodology. The nature of these interventions is not known at the moment as the initial project has not concluded. However projects elsewhere have identified issues relating to accessibility, location, and peer group support. In addition there is a need to do further social marketing work to understand how we can prevent young people from taking up smoking. This needs to be centred around marketing of “social norms”

Initiative: To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Implement the Smoke Free Strategy Action Plan	To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy to ensure its aims are met	Revise smoking strategy action plan in light of feedback from NST	1st April 2010	Failure to engage all stakeholders in delivering action plan - Score 9
		Strategy group to develop implementation plan for proposed interventions arising from the current social marketing work	June 2010	Failure to prevent uptake of tobacco use - Score 9
		Assess impact of interventions on uptake of smoking cessation services.	March 2011	Failure to reduce gap in health inequalities - Score 9
		Develop specifications for further social marketing work with young people.	Sept 2010	

d. Key Enablers and Links

1. Market Implications

NHS Portsmouth will be seeking providers who can demonstrate methods of working that not only reach a larger proportion of the City population but can also effectively engage with those long-time smokers who we know are more resistant to giving up smoking.

2. Workforce

NHS Portsmouth will expect all providers of NHS services to assess all users for smoking, alcohol and weight status, providing brief opportunistic intervention and referring onwards to specialist services. This will require basic brief intervention competencies and an awareness of promoting health in all staff and as part of ongoing professional development.

e. Organisational Support Required

- PHT - to ensure referrals to smoking cessation service form maternity and within acute services
- PCC and HIOW tobacco control Alliance - to support wider tobacco control agenda

- GPs and community pharmacies to support delivery of LES

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: VSBO5 – Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services whilst achieving value for money	
Key Performance Indicators	Link
Number of 4-weeksmoking quitters who attended NHS Stop Smoking Services whilst achieving value for money	VSBO5
Quarterly performance against target number of 4 week quits for 2010/11	LAA 7.5
CO monitoring to verify quit status in at least 85% of cases	Local KPI
Outcome Measures	Link
Year on year reduction in overall prevalence of smoking within the city	PSA SR07
Reduce the gap between those geographical communities with the highest and lowest prevalence by increasing the conversion rate to 52% in these communities (i.e. those who successfully quit having set a quit date)	Local KPI
Narrowing of the gap in life expectancy within Portsmouth	WCC
Improvements in life expectancy	WCC
Reduction in excess admissions for COPD, CHD and cancer	WCC

Measures of Achievement	
Initiative: Reduction in smoking prevalence amongst pregnant women	
Key Performance Indicators	Link
Number of pregnant woman referred to smoking cessation services	
Number of pregnant women successfully quit at 4 weeks	WCC
Outcome Measures	Link
1% year on year reduction in the number of women who continue to smoke during pregnancy	LAA
Increase referral to the smoking cessation service to support achievement of vital sign	VSC
Reductions infant mortality , particularly in routine and manual groups	WCC
by 2010 reduce health inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.	PSA

Measures of Achievement	
Initiative: Increase referral of a patients with established health conditions to smoking cessation services	
Key Performance Indicators	Link
Number of referrals from outpatient clinics to smoking cessation services	
Outcome Measures	Link
Narrowing of the gap in life expectancy within Portsmouth	WCC
Improvements in life expectancy	WCC
Reduction in excess admissions for COPD, CHD and cancer	VSC
Year on year reduction in overall prevalence of smoking within the city	PSA SR07

Measures of Achievement	
Initiative: To ensure provision of work based smoking cessation services, particularly to support routine and manual workers	
Key Performance Indicators	Link
Minimum of 50% of clients accessing service to be from routine and manual groups	Local KPI
At least 52% of clients who set quit date, go onto quit at 4 weeks	Local KPI
Outcome Measures	Link
Increase the number of 4-week quitters specifically derived from Portsmouth's deprived communities and national and local target groups	Local KPI
Reduction in overall prevalence of smoking within the city	PSA SR07
Reduce the gap between those geographical communities with the highest and lowest prevalence by increasing the conversion rate to 52% in these communities (i.e. those who successfully quit having set a quit date)	Local KPI

Measures of Achievement			
Initiative: To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy			
Key Performance Indicators			Link
Active engagement of all stakeholders in work of strategy group			Local KPI
Outcome Measures			Link
reduce tobacco uptake and use especially in young people			Local KPI
increase in number of smoke free environments within the city			Local KPI
reduction in smoking related health inequalities			WCC

g. Financials - Alignment of investment / disinvestment – 1 year only			
Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Total	0	0	0

4.1.5 Other Prevention

Staying Healthy – Other Prevention
Name of Initiative: <ol style="list-style-type: none"> 1. Fluoride Varnish 2. Glaucoma Locally Enhanced Service 3. Public Health Advertising / Advertising Campaigns
Name of National, Regional, Sub-Regional or Local Priority supported: <p>PCT Strategic Aims</p> <ul style="list-style-type: none"> • Improving the quality and safety of services • Avoiding unnecessary use of hospital services by ensuring only appropriate referrals are made to Ophthalmology (secondary care). • Reduce unnecessary visits for patients and their carers therefore improving the patient experience. <p>Other National, Regional and Local Priorities Supported</p> <ul style="list-style-type: none"> • Relates to Capacity Map in terms of reducing elective admissions by implementing a referral management scheme. • National Patient Safety Agency Alerts
a. Executive Lead <ul style="list-style-type: none"> • Paul Edmondson-Jones
b. Current Position <p>1. Fluoride Varnish</p> <p>Fluoride varnish is one of the best options for application of topical fluoride to teeth in the absence of water fluoridation (Delivering Better Oral Health 2009). High quality evidence of caries-preventive effectiveness is available and indicates that twice yearly applications produce a mean caries reduction of 33% in primary teeth and 46% in permanent teeth. Fluoride varnish is considered to be safe and simple to apply with minimal training.</p> <p>2. Glaucoma Locally Enhanced Service</p> <p>In April 2009 NICE published guidance on the diagnosis and management of glaucoma. This, along</p>

with the simultaneous introduction of the new General Optometry Contract, led to a change in referral behaviour by community optometrists nationally. The local effect of this change has been a marked increase in referrals to the PHT ophthalmology department. Many patients who would have previously been monitored in the community are now referred leading to an overheat in the ophthalmology department, which threatens the 18 week target, and increased workload for GPs who handle the referrals on request from optometrists.

While national negotiations continue a local solution needs to be found. Two schemes need to be explored – a local LES (similar to NHS Hampshire) or the legitimising of the PHT system of outsourcing the measurement of low risk patients to selected community optometrists. While the exploration of this is currently underway the activity either scheme generates will fall into 2010/11.

3. Public Health Advertising / Advertising Campaigns

Throughout 2009/10 the PCT has focused more on using advertising in the city to communicate important health messages to local residents. These campaigns have a positive impact in raising awareness of health issues and services, and social marketing techniques are helping us tailor messages to affect behaviour change within the target audience.

4. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

WCC Outcome Measures

- Health inequalities

PCT Strategic Objectives

- Improve people's quality of life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all
- Invest in health services and ill-health prevention advice, focusing on the young and recognising the long term benefits this brings to them, and future generations, in both health and social attainment
- Improve the quality and safety of services ensuring dignity, control and choice for those who use our services
- Improve access to services for the most vulnerable people amongst our local population (such as those with mental health problems or learning disabilities) and those from the most deprived populations
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)
- Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and well-being

PSA

- PSA 17: Indicator 3 'Healthy Life Expectancy at 65'.
- PSA 19: Indicator 3 'NHS reported referral to treatment times for non-admitted patients'.

LAA

- LAA indicator 7.8: 'Health issues faced by BME communities' - higher risk of glaucoma for African communities.

c. Planned Change

1. Fluoride Varnish

A clinical dental group across SHIP, led by the Oral Public Health Consultant has developed a standard protocol to carry out fluoride varnish applications in community settings. In Portsmouth this protocol will be piloted to test feasibility, acceptability, cost effectiveness and clinical effectiveness of topical fluoride varnish as an alternative to water fluoridation. For the first year (of 3 years) this will be delivered by 2 providers in parallel, the existing Salaried Dental Service as part of their existing Oral Health promotion and the New Portsmouth Dental Academy due to open in Sept 2010. Key objectives will include:

- Engage with the local community, nursery schools, councillors (through HOSP) to raise awareness of and get support for pilot
- Identifying and engage with 2 schools to work with that has children that are most at risk from dental decay (based on geographical area / feed into schools that have the highest dmft) that are already part of a supervised tooth-brushing programme
- Gain parental consent for children to take part
- Deliver a 3 year pilot that includes screening, referral for treatment and ongoing dental care, ongoing OH promotion, fluoride varnish application and review 3 times per year.
- Deliver an evaluation programme to measure effectiveness, acceptability and feasibility of FV.
- Produce and disseminate an evaluation report with recommendations

Initiative: Fluoride Varnish				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Oral Health improvement project with fluoride varnish	The aim of the pilot will primarily be to assess clinical and cost effectiveness, acceptability and feasibility of an oral health improvement project with fluoride varnish in Portsmouth	Develop service specification and agree with SDS and dental academy	Aug-10	Negotiating difficulties - Score 4
		Programme starts	Sep-10	
		First screen and fluoride varnish	Nov-10	Low consent from parents/anti fluoridation lobby may be negative - Score 8

2. Glaucoma Locally Enhanced Service (LES)

There are two streams of work that are needed to tackle this problem:

1. Short Term: There are two possible schemes which will help the overhear – a local LES and PHT outsourcing further measurements to prevent patients attending OPD.

A time-limited LES for local optometrists, working with the LOC and NHS Hampshire, will pay optometrists who sign up to take on the monitoring of patients with high readings until it is certain that they need referral or discharge.

PHT are currently out-sourcing the measurement of some referred patients. It is not clear whether this breaches their contract, and whether there are clinical governance issues, but the model does have its merits and cannot be rejected without further investigation.

2. Mid – long term: this is to redesign the care pathway for glaucoma patients from primary care into secondary care and then out into community care again. This piece of work is being led by NHS Hampshire and commenced in Sept 2009.

The LES will be fully operational by 1st April 2010. The LES will initially be run for 12 months, at the end of which data will be reviewed against indicators of success including reduction in referrals to Ophthalmology and a reduction in number of first appointments not requiring follow-up. During 2010/11, an alternative service innovation will also be evaluated, and impact on the above outcomes will be compared - informing the longer-term commissioning strategy for 2011 onwards. Ongoing resources will be required at least to the same level to continue the LES or the alternative service innovation in 2011/12 and onwards.

Initiative: Glaucoma LES				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To reduce the pressure on the Ophthalmology department at PHT resulting from increase in patients with raised intra-ocular pressures.	Implementation of a local Glaucoma LES Legitimising of the PHT system of outsourcing the measurement of low risk patients to selected community optometrists	Draft LES	25-Jan-10	Lack of Public Health Development Manager commissioning capacity - Score 8
		Amend LES based on feedback	22-Feb-10	Association of Optometrists refusing to support LES - Score 12
		LES Scheme starts	12-Apr-10	

3. Public Health Advertising / Advertising Campaigns

This initiative proposes a centralised budget for and increased investment in structured local advertising campaigns in the 2010/11. This additional investment will improve the value for money we gain from bulk and advance ordering - for instance in our use of billboard or bus advertising, broadcast and other paid for media. This will be met with greater commitment to forward planning and the development of social marketing approaches across four planned themes - urgent care, smoking, alcohol and screening. This proposal incorporates therefore two public health project brief proposals - alcohol social marketing and improving uptake of screening for breast and cervical cancer.

We propose running campaigns over one or more advertising platforms for consecutive three month periods. Campaigns will be switched throughout the year in order to take advantage of greater discounts when booking for a longer period, when a channel is to be used continuously for more than one campaign.

Initiative: Public Health Advertising / Advertising Campaigns				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To improve communication with regard to important health messages to local residents by better use of advertising in the city and obtaining value for money	To run campaigns over one or more advertising platforms for consecutive three month periods. To switch campaigns throughout the year in order to take advantage of greater discounts when booking for a longer period.	Prepare draft overarching campaign plan	15-Feb-10	Possible reduced lead in time for quarter 1 campaign to be developed, agreed and launched - Score 4
		Finalise/agree year 1 campaign plan	22-Feb-10	Local campaign going against or not coordinated with national/SHA wide messages - Score 3
		Agree campaign advertising themes and topics	24-May-10	New campaign topic introduced (or becomes national priority) at short notice (eg swine flu) - Score 6
		Evaluation of Q1 campaign report	04-Oct-10	
		Agree campaign advertising themes and topics	23-Aug-10	

d. Key Enablers and Links

1. Other Key Enablers

- Informatics
- Information management
- Knowledge management
- Pathway re-design
- Solent Supplies
- Darzi work streams – Staying Health / Children
- NPSA
- NICE guidance

2. Links to other workstreams

- Darzi work-streams - Long Term Conditions, Planned Care, Children & Young People & Maternity, Staying Healthy
- South Central Programme – Active Ageing
- 2007 General Ophthalmic Services Review
- UK Vision Strategy (2008)
- Out Health: Our Care, Our Say (DH 2006)
- NHS Constitution
- New national General Optometry Service Contract

e. Organisational Support Required

1. Fluoride Varnish

This project is under the umbrella of the Oral Health Action Group (OHAG) which has representation from dental commissioning, public health and dentistry. The OHAG in consultation with a broader stakeholder group developed the Oral Health Strategic Action Plan for Portsmouth City (2007 – 2010). A formal Oral Health Stakeholders group is due to resume in March 2010 as a forum for refresh of Oral Health Strategic Action Plan. This will have representation from salaried dental service, university, dentists, oral health promotion and the general public and others to be agreed. This project links to other key work streams within NHSP, particularly the healthy weight strategy delivered through the childhood obesity advisory group. External multi stakeholder groups are Food and Health Group and Social Marketing Group. These groups have representation from HIDs, health visitors, nurses, healthy schools, oral health promotion, dieticians. There will also be developments through SHIP.

2. Glaucoma LES

This will need support from the Local Ophthalmic Committee with regard to organisational support, as well as internal support with report with regards to informatics, clinical governance, clinical engagement, pathway redesign and knowledge and information management.

3. Public Health Advertising / Advertising Campaigns

Although this project would be coordinated within the PCT, there are likely to be several opportunities for joint working across each campaign theme - Portsmouth City Council (HIDS team), Portsmouth Hospitals Trust, Portsmouth Football Club, NHS Southampton and the new Community Provider organisation will all be key stakeholders. Contact will be maintained with each of these through existing communications and public health channels. The Media and Communications teams from Portsmouth City Council, NHS Portsmouth, Portsmouth Hospitals Trust and the Safer Portsmouth

Partnership would work together to deliver the campaign. We will also be engaging with a wide range of other local partners to support the promotion of each individual campaign. Workplaces would also be used to deliver the messages. The Alcohol Strategy Group, smoking cessation team, health trainers, primary care and staff working within each relevant frontline service will be important and we will seek support with publicity from key PCT partners and, where appropriate, service users and members of the public (incl. LINK.)

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Fluoride Varnish	
Key Performance Indicators	Link
Engagement and support from the local community, schools, councillors	Local KPI
Consent from parents	Local KPI
Dmft for children taking part in the pilot	
Proportion of children who receive continuing dental care	Local KPI
Knowledge of parents	Local KPI
Effective tooth-brushing at home	Local KPI
Outcome Measures	Link
Reduction in dmft/ DMFT for children taking part in the pilot	
Differences in proportion of children who receive continuing dental care	
Improved knowledge of parents	
Effective tooth-brushing at home	
Delivering Better Oral Health (2009)	
Local Area Agreement (2008-11)	LAA

Measures of Achievement	
Initiative: Glaucoma LES	
Key Performance Indicators	Link
No. of new Glaucoma referrals into Ophthalmology	Local KPI
% of Glaucoma first appointments at Ophthalmology not requiring follow-up	Local KPI
Outcome Measures	Link
PSA 17: Indicator 3 'Healthy Life Expectancy at 65'	PSA
PSA 19: Indicator 3 'NHS reported referral to treatment times for non-admitted patients'	PSA
Improved access within 18 weeks (PHT's ophthalmology department)	VSA
LAA indicator 7.8: 'Health issues faced by BME communities' - higher risk of glaucoma for African communities.	LAA
Will support delivery of the actions outlined in the SE Hants Capacity Map in terms of reducing elective admissions by implementing a referral management scheme.	Local KPI

Measures of Achievement	
Initiative: Public Health Advertising / Advertising Campaigns	
Key Performance Indicators	Link
Success of the project will be measured by the numbers of people accessing information (i.e. website) and the numbers seeking support (referrals).	Local KPI
Outcome Measures	Link
Will help enable the achievement of the following:	
A&E waiting times	
Smoking cessation	
Reducing the harm caused by alcohol and drugs	PSA 25
LAA Priority 7,	LAA
Encourage healthy choices and appropriate access to health care and support.	
Proportion 53-64 offered screening for breast cancer	VS22
Proportion 53-70 screened for breast cancer within last 3 years	VS23
80% women screened within 36 months of their previous	NHSPSP
Develop programmes to increase screening uptake in deprived/BME communities	CRS (07)
PCT WCC priority to increase breast screening uptake rates in females aged 50-70 to a level equal to or exceeding that of the England/Wales average by 2015.	WCC
Proportion 25-64 screened for cervical cancer	VS 23
Proportion 25-49 who have received cervical screening	VS 24
Proportion 50-64 received cervical screening	VS 25
NHS cervical screening programme national target	
To halt the decline in cervical cytology uptake rates in females aged 24-64 and maintain above 75% by 2015.	WCC

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Fluoride Varnish	-	-	-
Glaucoma LES	26	(54)	(28)
Public Health Advertising	200	-	200
Total	226	(54)	172

4.1.6 Teenage Pregnancy

Staying Healthy – Teenage Pregnancy
Recovery Area: Under 18 conception rate
a. Executive Lead
<ul style="list-style-type: none"> Dawn Saunders
b. Current Position & Reason Recovery Required
<p>1. Current Position</p> <p>In 1998 the baseline figure for Portsmouth was agreed at 57.0 while the national was 46.6, the ten year target was to halve the baseline figure by 2010 to a rate of 28.5. Portsmouth has a teenage conception rate of 49.3 per 1000 15 – 17 year olds compared with an English average of 40.9 (based on 3 year rolling figures) and 45.3/100 compared to an England average of 40.4 (based on annual figures).</p> <p>There has been a 2.3 % reduction on the 1998 baseline figures against a 9.1% England reduction based on the 3 year rolling data over the same period. Looking at the data on an annual basis the reduction is 20% against an England average of 13.3%. Caution should be used when interpreting the annual data due to small number variations.</p>

2. Reason Recovery Required

The majority of teenage conceptions are unplanned and over half end in termination. Below are some of the reasons why there is a drive to reduce the teenage conception rates:

- Poverty cycle
- Benefit system, extra cost on Income Support and Family Tax Allowance, government target to have 60% of young parents in EET
- Low educational attainment which contributes to the poverty cycle of the next generation
- Limited housing with support for young people with children
- NHS cost on mental health (studies show that ante-natal depression can be longer lasting in young parents and impact on their children)
- Social isolation and not access service
- Cost to the NHS on delivery and ante-care for under 18's and increased cost for second pregnancies
- Cost to the NHS on terminations
- Cost to the NHS for the treatment of sexually transmitted infections
- Cost to the NHS baby's of teenage parent are reported more likely to born pre term and have a lower birth weight, higher infant mortality, higher hospital admittance for accidental injuries, diarrhoea and vomiting.
- Baby of teenage parents are more likely to suffer from developmental delays which in turn affects their language development educational attainment.
- Baby's poor nutrition not meeting developmental milestone
- Cost to the police services domestic violence and abusive relationships

c. Planned Change

The planned changes are two fold: to focus on reducing the number of teenage conceptions and to support teenage girls who go ahead with their pregnancies.

- We are presently working with the Children's Trust Board in setting a realistic but challenging target for Portsmouth City.
- The latest impact for change has centred on risk taking behaviour and the impact of the family. These two areas provides a lever for change on the young people's behaviour as a whole versus focussing at sexual activity, we are looking at the significant contribution of alcohol and binge drinking on sexual behaviour and conception.
- Portsmouth City Council (HIDS) commissioned a DVD highlighting risk behaviour in a party situation interspersed with candid interviews with young parents and looking at why they got pregnant. This was developed as an educational tool to use within the educational settings as well as community settings
- The department for Children, Schools and families has also brought out a Think Family Toolkit which helps in improving support for families at risk this will also contribute as a lever for change.
- Focus on SRE and PHSE in local schools with a focus on those schools with girls in the risk categories
- Benchmarking best practice against ONS comparator authorities

d. Key Enablers and Links

- Undertake data analysis with CYPP on teenage parents and teenage pregnancy in order to ascertain ward data to look more in depth at hotspot areas within the city.
- Look at Care to Learn data on uptake of courses, if young parents are engaged less likely to

<ul style="list-style-type: none"> • have second pregnancy • Prevention work within the Portsmouth City secondary school, comprehensive SRE for all year groups sharing good practice between schools • Delivery of SRE to more vulnerable groups of young people (YOT, LAC, homeless, carers and special needs) in a variety of community settings • Multi-agency work between midwifery and Connexions, in order to engage and support transition for young pregnant women when they are most vulnerable. • Midwifery outreach worker engaging ante-natal and post-natal with young parents and parent to be in order to improve health quality of both parent and child. • Nurse in a box, accessing contraceptive and advice in order to reduce unplanned pregnancy • Teenage pregnancy re-integration officer working with young parents and parent to be in order to stay engaged in statutory education and achieve. • Use of DH money for expanding LARC and for counselling of under 20s post termination to prevent subsequent pregnancies
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e. Organisational Support Required

<ul style="list-style-type: none"> • Support from primary care in increasing LARC uptake rates • Engagement from schools to enhance SRE

f. Measures of Achievement

<ul style="list-style-type: none"> • LAA indicators • VSA targets • Termination rates reducing • Increase in LARCs in target group
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g. Financials - Alignment of investment / disinvestment

Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Teenage Pregnancy Co-ordinator	22.5		22.5
Total	22.5		22.5

4.1.7 In addition to the detail provided above for staying healthy, the additional 1011 work programmes for staying healthy are listed below.

Programme Initiatives	
Alcohol	Maintain the Adolescent Health Alcohol Project Develop Community Health Practitioners (CHP) Develop an Alcohol Advisory School Nurse service Deliver continuous Social Marketing programme for alcohol Maintain and increase the capacity of alcohol treatment services Maintain outreach services Maintain Alcohol Interventions Team Develop an Alcohol Local Enhanced Service in primary care Develop an Alcohol Psychosocial treatment service Develop an Alcohol Specialist Nurse Service in NHS acute services

	<p>Further develop Service User and Carer Involvement</p> <p>Maintain a City Alcohol Strategy Officer</p> <p>Maintain Alcohol Arrest Referral services</p> <p>Extend support to the Street Pastors service</p> <p>Pilot a multi-agency one-stop shop</p> <p>Develop a domestic abuse service (ACES)</p>
Smoking	<p>Review the smoking service model and data</p> <p>Reduce smoking prevalence in pregnant women</p> <p>Reduce smoking prevalence amongst people with established health conditions</p> <p>Establish work-based smoking cessation services</p> <p>Deliver the City's 'Smoke Free Portsmouth' Strategy</p>
Obesity	<p>Maintain the national child measurement programme (and support services)</p> <p>Identify local policies that influence obesity</p> <p>Improve physical activity and diet opportunities</p> <p>Improve care pathways for adults with obesity (bariatric surgery)</p> <p>Commissioning adult obesity weight management services</p> <p>Evaluate existing and commission further child obesity weight management services</p> <p>Pilot a physical activity care pathway across primary/community care ('Let's Get Moving')</p>
Screening: Cervical Cancer	<p>Maintain and improve the current cervical screening programme and demonstrate value for money</p> <p>Improve cervical screening reporting time to national standards</p> <p>Deliver a social marketing project to increase the uptake of cervical screening</p>
Screening: Bowel Cancer	<p>Maintain and improve the current bowel screening programme and demonstrate value for money</p> <p>Manage the devolvement for the commissioning of bowel screening from national office to NHS Portsmouth</p>
Screening: Breast Cancer	<p>Maintain and improve the current breast screening programme and demonstrate value for money</p> <p>Deliver a social marketing project to increase the uptake of breast screening</p>
<p><i>For all other Staying Health initiatives please refer to 'NHS Portsmouth Staying Health Commissioning Plans 2010-14'</i></p>	

4.2 Long Term Conditions

4.2.1 Managing Long Term Conditions in the Community

Long Term Conditions – Managing Long Term Conditions in the Community	
Name of Initiative:	<ol style="list-style-type: none"> 1. Managing Respiratory Conditions in Primary Care 2. Diabetes Intermediate Care 3. Home Oxygen 4. Implementation of a Joint Carers Strategy
Name of National, Regional, Sub-Regional or Local Priority supported:	<p>Local Priority</p> <ul style="list-style-type: none"> • Local Implementation of the National Carers Strategy in partnership with Portsmouth City Council

<p>National Target</p> <ul style="list-style-type: none"> • NI 135/Vital signs "Proportion of carers receiving a "carers break" or a specific service for carers as a percentage of clients receiving community based services"
<p>a. Executive Lead</p> <ul style="list-style-type: none"> • Innes Richens
<p>b. Current Position</p> <p>1. Managing Respiratory Conditions in Primary Care</p> <p>In 2009/10 the PCT Adult Respiratory Care Steering Group (ARCSCG) which consists of local GPs, physiotherapists, nurses, physicians, commissioners and managers have carried out a series of workshops looking at pathways for respiratory patients, and patient groups have been consulted. This work has identified gaps in skill mix in primary care and a lack of specialist resource to support community services in relation to respiratory conditions.</p> <p>2. Diabetes Intermediate Care</p> <p>Currently PHT provide a nurse that works in the Chronic Disease Management centre at SJH. The funding stream for this service is historical and according to the Diabetes department is no longer reflected through PbR. As a result PHT have withdrawn this service with immediate effect.</p> <p>3. Home Oxygen</p> <p>The PCT currently spends over £300,000 per year on providing Home Oxygen (HO) services to patients. The recommended model of care is that patients are fully assessed by a clinician with expertise in respiratory care before being prescribed oxygen, especially long term oxygen therapy (LTOT) (as it can be harmful to some COPD patients) and that patients are reviewed to ensure that their ongoing needs are met and that LTOT is being utilised properly.</p> <p>Currently GPs are still prescribing LTOT without full assessment in some cases. There is no follow up service commissioned. Almost a third of patients are receiving Short Burst Oxygen Therapy (SBOT) despite the fact that there is no evidence base to support its use except in palliative care.</p> <p>The PCT is charged a daily rate per patient, depending on the mode of oxygen they are in receipt of; regardless of how much they use it, whether they cease to use it, or whether they still require it clinically. Currently there is a high risk of patients being left for years on the original oxygen prescription, which is at best expensive and at worst detrimental to their care. There are also health and safety implications because there have been reports of patients stock piling cylinders of oxygen when they are supplied more than they use.</p> <p>4. Implementation of a Joint Carers Strategy</p> <p>Based on Census 2000 data there are 5,000 unpaid carers in the city; 1500 provide 20-49 hours of care per week and 3500 provide over 50 hour per week. People who provide these long hours of care are twice as likely to be in poor health themselves both physically and mentally, and need to be supported both in their own right and in their role as carers.</p> <p>This year we have consulted with local carers who have identified breaks (these can take many different forms) as being the most important element in helping them continue their caring role.</p> <p>Work is underway on developing a 3 year joint carers strategy, including the mapping of all local</p>

carers service and groups, analysing data, identifying unmet needs and further consultation with carers. This work will be completed in spring 2010 and will include a joint plan on how health and social care will support carers in the future.

5. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

PCT Strategic Objectives

- Improve people's quality of life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all
- Improve access to services for the most vulnerable people amongst our local population
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)

c. Planned Change

1. Managing Respiratory Conditions in Primary Care

This project is about Improving the management of patients in primary care by Investing in training, education, and support for primary care and community services. . Bridging this gap will be achieved by:-

- Providing written information and guidance for GPs, practice nurses and community health professionals regarding managing conditions like COPD and asthma, and providing clear guidance about how best to utilise the various community services available and how to help patients self manage.
- Providing new specialist roles such as specialist respiratory nurse or physiotherapist to work in the community managing complex patients but also providing important expert support and advice to our existing community staff such as Community Matrons and district nurse, who have a generalist role but are not always skilled at recognising and treating exacerbations.
- This initiative is expected to reduce emergency admissions for COPD and asthma, improve quality of life for patients, and reduce referrals to the PHT respiratory centre. The project assumes that the specialist will be in post by month 5 and a reduction in ACS admissions will be seen by month 8. The reduction is based upon a trajectory which takes our ACS admission rates down to national benchmark levels by 201415

The existing Adult Respiratory Care Strategy Group has identified the need for this project. Patient feedback from COPD patients has highlighted the need for earlier self management information. The project is about a pathway of care, not a particular treatment, but this model reflects what is considered to be clinical best practice.

Initiative: Managing Respiratory Conditions in Primary Care				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To improve the management of patients in primary care through training, education, and support for primary care and community services.	To employ a specialist resource to support community services in relation to respiratory conditions, and to fill gaps in skill mix in primary care.	Agree job descriptions	22-Feb-10	Unable to recruit to specialist post - Score 8 GPs do not access the service - Score 8 Savings are not realised because ACS admissions do not decrease as planned. - Score 15
		Specialist in post	05-Jul-10	
		Service starts	05-Jul-10	
		Info pack and referral criteria to GPs and secondary care	07-Jun-10	

2. Diabetes Intermediate Care

It is proposed therefore that we commission a diabetes nurse, to educate and support the management of patients in the community and primary care. PHT currently provide DESMOND training, which is group education sessions for newly diagnosed type 2 diabetics, and is a NICE requirement. Commissioners need to scope the efficiency of the current DESMOND service to understand how it needs to be commissioned for the future. Once support and education for primary care is established by the nurse, there may be the potential for the DESMOND sessions to become part of his/her workload.

A key role of the nurse will be to educate GPs and nurses about the use of Xenotide. Use of insulin often results in significant weight gain in patients. Xenotide is an alternative to insulin which does not cause weight gain. It is an expensive drug but cost effective overall. Currently some GPs prescribe it but PHT consultants report that more patients could benefit with the right support. Further savings may be achieved long term then, given the health issues associated with obesity. These have not been quantified.

Initiative: Diabetes Intermediate Care				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To provide education and support to GP practices and community services to manage patients in the community.	Commission a diabetes nurse, to educate and support the management of patients in the community and primary care.	Set Up Service	by 2010	Recruitment issues [Score 3]
		Activity deflected	by 2011	OP appointments increase [Score 6]

3. Home Oxygen

PCTs who have invested in follow up services for patients receiving HOS have saved thousands of pounds by ensuring patients are only receiving the right mode of oxygen delivery and by ensuring correct dosage and utilisation.

Members of the Adult Respiratory Care Strategy Group have highlighted the high numbers of patients receiving Short Burst Oxygen Therapy, which is expensive. It is expected that reviewing these patients would enable significant numbers to either cease therapy or change to LTOT which is the evidence based and value for money treatment for many patients.

The PCT is currently undertaking a validation exercise on our Home Oxygen Service database. This has already highlighted the fact that there are significant numbers of patients listed as in receipt of the HOS, and for whom we are being charged, despite the fact that there is no record of physical input by Air Liquide (implying that they may have not been using their oxygen). Early indications are that the PCT is overspending by £60,000 to £100,000.

Commissioning a follow up service for these patients would both enhance their clinical care and also reduce the inappropriate prescription and ongoing use of oxygen therapy and the associated costs.

The finance and activity figures detailed below are estimates. A more accurate project brief will be possible early in December when the audit should be complete.

The demand for the HOS is likely to increase as our population ages, which makes it imperative that we ensure efficiency and value for money are achieved. COPD rates will directly impact on demand for the service.

Initiative: Home Oxygen				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Identify 1% additional productivity / allocative efficiency in local tariff acute services from 2010/11 onwards -£1.5 m 31/3/2011. Home Oxygen Assessment and Follow up service.	To commission a follow up service for Home Oxygen patients to enhance their clinical care and also reduce the inappropriate prescription and ongoing use of oxygen therapy and the associated costs.	Set up Service	April 2010	recruitment issues [Score 4]
		Target Savings achieved	by end 2010/11	

4. Implementation of a Joint Carers Strategy

The commissioning of a joint breaks service for carers has been identified as a key priority in the emerging joint carers strategy for Portsmouth. Government funding of 150m for 0910 and 1011 has been made available to PCTs to provide breaks for carers. PCTs have been allocated a share of this funding in their baselines. In line with the NHS operating framework PCTs are required to work with their local authority partners and publish joint plans on how their combined funding will support breaks for carers, including short breaks in a personalised way. Consultation on the local carers strategy is underway and will inform the development of the breaks service. Although it is not possible to specify the model of service delivery at this time, the underlying commissioning principles will be; targeting hidden carers; promoting choice & control by providing a carers with a menu of breaks options and offering individual budgets / direct payments.

Initiative: National Carers Strategy				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Local Implementation of the National Carers Strategy	To work with local authority partners and publish joint plans on how combined funding will support breaks for carers, including short breaks in a personalised way	Identification of Service Model	May-10	Service provision and expenditure inadequate to meet needs without the investment requested [Score 12]
		Specification or operational policy agreed	May-10	
		Completion & Launch of Carers Strategy	Jun-10	
		Service publicised	Jun-10	
		Service launched	Jul-10	

d. Key Enablers and Links

1. Market Implications

The majority of services for patients with long term conditions are currently provided by NHS organisations (such as primary care, community services and acute NHS providers).

Primary Care: Integrated primary, community health and social care services will require current providers to strengthen partnerships or form new organisational shapes (such as Integrated Care Organisations) in order to deliver care along the total care pathway for each long term condition.

Community Services: NHS Portsmouth is already transforming its community services to provide a single point of access to integrated health and social care multidisciplinary teams, and is now

beginning to explore the role of specialist disease specific health professionals within these teams.

3rd Sector: With the focus on more individualised care for both people with long term conditions as well as their carers, the role of 3rd Sector providers will become more important over the next 3-5 years.

All: There will be a greater emphasis placed on self-care and management with the need for a marketplace of providers who will be able to support individuals in care planning and management.

2. Estates and Facilities

NHS Portsmouth's existing plans to develop a St Mary's Community Campus will be critical to the delivery of comprehensive community and primary care services. This will also present an opportunity to review primary care premise locations, seeking to use the St Mary's site development as an opportunity to strengthen partnerships between community and primary care providers.

Intermediate care: Turner Centre, St James Hospital, capacity expansion to run one-stop rehabilitation assessments and support Single Point of Access (SPA).

Diabetes: reprovision of diabetes intermediate care to a community setting – currently planning at St James Hospital.

3. Workforce

Training and education for GPs and practice nurses to support early diagnosis of long term conditions and to give patients the information they require to effectively self care.

People with long term conditions will require disease management from community-based multidisciplinary teams, often through the use of specialist nurses. There is also a significant group of high-risk patients who need their condition actively managed.

4. Information Technology

The adoption and greater use of telehealth and IT solutions to enable easier remote access with patients and experts as well as patient records will be required. Currently in Portsmouth City there is an acknowledgement of unnecessary complexity in multiple community and social care systems and a significant programme of work integrating health and social care will be required to be maintained.

5. Other Key Enablers and Links

5.1 Managing Respiratory Conditions in Primary Care

The project links to the HaSP project, 18 weeks and 4 hour waits, Practice Based Commissioning (PBC), and all Long Term Conditions (LTC) work. Stakeholders are patients, carers, GPs and practice nurses, community nursing and therapy services, acute services, emergency services, ambulance service. It is proposed that the project board would involve all interested parties and that the communication plan would be developed by that group.

5.2 Home Oxygen

Information from Air Liquide (oxygen supplier) and input from the Adult Respiratory Care Steering Group would be essential to take this work forward.

5.3 Diabetes Intermediate Care

Practice based commissioning will link into this initiative, along with respiratory care and personalised

care planning (but not dependent). Local clinicians are supportive of the project and have been involved.

e. Organisational Support Required

Managing Respiratory Conditions in Primary Care

PHT and community services will need to be involved in improving pathways of care for patients

All: - For all three initiatives there will be input and collaborative working with Portsmouth Hospitals Trust, South Central Ambulance Trust (SCAS), Portsmouth City Council, Social Services, Stakeholder – patients and carers, Specialist services commissioning – as lead commissioner for SCAS, Primary care, GPs, Practice nurses and community services.

Joint Carers Strategy

Particular involvement from the Integrated Commissioning, Adult and Children's Social Care Leads, Health Improvement and Development Service leads, GPs, current providers and carers.

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Managing Respiratory Conditions in primary care	
Key Performance Indicators	Link
Reduction of 29 asthma admissions	Local KPI
Reduction of 49 COPD admissions	Local KPI
Outcome Measures	Link
Patients will be managed in the community more frequently, reducing need for hospital attendance and admission, so access will be improved for all.	Local KPI
Improves quality of services by ensuring patients get optimal care in primary care.	Local KPI
Reduces unnecessary use of hospital resources by improving community care.	Local KPI
Focusses on ill health prevention by encouraging patients to self care.	Local KPI

Measures of Achievement	
Initiative: Diabetes Intermediate Care	
Key Performance Indicators	Link
10% Reduction in Diabetic first outpatient appointments at PHT	Local KPI
5% Reduction in Diabetic follow up appointments at PHT	Local KPI
Outcome Measures	Link
Improvement in patients care	Local KPI

Measures of Achievement	
Initiative: Home Oxygen	
Key Performance Indicators	Link
Reduced number of patients on SBOT	Local KPI
Reduced spend on HOS	Local KPI
Reduction in numbers of patients the PCT is invoiced for	
Outcome Measures	Link
Improved efficiency and effectiveness of Home Oxygen Therapy	Local KPI
Decreased risk of harm through inappropriate oxygen use.	Local KPI

Measures of Achievement	
Initiative: National Carers Strategy	
Key Performance Indicators	Link
Number of carers assessed for a break	Local KPI
Number of carers helped by a break	Local KPI
NI 135/Vital signs "Proportion of carers receiving a "carers break" or a specific service for carers as a percentage of clients receiving community based services"	NI/VIS
Outcome Measures	Link
Improved quality of carers services and value for money	Local KPI
More carers receiving services	Local KPI
Provision of services and support for carers better aligned to carers needs	Local KPI
Greater carer satisfaction in the provision available to support them	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Managing Respiratory Conditions	51	-	51
Diabetes Intermediate Care	27	-	27
Home Oxygen	56	50	6
Joint Carers Strategy	100	-	100
Total	234	50	184

4.2.2 Stroke

Long Term Conditions - Stroke
Recovery Area: Stroke - VSA14 % people spending at least 90% time on a stroke unit
a. Executive Lead
<ul style="list-style-type: none"> Innes Richens
b. Current Position & Reason Recovery Required
<p>1. Current Position</p> <p>PHT offer an excellent model of care in that patients are discharged home quickly from the inpatient stroke unit to a community stroke team led by a consultant nurse. The community team offers a nationally recognised model of care however it is not consultant led and does not fit the definition of a 'stroke unit'; thus the time spent by patients within the community stroke team is not counted towards this target. (PHT have approached the DH to challenge their definition of this target, particularly as the DH hold their model up as an example of good practice.) However, patients are not always admitted directly to the stroke unit but are spending time on MAU.</p> <p>2. Current Performance</p> <p>Current performance is 52.6% against the organisations revised annual target of 62.5%. The trend to date has been:</p> <ul style="list-style-type: none"> Q1 09/10: 50.82% Q2 09/10: 50.88% Q3 09/10: 52.63%

As an organisation we are forecasting a year end outturn of 60%. (Target: 62.5%).			
c. Planned Change			
At the present time we can find no evidence of any actions being taken within PHT to reduce the time patients spend in MAU and/or to increase the numbers of patients admitted directly to the inpatient stroke unit. Further assurance from PHT with regard to this has been requested.			
d. Key Enablers and Links			
<ul style="list-style-type: none"> • Links to the Clinical Leaders Network and the Intensive Support Team • Reducing all emergency admission projects 			
e. Organisational Support Required			
The Emergency Pathway is being looked at as part of the Whole Systems work. Progress is also monitored through the PHT Stroke Steering Group, which commissioners attend.			
f. Measures of Achievement			
<ul style="list-style-type: none"> • Performance against VSA14 • Increase in % patients admitted directly to stroke unit 			
g. Financials - Alignment of investment / disinvestment			
Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Initiative 1			
Total			

4.2.3 In addition to the detail provided above for long term conditions, the additional 1011 work programmes for long term conditions are listed below.

Programme Initiatives	
Primary and community care	Develop specialist support to primary and community care teams for key LTCs. This will include primary care skill development, care guidelines, advice as well as providing care with the primary and community care team within community settings.
Diabetes Intermediate Care	Develop alternatives to acute-based care
COPD	Review and increasing capacity of pulmonary rehabilitation in the community Reviewing provision and access to home oxygen
Stroke	Reviewing and delivery of improved stroke rehabilitation services
Pain	Reviewing current pathways for pain management and develop further support in community settings and for self care Decommission elements of pain care pathways that are not supported by effectiveness evidence reviews

Community Equipment	Maintain existing services and improve access for people with LTCs
Independent Living	Continue to develop options for independent living and care at home, away from institutionalization, through partnership work with Portsmouth City Council
Telehealth	Develop of telehealth options to support independent living
Integrated services	Develop strong partnerships between health and social care that deliver co-ordinated, timely, responsive services through actual and virtual co-location of locally based multidisciplinary, multi-agency teams
Carers	Work with Portsmouth City Council to complete and deliver the City Carer's Strategy
Carers and respite	Work to support carers, enabling choice and respite using outcomes from national pilots looking at how the NHS can better support carers through more joined up provision with social care and the third sector. Improve the support offered by GPs for carers, and annual health checks for carers

4.3 Unscheduled Care

4.3.1 Managing Growth in Continuing Care

Unscheduled Care – Managing Growth in Continuing Care
Name of Initiative: Community Healthcare
Name of National, Regional, Sub-Regional or Local Priority supported:
Local Priority <ul style="list-style-type: none"> Contribute to the reduction in the year on year increase in expenditure on continuing healthcare to 5% by March 2012
a. Executive Lead
<ul style="list-style-type: none"> Innes Richens
b. Current Position
<p>1. Community Healthcare</p> <p>Since the implementation of the National framework for NHS Continuing Healthcare and NHS-funded Nursing Care in October 2007, the caseload for those eligible for NHS Continuing Healthcare in Portsmouth has risen by 140%. The PCT are legally obliged to fund 100% of an individuals placement that qualifies for NHS continuing healthcare</p> <p>The PCT CHC budget for the last few years has been:</p> <p>0607 = £4.566 0708 = £5.261m 0809 = £5.171m 0910 = £7.446m</p> <p>The PCT invested an extra £2.4m into this area which took account of the 08/09 overspend plus an expected increase in 09/10. However despite this 40% increase in budget Continuing Care is</p>

projecting an overspend this year. This initiative contributes to reducing the growth in continuing healthcare spend each year to 5%.

2. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

PCT Strategic Objectives

- Improve People's Quality of Life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all
- Investment in health services and ill-health prevention advice focussed on the young recognising the long-term benefits this brings to them and future generations in both health and social attainment
- Improve the quality and safety of services ensuring dignity, control and choice to service users
- Improving access to services for those most vulnerable, and those from the most deprived populations
- Focus on cost and clinically-effective ill-health prevention to allow greater independence and avoid the unnecessary use of hospital services.
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology).

c. Planned Change

1. Community Healthcare

This initiative aims to reduce the rapid increase on expenditure by the PCT on Continuing Healthcare. The project aims to ensure that all patients in receipt of continuing healthcare are regularly reviewed to ensure that their current package meets their needs. This will rely on joint working to ensure that the council and the PCT become the market drivers.

To reduce the year on year increase in expenditure on continuing healthcare to 5% by March 2012 a number of actions with regard to the following areas are planned. The areas are:

- Review of acute settings and Interim Services
- Address continuing care reviews backlog
- Look at possible areas of joint working
- Consider the role of a care broker
- Look at IT infrastructure with regard to a continuing care database
- Review Safeguarding and existing provider SLAs

For 1011 this initiative will have enabled a nurse assessor to have completed a review of all AMH and LD caseloads.

Initiative: Continuing Healthcare				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce growth in Continuing Care spend to 5% per annum	Review of all aspects of Continuing Care in order to deliver the target level of growth permitted (5%) on continuing care spend per annum. This will focus on for 1011 a nurse assessor completing a review of all AMH and LD caseloads.	Develop job descriptions and advertise new nurse assessor posts	Feb-10	The risk to the delivery of this project is that the numbers of patients that qualify for NHS continuing healthcare are predicted to continue to rise above the rate that can be sustained by the proposed funding levels - 20
		Recruitment of new nurse assessors	Apr-10	
		New nurse assessors to start	Jun-10	
		Analysis of existing caseloads and allocation of cases	Jul-10	
		Review of cases to be undertaken	Oct-10	
		All AMH and LD cases to be reviewed and have contracts	Mar-11	

d. Key Enablers and Links

1. Information Technology

For this initiative to be effective it requires a competent and effective database to track and monitor all cases, only through this can an effective picture of patient activity be gathered.

2. Workforce

Workforce development will be essential in the recruitment of the new posts. The area has high levels of skills and expertise it will therefore require an effective recruitment process with job descriptions reflecting the required skills and attracting the correct calibre of staff.

3. Estates and Facilities

Estates have a large role; currently the office space is unsafe and inefficient for the existing team. Should the project be successful and result in the recruitment of additional staff then estates will have an essential role in identifying and providing appropriate premises for the team.

4. Key dependencies

This work is also dependant on the HASP programme and the work being conducted on intermediate care. Due to the close links with social care this project will need to dovetail effectively with these programmes to ensure that there remains equity for the patients involved. The link with intermediate care is crucial considering the recent changes to the national framework and the identification of the hospital as an inappropriate venue for assessment.

This Project links very closely with similar projects across the SHIP Commissioning area, there is a local network for commissioners and a separate local network for practitioners. These networks are important in the sharing of information and the collaborative commissioning of providers. The SHIP networks enable a transfer of information between commissioners and clinicians and provide a joint approach on issues which are faced by all PCT's.

e. Organisational Support Required

This project will be primarily run from NHS Portsmouth; however, joint working with Portsmouth City Council on the delivery of care standards and cost management will be essential. It is hoped that through this joint working the standards of care and provision will be improved.

Regionally this project will work across the SHIP area to drive up quality and capacity manage

provision by care groups. Through working across the SHIP, a peer network will be developed to enable joint issues to be resolved.

There will be some support required from the COM to ensure that Service Specifications and SLA's are amended appropriately to reflect the need for Continuing healthcare involvement.

Others involved (NHSP and other stakeholders)

- NHS Portsmouth Provider Services
- Finance
- Adult Continuing Care Team
- Portsmouth City Council – Social Care and Education Teams.
- Stakeholders – Children and Young People, Parents/Carers
- Commissioners
- Primary care
- secondary care

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Continuing Care spend	
Key Performance Indicators	Link
Number of new full assessments completed in 28 days	Local KPI
Number of 117's as percentage of total that are transferred	Local KPI
Number of service specifications including CHC arrangements	Local KPI
Complete review of Intermediate care facilities (% of review complete)	Local KPI
Number of care agencies and residential homes with contracts (% of total number)	Local KPI
Number of placements reviewed	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Continuing Healthcare	89	(256)	(167)
Total	89	(256)	(167)

4.3.2 Reducing Non-Elective Admissions

Unscheduled Care – Reducing Non-elective Admissions	
Name of Initiative:	1. Reduce non-elective admissions 2. Health and Social Care Partnership Project 3. Reduce Paediatric Non-Elective Admissions
Name of National, Regional, Sub-Regional or Local Priority supported:	Local Priority: <ul style="list-style-type: none"> • Reduce Non Elective Admissions to Statistically Expected levels for Demographic make up by 31.3.2012. Then moving to upper quartile by 31.3.2014. • Reduce Paediatric Non Elective Admissions Rate to Statistically Expected Levels for Demographic Make up by 31.3.2012
a. Executive Lead	<ul style="list-style-type: none"> • Innes Richens

b. Current Position

1. Reduce non-elective admissions

The PCT is an outlier with regard to the number of non-elective admissions that occur every year, and NHS Comparators has identified that our rates of non-elective admissions are way above expected levels. Therefore a reduction of emergency admissions has been identified as a major priority for the PCT and is one of the organisations top down requirements. The initiative to 'reduce non-elective admissions' is being supported by other individual initiatives that will be occurring throughout 1011. These supporting initiatives to achieve the top down requirement of £5.9million savings include:

- Reduce Non-Elective admissions relating to Alcohol (Please see Staying Healthy-Alcohol above)
- Health and Social Care Partnership (Please see initiative below)
- Reduce Paediatric Non-Elective Admissions (Please see initiative below)

All the above initiatives will contribute to the overall savings.

2. Health and Social Care Partnership Project (HaSP)

The PCT, Portsmouth Hospitals NHS Trust and Portsmouth City Council have developed an improved understanding of how to configure Intermediate and Community Care services to better meet the needs of citizens, through the HRDS project. The HRDS project gathered the evidence needed to establish how to change the way that services are designed, delivered and managed.

The vision for this programme is to build a Health and Social Care system in Portsmouth City that supports people to develop and implement their own plans for health and wellbeing. This will be delivered through focussed community support that seeks to avoid referral to institutional care and safely reduce the length of any care away from home, in line with national benchmarks. This should enable local people to enjoy good health and a high quality of life, with consistent and measurable improvements. This programme, known as HaSP, is very shortly due to produce a service specification and financial plan which will enable delivery of the programme to transfer to a provider led delivery programme from April 2010. Programme milestones and a release schedule will be monitored through an assurance framework led by commissioners.

The programme supports and embeds work to improve demand management in acute services and medical wards. The programme will also develop some of the detail of the capacity map. The programme aligns with the SE Hants reform programme currently under development and will support delivery of draft objectives for this reform programme. The organisational change suggested by the work of the Kaleido programme will also be implemented in part through the implementation of the programme.

3. Reduce Paediatric Non-Elective Admissions

In 2008/9 there were 3,424 paediatric non-elective admissions against an expected average for PCT demographics of 2,078. The number of paediatric admissions into Portsmouth Hospital's Children's Assessment Unit (CAU) has increased steadily over previous years. In the period April 2007 until June 2009 76% of admissions had a Length of Stay (LOS) of twenty-three hours and fifty-nine minutes or less (Zero LOS). Of those with a zero LOS 52% remained on the CAU for less than four hours.

The current level of admissions into CAU remains unsustainably high, particularly for those with a zero LOS, which attracts the same tariff as children remaining on the unit within the agreed PbR trim point. There is a top down requirement to reduce the level of admissions to the expected rate for the PCTs demographics.

2. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

PCT Strategic Objectives

- Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and well-being
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)
- Improve People's Quality of Life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all
- Investment in health services and ill-health prevention advice focussed on the young recognising the long-term benefits this brings to them and future generations in both health and social attainment
- Improve the quality and safety of services ensuring dignity, control and choice to service users
- Improving access to services for those most vulnerable, and those from the most deprived populations

WCC Outcome Measures

- Hospital Admissions Cause by Unintended and Deliberate Injuries – Proportion of deliberate or unintended injuries to children or young people (per 10,000 aged under 19)
- MMR Immunisation by second birthday – Proportion of children aged 2 who complete immunisation for Measles, Mumps and Rubella (MMR)
- MMR Immunisation by fifth birthday – Proportion of children aged 5 who complete immunisation for MMR (1st and 2nd dose)
- DPT Immunisation by fifth birthday – Proportion of children aged 5 who complete immunisation for Diphtheria, Polio Tetanus (DPT)
- MMR Uptake by 5th Birthday (Direct)
- Life Expectancy (Direct)
- Obesity in Children (Direct)
- Health Inequalities (Direct)
- CVD Mortality (Indirect)
- Infant Mortality (Indirect)

c. Planned Change

1. Reduce non-elective admissions

In order to achieve the PCT top down requirement to reduce non-elective admissions to statistically expected levels for demographic make up by 31.3.2012 (moving to upper quartile by 31.3.2014); a reduction of non-elective spells has been identified through NHS Comparators data. To enable reduction to expected levels the Commissioning Team plan to lead an exercise of:

1. Scoping
2. Pathway redesign
3. Identifying where there is alternative and more appropriate provision
4. Decommissioning.

Initial scoping would involve analysing the key specialties identified at HRG and procedure level. This specific analysis will require a high level of Public Health and information team input and will involve clinical and data validation for each type of procedure taking place. Finance team assistance will also be required. Any future redesign will be based and in line with the Map of Medicine, Clinical best Practice, NICE, Productivity Metrics and Community provision.

The initiative highlights the need for innovation when considering the most appropriate methods of reducing demand for certain non-elective services. It is based upon benchmarking data which demonstrates the reduction in activity required to meet national average levels of non-elective admissions. The scheme is directly linked to improving cost effectiveness and Value for Money. Depending on the most appropriate methods highlighted during the scheme to reduce non-elective admissions, any potential change in service will involve patients and stakeholders.

The scoping exercise will be planned and project managed at specialty level. T&O, ENT, Oral Surgery and General Medicine will be prioritised as specialties with large variations and some savings are planned to be made within 2010/11 as a result. The data has been identified through NHS comparators and finances calculated in order to move the indicators towards the upper quartile position.

Initiative: Reducing Emergency Admissions (Non-Elective Admissions)				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce Non Elective Admissions to Statistically Expected levels for Demographic make up by 31.3.2012 (Moving to upper quartile by 31.3.14)	Specialty level scoping and non-elective admission reduction plans through: 1 Scoping 2 Pathway Redesign 3 Identifying where there is alternative and more appropriate provision 4 Decommissioning	Establish role outline (job description) for PH scoping	Jan-10	Recruitment delays/difficulties for Public Health consultant - Score 20
		Appoint to post	Feb-10	Benchmarked reductions highlighted unachievable or unrealistic - Score 16
		Further procedure/HRG analysis & benchmarking	Feb-10	Alternative provision necessary to achieve reduced admissions - Score 12
		Start review of clinical process/variations in procedures	Jul-10	Alternative provision more expensive than emergency admission - Score 8
		Identify if alternative provision is necessary	Jan-11	
		Begin process of establishing alternative provision	Feb-11	

2. Health and Social Care Partnership Project (HaSP)

The HaSP programme was developed to implement a model that supports more effective delivery of numerous care pathways, a number of recommendations in 'High Quality Health Care For All' and local demand management issues. The model was drawn from LEAN analysis and developed in

consultation with staff and people who use service. The HASP model addresses the involved staff at all levels, consulting with 300 or more and increasing patient choice and involvement in planning, consulting with over 70 older people. The model ensures preventative services can be accessed by people upon referral to the service and will give better information to commissioners about the range of preventative services on offer and any gaps or duplication in provision. The development of information sharing with the third sector through the DH Common Assessment Framework demonstrator site award will help to address the issue of bringing together choice and active planning for people to stay well. The development of better GP engagement and active management of people with health and social care needs, in line with plans they have developed will help to respond to demand management issues, better support GP's and respond directly to the agenda of the 'High Quality Healthcare For All' report.

The HaSP Programme is aimed at improving the quality of patient experience, also using measures from the patient perspective. The service KPI's will bring forward a holistic picture of community healthcare and social care support, which will avoid improvements made in one area impacting as a reduction in the quality of patient care in another. The programme model builds in measures to support preventative work and actively manages those at the most risk of poor health, improving the sustainability of the service. It is expected that tackling waste and improving access to community based services will positively impact demand for acute services, evidence from the HRDS project and other areas that have integrated service delivery supports this.

Initiative: HaSP				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To improve the experience of people using Health and Social Care services in Portsmouth City by the introduction of an integrated care pathway and service delivery model which meets national and local priorities.	This programme, known as HaSP, is very shortly due to produce a service specification and financial plan which will enable delivery of the programme to transfer to a provider led delivery programme from April 2010. Programme milestones and a release schedule will be monitored through an assurance framework led by commissioners.	Shared gatekeeping arrangements for Victory and Rembrandt inpatient rehab services	Apr-10	Potential loss of income for PHT - Score 12
		Integrated Community Rehab and Re-enablement Team established	Jul-10	Poor understanding of the money flow around the system - Score 12
		Virtual cluster teams in operation	Jul-10	Development of financial sub-group taking longer than expected - Score 12
		Common assessment framework policy in place	Jul-10	Expectations not communicated properly - Score 12
		Integrated Community Rehab and Re-enablement Team operating at full capacity	Oct-10	Rembrandt is left vulnerable - Score 12
		Integrated one point of access established	Jan-11	
		Co-located community health and social care cluster teams established	Jan-11	Initial project funding ceases March 2010 - Score 12
		Frontline integrated team delivery achieved	Mar-11	There is insufficient capacity to deliver on the HaSP model of service - Score 12
		Lead professional model operating	Mar-11	

3. Reduce Paediatric Non-Elective Admissions

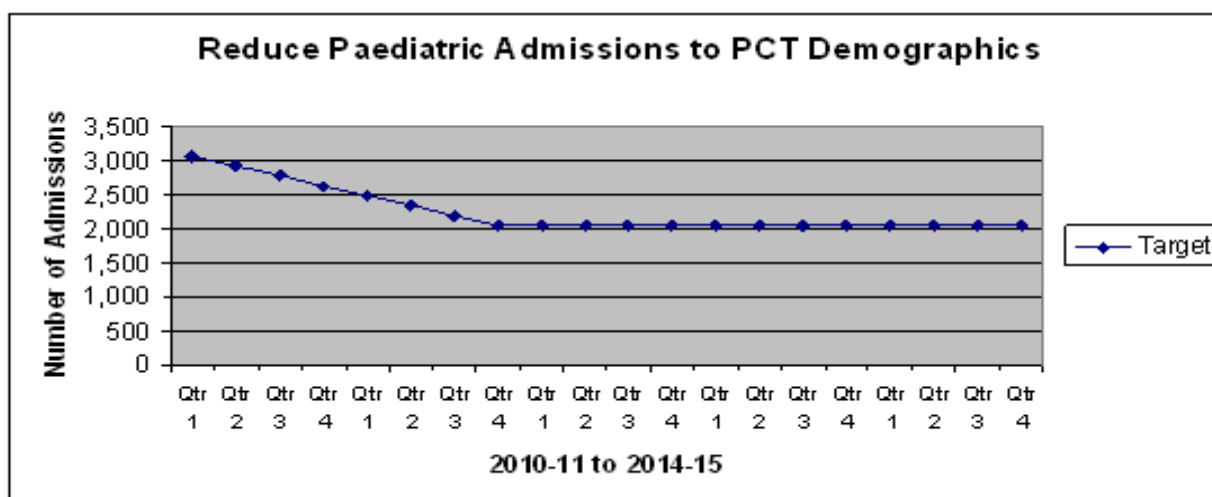
This initiative sets out to deliver the top down requirement 'to reduce paediatric non-elective admissions to the expected rate for PCT demographics by 31st March 2012'.

Taking into account population change the target for 2012 would be 2,057 admissions. This brings a

potential cost saving of approximately £1,193,391 based on average cost per case. Caution is needed with these figures as investment into primary, community and/or out of hours services will be needed to prevent admissions into the acute unit. This initiative will seek to reduce admissions by ensuring children are managed better in these settings.

The two main initial focus areas for 1011 are:

- Analysis of HRG code P03 (Upper Respiratory Tract Disorders) where the PCT is a distinct outlier and has a variation of 2.38 from the national average and 2.3 from the SHA average. Learning and development from this project will then be rolled-out to other HRG diagnoses.
- To improve community and primary care services for children in order to prevent admissions into the acute unit. The focus of this element is on community and primary care services, and links to other 1011 Children and Families objectives of:
 - Early years and prevention - Improving strategic planning and commissioning of children and families services



Initiative: Reducing Paediatric Non Elective Admissions				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To reduce paediatric non-elective admissions to the expected rate for PCT demographics by 31st March 2012	Analysis of HRG code P03 (Upper Respiratory Tract Disorders) followed by roll-out to other HRG diagnoses.	Creation of a task/finish group comprising appropriate members	Apr-10	Inability to achieve SE Hampshire wide sign up to project [Score 16]
	To improve community and primary care services for children in order to prevent admissions into the acute unit.	Review and analysis of data	Jun-10	Insufficient resource capacity allocated [Score16]
		Hold consultation workshops with stakeholders	Jul-10	Community services inability to manage increased demand [Score 16]
		Report on recommendations and implementation plan	Nov-10	Lack of engagement [Score 12]
		Design and contract for a new service specification for Paediatric Services	Mar-11	

d. Key Enablers and Links

1. Market Implications

NHS Portsmouth, through the review of core care pathways, will be exploring future opportunities for market development to deliver contestability across all services, in particular seeking providers who present opportunities to develop community-based alternatives to acute admissions, stronger partnerships with primary care and specific opportunities to improve integration of maternity and health visiting services.

Acute Providers: reduction in acute provider capacity required and a shift to community provision, managing people in a more planned way to avoid an unscheduled admission. The requirement for acute emergency beds will fall from a current level of 1,070 to 926 by 2011/12 and continue to fall by 3-5% per year.

Fast-response emergency service Providers (including ambulances): NHS Portsmouth will be seeking providers who are able to introduce different methods of working, such as conveying people to alternative community and primary care based services instead of to an Emergency Dept.

Primary/ Social and Community Care Providers: existing and new providers to consider partnership arrangements or new organisational forms to deliver integrated services, particularly for frail, complex patients in the community and where there are currently separate providers

Primary Care Providers: required to further enhance access, both in and out of hours. In addition greater partnerships between primary care and secondary care clinicians will be required, with secondary care clinicians delivering some services in primary care settings.

2. Workforce

Significant shifts in clinical culture and mindset will be required as NHS Portsmouth delivers the necessary changes to the system in order to achieve the unscheduled care programme.

There will be a greater need for care *out of hours* (evenings and weekends) in the community and primary care, presenting a significant challenge to working practices.

3. Estates and Facilities

NHS Portsmouth's existing plans to develop a St Mary's Community Campus will be critical to the delivery of comprehensive community and primary care services. This will also present an opportunity to review primary care premise locations, seeking to use the St Mary's site development as an opportunity to strengthen partnerships between community and primary care providers.

During 2010 NHS Portsmouth will be reviewing the content and utilisation of the St Mary's Treatment Centre ensuring it is considered as part of the overall St Mary's site development.

4. Information Technology

Diagnostics: deliver greater connectivity between St Mary's Treatment Centre and Portsmouth Hospitals NHS Trust for access to diagnostic results.

Develop greater interconnectivity between Community, GP Out of Hours and Portsmouth Hospitals NHS Trust to promote usage of ADAstra system for reducing unscheduled admissions for patients with long term conditions.

The adoption and greater use of telehealth and IT solutions to enable easier remote access by

patients and experts as well as patient records will be required.

5. Links to other workstreams

A&E 4 hour wait
Reduction of Emergency admission rates
Blunt measures
SE Hants Capacity map

e. Organisational Support Required

- Reducing Non-Elective Paediatric Admissions

Success of this project will entail engagement with the PCTs neighbouring PCT, NHS Hampshire. As two-thirds of the activity provided by PHT is for patients in the South East Hampshire region it is unlikely that the PCT will be successful in making significant changes to practices without buy-in and joint working with NHS Hampshire. To this end there is a requirement to identify opportunities for exploiting opportunities across the SHIP region and look to using Collaborative Operating Model (COM) opportunities.

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Reducing Emergency Admissions (Non-Elective Admissions)	
Key Performance Indicators	Link
Reduction in non-elective admissions to 1011 planned level for priority specialties T&O, ENT, Oral Surgery and General Medicine	Local KPI
Reduction in A&E referrals	Local KPI
Outcome Measures	Link
Reduction in emergency admission rates	Local KPI
Contribute to achievement of A&E 4 hour target	Local KPI

Measures of Achievement	
Initiative: HaSP	
Key Performance Indicators	Link
Reduction in non-elective admissions	Local KPI
Achievement of Project Plan milestones	Local KPI
Outcome Measures	Link
NI 124 – People with long-term condition supported to be independent	NI
NI 125 – Independence for older people	NI
NI 127 – Experience of social care users	NI
NI 128 – Respect and dignity in treatment	NI
NI 129 – End of life care	NI
NI 131 – Delayed transfers of care	NI
NI 132 – Timeliness of social care assessment	NI
NI 134 – Emergency bed days	NI
NI 136 – People helped to live at home	NI
NI 139 – Older people supported to live at home	NI

Measures of Achievement	
Initiative: Reducing Paediatric Non Elective Admissions	
Key Performance Indicators	Link
Paediatric non-elective admissions to be at expected rate of 2600 by 31st March 2011	Local KPI
Reduced number of non-elective admissions to Acute Paediatrics	Local KPI
An increased number of children managed within primary, community and Out of Hours services	Local KPI
Number of referrals for non-elective Peads by GP surgery to PHT	Local KPI
Number of admissions to CAU and ED – Monthly monitoring	Local KPI
Outcome Measures	Link
Reduced costs to the PCT	Local KPI
Increased productivity and efficiency within Community and Primary Care services.	Local KPI
Improved stakeholder satisfaction with services	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Reducing non-elective admissions	283	(739)	(456)
Reducing paediatric non-elective admissions	90	(128)	(38)
Total	373	(867)	(494)

4.3.3 A&E Performance

Unscheduled care – A&E Performance
Name of Initiative: 4 Hour Target
a. Executive Lead
<ul style="list-style-type: none"> Innes Richens
b. Current Position & Reason Recovery Required
<ul style="list-style-type: none"> Current performance is at 97%, 1% short of target Large number of 4 hour breaches due to system issues and an increase in ED attendances and admissions During the summer months the Trust failed to gain sufficient headroom to sustain the target when entering the winter period. The target is difficult to sustain particularly in the winter months with high numbers of COPD patients and fractures.
c. Planned Change
<p>There has been a number of work streams put in place:</p> <ul style="list-style-type: none"> Develop and agree whole system pathway thresholds – to be undertaken and developed by Clinical Leaders group Review and improve current community Services and Single Point of Access – in order to establish a more responsive and outcomes focused service Out of Hours Services review – review and redefine key performance indicators to identify an improved service model Paediatric Emergency Admissions – following on from the Paediatric audit in SUHT

- A whole systems action plan has been developed and is revised on a weekly basis.
- Department of Health Emergency Intensive Support Team conducted a whole system review. The formal ECIST report makes a number of significant recommendations which forms the basis of the whole systems recovery plan
- PCT has reset their community service contract Key Performance Indicators (KPIs)
- Ongoing PR and marketing campaign designed around the 'Choosing Well' publicity work.
- The threshold redesign group is a clinically focused group set up to examine the thresholds for admission and alternative routes for patients to take
- Potential for reviewing whether moving 'out of hours' GP service into QAH could be a first step in establishing a large scale primary care practice or urgent care centre at the front of A&E

d. Key Enablers and Links

The following are the key programme areas for wholes systems unscheduled care groups lead by Hampshire PCT:

- **Programme area 1: Prevention and Non-Conveyance (including commissioning of front door Emergency Department enhancements)** - The aim of this project is to promote alternatives to and to reduce the reliance on PHT (QAH) A&E department for those patients needing access for care of minor injuries and demand for services in A&E that might be otherwise be cared for within primary care.
- **Programme area 2: Acute Care Process Improvements** The aim of the project is to establish efficient and effective practices within the acute care service configuration which enables smooth and timely patient flows.
- **Programme area 3: Discharge Process management and community service support services** -The aim of the project is to establish efficient and effective practices within and between the acute and community and social services configuration which enables smooth and timely patient flows out of the acute service environment
- **Programme area 4: Strategy, Partnership and Governance: development of Unscheduled Care Strategy**- The aim of the project is to produce a comprehensive needs assessment for South East in order to produce an Unscheduled Care Strategy to support the development of services for the population of the South East

The work programme is linked to the elective work stream

e. Organisational Support Required

- Part of whole systems working group

f. Measures of Achievement

- Achievement of 4 hour target
- Reduced bed occupancy rate to 85%
- The 'Decreasing emergency admissions' programme aims to decrease emergency admissions to affect a decrease in PCT spending on emergency care to be achieved through:
 - Setting practice and team level targets to reduce admissions
 - Agreeing joint incentives, rewards and penalties to meet targets
 - Managing more frail elderly patients outside hospital
 - Agreeing and implementing tight, consistent admission thresholds

g. Financials - Alignment of investment / disinvestment			
Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Total	0	0	0

4.3.4 In addition to the detail provided above for unscheduled care, the additional 1011 work programmes for unscheduled care are listed below.

Programme Initiatives	
Prevention & Non Conveyance	Social marketing and Communication strategy Review Treatment Centre utilisation Nursing home frequent users
Ambulances	Maintain performance management of response times for the City; improvement schemes for South Central area Ambulance turnaround at Emergency Dept
Emergency Dept and Front Door	Community/hospital interface and model at Emergency Dept review Internal process improvements at Emergency Dept
Acute unscheduled care	Review pathways internal to acute setting to ensure effectiveness and smooth flow through from Emergency Dept to discharge (and beyond to community/primary care)
Discharge	Community/hospital/social care interface and model for discharge to be reviewed
Community and Primary Care	Implement the integrated health/social care model of service designed by the Health and Social Care Partnership (HaSP) Review of GP out of hours provision
Continuing Care	Review and implement of continuing care model, integration with social care. Collaboration with SHIP PCTs and Local Authorities

4.4 Planned Care

4.4.1 Low Priority Procedures

Planned Care – Low Priority Procedures
Name of Initiative: Procedures of Low Clinical Priority
Name of National, Regional, Sub-Regional or Local Priority supported:
Local Priority <ul style="list-style-type: none"> • Top down requirement - Identify Procedures of low clinical priority and develop controls to ensure only appropriate patients are treated – reducing volumes of procedures by 50% by 31.3.11
a. Executive Lead
<ul style="list-style-type: none"> • Innes Richens
b. Current Position
1.Low Priority Procedures

The PCT has introduced a system whereby any of the 7 key procedures outlined below will have to have PCT Prior Approval before the patient can be listed for Surgery. The prior approval system will exclude those patients with cancer or emergency procedures. This system is in addition to the normal individual funding request process and allows Portsmouth Hospitals to match patients against the procedure criteria via an electronic web-based system.

Procedures Requiring Prior Approval Include:

- Insertion of grommets
- Tonsillectomy
- Hysterectomy
- Dilatation & curettage (D&C)
- Varicose Veins
- Male Circumcision
- Arthroscopic Lavage & Debridement for Osteo Arthritis

2. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

PCT Priority

- Meets with Better Care Better Values supporting evidence

PCT Strategic Objectives

- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)
-

c. Planned Change

1. Low Priority Procedures

The main objectives and outcomes of this initiative will be to:

- Identify areas where Portsmouth Hospitals are not meeting the criteria and where funding will not be provided
- Reduce manual resources, save time and reduce paper work
- Assist in achieving the 18 week RTT target for each patient by reducing steps in approval process

In order to achieve the top down requirement "Reducing volumes of procedures by 50%. Identifying £500,000 savings by 31/03/2011" it has been identified that Low priority Procedures and Better Care Better Value indicators require further scrutiny. Although considerable work has already taken place within this area a number of procedures will require further examination and reduction to National levels, upper quartile levels and beyond.

The following areas have been identified as potential areas of saving for 2010/11:

Procedures	Estimated Reduction Required to achieve UO	Cost based on average costings
Abdominal excision of uterus	16	14,386
Dilation and curettage/hysteroscopy	51	35,167
Lumbar spine procedures	17	11,658
Myringotomy with/without grommets	21	18,823
Tonsillectomy	32	27,926
Vaginal excision of uterus	8	18,627
	145	126,586

This is based on the assumption that the modelling for overall elective admissions will shift the numbers of procedures down to upper quartile level. Therefore the additional reduction made through the above model will reduce from upper quartile SAR to upper Octile.

Information of other methods of reducing admissions through the Better Care Better Values is available on the NHS Productivity website (www.productivity.nhs.uk) - Managing variation in surgical thresholds, which highlights methods of dealing with the 5 high admission procedures. (tonsillectomy, dilatation and curettage, hysterectomy, lower back surgery and myringotomy).

- Analyse standardised admissions rates for these five areas and identifying which are higher than expected.
- Establish protocols for treating patients with conditions where surgical variation is very high. This will ensure that patients likely to benefit from these surgical procedures are operated upon, and those that are not are treated in more appropriate ways.
- Identify which individual GP practices have high rates of referrals that result in these procedures.
- Use practice-based commissioning to incentivise GPs to manage patients with these five conditions in the most appropriate manner. Ideally a local system to monitor GPs admission rates for these conditions should be set up, and regular feedback on performance given to practices to aid their improvement.
- Continue to monitor the rates of surgery for these procedures to ensure improvements are occurring.

Initiative: Procedures of Low Clinical Priority				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reducing volumes of procedures by 50%. Identifying £500,000 savings by 31/03/2011	Identify procedures of low clinical priority and develop controls to ensure only appropriate patients are treated.	Ensure Providers aware of change in policy and £ consequences	01/02/10	Resources available to audit activity data to ensure any activity taking place is in line with scheme. - Score 16
		Ensure audit standard operating procedure is written	22/03/10	Potential risk linking in with existing IT systems for scheme – Score 9
		Ensure data transfer/collection systems in place	08/03/10	Activity and KPI broken down in 12 month equal split, activity will have variation within months – Score 5

d. Key Enablers and Links

- Information Technology support for transferring of data - IT systems for managing and monitoring Low Priority Treatments will be required, particularly harmonized across SE Hampshire commissioners.
- GP's
- Provider organisations use of system
- Overall Planned care programme

e. Organisational Support Required

This is a work stream being picked up as part of the whole system work on planned care and is being led by the whole systems planned care board led by NHS Portsmouth.

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Procedures of Low Clinical Priority	
Key Performance Indicators	Link
Reducing volumes of procedures by 50%.	Local KPI
Identifying £500,000 savings by 31/03/2011.	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Low Priority Procedures	-	(151)	(151)
Total	-	(151)	(151)

4.4.2 18 Week Access

Planned Care – 18 Week Access
Name of Initiative: 1. National Target 18 Weeks Target (including Wheelchair waiting list backlog removal) 2. Reducing GP referrals
Name of National, Regional, Sub-Regional or Local Priority supported: National Target <ul style="list-style-type: none"> 18 Weeks RTT Local Priority <ul style="list-style-type: none"> Reduce GP referrals to levels found in Southampton / Brighton by 31.3.12
a. Executive Lead <ul style="list-style-type: none"> Innes Richens
b. Current Position <p>1.National Target 18 Weeks Target (including Wheelchair waiting list backlog removal)</p> <p>Due to Portsmouth Hospitals Trust (PHT) relocation moves, the increasing reliance on Waiting list initiatives due to a lack of capacity at PHT, the acute trust have been unable to deliver the 18 week plan for admitted patients and therefore have not achieved the national target of 90% for 0910. Current 18 week performance is expected to remain around 70% to year end. Performance in Q1 of 1011 will suffer as a result of the T&O backlog continuing until June. PHT has trajectories and plans which are developed with the Intensive Support Team to measure success and performance in this area.</p> <p>Both PHT and the PCT understand why performance has failed, and productivity analysis is being addressed by PHT as part of the Intensive Support team recovery plan.</p> <p>As detailed above, Portsmouth Hospitals Trusts have been experiencing extreme pressure on the achievement of the 18 weeks target. Portsmouth Hospitals Trust is experiencing demand for services, especially T&O, ENT and Ophthalmology, above that of available capacity. This is therefore leading to an increased waiting list and backlog. The short term issue therefore appears to be a lack of available capacity at Portsmouth Hospitals Trust to achieve the contracted level for admitted patients.</p> <p>In order to rectify the current backlog position the local health economy has been collaboratively working and combining free capacity at other providers to bridge the capacity gap. Portsmouth Hospital also has additional clinics in place till March 2010. Decreasing the capacity gap will ensure</p>

that patients are seen sooner and the waiting lists decreases to an acceptable level in order for any longer term plans to be more effective. However, the actual admissions of patients from the backlog will need to be carefully managed in order to treat patients in a timely manner while still performing at the highest level possible against the 18 week % targets.

2. Wheelchairs

One area where patients have historically experienced long waits has been within the wheelchair service. Following extensive work looking at the Disablement Service Centre, which includes Wheelchair services, orthotics and podiatry, the PCT decided to test the market to gauge what providers were willing to compete for this business should it be available.

3. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

PCT Strategic Objectives

- Improve people's quality of life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all
- Invest in health services and ill-health prevention advice, focusing on the young and recognising the long term benefits this brings to them, and future generations, in both health and social attainment
- Improve access to services for the most vulnerable people amongst our local population (such as those with mental health problems or learning disabilities) and those from the most deprived populations
- Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and well-being
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)

c. Planned Change

1. National Target 18 Weeks Target (including Wheelchair waiting list backlog removal)

In order to recover and maintain the 18 week target for 1011, careful capacity mapping will be required and elective activity, both outpatient and admissions, kept to an appropriate and manageable level in terms of the expected levels for a population of Portsmouth City's size and demographic.

In the longer term the aim would be to decrease demand for acute services to at least expected levels. In order to do this the following initiatives have been identified:

- Reducing inpatient admissions (Please see Reducing Elective Admissions Template)
- Reducing daycase admissions (Please see Reducing Elective Admissions Template)
- Reducing Length of Stay
- Low Priority Procedures (Please see Low Priority Procedures Template)
- Reducing GP Referrals (Please see below)

In addition:

- There is a drive for a cultural change being brought about by transfer of elective activity to

- other providers and ceasing waiting list initiatives
- Milestones and trajectories have been drawn up, along with the IST plan and the trajectories which are currently being developed by PHT
- The IST plan is the high level plan for 18 week delivery
- The access policy has been updated which will have an impact on waiting list management to enable delivery of 18 weeks

1.1 Wheelchairs

The current agreement with Portsmouth Hospitals is on a block contract arrangement which caused difficulties with separating the finances for each element. Following a successful market testing operation the PCT is planning to give notice on the current agreement. The PCT is in the process of handing notice to the current provider and commissioning with an alternative provider. However data has indicated that there is currently over 170 patients waiting over 18 weeks for an element of their treatment. There will therefore be a non-recurrent cost of removing the wheelchair backlog.

Initiative: 18 Weeks Target (including Wheelchair waiting list backlog removal)				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
18 weeks Referral To Treatment (RTT) 90% of admitted patients to be treated within 18 weeks 95% of non-admitted patients to be treated within 18 weeks	Ensure 18 weeks admitted RTT target is recovered and maintained	Monitor activity being transferred to alternative providers - trajectories	Apr-10	Interim plan of transferring activity to alternative providers not as successful as planned – Score 6
		Monitor PHT 18 week position in line with IST plan	Ongoing	Variation from planned activity levels – Score 6
		Monitor Overall 18 week position	Ongoing	PHT capacity plans not achieved – Score 9
	Remove Wheelchair backlog and recommission service	Notice to be given to PHT	Feb-10	Notice period with PHT and unknown demand – Score 20
		New provider service starts backlog removal	Aug-10	

2. Reducing GP referrals

Potentially a reduction in GP referrals to appropriate levels, as seen comparable PCT's, could reduce associated costs by an estimated £1million and assist in the recovery and maintenance of the 18 week target. The target to reduce GP referrals by £1m by 2012 links in with the Practice Based Commissioning section of the PCTs Primary Care supporting strategy.

This plan outlines opportunities to perform the following

- To set up a process to ensure clinical engagement between the PCT and clinicians
- To develop, and commence the running of, a Referral Incentive Model through Practice Based Commissioning.
- To deliver the operational processes to maintain PBC including:
 - Engaging practices through the management LES and practice visits
 - Developing indicative budgets at a practice level and mechanisms for identifying savings on these budgets
 - Working with practices on schemes and business cases to utilise these savings
 - Liaising between practices and commissioning managers
 - Working with, and regularly reporting to, the Strategic Health Authority
 - Working with clusters / federations / PBC groups as they appear

Initiative: Referral Incentive Programme (RIP)				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce GP referrals to levels found in Southampton/Brighton by 31.3.12	To develop, and commence the running of, a Referral Incentive Programme (RIP) through Practice Based Commissioning to improve the quality, cost-effectiveness and appropriateness of referral activity.	Commence the RIP in pilot practices	May-10	Potential capacity issues - Score 20
		Complete revision of format through feedback from pilot practices	Nov-10	Engagement of GPs - Score 5
		Set 2011/12 RIP	Feb-11	
		Practices engaged in order to start 2011/12 RIP	Mar-11	

d. Key Enablers and Links

18 weeks

- Links to and dependencies on other initiatives within Planned Care
- This work stream is effected by the Urgent Care work stream as urgent care can lead to cancellations in electives
- Links to the Clinical Leaders Network and the Intensive Support Team
- Links to Primary Care re: Referral Incentive Programme

e. Organisational Support Required

18 weeks

- This is a work stream being picked up as part of the whole system work on planned care and is being led by the whole systems planned care board led by NHS Portsmouth.

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: 18 Weeks Target (including Wheelchair waiting list backlog removal)	
Key Performance Indicators	Link
Reduction in outpatient attendances	Local KPI
Reduction in GP Referrals	Local KPI
Reduction in admissions	Local KPI
Increased activity in threshold management schemes	Local KPI
18 weeks % targets for admitted and non-admitted.	VSC

Measures of Achievement	
Initiative: Referral Incentive Programme (RIP)	
Key Performance Indicators	Link
At least 50% Practices engaged – 31 March 2011	Local KPI
At least 75% of practices engaged – 31 March 2012	Local KPI
Outcome Measures	Link
Increased understanding of referral activity in general practice	Local KPI
Improved quality and appropriateness of referrals activity	Local KPI
Improving the quality and safety of services, ensuring dignity, control and choice to service users	Local KPI
Achieving sustained financial stability to ensure good use of all of our resources	Local KPI
Clinical engagement	WCC
Manage knowledge and assess need	WCC
Promote improvement and innovation	WCC
Efficiency and effectiveness of spend	WCC

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Removal of Wheelchair Backlog	100	-	100
Reducing GP referrals (valued in OP attendance reduction)	-	(348)	(348)
Total	100	(348)	(248)

4.4.3 Reducing Elective Admissions

Planned Care – Reducing Elective Admissions
Name of Initiative: <ol style="list-style-type: none"> 1. Reduction in Elective Admissions 2. Hip Pain Pathway 3. Shoulder Injections 4. Podiatric Surgery
Name of National, Regional, Sub-Regional or Local Priority supported: <p>National Target</p> <ul style="list-style-type: none"> • 18 Weeks RTT <p>Local Priority</p> <ul style="list-style-type: none"> • Reduce Elective Admissions to expected levels by introducing Admissions thresholds by 31.3.12. Moving to upper quartile by 31.3.2014
a. Executive Lead <ul style="list-style-type: none"> • Innes Richens
b. Current Position <p>1. Reduction in Elective Admissions</p> <p>A work stream that will directly assist the 18 week target involves reducing overall elective admissions to the acute Trusts. Some threshold management initiatives have begun and others are commencing in the very near future such as the Physiotherapy led shoulder pathway, and Knee, Foot and ankle pathways as well as the Hip and Knee referral scorecard system. These are all aimed at treating patients in a more suitable setting at the appropriate time, rather than an acute referral which may not necessarily provide the best option.</p>

Should reductions not be planned for then the PCT will continue to see an increase in admission rates and finance the subsequent tariff costs as well as risk missing future Access targets. The Provider organisations will continue to experience increasing capacity issues while patients will wait longer for treatments that could be performed in more appropriate settings or even avoided altogether.

2. Hip Pain Pathway

PHT are unable to meet the demand on orthopaedic services, and as stated previously are not currently meeting the 18 week wait RTT target. The PCT has commissioned spinal, shoulder, foot/ankle, and knee pain pathways during 0910. The pathways have been designed to give GPs clear guidance on how best to manage musculoskeletal pain themselves, when to refer patients to community therapy services, and when to order investigations or refer to secondary care. Early indications are that the pathways are reducing outpatient referrals to orthopaedic services.

3. Shoulder Injections

Since the launch of the shoulder pathway the physiotherapy department have looked at case mix and estimate that up to 50% of patients seen by the shoulder physiotherapists could benefit from shoulder injections. The community physiotherapy department have the skills, expertise and qualifications to provide shoulder injections but have not to date been funded to do so.

4. Podiatric Surgery

Department of Health and Kings Fund studies have advocated the development of Podiatric surgery and recommend that commissioners should consider the role of podiatric surgery as a complimentary or alternative provider when contracting orthopaedic foot conditions. As stated previously PHT are currently underachieving the 18 week wait RTT for admitted patients. Commissioning a podiatric surgery service could potentially reduce demand on one of the most capacity strapped clinics in the orthopaedic specialty.

5. PCT Priorities and Strategic Goals

These initiatives align to many of the PCTs priorities and strategic goals:

PCT Priorities

- Reduction in GP referrals
- Financial Management.

PCT Strategic Objectives

- Invest in health promotion and social marketing, in partnership with Portsmouth City Council, to help people stay healthy and to take greater responsibility for their own health and well-being
- Focus on clinically and cost effective ill-health prevention to allow greater independence and avoid unnecessary use of hospital services
- Achieve sustained financial stability ensuring good use of all our resources (including financial, workforce, buildings, information and technology)
-

c. Planned Change

1. Reduction in Elective Admissions

In order to achieve the PCT top down requirement to reduce elective admissions to expected levels by introducing admissions thresholds by 31.3.12 (Moving to upper quartile by 31.3.2014), a reduction

of daycase and inpatient procedures has been identified through NHS Comparators data. To enable reduction to expected levels the Commissioning Team plan to lead an exercise of:

- Scoping
- Scorecard/Thresholds management
- Pathway redesign
- Decommissioning.

Initial scoping would involve analysing the key specialties identified at HRG and procedure level. This specific analysis will require a high level of Public Health and information team input and will involve clinical and data validation for each type of procedure taking place. Finance team assistance will also be required. Any future redesign will be based and in line with the Map of Medicine, Clinical best Practice, NICE, Productivity Metrics and Community provision. The 5 top specialties within scheduled care which contribute significantly to a reduction in activity are Anaesthetics; Ear, Nose & Throat (ENT); Ophthalmology; Oral / Maxillo Facial Surgery and Trauma & Orthopaedics. These will be prioritised over 1011.

Initiative: Reducing Elective Admissions				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To reduce elective admissions to expected levels by introducing admissions thresholds by 31.3.12	Specialty level scoping and admission reduction plans through: 1 Scoping 2 Scorecard/Thresholds management 3 Pathway redesign 4 Decommissioning	Establish role outline (job description) for PH scoping	Jan-10	Recruitment delays/difficulties for Public Health consultant – Risk 20
		Appoint (known to potentially take time)	Jul-10	Benchmarked reductions highlighted unachievable or unrealistic – Risk 16
		Start review of clinical process/variations in procedures	Jul-10	Alternative provision necessary to achieve reduced admissions – Risk 12
		Reduced admissions in T&O, Max Fax, Ophthalmology & Pain/Anaesthetics.	Nov-10	
		Reduced admissions in ENT.	Jan-11	
		Begin process of establishing alternative provision	Feb-11	

2. Hip Pain Pathway

A hip consultant at PHT has indicated that at least 5% of patients referred with hip pain to PHT orthopaedic clinics could be managed in primary care. It is therefore the intention of the PCT in 1011 to establish a Hip Pain Pathway. Savings are based on a 5% reduction in 1st outpatient activity and 5% reduction in follow ups. Costs are based on the therapy time required to manage these patients. Detailed modelling will include costs relating to injection therapy and diagnostics. There may be additional savings by preventing the need for surgical intervention.

Initiative: Hip Pain Pathway				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To commission a Hip Pain Pathway	To commission a Hip Pain Pathway	Notify provider arm of intended project	Jan-10	Clinical pathway is not agreed in time for April launch – Score 9
		Stakeholder meeting to draft pathway	Feb-10	Unable to recruit clinical staff – Score 5
		Sign off pathway	Mar-10	Demand for physio unexpectedly high – Score 8
		Send pathway and referral info to GPs	Mar-10	
		Launch pathway	Apr-10	

3. Shoulder Injections

The physiotherapists need equipment, consumables and drugs to provide shoulder injections. Funding physiotherapists to inject has the potential to prevent the need for onward referral for many patients because not all GPs are trained to inject. Savings are therefore based on assuming that 20% of patients who receive an injection in physiotherapy result in a deflected first outpatient appointment in orthopaedics. The staff are qualified to perform injections and a start date of April 2010 would be possible. There would be no 'ramp' up as these patients are already attending the physiotherapy

Initiative: Shoulder Injections				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To ensure that up to 50% of patients seen by the shoulder pain pathway community physiotherapists are given shoulder injections as required.	To enable the community physiotherapists to have the equipment, consumables and drugs needed to provide the shoulder injections.	Write to Provider Arm and Physio Managers	Jan-10	
		Transfer funding to Provider Arm	Apr-10	
		Service starts	Apr-10	
		Set up monitoring system	Mar-10	
		Begin monthly monitoring	Apr-10	

4. Podiatric Surgery

Key advantages of commissioning Podiatric Surgery are:

- Community based - Keeping patients out of secondary care.
- Choice - Provides consumers (GP and Patients) with alternative service.
- Quality - National audit tool (PASCOP) reviews results of all surgery and patient satisfaction
- Cost - Potential sizable cost saving on Tariff

Podiatric surgeons perform a defined range of foot procedures which can be carried out under local anaesthetic in a one stop clinic environment. So this service would potentially reduce demand on PHT for these procedures. The ISTC at SMH have indicated that they can provide theatre facilities and this should be confirmed by the end of January 2010. Savings will only be fully realised if PHT reduce the number of these procedures that they perform and therefore the PCT will need to decommission these HRGs from PHT.

Initiative: Podiatric Surgery				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To commissioning a podiatric surgery service to reduce demand on the orthopaedic specialty at PHT	To develop Podiatric surgery and establish the role of podiatric surgery as a complimentary or alternative provider when contracting orthopaedic foot conditions	ISTC to confirm costings	Jan-10	Unable to recruit podiatric surgeon – Risk 10
		Provisionally book theatre facilities	Feb-10	May need to find alternative theatre facilities once the current ISTC contract expires, depending on what happens to ISTC in the future – Risk 15
		Provider arm to recruit podiatric surgeons and admin staff, and subcontract theatre staff from ISTC - recruitment start	Feb-10	Orthopaedic surgeons do not support the new service, and influence GPs – Risk 9
		Staff in post	Aug-10	
		Info packs to GPs	Jul-10	Savings not achieved because PHT continue to provide these procedures, so that overall activity increases. – Risk 15
		Service start	Sep-10	

d. Key Enablers and Links

1. Market Implications

Acute providers: the requirement for acute beds will become considerably lower over time. High-level assumptions suggest that acute beds will fall from a current level of 1,070 to 926 by 2011/12 and continue to fall by 3-5% per year reflecting the average improvement in Length of Stay expected by upper quartile performing hospitals.

Community providers: there will be more requirement to work in geographic and specialist teams to care for complex and frail patients in the community, working more closely with primary care and GP colleagues.

Primary care: Primary care services will be required to further enhance access, both in and out of hours and by multiple methods (e.g. telephone, email). In addition greater partnerships between primary care and secondary care clinicians will be required, with secondary care clinicians delivering some services in primary care settings.

2. Workforce

Bank and agency staff within the acute sector will need to reduce by approximately 300 full-time equivalents within one year. This may indicate a reduction in substantive staff in the acute sector from the current level of 6,600 to 5,400 by 2013/14. This may be somewhat off-set by redeploying acute sector staff into the community sector along with the planned shift in activity.

Changes in working patterns with, for example, a shift towards more 24hr, 7 day per week shift working across all staff grades, including consultants.

Clinical culture change will require support and development, with appropriate incentives. In primary care, current incentive schemes (Locally Enhanced Services) will be reviewed to ensure alignment to the key aims of this programme. Similar incentives will be required for secondary, community and ambulance services and teams.

3. Information Technology

NHS Portsmouth will seek to design and build information systems that promote interconnectivity between any providers along planned care pathways. This will increase effective use of patient information both in direct care provision but also future commissioning of services.

The adoption and greater use of telehealth and IT solutions to enable easier remote access to patients and experts as well as patient records will be required. Currently in Portsmouth City there is an acknowledgement of unnecessary complexity in multiple community and social care systems and a significant programme of work integrating health and social care will be required to be maintained.

NHS Portsmouth will complete the merger of Choose & Book patient call centres with our GP Out-of-Hours call centre on the St James Hospital site.

4. Estates and Facilities

The planned shift away from acute settings of care will require a strong community and primary care base within the City. NHS Portsmouth's existing plans to develop a St Mary's Community Campus will be critical to the delivery of this shift. This will also present an opportunity to review primary care premise locations, seeking to use the St Mary's site development as an opportunity to strengthen partnerships between community and primary care providers.

A core element of providing alternatives to acute care will require the strengthening of evidence-based alternatives, including general and specialised physiotherapy services. NHS Portsmouth has included increased capacity within the St Mary's Community Campus development to accommodate this planned increase.

During 2010 NHS Portsmouth will be reviewing the content and utilisation of the St Mary's Treatment Centre ensuring it is considered as part of the overall St Mary's site development.

e. Organisational Support Required

- This is a work stream being picked up as part of the whole system work on planned care and is being led by the whole systems planned care board led by NHS Portsmouth.
- Information in monitoring performance and evaluating success will be key.

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Reduction in Elective Admissions	
Key Performance Indicators	Link
Reduction in daycase spells for Anaesthetics; Oral; and T&O	Local KPI
Reduction in inpatient spells for Anaesthetics; Oral; ENT; T&O and Ophthalmology	Local KPI
Outcome Measures	Link
18 week RTT achievement	VSA

Measures of Achievement	
Initiative: Hip Pain Pathway	
Key Performance Indicators	Link
5% reduction in hip pain 1st outpatient activity	Local KPI
5% reduction in hip pain follow ups	Local KPI
Outcome Measures	Link
Reduce outpatients and admission rates for Hip procedures through 2010/11.	Local KPI

Measures of Achievement	
Initiative: Shoulder Injections	
Key Performance Indicators	Link
Deflecting 40 x 1st consultant outpatient appointments	Local KPI
Outcome Measures	Link
18 week wait admitted RTT	VSA

Measures of Achievement	
Initiative: Podiatric Surgery	
Key Performance Indicators	Link
Deflected 1st podiatry outpatient appointments	Local KPI
Deflected podiatry spells	Local KPI
Outcome Measures	Link
18 week admitted and non-admitted RTT target	VSA

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Reduction in elective admissions - IP	126	(212)	(86)
Reduction in elective admissions - DC	159	(393)	(234)
Hip Pain Pathway	36	(50)	(14)
Podiatric Surgery	-	-	-
Shoulder Injections	3	(6)	(3)
Total	324	(661)	(337)

4.4.4 Independent Sector Treatment Centre (ISTC)

Planned Care - ISTC
Recovery Area –Treatment Centre Contract Re-Tender
a. Executive Lead
<ul style="list-style-type: none"> Debbie Tarrant
b. Current Position & Reason Recovery Required
<p>At the end of November 2010 the contract that NHS Portsmouth holds with Care UK for the provision of services at the St Mary's NHS Treatment Centre expires.</p> <p>The contract was part of the nationally negotiated wave one procurement of independent sector treatment centres.</p> <p>The treatment centre is situated on the St Mary's Hospital site in Portsmouth. The ownership of St Mary's Hospital was scheduled to transfer to NHS Portsmouth in January 2010 in line with the health economy agreed strategic plan to redevelop the site as a community health campus (following the completion of the redevelopment works at QAH).</p> <p>Since the ISTC contract was negotiated there have been significant changes within the local health economy. The outline business case approved in 2007 proposed the phased development of a community health campus on the St Mary's site which included around 80 inpatient beds. Since that time a capacity map review has been undertaken which assessed all capacity within the local health economy. This has resulted in a number of recommended changes to the proposed community health campus, the most significant being that all inpatient beds would be relocated to the Queen</p>

Alexandra site leaving only six midwife-led maternity beds in Phase 1 of the development. These changes were incorporated into the full business case which was approved by the PCT Board in November 2009. The PCT is still awaiting SHA /DH final approval to release the funding in order that the community hospital development can progress. This was anticipated prior to Christmas 2009 but has been delayed so that further financial modelling can be carried out. A decision is now anticipated by 14 January.

Plans for the treatment centre have therefore not been progressed until confirmation is given that the community health campus development will proceed. If it does not proceed the PCT will need to review the range of clinical services to be commissioned to ensure that they are still of strategic fit and meet the consequent requirements of the PCT. It is likely that a much wider range and volume of services will need to be commissioned from the Treatment Centre.

It is also worth noting that current plans for the community health campus include some duplication of services provided through the existing ISTC contract which will require review. If the community health campus development is supported a strategic plans for the whole of the site will be needed in order to avoid duplication, wasted resources and fractured pathways.

c. Planned Change

- Appointment of TC Senior Project Manager – in post with effect from 6 January 2010
- Confirmation of community health campus plans expected 14 January 2010
- Draft ISTC Project Initiation Document – Attached
- Draft ISTC Project Timeline and key milestones – Attached (NB Timelines and milestones assume confirmation of CHC plans by 14/01/10)
- Regular planned meetings with the SHA
- Planned meeting with legal advisor to discuss possible current contract extension plans to enable strategic fit of re-tender to link with CHC plans for the St Mary's health campus site – subject to PEC/Board approval – meeting scheduled 28 January 2010.

d. Key Enablers and Links

The dependency of the future of the treatment centre on the agreed plans for the CHC on the St Mary's site should not be underestimated. The key enabler to the TC project gathering pace is a decision on whether the CHC full business case is supported by the SHA/DH. The range of services to be commissioned from the treatment centre will vary significantly depending on the outcome of the plans for the CHC.

With the appointment of the TC Senior Project Manager, early attention is now being given to the possibility of extending the current ISTC contract (assuming satisfactory terms and conditions) so that the timescales for this development link with those for the community hospital. A meeting has been scheduled for 28 January 2010 to examine the legal position of this. Discussions with the current provider will need to be held as soon as possible if this is to be a realistic option.

e. Organisational Support Required

The DRAFT TC contract re-tender project imitation document (PID), attached outlines the suggested process for developing the ISTC project, once the outcome of the CHC is known. The PID identifies suggested leads within the organisation to progress identified work stream areas. Organisational support will be required in identifying these work stream areas as a priority and freeing up time and resources to implement the project plan with immediate effect.

f. Measures of Achievement			
Achievement of timeline targets and milestone indicators.			
g. Financials - Alignment of investment / disinvestment			
Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
ISTC	-	(102)	(102)
Total	-	(102)	(102)

4.4.5 Readmission Rates

Planned Care – Readmission Rates
Name of Initiative: Readmission rates within 7 days
a. Executive Lead
<ul style="list-style-type: none"> Innes Richens
b. Current Position & Reason Recovery Required
<ul style="list-style-type: none"> PCT not currently meeting targets for readmission rates
c. Planned Change
<ul style="list-style-type: none"> A significant proportion of patients return to hospital within 28 days because complications have arisen as a consequence of their health at the time of admission, or because of a variety of complications that might occur and hospital readmission rate is seen as a potential quality of care indicator There is evidence that patients that are readmitted have a longer length of stay than for first admissions and that providers with lower than average lengths of stay for first admission have higher readmission rates. (NHS Institute) The PCT will identify the frequency and characteristics of potential avoidable readmissions and to compare the assessment of quality of care derived from readmission rate with other measure of quality <p>The PCT will look to tackle the key causes through:</p> <ul style="list-style-type: none"> Improved health assessment, planning and improvement Adopting the enhanced recovery model where this can be rolled out reducing hospital associated infection
d. Key Enablers and Links
<ul style="list-style-type: none"> this links to the urgent care and scheduled care agenda

e. Organisational Support Required			
<ul style="list-style-type: none"> • Already in place 			
f. Measures of Achievement			
<ul style="list-style-type: none"> • Reduced readmission levels in line with anticipated levels 			
g. Financials - Alignment of investment / disinvestment			
Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Total	0	0	0

4.4.6 In addition to the detail provided above for planned care, the additional 1011 work programmes for planned care are listed below.

Programme Initiatives	
Orthopaedics Pathway Review	Arthroscopies, Knee Replacements, Prolapsed Disk, Hip Replacement, Category 2 Bone/Soft Tissue and Minor MSK procedures
Ear Nose and Throat Pathway Review	With an initial focus on intermediate mouth and throat procedures
Ophthalmology Pathway Review	Retinal surgery (intermediate complexity), cataracts
Rheumatology Pathway Review	In particular Inflammatory Spine, joint or tissue disorders
Maxillo Facial Pathway Review	In particular extractions (teeth)
Implement Hip and Hand Pathways	Pathway review completed in 2009, revised pathways and alternative community-based provision to be implemented in 2010
Maintain and monitor completed MSK pathways	Shoulder, knee, ankle
<i>*Care Pathway Review includes: agreeing GP referral clinical standards, clinical threshold reviews, evidence-review, development of alternatives to acute setting</i>	
18 –weeks Waiting Times	Reduce waiting list backlog to within guideline limits and sustain delivery on 18-weeks targets Focus on reducing outlier services, such as wheelchair provision
Treatments of limited effectiveness	Identify procedures of low clinical priority and develop controls to ensure only appropriate patients are treated – reducing volumes of procedures by 50%

4.5 Children and Families

4.5.1 Prevention and Early Intervention

Children and Families – Prevention and Early Intervention
Name of Initiative: 1. Autism Waiting Times
Name of National, Regional, Sub-Regional or Local Priority supported:
National Target: <ul style="list-style-type: none"> • 18 Weeks RTT

a. Executive Lead
<ul style="list-style-type: none"> Paul Edmondson-Jones
b. Current Position
<p>1. Autism Waiting Times</p> <p>There is currently an approximate wait for autism assessments of approximately 98 weeks. This is far beyond the target of 18 weeks from referral to treatment. Analysis of the issue suggests that there are insufficient assessments ‘purchased’ compared to the number of children requiring them. The way in which assessment services are commissioned also requires attention. The current system sees sessions purchased across Portsmouth City Provider Services and Hampshire Provider Services. Children are allocated to slots as they arise. There is also a need to review the thresholds for referral to see if this will assist in reducing waiting times.</p> <p>Autism assessments are required only for those children where there is diagnostic uncertainty, for example where there is no straightforward diagnosis or where there are complex needs/co-morbidities such as OCD or ADHD. Where a diagnosis is possible this is done within the PCTs community paediatric service and no assessment is requested.</p> <p>2. PCT Priorities and Strategic Goals</p> <p>These initiatives align to many of the PCTs priorities and strategic goals:</p> <p>PCT Strategic Objectives</p> <ul style="list-style-type: none"> Improve People’s Quality of Life, along with an increase in life expectancy, raising the lowest to the best to ensure equity and equality of access for all Investment in health services and ill-health prevention advice focussed on the young recognising the long-term benefits this brings to them and future generations in both health and social attainment Improve the quality and safety of services ensuring dignity, control and choice to service users Improving access to services for those most vulnerable, and those from the most deprived populations
c. Planned Change
<p>1. Autism Waiting Times</p> <p>Children who require an assessment should receive this assessment around four years old. With the current waiting list children are not being seen until they are 6 or 7 years old, by which time they have started full time education. Early education can, therefore, be severely affected. Not diagnosing a child correctly could mean that they are ultimately receiving incorrect treatment which can have a long-term impact on the child, their families as well as on the delivery of services. In addition, levels of parental stress can also be high when the diagnosis is uncertain.</p> <p>This initiative covers three main objectives:</p> <ol style="list-style-type: none"> A waiting list initiative to clear the backlog of 98 weeks. Purchase of 11 additional slots each year recurrently to manage the demand for assessments. Even if the referral criteria is reviewed it is not going to be possible to sustain an 18 week RTT without

purchasing additional assessments.

3. Review the existing commissioning arrangements with a view to improving the care pathway and referral process.

Benefits of the project are that it will enable children with suspected Autism to be seen within a reasonable timeframe to ensure that the level of support required can be implemented across health, social care and education, and that appropriate long-term treatment is available.

Delivery of the Autism project forms part of the overall Children with Disabilities agenda.

Initiative: Autism Waiting Times				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce waiting times for Autism Assessment Services to within the 18 week RTT.	Waiting List Initiative to clear the backlog	Recruitment of joint commissioner	Apr-10	Inability to recruit joint commissioner [Score 12]
	Purchase of additional slots	Conduct stakeholder workshop	Jul-10	Lack of clarity around needs analysis for disabled children may mean some children are not able to access services. [Score 12]
	Review the thresholds for referral to see if this will assist in reducing waiting times	Agree care pathway/referral criteria	Sep-10	
		Waiting times to within 18 week RTT	Dec-10	
		Re-tender service (if appropriate)	Jan-11	

d. Key Enablers and Links

1. Market Implications

Given Portsmouth's geographical constraints there remains a lack of market development and competition for the provision of Children and Families services. In the short term NHS Portsmouth will work with existing providers to improve costs quality and efficiency.

NHS Portsmouth, through the review of core care pathways, will be exploring future opportunities for market development to deliver contestability across all services, in particular seeking providers who present opportunities to develop community-based alternatives to acute admissions, stronger partnerships with primary care and specific opportunities to improve integration of maternity and health visiting services

2. Workforce

There will be an ongoing requirement to ensure capability across all children's services to conduct basic autism assessments.

3. Other Key Enablers and Links

- NICE Guidelines for Autism – currently in consultation phase
- Joint/integrated working with Portsmouth City Council Social Care and Education teams
- Parent participation
- Workforce development to ensure a well-developed, highly skilled workforce capable of managing children with complex healthcare needs

e. Organisational Support Required

Others involved (NHSP and other stakeholders)

- Portsmouth City Council – Social Care and Education Services
- NHS Portsmouth Provider Services
- Stakeholders – Children, Young People and Families/Carers

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Children with Disabilities - Autism Waiting Times	
Key Performance Indicators	Link
Number of children on waiting list and time waiting	Local KPI
Number of assessments completed each month	Local KPI
Outcome Measures	Link
PSA 12 Improve the health and wellbeing of children and young people	PSA
PSA 13 Improve children and young peoples safety	PSA
PSA 18 Promote better health and wellbeing for all	PSA
PSA 19 Ensure better care for all	PSA
Improved patient experience and quality of care	Local KPI
Improved parent/carer wellbeing – reduced stress	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Autism Waiting Times	88	-	88
Total	88	-	88

4.5.2 In addition to the detail provided above for children and families, the additional 1011 work programmes for children and families are listed below.

Programme Initiatives	
Review of Children & Young People's Pathways	Using category management approaches, review core pathways for children to ensure alignment with NHS Portsmouth strategic direction
Children and Adolescents with Mental Health Problems	Delivery of City CAMHS Strategy, ensure full provision of services
Paediatric Admissions	With particular focus on primary care/hospital interface and pathways
Children with Disabilities (inc Autism)	With initial focus on access to autism assessments, short breaks and palliative care
Safeguarding Children	With initial focus on maintaining rapid response and primary care
You're Welcome Standards for Children's Services	Establishing standards in all relevant and appropriate service specifications and accreditation that includes young people as assessors
Prevention and Early Intervention	With focus on improving the quality and reach of universal and extended services
Children's NHS Continuing Care	Implementing 2009 national framework for Children's NHS Continuing care, improving effectiveness of placements in order to reduce annual cost growth

4.6 Maternity and Newborn

4.6.1 Reducing Caesarean Sections

Maternity and Newborn – Reducing Caesarean Sections
Name of Initiative: 1. Reducing Caesarean Section Rates
Name of National, Regional, Sub-Regional or Local Priority supported:
Local Priority <ul style="list-style-type: none"> Reduce caesarean rate to 20% by 31st March 2012
a. Executive Lead
<ul style="list-style-type: none"> Paul Edmondson-Jones
b. Current Position
<p>1. Reducing Caesarean Section Rates</p> <p>Caesarean Section (CS) rates remain high nationally and locally. Evidence-base demonstrates that there is no demonstrable or measurable improvement in outcomes for baby and that there is, in fact, an increased risk to mothers in terms of morbidity and mortality. The financial impact of CS rates is also significant and reducing CS rates will result in efficiency savings. The cost of CS rates is often significantly higher particularly due to longer length of stays.</p> <p>Nationally, Caesarean Section (CS) rates have been increasingly steadily over many years. In 1989/1990 Caesarean Sections accounted for approximately 12% of all births. The current CS rate for Portsmouth City is approximately 28.1%. This compares to a national average of 24%. Local comparators of Oxford and Southampton have rates of approximately 20%.</p> <p>The latest, November 09, High Impact Changes for Nursing and Midwifery also highlight the promotion of normal birth as one area where changes will bring significant impact. In addition, there are other high impact actions which affect this area, which include reducing avoidable ulcers in NHS provided care and improving discharge planning.</p> <p>2. PCT Priorities and Strategic Goals</p> <p>These initiatives align to many of the PCTs priorities and strategic goals:</p> <p>WCC Outcome Measures</p> <ul style="list-style-type: none"> Health Inequalities – Average IMD Life Expectancy – Life Expectancy at Birth Infant Mortality – Mortality Rate per 1,000 live births under 1 year <p>PCT Strategic Objectives</p> <ul style="list-style-type: none"> Investment in health services and ill-health prevention advice focussed on the young recognising the long-term benefits this brings to them and future generations in both health and social attainment Improve the quality and safety of services ensuring dignity, control and choice to service users Improving access to services for those most vulnerable, and those from the most deprived

populations

c. Planned Change

1. Reducing Caesarean Section Rates

The overall objective is to reduce caesarean rate to 20% by 31st March 2012.

There are two specific indicators for this target:

- Reduce Caesarean Section rates from 2009/10 expected baseline of 28.1% to 20% by 31st March 2012.
- Increase VBAC rates from 22.8% to 28.8% by 31st March 2012.

There is likely to be a particular focus paid to elective sections and VBACs, although non-elective admissions will still require focus and action. There is a need to understand the data around elective and non-elective admissions to understand the current activity and agree appropriate actions.

It should be noted that increasing vaginal births brings with it a risk of increasing the levels of births with complications (forceps, for example). This can in itself produce a longer length of stay compared to 'normal' deliveries.

The activity targets for this project plan include the following assumptions:

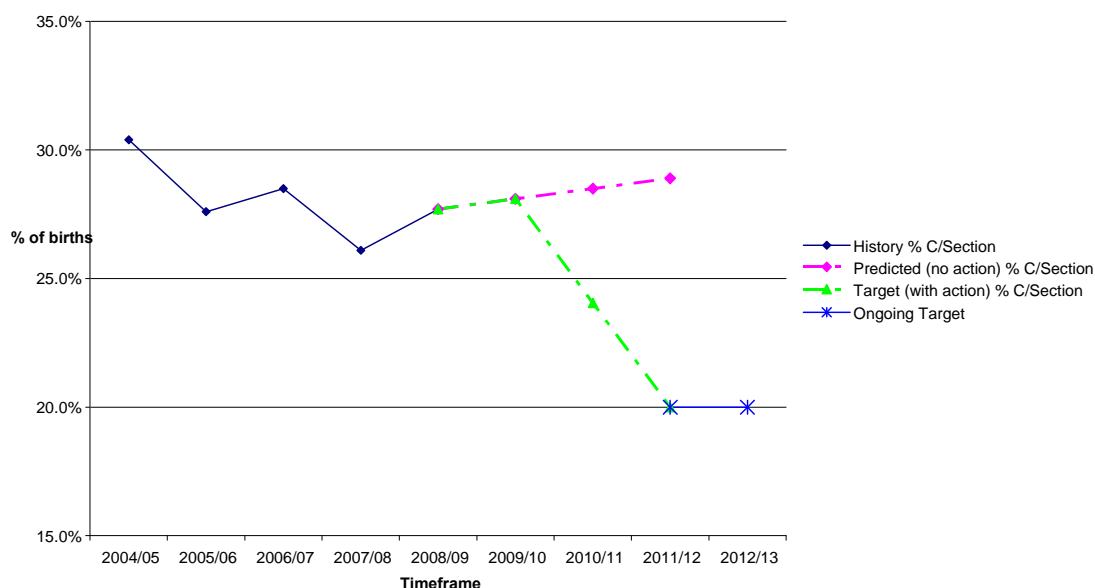
- That birth rates are exceeding the expected rates from JSNA and will continue to grow at 3% per year as in 2009/10
- That CS rates will continue to rise in line with increasing birth rates and in line with current trends.

Costs for CS are higher than for normal vaginal deliveries and represent, nationally in 2005/6, approximately 40.3% of costs for all deliveries. It is estimated that dropping the CS rate to below 20% could save an estimated £37.7 million (based on 2005/6). Within Portsmouth the average cost for a CS is £2,579 compared to £1,174 for a normal delivery. Reducing CS rates from current levels to 20% could save approximately £500,000 in two years. Reducing CS rates down to 20% is a top down requirement by March 2012.

Given the clinical benefits to mother and baby of normal birth and the high costs associated with CS there is a clear financial and clinical case for change which would focus on the reduction of rates to 20% within two years.

The following graphs shows the targeted reduction in Caesarean Section rates from 2010 until 2012 when it is expected the rates will be static. This graph shows expected activity if no action is taken and potential activity with interventions.

Trend of Caesarean Sections



Initiative: Maternity & Newborn				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
Reduce Caesarean Section rates from 28.1% to 24% by 31st March 2011 (20% by 31st March 2012).	To understand the data around the current elective and non-elective admissions and agree appropriate actions to deliver the 1011 target.	Identify current work within existing pilot project with PHT	Jun-10	Inability engage NHS Hampshire [Score 12]
		Analysis of existing data to understand current CS rates and ways in which these can be reduced	Sep-10	Lack of engagement by provider services [Score 16]
		Implementation/action plan produced	Dec-10	Insufficient resource capacity allocated to undertake work identified and enable actions to be implemented [Score 12]
		Implementation of plan	Dec-10 to Mar-10	Lack of stakeholder engagement [Score 9]
		Monitor PHT's delivery of reduction in rates	Ongoing	Increase in complications within vaginal deliveries [Score 12]

d. Key Enablers and Links

1. Market Implications

Given Portsmouth's geographical constraints there remains a lack of market development and competition for the provision of maternity and neonatal services. In the short-term the PCT will work with existing providers to improve quality, safety and the efficiency of existing services.

NHS Portsmouth, through the review of core care pathways, will be exploring future opportunities for market development to deliver contestability across all services.

2. Estates and Facilities

As part of the St Mary's Community Health Campus, ensure a City-based midwife-led Birthing Unit in order to provide a full range of choice of birth-places for women in the City.

e. Organisational Support Required

NHSP and other stakeholders

- Portsmouth Hospitals Trust (PHT)
- GPs/Primary Care

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Maternity & Newborn	
Key Performance Indicators	Link
% of deliveries vaginally against targets set (see trajectory)	Local KPI
% of deliveries by CS against targets set (see trajectory)	Local KPI
% of women opting for VBAC (target = 80%)	Local KPI
% of women choosing VBAC who go onto have vaginal delivery (target 80%)	Local KPI
Outcome Measures	Link
Increased vaginal deliveries	Local KPI
Decrease in CS deliveries	Local KPI
Increase in VBACs	Local KPI
Cost savings	Local KPI
Reduce Caesarean Section rates from 2009/10 expected baseline of 28.1% to 20% by 31 st March 2012.	Local KPI
Increase VBAC rates from 22.8% to 28.8% by 31 st March 2012.	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Reducing Caesarean Section Rates	-	(173)	(173)
Total	-	(173)	(173)

4.6.2 In addition to the detail provided above for maternity and newborn, the additional 1011 work programmes for maternity and newborn are listed below.

Programme Initiatives	
Quality and effectiveness of maternity services (including workforce)	Focus on access, named midwives, choice, Portsmouth City Midwife Centre, workforce levels/mix and parenting support
Screening	Maintain and monitor uptake of established screening, develop BMI screening
Neonatal Care	Collaborative category review with South Coast Specialised Services Commissioning
Caesarean sections	Complete pilot and roll-out of recommendations
Breast feeding	Focus on UNICEF Baby Friendly Scheme
Review of Children & Young People's Pathways	Using category management approaches, review core pathways for children to ensure alignment with NHS Portsmouth strategic direction. <i>Please also refer to Children & Families Programme.</i>
Stakeholder engagement	Initial focus on training and use of Maternity Services

	Liaison Committee
Infant Mortality	<i>Please refer to Smoking, Obesity, Screening and Teenage Pregnancy plans in Staying Healthy Programme</i>

4.7 Mental Health

4.7.1 Mental Health

Mental Health
Name of Initiative: 1. Memory Assessment 2. Needle Exchange
Name of National, Regional, Sub-Regional or Local Priority supported:
National Target <ul style="list-style-type: none"> • VSB14 Increase number of problem drug users in effective treatment
a. Executive Lead
<ul style="list-style-type: none"> • Paul Edmondson-Jones
b. Current Position
<p>1. Memory Assessment</p> <p>It is likely that the current dementia pathway will not be sufficient to meet the predicted increase in demand that is likely to occur as a consequence of the ageing population, thereby increasing the proportion of people with undiagnosed dementia who fall into crisis and consequently increase the number of emergency acute and specialist OPMH admissions.</p> <p>The anticipated increase in dementia cases and the drive for early diagnosis and intervention means that memory assessment services need to be able to respond to this. The remodelling and expansion of existing memory clinic services will be required and the creation of a formal Memory Assessment and Treatment Service (MATS), inclusive of shared-care prescribing of memory enhancing drugs.</p> <p>2. Needle Exchange</p> <p>The HPA and NTA have identified that Portsmouth's Hep C infection rate among injecting drug users (IDUs) is the highest in the South East (57%) - at current needle exchange coverage rates this is projected to increase significantly (model estimates up to 73% within 12 months); additionally a survey of current IDUs in November 2009 confirmed a high level of equipment re-usage and sharing, both of which present health risks with associated treatment costs. Increasing availability and coverage of injecting equipment has been identified as the most effective means of reducing the escalation of infection rates.</p> <p>3. PCT Priorities and Strategic Goals</p> <p>These initiatives align to many of the PCTs priorities and strategic goals:</p> <p>WCC Outcome Measures</p> <ul style="list-style-type: none"> • Health Inequalities • Life expectancy – Males/Females • Cancer Mortality (through causal link Hep C - Liver Cancer)

PCT Strategic Objectives

- Improving **quality of life**, raising the lowest to the best to ensure equity and equality of access for all
- Improving the **quality and safety of services**, ensuring dignity, control and choice to service users
- Improving access to services for the **most vulnerable** (such as those with mental health problems, learning disabilities and those from the most deprived populations)
- Focusing on **cost-effective ill-health prevention** to allow greater independence and avoid the unnecessary use of hospital services

c. Planned Change

1. Memory Assessment

Memory assessment services need to be able to respond to the anticipated increase in dementia cases and the drive for early diagnosis and intervention. The creation of a formal Memory Assessment and Treatment Service (MATS), inclusive of shared-care prescribing of memory enhancing drugs, will be required. This is a new element of service which is not currently commissioned in Portsmouth.

The creation of high quality, effective MATS services, based on a single point of referral and the provision of services within primary care, will support the early diagnosis and care of dementia, and enable a key gap in current service provision to be filled. A MATS service should be provided by a multi-disciplinary team, with the specialist skills and expertise in the early identification, diagnosis, treatment and management of dementia (including early onset dementia). This presents significant changes to the way existing memory clinic and support services are run. A proposed service model should incorporate a number of key principles, and MATS services need to involve specific provision of care/treatment. It is intended that implementation of a new service model will be achieved within year one of the overall implementation of the strategy.

Initiative: Memory Assessment				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To commission a formal Memory Assessment and Treatment Service (MATS)	To set up a full memory assessment service	Review models of service provision elsewhere and best practice guidance to develop service specification	Mar-10	Failure to meet NICE guidelines in relation to memory assessment services - 12
		Contract negotiations with provider to agree service model and KPIs	Mar-10	Stigma associated with dementia could mean less referrals than expected into the service - 9
		Monitor provider led set up and recruitment processes	Aug-10	Early diagnosis and support does not have the expected impact on admissions - 8
		Full Memory Assessment service operating at full capacity	Sep-10	Service ability to recruit to new posts - 12
		3 month review of service	Jan-11	Cost of scanning exceed expectations - 12
		6 month / end year review - to confirm new service operating successfully	Mar-11	

2. Needle Exchange

1011 will establish a new model for needle exchange provision, to increase accessibility of services through providing multiple outlets, with the overall aim of increasing the level of coverage to reduce sharing of equipment and the spread of blood borne viruses.

The project proposes to significantly increase the number of pharmacies offering needle exchange through the development of a Locally Enhanced Service agreement with pharmacists, targeting areas of high drug use. This will be supported by re-modelling the existing specialist service to focus more on supporting pharmacies in addition to the current direct delivery and collection service. In addition it is proposed to trial a 24 hour vending machine service, to further improve accessibility for drug users. The key risks if this project is not undertaken are an increase in the numbers of individuals infected with Hepatitis C and other blood borne viruses, leading to increased numbers of people requiring more expensive treatment and an increased number of individuals going on to develop longer term chronic liver diseases, with even higher associated treatment costs.

Initiative: Needle Exchange				
Target	Programme of Work	Milestones	Date	Risk & Risk Score
To establish a new model for needle exchange provision in order to reduce sharing of equipment and the spread of blood borne viruses.	To re-model needle exchange provision	Younger adults transition service operational	Jul-10	Difficulty recruiting pharmacies - Score 8
		Review of in-patient detoxification service completed	Jun-10	Potential community resistance to expansion - Score 12
		New model of needle exchange implemented	Jul-10	Reduced financial resources threatening long-term model - Score 12
		Proposals from review implemented	Apr-11	BBV screening programme has inter-dependency with investment in Hep C treatment - Score 4 Project over-spend - Score 9

d. Key Enablers and Links

1. Market Implications

Dementia:

NHS Portsmouth is looking to develop earlier diagnosis and support for people with dementia (including memory assessment services) In addition, national strategy recommends dementia advisors in place to support people with dementia and their carers in navigating through dementia and other services.

Service responses across the dementia pathway will need to ensure integrated delivery of community and primary care services to minimise emergency hospital stays and facilitate early discharge for people with dementia. Service delivery must enable independence to be maintained and a rehabilitation/ re-enablement focus will be required. NHS Portsmouth will be interested in providers who can support the delivery of the personalisation and independence agenda.

NHS Portsmouth will also be looking for increased support for those family members caring for people with dementia. Respite support will be required, on both a programmed and emergency basis.

Substance Misuse:

A strong market of providers of substance misuse services exists in the City. Existing NHS community providers are in a competitive market and must therefore demonstrate competitive value for money. Stronger integration with primary care is required and new ways of working with the 3rd sector, especially around rehabilitation, employment and training.

2. Workforce

Dementia:

Future services will require personnel who can co-ordinate the delivery of personalised care. This will require a skill mix able to meet the varied needs of the patients, improve outcomes, reduce stigmatisation and deliver flexible care management.

NHS Portsmouth will be seeking an informed and effective workforce to support people with dementia. Working with other PCTs on the south coast (SHIP), NHS Portsmouth will determine competency and skills requirements across the dementia pathway.

To support the shift in service from inpatient and long term care, there may be a requirement to re-train and redeploy staff to enable effective support to be provided in the community.

Increased awareness and understanding of dementia by staff in generic NHS services will be sought. In particular there is likely to be a growth in the independent sector, providing care to people with dementia in their own home.

It is anticipated that dementia advisor roles could be provided by the 3rd sector and there is arguably greater scope for increased provision in this area to provide additional prevention and well being services

3. Estates and Facilities

Dementia: Delivery of the new Limes residential service. Review estate capacity for provision of Memory Assessment clinics – explore feasibility of locating in St Mary’s Community Campus development.

Substance Misuse: review pressure on current inpatient capacity and need for further activity space to promote greater engagement in treatment – possible co-location opportunities with AMH ‘wellness’ services.

4. Other Key Enablers

Needle Exchange

This project has links with the Hepatitis C treatment project: that project identifies the very significant cost of long-term treatment for Liver Diseases (£98K lifetime cost for treating liver cirrhosis) and costs of Hep C treatment between £1k and £4k per patient. Increasing needle exchange coverage will reduce the rate of Hep C transmission among injecting drug users, this will lead to less people requiring Hep C treatment and less people going on to develop chronic liver disease. Additionally, by including blood spot test screening in pharmacies as part of needle exchange services, this project will assist with earlier identification, referral and treatment - thus increasing the efficacy of the Hepatitis C treatment project.

e. Organisational Support Required

- Integrated Commissioning Team
- current providers
- contracting team

- GPs
- finance team
- service users and carers

f. Measures of Achievement

High-level measures of achievement for the initiatives are set out below.

Measures of Achievement	
Initiative: Needle Exchange	
Key Performance Indicators	Link
Increased number of 16 – 25 year olds in treatment (2% per annum from 2010/11);	Local KPI
Increased volume of injecting equipment distributed through needle exchange network to achieve 25% "coverage" rate by March 2012 (currently 13%)	Local KPI
Outcome Measures	Link
Greater proportion of people successfully completing drug treatment (currently around 25% of all completions)	Local KPI
Reduction in rate of Hep C infection	Local KPI

Measures of Achievement	
Initiative: Memory Assessment	
Key Performance Indicators	Link
Number of consultant contacts	Local KPI
Number of nurse led follow-up contacts	Local KPI
Year on year increase of people diagnosed with mild dementia (indicating early diagnosis being achieved)	Local KPI
Number of service users undergoing short courses able to demonstrate new skills as a result of partaking in the course.	Local KPI
Number of service users supported to live at home.	Local KPI
Outcome Measures	Link
Patient and carer satisfaction.	Local KPI
Service user reflection of benefits from accessing MATS services.	Local KPI
GP feedback and compliance with shared-care prescribing.	Local KPI
Improved quality of life (independent living assessments)	Local KPI
Number of carers reporting a reduction in stress/anxiety/depression levels as a result of learning new skills.	Local KPI
Use of wellness scales to demonstrate improved outcomes.	Local KPI

g. Financials - Alignment of investment / disinvestment – 1 year only

Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Memory Assessment	0	-	0
Needle Exchange	88	-	88
Total	88	-	88

4.7.2 In addition to the detail provided above for mental health, the additional 1011 work programmes for mental health are listed below.

Programme Initiatives	
Adult Mental Health	
Mental Health Promotion	Review City Mental Health Promotion and Suicide Prevention Strategies, focus on training and monitoring (suicide audit)
Adult Mental Health Care Pathways	Using category management approaches, review City model of care for adults with mental illness, focus on personality disorders and recovery models of care
Improving Access to Psychological Therapies (IAPT)	Continue roll-out of IAPT programme
Out of Area Placements	Review and reprovide out of area placements
Dementia	
National Strategy Implementation	Using collaborative category management started

	across SHIP in 2009, roll-out national requirements
Early intervention	Specific focus on early diagnosis and support, particularly in primary care
Substance Misuse	
Drug treatment pathways	Focus on increasing problem drug users in treatment, assertive outreach and criminal justice system interface
Drug related harm	<i>Please see Staying Healthy Programme</i>
Needle exchange	Re-model/re-tender needle exchange provision
Engagement in treatment	Review existing services to improve effective engagement of individuals in drug treatment
Stimulant users	Develop interventions for stimulant users within existing services
Quality and Productivity	Increase speed of access to substitute prescribing
User engagement	Expand existing peer support/user engagement network

4.8 Learning Disabilities

4.8.1 The 1011 work programmes for learning disabilities are listed below

Programme Initiatives	
Healthcare for All	Focus on local needs assessment, family/care involvement and training of generic services
Assessment and Treatment Services	Focus on current model review against pattern of demand and expected shift over next 3-5years
Integrated community services	Completion of formal integration of health/social care services for learning disability
Locally based hospital units	Reprovide 2 NHS LBHUs
Special placements	Review placements in specialist provider services outside the City in order to assess appropriateness to repatriate them closer to their families
Autism	Review services for people with autistic spectrum disorder
Specialist Learning Disabilities Services	Review provision of forensic services and specialist community learning disability service
Workforce	Develop a long term workforce development plan to support the ongoing transition of services to a more social-care focused model
Quality and Productivity	Identify further opportunities for quality and effectiveness improvements

4.9 End of Life

4.9.1 Dedicated End of Life Commissioner

End of Life
Name of Initiative: Dedicated End of Life (EOL) Commissioner
a. Executive Lead
<ul style="list-style-type: none"> Innes Richens
b. Current Position & Reason Recovery Required
<ul style="list-style-type: none"> Currently the PCT does not have a dedicate EOL commissioner – though the commissioning

<p>for this area is being led by the LTC commissioner</p> <ul style="list-style-type: none"> EOL is seen as part of the LTC and planned care agenda and not as a stand alone area 			
c. Planned Change			
<ul style="list-style-type: none"> The PCT is recruiting new posts one of which will have a responsibility for EOL 			
d. Key Enablers and Links			
<ul style="list-style-type: none"> Successful recruitment Links to LTC and Planned care. There is already a commissioner looking after EOL as part of this portfolio 			
e. Organisational Support Required			
<ul style="list-style-type: none"> Already in place 			
f. Measures of Achievement			
<ul style="list-style-type: none"> EOL commissioning is sustained 			
g. Financials - Alignment of investment / disinvestment			
Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Total	0	0	0

4.9.2 In addition to the detail provided above for end of life, the additional 1011 work programmes for end of life are listed below.

Programme Initiatives	
Reduce palliative care deaths in hospital settings	Focus on community palliative care service interface with acute clinical care pathways
Dementia	Development of care pathways for people with dementia and palliative care needs
Single point of access	Ensure Single Point of Access to community services includes access to palliative care services
Personalised care planning	Providing combined health and social care needs assessments and individual carer plans; providing information on progress of people's condition and services available
Carers	Focus on further involvement in planning for palliative care and carer needs
Palliative Care Register	Developing a locality wide register, so that people can receive priority care when needed
People with non-malignant illness	Increasing the numbers of patients suffering from non-malignant disease, who are accessing palliative care services and supported to die at home
Training for generic services	Conducting a local training needs analysis and developing a corresponding development programme for generic health and social care services

5 Commissioning and System Reform Programmes

5.1 Introduction

The PCT is mainstreaming the national programme of system reform into its operating arrangements and therefore much of the PCTs response in embracing the principles and requirements of system reform is embedded within its strategic work programmes. This section focuses on the PCTs plans in response to four areas:

- World Class Commissioning
- System Management
- Transforming Community Services
- Clinical Commissioning and Primary Care

5.2 World Class Commissioning

We will continue to progress the WCC agenda throughout 2010/11, and our expected ratings for the 11 competencies in the year 2 assessment are shown below.

		Level 1	Level 2	Level 3	Level 4
Are recognised as local leaders of the NHS	Reputation as local leader Reputation as a change leader for local organisations Position as an employer of choice			▲ ▲ ▲	
Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities	Creation of Local Area Agreement based on joint needs Ability to conduct constructive partnerships Reputation as an active and effective partner			▲ ▲ ▲	
Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health	Influence on local health opinions and aspirations Public and patient engagement Improvement of patient experience			▲ ▲ ▲	
Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation	Clinical Engagement Dissemination of information to support clinical decision making Reputation as leaders of clinical engagement			▲ ▲ ▲	
Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements	Analytical skills and insights Understanding of health needs trends Use of health needs benchmarks			▲ ▲ ▲	
Prioritise investment according to local needs, service requirements and the values of the NHS	Predictive modelling skills and insights Prioritisation of investment to improve population's health Incorporation of priorities into strategic investment plan			▲ ▲ ▲	
Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes	Knowledge of current and future provider capacity and capability Alignment of provider capacity with health needs and projections Creation of effective choices for patients			▲ ▲ ▲	
Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation	Identification of improvement opportunities Implementation of improvement initiatives Collection of quality and outcome information			▲ ▲ ▲	
Secure procurement skills that ensure robust and viable contracts	Understanding of provider economics Negotiation of contract around defined variables Creation of robust contracts based on outcomes			▲ ▲ ▲	
Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money	Use of performance information Implementation of regular provider performance discussions Resolution of ongoing contractual issues			▲ ▲ ▲	
Ensuring efficiency and effectiveness of spend	Measuring and understanding efficiency and effectiveness of spend		▲		
	Identifying opportunities to maximise efficiency and effectiveness of spend		▲		
	Delivering efficiency and effectiveness of spend sustainably		▲		

Our strategic commissioning plan has been developed for year 2 to reflect the move to NHS Portsmouth and also the maturity and development we have acquired since year 1. The strategy and some of the accompanying sections in this document set out how we will action

the strategic plan, along with the organisational development plan, in terms of our capability and capacity to achieve this.

5.2.1 Organisational Development

An Organisational Development (OD) plan has been produced for NHS Portsmouth which supports the World Class Commissioning agenda and also provides an oversight of our key needs as we move into a new way of delivering our business. 9 workstreams (enabling initiatives) have been identified as necessary for taking the organisation forward and underpinning the way in which we commission services for the local population. Each of these are cross cutting, enabling programmes that support a wide range of business areas; the top level work programme can be summarised under the following headings:

Project	Target
Programme Management Office (PMO)	Create a PMO and roll out project management methodology, training and language throughout organisation
Culture Change and Knowledge Management	Further embed the new NHS Portsmouth ABLE values and behaviors, creating a cultural shift towards an improved knowledge management way of working
Clinical Engagement	Increasing and enhancing the quantity and quality of our clinical engagement to support and enhance the commissioning process, including finding innovative solutions for Practice Based Commissioning and explicit involvement in all aspects of the PCTs commissioning decision making processes
Strategic Planning: approach	Embed the 10 step strategic commissioning approach, including the development of a 'road map' to guide and create a consistent and robust methodology within the organisation.
Development of the Commissioning Workforce	Further work to expand on our commissioning development framework in the form of a development matrix, to provide a robust and consistent approach to the development of commissioning staff right across SHIP, offering development across core skills and linking technical expertise
Reputation Management	Ensuring that we get better at saying what we are good at, by positively promoting ourselves, and our successes and achievements, into the wider economy. We will develop a proactive programme of communication in this respect.
Transforming Community Services	Focused on implementing the PCT board decision taken in January 2009 to divest of its provider function.
SHIP Collaborative Working: COM	This is focusing on the establishment of a shared provider relationship management team for the four PCTs in SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) as well as identifying priorities to take a collaborative approach in respect of category management. Additionally a strong focus is collective organisational development.
Commissioning Enablement Service: CES	As an integrated part of COM (Collaborative Operating Model) will enable PCTs to deliver better health outcomes, by providing methods, resources, and high level analytics to support the commissioning process shared across the nine PCTs in South Central Region.

The following table shows how these link to strategic goals and WCC competencies; we expect that the further development of these areas will support development within the competencies over time.

OD Initiative	Link to Strategic goals/Priorities	WCC Competency
PMO	Darzi group support Communications Culture & Knowledge management	1, 5, 6, 8
Culture change and Knowledge Mgt	CES PMO Communications Darzi group support	1, 5
SHIP/COM	Strategic commissioning Collaborative working Communications	All
CES	Darzi group support SHIP/COM Strategic commissioning	5, 6, 8, 9, 10, 11
Clinical Engagement	PBC SHIP/COM Strategic commissioning	1, 4, 6, 8, 10
Strategic Planning approach (Road map)	Clinical Engagement PMO Staff Development SHIP/COM	All
Development of Comm'g staff	SHIP/COM Staff Engagement	1
Reputation Management	Communications Staff Development Collaborative working	1, 3
TCS	Strategic commissioning SHIP/COM Staff Development Communications	7, 8, 9, 10, 11

The focus of the OD Plan is to help move NHS Portsmouth forward in the way it conducts business, and in the way that the workforce behave. The OD plan lays out the above workstreams in much more detail and with specific actions and milestones, risks and issues. What they essentially do is lay out how these will help prepare, develop and adapt our staff for a new business oriented environment. Using whole system changes (i.e. through COM/SHIP, PRM etc) NHS Portsmouth will influence and hold to account, staff behaviours. The ABLE values that we have adopted (grown from staff engagement) will play a key part in providing clarity and direction for staff, and through a series of development sessions and new governance arrangements within the PCT the senior team will become much more visible role models and accountable members of the PCT for how our business is conducted. By challenging and changing the workforce at NHS Portsmouth to change, and providing them with the tools and training to enhance their commissioning capabilities, this change in behaviour should be transmitted to our providers and partners and therefore allow us to influence their behaviours and activities in a much more robust and overt way.

5.2.2 Board Development

The development of the PCT Board was identified as an area of need within the WCC assurance process. The PCT has invested in Board development activities over the past year. This has included values and culture work; Board behaviours; financial and political scenario planning; Transforming Community Services; and a range of different aspects concerned with World Class Commissioning, from strategic priorities and planning, to a review of the evidence for assessing competencies and development. There has been an emphasis on the clear distinction between non executive director and executive director responsibilities and a review of individual portfolios to ensure that skills and competencies are deployed and utilised appropriately and effectively.

Work will continue with Board development to ensure that the Darzi work streams and associated strategies have regular input and guidance from the PCT Board and that they align with overall PCT priorities. This too will ensure that there is cross fertilisation amongst the different directorates and portfolios of both the non executive and executive directors.

The Board and Committee governance and business arrangements have been reviewed and revised to reflect these changes being implemented in the way that commissioning will be undertaken within NHS South Central, and Hampshire and the Isle of Wight, which will have a direct influence on the PCT's governance arrangements as a commissioning organisation. These include:

- the development of the South Central Collaborative Operating Model (COM)
- the development of the Programme Management Office (PMO)
- the development of the Target Operating Model (TOM).

The key objectives for the revised governance structures are to create a modern and world class commissioning organisation, NHS Portsmouth, capable of fulfilling its vision and delivering its strategic aims. This will be achieved either through the deployment of resources available to the PCT or via collaborative working with other NHS colleagues and our local authority partner.

The revised governance arrangements have been developed to:

- Ensure legal and mandatory governance requirements are met
- Provide robust and transparent governance and accountability structures and processes
- Enable assurances to be provided to the PCT Board and external regulators
- Demonstrate that structures and processes are in place which will enable the PCT to demonstrate its development against the WCC competencies.

Clinical engagement will continue to be developed across the organisation and through the PCT's revised governance arrangements, in particular through the changes in the PCT's strategic planning processes. The creation of Commissioning Darzi Groups as a key way of working will ensure that clinicians are engaged with in a managed and meaningful way, enabling improved access to knowledge across the organisation. The establishment of the Clinical Executive Committee (CEC) will provide a forum through which clinical engagement, ideas or innovation can be pursued. The CEC will report directly to the Board and provide a direct link to the clinical community.

The Board and Committee governance and business arrangements will continue to be kept under review throughout the year and revisions made to ensure that they remain fit for purpose and reflect any published policy and guidance relating to Board effectiveness and assurances processes, as well as external reviews, for example by NHS South Central and the PCT's external auditors.

5.3 System Management

5.3.1 QIPP, Sustainability and the Emerging Financial Climate

All 9 of the PCT's Strategic Work Programmes plus the enabling programmes that are outlined in the following sections are part of the delivery mechanism for the SE Hants Sustainability Programme. Additional investment for 1011 is being made into this area in order to ensure that the requirements of the SE Hants Capacity Map are met. The additional 1011 investment is detailed below.

Financials - Alignment of investment / disinvestment – 1 year only			
Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Pump priming system reform	300	-	300
Pump priming community services	700	-	700
Pump priming primary care	450	-	450
Total	1450	-	1450

The McKinsey QIPP work that has recently been published has been analysed locally and the key messages are being built into the SE Hants sustainability programme to address the current and longer term financial challenges. The majority of areas align with the local McKinsey capacity map work that was done at the beginning of 2009/10. This identified an overall financial gap within the SE Hampshire health system of £218million over the next 5-years between the planned income of the Primary Care Trusts and the current level of expenditure on NHS services. This £218million is comprised of £144million related to acute (hospital) care and £74million in non-acute (primary or community) settings.

Based on this and our finance scenario planning, for Portsmouth this means there is a substantial gap between our current expenditure and predicted income over the same time period. This, in effect, means a number of efficiencies will need to be found within the Portsmouth system alone in order to maintain status quo. This excludes any new investment; further efficiencies would need to be realised in order to invest in new developments.

Based on this work the PCT developed a set of top down requirements which set out a number of targets aligned to delivering significant savings to assist in ensuring the financial stability of the SE Hants economy. These top down requirements have formed the basis of the direction of the operating plan and are detailed below:

Target	Strategic Programme	Timescale	Savings Value (£m) 2010–2014
Reduce Non Elective Admissions to statistically expected levels for demographic make up by 31.3.2012. then moving to upper quartile	Urgent Care	31.3.2012	5.9m*
Reduce GP referrals to levels found in Southampton / Brighton.	Planned Care	31.3.2012	1.0m*
Reduce alcohol related admissions to England average	Staying Healthy	31.3.2012	Inc Above
Identify 1% additional productivity / allocative efficiency in local tariff acute services from 2010/11 onwards	Planned Care / Long Term Conditions	31/3/2011+	1.5m
Reduce elective admissions to expected levels by introducing admissions thresholds. Moving to upper quartile by 31.3.2014	Planned Care	31.3.2012	2.8m*
Identify procedures of low clinical priority and develop controls to ensure only appropriate patients are treated – reducing volumes of procedures by 50%	Planned Care	31.3.2011	0.5m

Target	Strategic Programme	Timescale	Savings Value (£m) 2010/– 2014
Develop plans to ensure that PCT infrastructure is utilised by 80% for x7 days of the week 8-8	Estates Strategy	31.3.2014	2.0m (est.) [^]
Reduce paediatric non elective admissions rate to statistically expected levels for demographic make up	Children & Families	31.3.2012	Inc Above
Reduce expenditure on special placement ECRS back to 2008/9 levels from 2009/10 levels	Mental Health	31/3/2011	1.6m*
Ensure palliative care deaths in hospital are at national average level by 31.3.2011 and upper quartile by 2012	End of Life	31/3/2012	0.3m (est.)
Reduce growth in continuing care spend to 5% per annum	Long Term Conditions, Mental Health, Learning Disabilities	31/3/2012	1.5m
Review PMS agreements to ensure that cost per weighted patient is comparable with GMS fro similar outputs	Primary Care	31/3/2014	1.2m
Primary Care Prescribing costs to grow by no more than 4% per annum from 2010/11	Medicines Management Strategy	31/3/2011+	1.3m
Identify 1% annual additional productivity/ allocative efficiency in non tariff services from 2010/11 onwards	All programmes	31/3/2011+	3.5m
Reduce cost of back office and administrative functions by 3% per year in real terms	Workforce	31.3.2011+	0.8m
Reduce acute spend by 1% through better data challenge and validation through CES and SHIP	Workforce	31.3.2011+	1.6m
Total Top Down Requirements:			£25.5m

It is essential that for 201011, and beyond, the SE Hants organisations align income and expenditure, demand management schemes and deliver productivity and efficiency measures to ensure a sustainable financial picture for future years. The work to develop this is being overseen by the System Programme Board and working groups below this will deliver aligned contracts, with agreed realistic demand management schemes and in the short-term ensure:

- An agreed demand and capacity plan by specialty
- A risk assessed schedule of cost savings across the system with milestones and success measures
- An agreed risk management strategy and contractual framework to support the above
- A system wide Sustainability Plan that is mapped to the sustainability workstreams and can be used to hold organisations to account
- A signed Heads of Agreement and contract documentation

For 201011 the delivery of demand management schemes will be imperative, and the workstreams above and the supporting strategies of the PCT will endeavour to ensure that the productivity and efficiencies required are delivered.

5.3.2 SHIP and the COM

In 2010/11, SHIP PCTs have agreed the following further areas for collaborative category management:

- Unscheduled Care
- Continuing NHS Healthcare
- Respiratory Conditions
- Musculo-Skeletal Conditions

Initiatives for 1011 to support these areas are detailed in the Commissioning Programme Areas section above.

5.3.3 Integration

NHS Portsmouth regards integration as a key enabler to achieve its Strategic Plan and vision for the future system in Portsmouth City. We have a good track record of integrating health and social care services (mental health, substance misuse) and our strategic intent is to continue to commission further integration, in particular for community services for the most frail and vulnerable. However, our Strategic Plan will only be achieved if we do extend integration of provider services beyond the traditional health/social care domain; we are actively looking to work with providers who can integrate primary, secondary, community and social care so that are able to deliver care along the entire care pathway. This results in better care for patients and their families, improved communication and opportunities for innovative quality improvements.

NHS Portsmouth has also recently integrated some aspects of its commissioning function (mental health, learning disabilities, substance misuse and some aspects of community pathways) with Portsmouth City Council under a Section 75 Agreement. We will continue to test the effectiveness of this arrangement in terms of outcomes for our users and communities and, if appropriate, extend this arrangement for other commissioning functions.

5.3.4 Risk management across the system

NHS Portsmouth has a key partner in the SE Hants Sustainability Programme which aims to identify and manage the main risk within the Portsmouth and SE Hants health and social care system. In 2009 the Programme delivered a 'capacity map' of the local system which set out significant gaps in capacity and resourcing in the current system. Further the map set out the impacts and risks on the local NHS resulting from the likely national economic environment over the next 5 years and set productivity targets and contingencies required in order to maintain the system in balance. The SE Hants Sustainability Programme Board, led at Chief Executive and Chair level, will establish and maintain the Programme for delivery, including a risk strategy. NHS Portsmouth, as an active member of this Programme, will also maintain risk management via its own corporate governance arrangements.

5.3.5 Overview of Risks to delivery

As part of the development of this operating plan a review of the strategic risks facing the PCT in its delivery has been undertaken along with consideration of the range of mitigating actions the PCT should take if these risks materialise. These are illustrated in the table below:

NHS PORTSMOUTH: STRATEGIC RISKS					
Ref	Risk	Likelihood (Highest=5)	Consequences (Most severe= 3)	Risk Rating (Highest=25)	Mitigating Action (High level)
1 Impact of Past/Current System Performance					
1.1	Significant financial pressure in SE Hants health system partners	5	4	20	SE Hampshire Sustainability Programme
1.2	Falling performance in acute and ambulance services	4	4	16	SE Hampshire Sustainability Programme, SHIP Provider Relationship Management Service
2 Delivery Delays					
2.1	Lack of leadership to mobilise delivery	2	5	10	SE Hampshire Sustainability Programme, NHS Portsmouth Capacity Review
2.2	Lack of commissioning capacity to deliver all priorities	4	4	16	Shared leads for Sustainability Programmes, Collaborative Category management (SHIP)
2.3	Limited availability of suitable workforce with skills required for new ways of working	3	3	9	Workforce Strategy, Organisational Development Plan, South Central System Transformation
2.4	Protracted consultation periods and public opposition to proposed changes	3	3	9	Stakeholder Engagement & Communication Strategy
3 Market and Provider Landscape					
3.1	Constraints of contract size and geography to attracting new providers to the City	4	3	12	Collaborative Commissioning (SHIP)
3.2	Capacity of providers to match commissioner requirements and pace	3	4	12	Transforming Community Services, SE Hampshire Sustainability Programme
3.3	Pace of integration (health/social care) does not match required timetable	4	3	12	Integrated Commissioning Service and Board
4 Managing Demand					
4.1	Demand management schemes do not reduce demand as much as planned	4	4	16	Programme Management Office, SE Hants Sustainability Programme
4.2	Clinicians fail to engage and change referral/clinical thresholds	4	4	16	Clinical Leadership Enabling Programme
4.3	Lack of clear evidence to support change in service models or decommissioning	3	4	12	Clinical Leadership Enabling Programme, Commissioning Enablement Service
5 Infrastructure					
5.1	Delivery of St Marys Community Hospital delayed	2	5	10	Review of St Marys Community Hospital delivery and timescales
5.2	Capacity of current informatics provision to enable commissioning requirements	3	3	9	Prioritisation of informatics input, alignment of informatics delivery to category management
6 Reducing Costs					
6.1	Demand management schemes are more costly than current delivery	3	3	9	Financial assessment applied to all business proposals, Programme Management Office
6.2	Decommissioning costs are unaffordable	3	4	12	Financial assessment applied to all business proposals, Programme Management Office
6.3	Capacity in acute sector is not reduced at same pace as activity falls	4	4	16	SE Hants Sustainability Programme
7 National economy					
7.1	NHS financial pressures greater than expected	3	4	12	Financial and capacity scenario planning (City, SE Hants)

5.4 Transforming Community Services

The national Transforming Community Services programme provides Commissioners and Providers in PCTs with the opportunity to assess their future in terms of organisational form, service provision, quality and value for money. With the demands of an increasingly complex and constrained operating environment and the requirements of World Class Commissioning NHS Portsmouth made the strategic decision to focus on development of its commissioning capability at Board and organisational level. As such the Board decided in January 2009 to focus explicitly on commissioning and therefore divest, in a safe and appropriate manner, of its provider function, Portsmouth Community and Mental Health Services (PCMHS).

In November 2009, the Board accepted the following recommendations:

- That Portsmouth Community & Mental Health Services and Southampton Community Healthcare Services should integrate to create a new autonomous provider organisation.
- That the new Community and Mental Health Provider should be hosted by NHS Southampton City in the interim with a commitment to establishing a full autonomous statutory organisation in its own right.
- That the new Provider will be created as a Directly Provided Organisation in the interim and will progress as rapidly as possible towards Community Foundation Trust status

The Full Business Case also set out several transformational programmes which were a direct response to NHS Portsmouth's outline commissioning intentions published in July 2009.

5.5 Clinical Commissioning and Primary Care

5.5.1 Practice Based Commissioning (PBC) / Clinical Commissioning

PBC was developed to increase engagement of GPs in the commissioning of services and their own referral activity. In 2009 the Department of Health published "Clinical

Commissioning: our vision for practice based commissioning”, to firmly position PBC as providing the clinical engagement at the heart of commissioning.

Guidance (PBC Development Framework Dec 08) asks PCT's to improve health outcomes through PBC by:

- Practice level indicative budget setting
- Provision and management of high quality referral data for practices
- Developing and planning PBC structures with appropriate governance
- Agreeing the use of efficiency savings
- Providing processes to facilitate service re-design
- Assisting the production of sound business cases
- Contract (LES) setting/monitoring and management to assist the PBC process
- Using incentive schemes
- Patient and Public Involvement

Since the internal reorganisation in October 2009 Practice Based Commissioning (PBC) in NHS Portsmouth is increasingly being thought of in 3 parts:

1. Clinical engagement
2. A referral incentive programme (See Reducing Elective Admissions above)
3. PBC business continuity

1. Clinical Engagement

Clinical Engagement is a key strand of the Next Stage Review. Effective engagement is a core part of high quality commissioning. Enabling commissioners to engage with clinicians will improve the quality and nature of commissioned services, remove waste and improve the patient experience

NHS Portsmouth needs to have a mechanism by which commissioning managers have access to good clinical advice. Clinicians need to have a mechanism by which they can input to the commissioning work of NHS Portsmouth

To meet this need a process needs to be formalised – to this end discussion is underway and a process is becoming clearer.

Clinical engagement will include a variety of work streams including:

- Creating a core group of clinicians to provide clinical input
- Enabling the core group to network with the wider clinician community
- Enabling commissioning managers to engage with clinicians using the PCT mechanisms
- Ensuring commitment from, and a mechanism for, the PCT to consider clinical input received
- The creation, and management, of digital mechanisms to communicate with and between GPs (online, by email etc)

The provision of the mechanisms for clinical engagement will be the responsibility of the PBC team. Using the engagement mechanism will be the responsibility of individual commissioning managers in their commissioning work.

“Primary Care & Community Services: improving quality in primary care” (DH 2009) states that “PCT's will want to ensure that they have the right people round the table, covering all

contracted professions, and that the experience of these individuals are effectively harnessed”.

2. A Referral Incentive Programme

The success of the Prescribing Incentive Schemes has demonstrated how GPs who are supported adequately with resource and data can make a significant contribution to improving the quality of prescribing within the city. NHS Portsmouth would like to apply that model to referral activity.

The purpose of the Referrals Incentive Programme (RIP) is to improve the quality, cost-effectiveness and appropriateness of referrals.

It could consist of 5 parts:

- Clinical engagement in agreement of best practice regarding referral, locally.
- Education about that agreed best referring practice
- Provision of high quality, accessible information on referral activity, with facilitated opportunities for examination and discussion
- Audit against agreed best practice
- Peer review of referring activity

This would all be done against a background of the practice level indicative PBC budget.

This activity would result in more uniform referral activity, in line with local guidelines and protocols. It would help to identify areas for where referral protocols need to be developed or revised, thus feeding into the other strand of PBC work on clinical engagement.

The RIP is in the early days of development and being discussed as part of wider developmental discussions on the future of PBC in the PCT. This links to the detail provided for ‘RIP’ within the Planned Care section earlier in the document.

3. Operational PBC

There is much activity that has been ongoing as part of PCT for the last 2 years and which will continue. This includes:

- Engaging practices through the Management Allowance LES and practice visits
- Developing indicative budgets at a practice level and mechanisms for identifying savings on these budgets
- Working with practices on schemes and business cases to utilise these savings
- Liaising between practices and commissioning managers
- Working with, and regularly reporting to, the Strategic Health Authority
- Working with clusters / federations / PBC groups as they appear

As a result of the additional resources that have been secured by the trust, an evaluation of current business processes has been undertaken. Consequently, a programme has been initiated focussing upon the continuous process of improvement within the team. The outputs of this programme will result in fully documented internal business processes.

Therefore, where interfaces exist between the trust and GP practices, the business processes have been revised to maximise the efficiency and expedite the decision making process. This will enable the implementation of enhanced services and savings proposals in a speedier fashion, thereby supporting improvements in the quality and outcomes delivered to patients through PBC.

In addition to the detail provided above, the additional 1011 work programmes for this area are listed below.

Project	Target
Develop a Referral Incentive Programme	To reduce GP referrals to Southampton / Brighton PCT levels by 31 March 2012
To set up a process to ensure clinical engagement between PCT and clinicians	In 2010/11, 50% of commissioning plans will be written with clear clinical input, rising to 100% in 2011/12 New Clinical Ideas Group to feed clinical engagement strategy in line with PBC
Develop Practice Based Commissioning	Ensure annual setting of practice based indicative budgets in May Introduce "One Stop Shop" for GP information requirements with new Extranet facility Ensure ongoing commitment to facilitating practice utilisation of PBC savings with new infrastructure and process development.
GP Contracting	Review PMS agreements to ensure cost per weighted patient is comparable with GMS for similar outputs All QOF assessment completed between October and February annually
Access to primary Care	Continue to exceed uptake of 50% target for extended hours
Dentistry <i>(please see Oral Health Strategic Programme)</i>	Year on year increase in numbers of patients receiving NHS primary dental services located within the PCT area within a 24 month period. Increase from 115,857 (08/09) to 18,185 by end of March 2011
Optometry	Monitoring of GOS contracts Review of Low Vision services
Pharmacy	Maintain annual monitoring of Pharmacies via questionnaires and practice visits

5.5.2 Medical Revalidation and Appraisal

Revalidation of medical professionals was proposed in the 2007 White Paper, "Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century".

The purpose of revalidation, when it is introduced, will be to ensure that licensed doctors remain up to date and continue to be fit to practice.

NHS Portsmouth has responsibility for enabling the revalidation of the doctors that are directly employed by NHS Portsmouth (including Public Health Consultants) and for the GPs contracted to it.

At a national level there has been a huge amount of work to thrash out the many issues that this creates, and the uncertainty continues.

Elements of the revalidation process will include:

- strengthened appraisal
- processes for dealing with poor performance
- the appointment of a Responsible Officer.

Element	What currently happens in NHS Portsmouth	
	Directly employed doctors	GPs
Appraisal	Annual professional appraisals in the PCT are undertaken alongside, but in addition to, the PCT management annual appraisal process. There is a clear framework for consultant appraisals which is followed.	The PCT is responsible for ensuring that 100% of GPs undergo appraisal. To ensure this occurs the PCT is now in its second year of commissioning NESC to undertake the GP appraisals. This successful and innovative arrangement has ensured that appraisals are independent and of high quality.
Poor Performance	Poor performance issues are dealt with as they arise – which is “never” so far.	Poor performance issues are dealt with through a local process agreed between H&loW PCT's and the Local Medical Committee.
Responsible Officer (RO)	In August 2009 DH consulted on a framework and draft regulations for ROs. The results of that consultation are imminently expected to be published as recommendations. Until they are published PCT's cannot be sure of their duties and obligations, or the role of the RO. In many PCT's it is expected that the “Medical Director” will automatically become the RO. NHS Portsmouth does not have a Medical Director at present, and the need for such a role will be considered once the guidance is published.	

At a local level NHS Portsmouth is covered by the South Central Revalidation Pilot, one of ten pilot sites across the country. This pilot will test out the systems for strengthened appraisal and other elements of revalidation. NHS Portsmouth is engaging with the pilot to ensure that GPs and public health doctors are included.

6. Financial Strategy and Programme

6.1 Financial Context

6.1.1 Introduction

This section of the Operating Plan sets out the Financial Plan for NHS Portsmouth, for the year 2010/11. The planning phase is arguable one of the most important parts of the Operating Plan process, during which the Finance team interpret the financial impact of Commissioning Plans and priorities and present Commissioners with the results. The iterations and different scenarios are a valuable product as it supports Commissioners in understanding the relative impact of planned work streams and then finally in bringing together the complete financial picture for the PCT.

6.1.2 National Context

The NHS has been fortunate in the level of growth it has received in the last decade; this has enabled Commissioners to target the money available to meet both national and local priorities, thus securing major improvements to the health of the population, increased

access and waiting times, better quality care and choice for patients. However, the national economic financial climate has been challenging in the last year or so and the resultant impact on the Government Economic Strategy will mean that in the next few years funding for the public sector will be constrained.

Early notice of the growth and efficiency assumptions for the next few years has been given and it is not a surprise given the need to bring down government borrowing, that although there remains some growth in 2010/11 beyond this year there will be financial reductions in NHS funding. It is entirely sensible therefore that in 2010/11 the growth must be used to support changes which will deliver considerable financial benefits in future years.

This Operating Plan brings together financial data with regard to the funding allocation available to NHS Portsmouth, and extrapolates the financial impact of the Commissioning plans. Delivering value for money has always been a key consideration in the PCT, but with less money, and a forecast of greater need for health care it will become even more important to get the most from the resources available.

6.1.3 Health Community Financial Context

Unfortunately it is anticipated that two of the NHS organisations within the Health Community will end the year having underlying deficits. Portsmouth Hospitals Trust with a year end deficit of £12m at 31st March 2010, and Hampshire PCT although aiming to breakeven have indicated that their underlying position is also one of deficit. However, the current financial position in the Health Community, has led to clear signals from Commissioners to the Providers that “trading out of deficit” is now not appropriate, this change in approach has helped to generate a “burning platform”. This will also facilitate whole systems planning and working, to enable transformation to take place, using the resources available in order to deliver better value. The NHS is fortunate to have both benchmarking information, and evidence of good practice across the country, locally this information can be used to support targeted transformation and improved efficiency.

6.1.4 PCT Financial Context

The PCT has a number of long standing major commitments which have been financially reflected in its financial plans, essentially funding has been set aside to meet the transitional revenue cost of the Community Health Care Campus on St Mary's, the ongoing revenue costs of both Dental Academy and the replacement of Primary Care infrastructure. The PCT is forecast to end 2009/10 with a non recurrent surplus of £4.729m, of which £930k relates to the PCT Provider function and will transfer with them into Southampton PCT in April 2010. The surplus also excludes funding of an additional £2.762m brokered to the SHA; including ring fenced under spends for Dental services (£529k), and Cancer Network (£877k) and Provider projects (£275k).

Although there is a non recurrent financial cushion taken into 2010/11, the PCT must increase its attention to seek greater value for money from its resources. The PCT recognises that its use of secondary care exceeds good practice quartile benchmarks, that its expenditure is also high in other areas. In order for the Health Community to be sustainable in longer term growth should be used to support major change, such as keeping people healthy, managing demand for secondary care, delivering productivity and efficiency improvements. There is a need to take out capacity, yet minimise the impact on patient care.

6.1.5 Long Term Financial Strategy

NHS Portsmouth has also recently produced a 5 year Strategic Plan which has set out the direction of travel for the period 2010-15. The financial consequences set out in the Strategic

Plan look at three scenarios; a base case, worst and best case using nationally stipulated assumptions with regard to resources available and inflation assumptions. This Operating plan mirrors the direction of travel and the priorities for the PCT, set out in the 5 year plan; however, it should be noted that there is a difference between the 5 year plan and the Operating Plan. The Strategic Plan uses forecast national assumptions; the Operating Plan uses announced actual allocations and tariff and inflation figures to be used in the 2010/11 contracting round

6.2 Resources Available 2010/11

6.2.1 Recurrent Allocation

The National Resource Allocation formula was revised from 09/10; as such, Commissioners' baseline Revenue Allocations included adjustments for tackling health inequalities, and a review of the market forces factor; this change brought additional resources to NHS Portsmouth.

The opening PCT's Baseline Revenue Allocation in 2010/11 is £328.095m, added to this was £17.052m of growth which equated to an increase of 5.2%. The growth included an allowance for inflation to cover pay awards and contract inflation uplift. Looking ahead to 2011/12, for planning purposes the SHA has asked that it is assumed the allocation will rise by a small percentage of 2.4% to an expected allocation in 2011/12 of £336.297m.

6.2.2 Non Recurrent Allocations

There are several assumptions regarding expected revenue allocations of £23.094m (net) that have been included in this plan. The material revenue resource assumptions within our financial forecast are set out below:-

- Central Funding for the St Mary's NHS Treatment Centre of £2.876m.
- Central Capital Grants funding for the University of Portsmouth's Dental Out-Reach School development of £1.150m.
- 1.0% contribution, towards the 'Build, Share, Procure' Fund (BSP), held by the Strategic Health Authority.
- Prior year surplus and sums lodged in the system reform fund (£4.729m - Provider £930m, Commissioning £3.799m).
- Devolvement of national budgets (Pharmaceutical £2.587m & Ophthalmology £1.650m)

Table 1: Summary of Non-Recurrent Allocations and Allocations Adjustments (local assumptions)

Allocation/Adjustment	10/11 £'000
Strategic Investment and Reform Fund	(3.110)
Confirmed National Non Recurrent Allocations (Dental, Substance Misuse, DAT, Ophthalmic, Pharmaceutical, NCG transfers)	12.749
SHA Central Budgets (including ISTC Dual Tariff)	3.465
Capital Grants (Dental Out-reach School)	1.150
Cancer Network Funding	983

Prior year surplus return	4.729
Return of Prior years repayable lodgement	3.131
Other	(3)
	23,094

6.3 Efficiency and Demand Management

The PCT has an overall efficiency target of 3.5%. It recognises the fundamental requirement that its efficiency and demand management plans are enacted and savings realised in 2010/11, and as such investment in resources to form a Programme Management Office has taken place. In the transition to permanent appointment PriceWaterhouseCoopers have been supporting the PCT to:

- Set up documentation to underpin the performance management process.
- Identify schemes and produce robust plans with Commissioning Managers encouraging the need to increase the PCT response to Demand Management initiatives.

The PMO will report fortnightly to the Strategic Health Authority on delivery, on a monthly basis to the Professional Executive Committee and to the PCT Board at every Meeting.

In 2010/11 the PCT has to deliver an ambitious target of 3.5% plus demand management initiatives of £4.563m equating to a total of 3.7% (£12.206m) and a further 4.8% (£16.175m) in 2011/12. As outlined earlier the PCT has used benchmarking data to establish where there is greatest opportunity to make efficiency savings.

The overall efficiency plan is summarised below:

Table 2: Areas of Planned Efficiency

Area of Planned Efficiency	2010/11 Value of efficiency plans £000
Tariff Efficiency Other Providers	3,724
Non-Tariff Efficiency Other Providers	1,778
Community & Mental Health Provider	2,399
Secondary Care Elective Access	1,521
Secondary Care Non Elective Admissions	832
Maternity and Children	173
Supporting schemes	190
Reducing Continuing Care	167
Primary Care Prescribing	777
Reduction in Management Costs	566
Learning Disability	79
Total Commissioning Efficiency Plans	12,206

6.4 Planned Surplus

The PCT is planning to achieve a surplus in 2010/11 of £3.763m. The underlying surplus is £3.683m (1%) of our baseline (excluding a 1% contingency of £3.110m). This is to provide financial headroom which it is anticipated will be required in future years.

The most significant element of committed future expenditure relates to transitional costs of £1.246m associated with the Healthcare Campus on St Mary's site.

6.5 Expenditure Plans

6.5.1 Inflationary Costs

Tariff inflation uplift is set by the Department of Health at 0% for 2010/11, net of a 3.5% efficiency target. This uplift is expected to cover the effect of pay awards, NICE guidance, Clinical negligence costs, PFI capital costs, and European working time directives. In the PCT plan, the net Inflation for Primary Care is assumed as 2% for GPs contracts, 0.2% for Dental contracts and 5% for prescribing costs. The anticipated impact of inflation adjustments are summarised below:-

Table 3 – Financial Impact of Inflation changes		2010/11
		£'000
Community Services		2,459
Dental		19
GP Contracts		974
Non PbR Tariff		108
Non PBR Tariff		5,353
Prescribing		2107
Commissioning Pay		230
		11,250

6.5.2 Investing in Quality

In addition to inflationary uplifts the PCT is setting aside a sum equal to 1.5% of acute, community and mental health contract values in order to fund the costs of implementing Commissioning for Quality Initiatives (CQUIN). This funding will be used to incentivise providers to improve the quality of care. This sum equates to £3.212m (£3.182m in 2011/12).

6.5.3 Population Growth

The latest population estimates using ONS data have been used. This data has been used in the model to reflect the likely growth in activity and hence the expenditure impact of population changes over future years, analysed by provider at speciality level by age band.

Whilst overall population increases are relatively small, there is a steady increase, particularly in respect of the elderly who have particularly complex health needs. Both the population increase and complexity will thus increase the call upon health services.

For 2010/11 £2.603m will be set aside to fund the costs associated with demographic change.

Table 4 – Forecast Population Growth					
	2008/9	2009/10	2010/11	2011/12	2012/13
	000s	000s	000s	000s	000s
Unweighted population (ONS)	201	203	205	207	210
Weighted population	202	202	203	205	208

6.6 Investment and Cost Pressures

The Operational plan includes the impact of investment in a number of key initiatives that are planned in support of the PCT's high priority areas. A summary of the investments for 2010/11 is detailed below. A more detailed analysis can be found in the relevant work group area within the operating plan.

Table 5.1- Work Programme Investment

	£000
Wheel chair waiting times	100
Pump priming community Services	700
Community Chronic Pain Service	286
Community TB Service	118
Diabetes intermediate care	27
Home Oxygen Follow up service	56
Home Oxygen Follow up service saving	-50
MSK Diagnostics	76
Fluoride Varnish (through University contract)	-
Autism - Waiting Time Initiative	88
Pump priming system reform	300
Pump priming Primary Care	450
joint breaks for carers	100
Bowel Cancer screening - Age Extension	293
Breast screening - Age Extension	60
Cervical Screening - Abnormal letters costing	3
Safeguarding children	36
Alcohol Specialist School Nurse	50
Alcohol Psychosocial Treatment Service	138
Street Pastors	16
AIT	77
HealthChecks	126
Managing LTC in Primary Care	51
Physical Activity Pathway	138
Public Health advertising/communications campaigns	200
Chlamydia	51
Teenage Pregnancy Coordinator	23
Needle Exchange	88
Healthy Living Pharmacy	34
Medicines Managers - developing practice expertise	47
	3,681

6.7 Key Financial Risks

The PCT has identified a number of key risks facing the PCT for the period of the plan and beyond. The main risks for 2010/11 include:

- Implementing HRG4: Whilst national modelling shows that HRG4 should be broadly cost neutral for the PCT there is the likelihood that improvements in acute providers coding and counting of activity will result in cost pressures to the PCT.

Mitigating action: Through CES acute invoice validation and local contractual challenge.

- GP referral growth: Whilst the PCT is planning for outturn GP referral rates plus population growth, reduced by demand management schemes, recent years have seen continued increases in GP referrals. Demand management schemes are dependent in some cases on GP's clinical engagement to redesign pathways and act as gatekeeper.

Mitigating action: Using practice based referral incentive modelling and regular discussion with outlying GPs.

- Anticipated NICE guidance: The PCT has undertaken some modelling of the potential financial impact of anticipated NICE guidance in 2010/11. This modelling is by its nature crude, and actual costs could differ from expected levels.

Mitigating action: Through whole systems management of timetable and use of prescribing formulary.

- New Paediatric Continuing Care Criteria: The new criteria was implemented in 2009/10. Whilst the number of Paediatric Continuing Care clients is significantly smaller than adults, the costs tend to be higher. It is not clear yet what the overall impact of the criteria will be, therefore this remains a provision at this stage.

Mitigating action: Robust adherence to process and regular review of patients.

- Potential impact of credit crunch on the demand for Healthcare: As the impact of the credit crunch increases it is likely that demand for some areas of healthcare will increase. No funding has been set aside for increased demand related to local economic conditions.

Mitigating action: Through demand management initiatives.

- Potential shortfalls in capital allocations: The PCT has a significant Capital programme in 2010/11. It is apparent that there are pressures on the South Central Capital Allocation in 2010/11 which may make the PCT's capital requirements a challenge to manage.

Mitigating action: Reduce capital programme.

- As a result of the recent opening of the newly refurbished Queen Alexandra Hospital, PHT are seeking for the PCT to supplement the PBR tariff to support their financial position.

Mitigating action: Financial strategy emerging for whole systems to ensure any financial support is used to benefit the whole system

The level of potential risk has been used to determine the size of the financial contingency planned for 2010/11.

6.8 Contingency

The Strategic Health Authority operating plan supporting guidance suggested a minimum surplus/contingency of 2%. The PCT has planned for a contingency of 1% plus a surplus of 1% (£3.11m) which will help should the risks above result in financial consequence. The use of the contingency will be agreed by the Executive Team. New investment plans have been identified which could be enacted in 2010/11 should the contingency not be required.

6.9 Summary Sources and Application of Revenue Funding

The table below summarises the source and application of revenue funding in 2010/11. It includes details of spend areas outside of the work streams.

Table 6 Sources and Applications

Sources	000s	000s	Notes
Recurrent growth	17,052		
Underlying surplus	3,683		
Return of prior year surplus	4,729		
Strategic Investment Fund Lodgements	- 3,110		
Return of Strategic Investment Fund lodgements	3,131		
Non recurrent allocations	1,051		
Available resources		<u>26,536</u>	
Applications			
Recurrent			
Inflation		11,121	
CQUIN		2,156	
Efficiency and Demand Management		- 12,206	
Cost pressures			
PBR Drug exclusions/NICE guidance implementation	635		
Continuing Care Client Pool Growth 10/11	1,026		
Continuing Care Paediatric Criteria change	200		
Continuing care additional investment (buying out 09/10 recurrent overspend)	1,965		
Demand Bariatric Specialist Services	198		
IAPT Prior commitment	173		
QUOF Removal of 5% buffer	16		
Special placements additional investment (buying out 09/10 recurrent overspend)	858		
Cancer related training allocation shortfall / cost pressure	33		
Fruit for schools allocation shortfall / cost pressure	140		
Ophthalmology Devolved budget cost pressure / shortfall	140		
Devolved Pharmaceutical Spend (cost pressure)	302		
Impact of Population changes and Consumerism	4,127		
Work programme investment		9,812	
		3,681	See table 5.1
Prior commitments			
Initiative - dental outreach school (revenue pick up)	277		
LD Integrated Commissioning Development (part of agreed allocations transfer)	122		
PCT Staffing / Consultancy Changes to meet WCC etc	834		
initiative - Standalone maternity unit - comm midwifery	370		
Chlamydia Screening Expansion (09/10 BC)	199		
Smoking Cessation - expansion to target most deprived communities (09/10 BC)	166		
Devolved Ophthalmic Spend	1,650		Now PCT budget
Devolved Pharmaceutical Spend	2,587		Now PCT budget
		6,204	
Total recurrent application		<u>20,768</u>	
Non Recurrent Application			
Pass throughs			
Solent Healthcare 09/10 lodgement return	275		
Initiative - dental outreach school (Second tranche capital grant)	1,150		
Dental capital grant Adjustments for 09/10 non-recurrent spend	- 2,759		
Healthy Communities carried forward	677		
Reduction in Dual tariff ISTC	- 1,481		
		- 2,138	
Prior commitments			
Health Trainers - DH GOSE carry forward	176		
Health Trainers - National Programme - carry forward	154		
Practice Based Commissioning Savings Spend	385		
Pharmacy Healthy living carryforward	35		
Your Welcome project carry forward	30		
Family planning - LARC	82		
		862	
Total Non Recurrent Application		- 1,276	
Unallocated Funds (risk management)			
Contingency		3,281	
Total Recurrent & Non-Recurrent Applications		<u>22,773</u>	
Surplus		<u>3,763</u>	

6.10 PCT Provider Function Financial Planning

The PCT Provider Function is in recurrent financial balance, and intends to build on this strong financial foundation into 2009/10 and beyond. The financial strategy is to continue to plan for surpluses, and to set aside a contingency, it also assumes any surpluses achieved by the Provider will be returned in the following year.

The financial framework in the 2010/11 Operating Plan has been followed for inflation assumptions and contract terms, and includes 1.5% additional non recurrent income for CQUIN schemes. This non recurrent funding will be spent in accordance with the agreed quality improvement plans.

The majority of the Provider Function's income is on a block contract arrangement with NHS Portsmouth and NHS Hampshire. No allowance has been built into the plans for any penalties arising from the new Community & Mental Health contract (should any non performance issues arise), other than setting aside a general contingency.

As such, the Provider financial plan has been developed on the following assumptions:

Table 7 – 2010/11 Provider Function Key Financial Assumptions

Key Financial Assumptions:		
Planned surplus	1.0%	£906k
Net inflation uplift	0%	£3.2m
Efficiency	3.5%	(£3.2m)
Contingency	0.5%	£0.465m
CQUIN	1.5% (of clinical income)	£1.35m

6.11 Analysis of Contract Value with Providers

At the time of writing, the proposed contract values with Providers are as follows:-

NHS Portsmouth: 2010/11 Provider Contract Envelopes	Portsmouth Hospitals Trust £000	Solent Healthcare £000	South Central Ambulance Service £000	SUHT £000	Hampshire Community Health Care £000
Agreed recurrent baseline value from 09/10	112,858	65,655	6,519	8,084	2,113
Adjustment for Forecast Outturn	-	-	-	(601)	-
Volume growth	2,222	-	130	150	-
Demand Management reductions	(3,596)	-	-	-	-
Proposed Contract Value for 2010/11 (excluding CQUIN)	111,484	65,655	6,649	7,633	2,113
CQUIN	1,672	985	100	114	32
Cash Envelope including CQUIN	113,156	66,640	6,749	7,747	2,145

6.12 Sustainability Whole System

The Health Community in this context covers the geographical area known as Portsmouth and South East Hampshire; it is largely the area where patient care pathways use Portsmouth Hospitals NHS Trust, and Solent Healthcare (Community and Mental Health). The NHS Commissioners for the area are NHS Portsmouth and NHS Hampshire.

Whilst NHS Portsmouth has experienced a stable financial position since its inception, both NHS Hampshire and Portsmouth Hospitals NHS Trust have a challenging financial position. In 2009/10, due to the size of the financial deficit, together with the forecast impact of reduced funding, a South East Hampshire Sustainability Board was set up to support a strategic whole systems approach to delivering a sustainable Health Community.

Size of the Community Financial Challenge 2010/11

	Organisation			
	NHS Portsmouth	NHS* Hampshire	PHT	Solent Healthcare
	000s	000s	000s	000s
2010/11 Cash Efficiency requirements	4.2m	9.9m	29.1m	43.2m
Demand Management Initiatives	4.4m	14.4m	7.3m	26.1m
Total	8.6m	24.3m	36.4m	69.3m

*South East Hampshire element only

The NHS has been expected to deliver between 1% and 3% efficiency savings every year; however, 2010/11 sees a higher percentage that will need to be achieved. With the size of the challenge and with forecast reductions in growth in the future, effective capacity planning based on achieving reduced demand for healthcare will be key. Locally there is a commitment to ensuring that transformation and productivity initiatives are where possible joined up so the maximum financial benefits can be delivered.

NHS Portsmouth recognises that some degree of transitional and pump priming funding could support and motivate action; to this end, a minimum of £1m has been set aside in this respect. However, the Board of NHS Portsmouth would seek to use this funding to support a partner (Commissioner or Provider) to:-

- Transform care pathways prioritised in Commissioning Plans (e.g. Trauma and Orthopaedics, ENT, Stroke, Long Term Conditions)
- Improve quality or clinical outcome
- Achieve key targets which would otherwise be difficult to attain
- Secure the spreading of good practice
- Secure recurrent system wide savings.

6.13 Capital Programme

The PCT is proposing a sizeable capital programme with the primary development being the Community Healthcare Campus on the St Marys site. The campus is a long standing aspiration for Portsmouth, originally planned to provide community based services, with alignment with the Queen Alexandra Hospital re provision under a Private Finance initiative. Capital funding was sought and the bid was successful under the national community hospital programme. However it remains important that the clinical services content in the facility planned is able to substantiate that it will provide value of money in the long term; as such a review of contents is currently taking place before contracts are enacted.

The Primary Care Trust is also anticipating allocations for Capital Grants associated with the University of Portsmouth Outreach Dental School development. This will be transferred from capital to revenue funding in year.

The remaining focus of the PCT capital programme is based upon an anticipated reduced allocation of funding to be made available (Capital Resource Limit CRL). In 2009/10, the PCT was asked to limit the amount of capital schemes which would cross over 2 years into 2010/11, whilst none were planned, some urgent maintenance work has meant that cross year expenditure has been unavoidable.

NHS Portsmouth has had a programme of investment in backlog maintenance in over the last 5 years this has had a positive impact upon the quality of its premises. However there still remain a small number of key buildings where backlog issues remain, the PCT has an Estates Strategy 2010-15 which provides further details on the estates which supports the delivery of healthcare in Portsmouth. The Estates Strategy also sets out the priorities for backlog maintenance and development aspirations in order to further support planned changes to service provision or are necessary to improve the environment.

The table below summarises the PCT's planned capital spend.

Table 8 – 2010/11 Summary Capital Programme

Capital Sources	£000
Dental Capital Grant	1,150
St Marys Healthcare Campus	10,692
Capitalisation Share	1,958
Transfer to Solent Healthcare (indicative)	(250)
Learning Disabilities Grant	810
Total Capital Sources	14,360
Capital Applications	
St Marys Health Care Campus	10,692
Dental Capital University	1,150
Backlog Maintenance	1,438
Learning Disabilities – Avenue and Hamilton House	1,080
Total Planned Capital Programme	14,360

6.14 Cash Management

NHS Portsmouth are currently modelling the cash requirements for 2010/11 and intend to use some of the working balances to continue to improve performance against the Better Payment Practice Code (BPPC) in order to reach the 10 day payment target. The target was applied to public bodies to alleviate some of the cash flow impacts of the credit crunch. NHS Portsmouth is also planning a revenue surplus which will result in a small cash surplus of which will be managed through working capital.

6.15 Finance Department Objectives

The key objectives in 2010/11 for the Finance Department are detailed below

Table 9 – Finance Department Key Objectives

Corporate Finance	Lead: Martin Wilkinson
Objective	KPI/ Milestone
To contain overall PCT revenue expenditure to within the PCT's revenue resource limit	<ol style="list-style-type: none"> 1. Year to date and in month financial balance as indicated in the monthly financial report 2. Forecast Expenditure remains within resource limit
To contain capital expenditure within the PCT's capital resource limit	<ol style="list-style-type: none"> 3. Year to date capital spend is in accordance with monthly profile as indicated in PCT FIMS plan 4. Forecast Expenditure remains within resource limit
To deliver the PCT's planned Surplus (As adjusted by any agreed payment to PHT for double running costs)	<ol style="list-style-type: none"> 5. Year to date surplus is within the monthly profile indicated within the PCT's FIMS plan. (As adjusted by any agreed payment to PHT for double running costs) 6. Forecast Surplus remains greater than or equal to plan (As adjusted by any agreed payments to PHT for double running costs)
Commissioning Finance	Lead: Clare Bryan
To deliver the PCT's planned commissioning surplus (As adjusted by any agreed payment to PHT for double running costs)	<ol style="list-style-type: none"> 7. Year to date surplus is within the monthly profile indicated within the PCT's FIMS plan. (As adjusted by any agreed payment to PHT for double running costs) 8. Forecast Surplus remains greater than or equal to plan (As adjusted by any agreed payments to PHT for double running costs)
To ensure that the PCT delivers its planned Commissioning Cost Improvement (CIP) and Demand Management (DM) Plans	<ol style="list-style-type: none"> 9. Monthly achieved efficiency is in accordance with the planned delivery profile 10. Forecast CIPs and DM is equal to or more than plan
Provider Finance needs updating	Lead: Jo Gooch
To ensure that the PCT provider function delivers operational financial balance	<ol style="list-style-type: none"> 11. Year to date and in month financial balance as indicated in the monthly financial report 12. Forecast Surplus remains greater than or equal to plan
To deliver the PCT's planned Provider Surplus	<ol style="list-style-type: none"> 13. Year to date surplus is within the monthly profile indicated within the PCT's FIMS plan. 14. Forecast Surplus remains greater than or equal to Plan
To ensure that the PCT delivers its planned Provider Cost Improvement (CIP) Plans	<ol style="list-style-type: none"> 15. Monthly achieved efficiency is in accordance with the planned delivery profile 16. Forecast CIPs are equal to or more than plan
Treasury Management and Statutory Reporting	Lead: Lee Williams
To deliver the requirements of the Better Payment Practice Code	17. Monthly Cumulative BPC Performance
The PCT's cash requirements remain within the PCT's Cash limit	<ol style="list-style-type: none"> 18. Monthly cash drawings are in accordance with planned drawings as indicated within the PCT's FIMS plan 19. Forecast Cash Requirements remain within the Cash limit
To produce the 2010/11 accounts in accordance with the faster closedown timetable	20. To provide Auditors with a complete set of financial statements for audit by midday 23 April 2009

7. Contracting and Commissioning for Quality

7.1 1011 Contracting Process

Contracting for 1011 is taking place via the Provider Relationship Management (PRM) part of the Collaborative Operating Model (COM) on a SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) basis. All organisations within SHIP are contracting via the PRM and negotiations are taking place on a SHIP basis. A negotiating strategy has been devised and will be used as the basis for 1011 contracting with acute, mental health and community providers. Supporting this are a set of contracting principles which will support the negotiations and be built into all contracts. The contracting principles have been based on the 1011 PBR rules, the commissioning intentions of each of the 4 organisations and include rules which support the SE Hants Capacity Map and NHS Portsmouth's top down requirements.

The revised national standard contracts for 1011 provide an excellent basis to support commissioners in delivering high quality services and meeting national targets. In addition the incentives and business rules within the operating framework and the PBR guidance will again assist with driving up the quality agenda through the contracting process whilst containing levers to ensure targets are met. These incentives and business rules set the shape and structure of national tariffs for 2010/11 and signal the direction of future development. They provide key business rules between commissioners and providers at a contractual and health system level and state how CQUIN will operate in 2010/11. Some of the main incentives and business rules impacting on 1011 are:

- Introduced first set of best practice tariffs : cataracts, cholecystectomy, fragility hip fracture and stroke
- New currency for mental health services now available for local use
- CQUIN income trebles to 1.5% of income and required to include patient experience element. From 2011/12 PCTs have power to withhold up to 10% of contract payment for providers failing to meet satisfaction goals on a service by service basis
- No payment to be made for seven nationally defined 'never events'
- Zero percent uplift in tariff prices and the uplift for following three years will be a maximum of zero percent. For 2010/11 this includes a 3.5% efficiency requirement. This is expected to increase in future years.
- Zero percent also applies to all non tariff arrangements
- Emergency activity above baseline will only attract 30% of relevant tariff. Baseline will be 2008/09 activity
- SHA's retain flexibilities locally to amend or suspend contractual arrangements
- After 2010/11 national tariffs will represent the maximum price payable as opposed to the mandated price

7.2 Activity and Financial Planning

Activity levels have been modelled for all 1011 contracts in order to establish the capacity required from providers, the types of services and how much of them we wish to commission, and the associated financial impact of commissioning those levels of activity. The STRATCOMM modelling tool has been used to forecast the activity required. The modelling takes into consideration population projections, rises in demand, the waiting list position and impact of demand management and service redesign programmes. The impact of these factors, mainly due to the PCT top down requirement targets shows a decrease in the main on overall activity levels compared to 0910.

7.3 Quality as an organising principle

The *NHS 2010-2015: from good to great* makes it clear that the NHS remains committed to the *Next Stage Review* vision of putting quality at the heart of what we do. *The Operating Framework for the NHS in England for 2010/11* also emphasises that quality must continue to drive all that the NHS does.

NHS Portsmouth is committed to this vision and commissioning for quality.

7.4 Commissioning for Quality

Since the Darzi review, “commissioning for quality” has become the organising principle for commissioning services. From this has been developed the NHS Quality framework and the World Class Commissioning competency framework.

NHS Portsmouth will widen its focus on quality over the year to begin to develop a quality culture that runs through the whole organisation and does not remain only the concern of the quality team. Commissioners have a legal duty to secure the best services in terms of quality and productivity for the people they serve. We will be developing a shared understanding of “quality” to support the organisation using the Quality Framework and other national initiatives to aid this process; for example Quality, Innovation, Productivity and Prevention (QIPP), Measuring for Improvement, the National Quality Board, the Commissioning for Quality and Innovation payment framework (CQUIN) and Quality Accounts. Local initiatives include the Patient Safety Federation.

Safer care is a priority for all boards of all NHS organisations. NHS Portsmouth will further develop the existing mechanisms of providing assurance to the Board and other key partners, including patients and residents, on the quality and safety of services commissioned from providers.

NHS Portsmouth will ensure the PCT remains compliant with Safeguarding duties following the separation of the commissioner and provider functions.

7.5 Contracting for Quality

The standard national contracts provide commissioners with improved mechanisms to take forward the quality agenda. The quality parts of these contracts provide the PCT with very important mechanisms for improving patient care and outcomes. The contracts include the PCT's expectations on quality and standards outlined in the new registration requirement regulations from the Care Quality Commission (CQC) for NHS organisations from April 2010 onwards, which includes the requirement of providers to publish a set of Quality Accounts. Quality Accounts are annual reports to the public on the quality of the services which an NHS organisation delivers.

From 2010, nursing home providers will be on a new standard contract; currently the monitoring and performance management of these sit outside of the systems developed for other providers and will need to be integrated. Closer links also need to be developed with the independent contractor teams.

The PCT will continue to review the process of how the contracts are developed in alignment with SHIP to refine the process for future negotiations. This will inform a long term plan for the development of the quality aspects of our commissioned services. A key area for future development will be around including disease-specific quality indicators. Priority areas for development are vascular disease (heart attacks, stroke and diabetes), cancer and children and maternity services; these were highlighted in the last two Annual Public Health Reports

as the key areas for increasing life expectancy and reducing health inequalities, and remain a focus. They link directly with the PCT's World Class Commissioning Strategy and outcomes and the National Operating Framework top 5 national priorities which remain:

- Improving cleanliness and reducing healthcare-associated infections (HCAIs)
- Improving access through achievement of the 18-week referral to treatment pledge, and improving access to GP services (including at evenings and weekends)
- Keeping adults and children well, improving their health and reducing health inequalities
- Improving patient experience, and staff satisfaction and engagement
- Preparing to respond in a state of emergency, such as an outbreak of a new pandemic

7.6 Commissioning for Quality Initiatives: CQUIN

For 2010/11 the PCT will continue to use the Commissioning for Quality Initiatives (CQUIN) framework within the Acute, Community, Mental Health and Learning Disability contracts. This funding will be used to incentivise providers to improve the quality of care. This sum equates to 1.5% of the total contract value.

CQUIN will focus on the following areas for 2010/11

- Patient experience and satisfaction
- Patient Reported Outcome Measures (PROMS)
- Venous thromboembolism (VTE)
- Stroke measures; improving variation in the quality and safety of care
- Advancing Quality
- Pressure ulcers

7.7 Never Events

NHS Portsmouth will continue to performance manage providers of care on their process of investigating and learning from Serious Untoward Incidents (SUIs). In the future these will be called Serious Incidents Requiring Investigation (SIRI).

We will continue to use a national set of Never Events as part of the contractual agreements with providers. Never Events are indicators of how effective an organisation is at implementing safer practices. From April 2010 no payment will be made to providers where treatment results in a Never Event.

Providers will not only be required to demonstrate to NHS Portsmouth that a thorough investigation and analysis of the SUI including Never Events has occurred, they will also be required to report to the National Patient Safety Agency (NPSA) and publicly declare Never Events as part of annual reporting on quality and safety within Quality Accounts.

7.8 Elimination of mixed sex accommodation

NHS Portsmouth will be monitoring that providers of NHS care have published a declaration by March 2010 that they have virtually eliminated mixed sex accommodation and that all providers have robust plans in place for continued delivery of this commitment. The PCT will be reporting on an exception basis any organisation that has failed to provide same sex accommodation and that has had funds withheld as a result to the SHA.

7.9 Effectiveness

As a World Class Commissioner the PCT needs to ensure that high quality evidence is fed in to the commissioning cycle. Ensuring services are based on the best available evidence and offer value for money is a key priority for the PCT given the current financial challenges and in line with national priority. NHS Portsmouth is reviewing its procedures for assuring the implementation of clinical guidelines and analysing data reports on guidance compliance from providers. It will promote the use of NHS Evidence to ensure that NICE guidance, guidelines and best practice are used to inform decisions. The PCT will continue to use other benchmarking tools, for example Better Care, Better Value indicators, Dr Foster, NHS Comparators and Programme Budget Data. Developing the evidence base is important and NHS Portsmouth will continue to support audit and research and will continue development of organisational systems with respect to these. The PCT will also be collaborating with neighbouring PCTs to examine ways of making the process for individual funding requests (previously called Not Normally Purchased) more efficient by reducing duplication of effort and sharing knowledge.

1011 objectives for this area can be summarised as follows.

Project	Target
Embedding quality within commissioning business	Develop and integrate the quality contracting process within NHS Portsmouth working with partners in SHIP Maintain management of quality reports, information and data Maintain the Commissioning Clinical Standards and Clinical Subgroup of NHS Portsmouth's Professional Executive Committee
Clinical governance and standards	Maintain clinical governance/standards database and assurance process
Primary care clinical governance	Continue the development of primary care clinical governance systems with a particular emphasis on ensuring integration of corporate systems (e.g. complaints and incidents) with systems aimed at the individual (e.g. annual appraisal and revalidation)
Serous Untoward Incidents	Working collaboratively with both internal and external partners continue to develop the Serious Untoward Incident process
Not Normally Purchased Procedures	Ensuring Not Normally Purchased Policies and Procedures are embedded within the organisation
Safeguarding	Ensure the PCT remains compliant with Safeguarding (adults) duties following the separation of the commissioner and provider functions
Audit, Research and Clinical Effectiveness	Continuing development of the organisation's systems with respect to audit, research and the use of clinical effectiveness evidence

8. Informatics

8.1 Introduction

NHS Portsmouth has a long tradition of working with local NHS and Social Care partners to ensure that the direction of travel for Information Systems is such as to support the efficient and effective delivery of Health and Social care to the population.

It is the PCT's belief that strategic investment in Information Systems and Technology will produce significant benefits and it is important these benefits are realised effectively. Such benefits include:-

- Facilitating shared access to clinical data, which can either, be patient specific or collective data used to drive improvements in quality and in making evidence based decisions.
- Enabling patients to make use of their right to choose their care provider, location or type of care. Using technology to book appointments, rearrange and receive notification of appointments.
- Strengthening communication and the sharing of information between organisations, to ensure patients are cared for seamlessly across organisations or speciality boundaries, this will promote less duplication, improved quality and safer ways of working.
- Ensuring personal/sensitive data is kept securely and only used for the purpose it was collected.
- Achievement of financial savings, through efficient working using technology to minimise manual administration.

8.2 Strategic Role

NHS Portsmouth as the local leader of the NHS will continue to influence, the direction of travel for IM&T in the local Health Community, working to agree strategic principles across partner organisations, including Portsmouth Hospitals NHS Trust, the Community and Mental Health Provider, ISTC, Independent Practitioners and the City Council. The aim being to ensure that priorities are aligned and deficiencies identified with a clear management improvement plan.

Good quality data and analytical expertise is a fundamental requirement of Commissioners. It is also essential that Informatics enables strategic plans and decisions to be formulated based on evidence. Public health needs analysis is the start of the data flow however data repositories, governance, clinical and data validation, benchmarking and sharing of information, continues to be a key work stream. The Commissioning Enablement Service (CES) recently set up across the PCT's in South Central will help to support the development of appropriate systems and procedures, promote analytical expertise and the use of data and information by Commissioning Managers in NHS Portsmouth to inform their work.

8.3 Working with the Local Authority

The PCT has a strong history of working with the Local Authority, in public health and health promotion, joint commissioning, provision, and through the delivery of joint strategic initiatives and projects. The Informatics agenda is also underpinned with similar strong relationships, enabling a joined up approach to informatics. The City Council and the PCT have worked to ensure that Health and Social Care Staff are able to access Health and Social Care systems from all of the premises from which they occupy. The NHS number as the key link between Health and Social care has been populated in the Local Authority systems. Use has also been made of the City Council Swift system to facilitate the Care Planning Approach; the lessons learned are now being applied to the pilot project known as Common Assessment Framework (CAF), which looks to further move forward the integration of records.

8.4 Contract Negotiation and Performance Management

2010/11 will see a greater emphasis on information requirements and the requirements will be formally set in the contracts with Providers. This will ensure that Commissioner's requirements for timely and relevant information are delivered. This will include a requirement to regularly feed into key data repositories, such as SUS and the Hampshire Health Record (HHR). The PCT has built into Provider contracts the expectation that there will be improvements in key areas such as the availability of Choose and Book, coding quality, the timely sending of discharge letters to GP's and the use of HRG 4 as the basis for activity recording and reporting.

8.5 Joined up Records to Support the Patient Journey

The delivery of an Integrated 'patient centred' care pathways will be supported ultimately by Electronic Patient Records and the implementation of Care Records Services (CRS). In support of this aspiration NHS Portsmouth is looking to secure:-

- The continued integration of Community, Acute and Social care systems
- Increased efforts to ensure that all systems use the NHS number (where possible as the key patient identifier).
- Continued deployment of the Community of Interest Network (COIN)
- Making greater use of the Map of Medicine to support the management of patients along the appropriate care pathway
- Integration technologies

Information support for urgent care will continue to be improved. Appropriate information sharing is already being undertaken between the Out of Hours Service (OOH), GPs, and the Emergency Department (ED) and the GP Led Health Centre which opened in the summer of 2009. But use of the information is patchy particularly in ED, its effective use will build as more useful and timely information is available. Nevertheless, the foundations are laid and with further encouragement the benefits for the clinician and patient will be realised.

8.6 Interoperability

NHS Portsmouth are exploring integration methodologies that will support a continuous care record across multiple clinical systems whilst maintaining high levels of security based on a users clinical role and clinical relationship with the patient.

Although the work is in early stages, initial discussions with systems suppliers are positive and would seem to indicate that a lot of the enabling technology is already in use in the health community.

NHS Portsmouth plan to work with our NHS, Social care and private sector partners to develop an integration strategy and framework that would see 'joined-up' care records across organisations and multiple clinical systems.

8.7 Technical Infrastructure

It is important to ensure that the technical infrastructure is maintained at high levels of technical readiness to support all major informatics programmes from both a local and national perspective. The Health community has a solid technical foundation having implemented planned improvement programmes over a number of years, including fit for

purpose computer rooms, rolling PC upgrade and network and electrical infrastructure capacity programme and storage area networks.

8.7.1 NHS Infrastructure Maturity Level (NIMM)

The local and wide area network infrastructure (COIN), modern PC and file server hardware together with an accredited IT Helpdesk and support services places the PCT at level 2-3 (Controlled-Standardised) of infrastructure maturity with plans in place to improve the level of maturity to 3-4 (Standardised-Optimised) involving:-

- Moving from a request to service driven IT model (By integrating IT into mainstream PCT business and commissioning plans)
- File server consolidation (Virtualisation)
- Data storage management
- Framework managed IT Project / Programme management
- SLA Management
- Remote User Access
- Publishing the NIMM Level on the PCT Web site

8.7.2 Security

As the dependence on information technology continues to grow we must make sure we sustain high levels of security whilst continuing to enable improved productivity and without stifling innovation.

The PCT is working with all providers of healthcare to agree a framework that includes information governance and data security as a key element of programme and projects delivery.

8.7.3 Wireless Infrastructure (WiFi)

The PCT enjoys the benefit of a comprehensive IT infrastructure but also recognises the limitations that a wired network has and, therefore, the PCT has prioritised both wired and wireless technologies in all new build and refurbishments of clinical areas.

8.8 Influencing Providers

8.8.1 Independent Contractors

Work is ongoing to upgrade GP Practice systems to enable them to support the SCR, there are now (January 2010) 18 out of 27 Practices with systems which are compatible with the SCR. The information exchanges between independent contractors and NHS systems will be achieved through the joint use of services provided by National Health Application and Infrastructure Services. These services will enable independent health systems to integrate more closely.

Work with GP Systems (GPSoc and GP2GP) continues, with GPs being encouraged to adopt a Managed Service solution. The PCT is encouraging the use of InPractice Managed Services where GP systems require replacement. The electronic transfer of patient records between GP practices (GP2GP) is well underway with work to resolve GP software taking a high priority. Although NHS Portsmouth has promoted the input of data from GP systems into the Hampshire Health Record repository, the uptake is poor as the Primary Care Commissioning team will be actively supporting and influencing compliance in 2010/11.

Following the implementation of release one of the Electronic Prescription Service (EPS), implementation of release two will start in April 2010. The projects will include training and support to help GPs and Pharmacists maximise use the system which provides full electronic prescribing from GP practices to Pharmacists of patients' choice.

8.8.2 Community and Mental Health

Our primary provider of Community and Mental Health services is the PCT's own provider function, (which will soon be under the umbrella of NHS Southampton). NHS Portsmouth has long been supportive of the need to modernise the methods of collecting for both Mental Health and Community Services. In the past, 'data pens' were used to collect data, which proved to be inadequate due to a lack of validation and control. A project to provide direct access to the Patient Administration System and a significant increase in the number of PCs available to clinicians, has improved data quality and has culturally improved use of information technology. This project was the precursor to the deployment of a specialist Community and Mental Health system (see below).

Summary Care Record - The PCT's as Commissioner has also supported the deployment of RiO as a strategic solution for both Mental Health and Community Provider services, and will actively performance manage the Providers implementation of the system during 2010-12.

Expanding the remit of Choose and Book - NHS Portsmouth are supporting the Community and Mental Health Provider in making use of Choose and Book technology for patients who are accessing its Mental Health services.

8.8.3 Secondary Care

NHS Portsmouth is required to deliver the Clinical 5. Although Secondary Care already have access to a Patient Administration system with sophisticated reporting tools, NHS Portsmouth needs to be assured that the following is present : Integration with other systems, order Communications and Diagnostics Reporting that includes all pathology and radiology tests and tests ordered in primary care, letters to patients with relevant coding (discharge summaries, clinic and Accident and Emergency letters), work flow scheduling (for beds, tests, theatres, etc), and e-Prescribing (including 'To Take Out' medicines)

NHS Portsmouth is actively performance managing its acute providers to deliver 'The Clinical 5' either through the development of existing systems or the procurement of new or interim solutions ahead of CRS.

clinical 5	Solution	Supporting	By	Provider
PAS A patient Administration System with integration with other systems and sophisticated reporting	Clinicom PAS by iSoft and Chimera	Integrated reporting	Already in place	Portsmouth Hospitals NHS Trust
Orders and Results Order Communications and Diagnostics Reporting (including all pathology and radiology tests and tests ordered in primary care)	Anglia ICE	Internal Trust and GP path orders	Majority of local GPs already use Anglia ICE Partial roll-out in hospital, full roll out expected by May 2010	
	Clinicom PAS	Radiology test results	Electronic results already available. Trial process to alert requesting clinician currently being rolled out and expected to be complete by Q2 2010/11	

	Clinicom PAS	Radiology test requests	Programme expected to be in place by Q2 2010/11 (subject to approved Business Case)
Coded letters Letters with coding (discharge summaries, clinic and Accident and Emergency letters)	Development of Clinicom PAS and Chimera	Coded letters and discharge summaries	Programme expected to be in place by end 2009/10
Scheduling Scheduling (for beds, tests, theatres, etc)	Theatreman	Theatre Scheduling	Already in place
	System yet to be procured	Bed Management	Programme expected to be in place by end 2010/11 (subject to approved Business Case)
	Clinicom Pas	Test scheduling	Already in place
e-Prescribing e-Prescribing (including 'To Take Out' medicines)	JAC	In-Patients	Already in place
	Development of Clinicom Pas and Chimera as part of the Discharge Summaries project Summaries	'To Take Out' – For In-Patients	Programme expected to be in place by end of 2010/11
		'To Take Out' – For Out-Patients	Programme subject to approval of ASCC and expected to be in place by end of 2010/11

Whilst NHS Portsmouth has actively promoted the availability of Choose and Book, there disappointedly remains considerable progress to be made in maximising its use, with challenges having been experienced in PHT making sessions/slots available. The PCT is working to encourage increased availability and more efficient use of the facility.

8.9 Informatics in support of Plans in 2010/11 Commissioned care pathway/service redesign

The year ahead will see a number of care pathways being redesigned, in order to secure a transfer of care to the most appropriate setting, to secure productivity gains, and greater efficiency. For a number of the plans alignment of the informatics impact will be essential not just to support service delivery but also to evidence through data recording and analysis the success or otherwise of the initiative. Key projects which require informatics support (either directly or through contractual performance monitoring) being:

Commissioning

- Maximising the benefits of Electronic Prescribing
- Ensuring the contract specification for the ISTC includes the requirements of informatics, learning from the existing contract challenges
- Maximising Provider data uploads into the Hampshire Health Record, e.g. include the requirement in appropriate GP LES.
- Facilitating the technical aspects in respect of the Common Assessment Framework.
- Facilitating and supporting decision making with regard to the replacement of the Child Health system.
- Supporting the appraisal of telecare opportunities and their introduction
- Delivering the IM & T requirements for the Community Hospital.
- Delivering the requirements of prison systems (primary care based system)
- Supporting the effective use of Choose and Book by Independent contractors.
- Supporting the introduction of web based technology to support the management process for requesting and authorising low priority procedures.

Providers *(through commissioning methodologies)*

- Secure an integrated system proposal to market test GUM and CASH in order each service is independently provided having separate systems
- Pain service – supporting the informatics requirements for the community based provision
- Out of Hours (GP provision) – realising the benefits of working across Portsmouth and Southampton without loss of interconnectivity with key partners e.g. ISTC and ED.
- Implementing RIO (Mental Health and Community)
- Implementing the replacement Child Health System
- Maximising effective roll out and slot availability of Choose and Book System

8.10 Greater Involvement of the Public

Enabling patient access to both their patient record and health care information is continuing, in support of patient choice. NHS Portsmouth is influencing the use of public involvement systems such as Choose and Book technology in Acute Care and also for Community and Mental Health Services. This work will underpin and inform plans for the implementation of the Summary Care Record (SCR) and 'My Health Space'.

The key priority in NHS Portsmouth Strategic Plan is one of “prevention” keeping the population healthy with a concentration on reducing the incidence of alcohol, obesity and smoking. It is recognised that there is huge opportunity to use technology to deliver health messages to the public on lifestyle issues through better use of websites, mobile phones etc the Informatics Team will be supporting the use of technology to facilitate social marketing.

8.11 Benefits Realisation

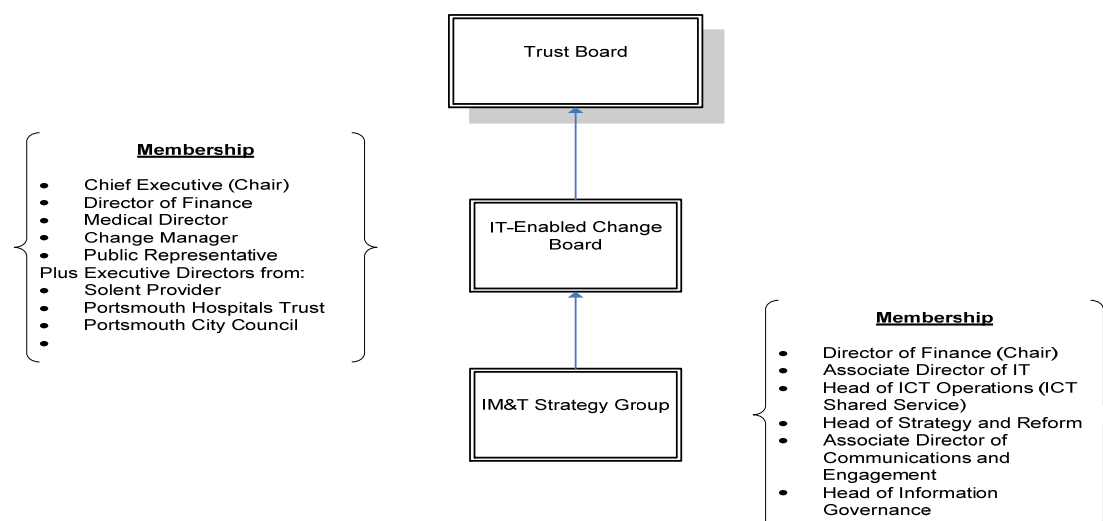
It is important that the advantages of technology and improved systems and information are identified and realised. Commissioners will need to seek benefits realisation plans (including IM&T) as part of every initiative they lead and then follow up the plans after implementation to ensure that the benefits are fully realised. Given the time lag between plan and execution of initiatives, it is important that such post project evaluation reviews are systematically built into the commissioning cycle. Benefits will include safety, quality and attaining financial savings through efficiency.

NHS Portsmouth has for some time planned to implement a governance process to drive forward the benefits of Technology. Due to the challenges facing the National Programme for IT, this has not been taken forward but there remains an aspirations to set up a PCT led IT-Enabled LHC Change Board.

8.12 Governance

The proposed governance structure of the IT-Enabled LHC Change Board is illustrated in the diagram below:

Local Health Community Change Board: Governance Structure



The key responsibilities for the IT-Enabled LHC Change Board are - to resolve conflicts across projects and organisations ensure benefits are realised, agree and resolve funding issues and to review and agree Local Health Community change strategic plans.

It is proposed that the agenda for the IT-Enabled LHC Board will also actively performance manage benefits realisation of specific projects where the scheme is fundamental to the Health Community or there is a high risk of delay or inertia namely:

- Primary Care - The use of the Hampshire Health Record
- Secondary Care - Influencing the direction of travel for the PAS replacement and availability of Choose and Book
- Community and Mental Health Provider - Driving out the benefits from the RIO System and recently implemented Substance Misuse and Contraception and Sexual Health systems

8.13 Information Governance

NHS Portsmouth takes an active role in continuously improving all aspects of information governance as patient and public confidence in the security of personal data is critical to deliver the benefits of NHS Care Record Service for NHS care. The key areas of information governance relevant are:-

- Registration Authority (RA) – NHS Portsmouth has a robust Registration Authority process supporting all applications of the NHS Care Record Service, and to conform to the national policy and guidance. The RA process provides staff and Independent Contractors with a smartcard which has had their identity checked to eGif level 3. The process ensures staffs are only given the appropriate access to functionality and information.
- Information Governance Toolkit – NHS Portsmouth is committed to building upon the high standards achieved in its last year’s submission of the Information Governance Toolkit. Disaster Recovery/Business Continuity - Technology is a fundamental part of the day to day work of the NHS. As Commissioners need to ensure that there are robust disasters recovery processes in place to ensure it and its providers can continue business in the event of a computer system disaster.
- Pseudonymisation - There is some good work already underway with the pseudonymisation of patient data. However, NHS Portsmouth will continue to

encourage the analysis of local data flows and localised plans to ensure that patient identifiable information is only used for direct patient care.

- Person Identifiable Information (Data) – PID - NHS Portsmouth takes its responsibility seriously in ensuring the storage and transit of all PID is managed safely and securely. The organisation continues to increase awareness of data protection issues amongst its staff and seeks assurance from Providers in this respect.
- Data Quality – The organisation continues to improve its access to good quality information and to skilled data analysis staff. This need is supported by the Commissioning Enablement Service CES.
- NHS Number and Personal Demographics Service (PDS) – NHS Portsmouth will work to secure the use of NHS number by all its Providers and the Local Authority. However, more work is required to achieve 100% compliance particularly in respect of written correspondence to patients

8.14 Resources

8.14.1 Capacity and Capability

Commissioners must be able to identify the data they require, be able to analyse and interpret it and know and use it when it is relevant in informing Strategies, and Commissioning plans. This is a key competence built into the competence framework. The work of CES will supplement the existing expertise in the PCT. There is a need to broaden understanding of the informatics agenda in the Commissioning team which will be addressed through seminars and general updates and cross departmental working. This would also aid performance management through provider contracts the informatics requirements of Providers.

The Informatics resource in NHS Portsmouth comprise of a small client team and by use of an SLA with Portsmouth Hospitals Trust. This arrangement help to secure specialist support and from a health community interconnectivity perspective provides a distinct benefit.

Financial challenges facing the Health Community in the next few years however will create the need for priority of resources and as such the need for clear strategic direction and alignment of the transformation agenda with the Informatics agenda will become even more important.

8.14.2 Finance

NHS Portsmouth has a number of budgets which fund the activities of IM&T. There is an SLA with Portsmouth Hospitals who provide most of the IT support that the PCT uses; this includes managing hardware and data repositories used to support the information needs of commissioners and developing reporting tools such as Chimera.

The PCT has a development budget of £189k IM & T costs in Providers particularly secondary care are considered to be within national tariff, in the Community and mental health provider £350k was devolved to meet the costs of implementing RIO. There are also budgets set aside in Primary care which are considered adequate to meet the costs of IM & T relating to Independent Contractors.

It is clear however and not surprising that the costs of ambitious the programme of activities which come under the umbrella of this function are a key pressure, however funding has been set aside which is set out below:

- Contribution of c£500k to fund the costs of the PCT's Commissioning Enablement Service.

- An NPfit Programme development budget, which will be used to fund IM & T infrastructure and reporting technology to support the Commissioning function.
- A primary care IM&T development budget of £236k which will meet improvements in General Practice, (including 2 GP Practice premises) and promoting the use the Electronic Prescription Service.

8.14.3 Supporting new ways of working – productivity gains

Supporting different ways of working is building momentum as the NHS looks at reducing the use of its infrastructure and achieving improved work life balance. Working from home is one strategy which can support this change. Supporting mobile working through pilot projects has been ongoing with the use of 3G enabled laptop and tablet computers, palm and PDA devices. Results indicate that a mixed economy approach is the way forward with some staff groups favouring the extra functionality a laptop or tablet offers whilst others prefer the convenience of Palm and hand held devices. Either way the projects have concluded that efficiency and time savings were significant where staff would otherwise need to return to base in order to input or obtain information.

Other efficiency savings initiatives are planned in 2010, these include; maximising the financial benefits of VOP technology in place but not fully understood by users. Encouraging GP's to transfer primary care systems to managed systems rather than through in-house provision.

8.15 Risks

The PCT has identified the risks facing the implementation to the IM & T agenda in the coming year, together with the mitigation we will take in order to minimise their impact on our business.

No	Description	Outcome	Mitigation
1	Mixed Local Health Community Programmes	There is a risk that the local health communities implement a range of national solutions in respect of patient care pathways which will not be supported across organisational boundaries.	Care Record Service programmes must make provision for the implementation of interfaces between disparate systems in order to support integrated care pathways
2	Clear and agreed priorities	There is a risk of ineffective and inefficient use of IM&T resources if priorities are not clear and agreed with the stakeholders	Ensure that Care Record Service programmes have clear and agreed priorities and managed by the Joint Development Board.
3	Failure to engage with key stakeholders to deliver the IM & T agenda and its benefits.	Lack of system ownership and poor system culture	Ensure there is regular engagement sessions with key stakeholders providing knowledge and education of system impacts and benefits
4	Care Record Service Fails to realise benefits	Systems fail to adequately support the business	Ensure that the Local Health Community providers identify key benefits that support the commissioning of services. This will be a major factor with all Care Record Service programmes
5	The merged community and mental health provider arrangements reduce their support for the implementation of the RIO system	Commissioner will experience a delays in being able to secure the information needs from its providers who will be unable to implement fit for purpose systems	Continue to use the Contractual arrangements to enforce the Commissioners requirements of the Provider.
6	Information Governance	The greater use and reliance of computer systems puts pressure on data security and back office functions	Management of Information Governance should be a standing agenda item of the LHC Joint Development Board.

No	Description	Outcome	Mitigation
7	Lack of Resources capability, capacity and finance, financial challenges particularly in Portsmouth Hospital Trust may result in reductions in IM & T resources	Poor technical capability putting Care Record Service deployment at risk	Ensure that the Care Record Service projects are managed within the resources available and that workload is prioritised and/or investment is made in IM&T resources through the development of Business Cases and service plans. Ensure that PHT fully consider the impact of staff reductions and minimise the impact on IM & T must do's
8	Engagement of secondary care and delivery of 'the Clinical 5' at a time where there are significant financial constraints	Limited engagement and delayed action	IT-Enabled LHC Change Board management and Board to Board discussions
9	Delivering an IT-Enabled LHC Change Board	Delay and un-coordinated actions	Influencing key players, understanding the enablers and hurdles.

Informatics
Recovery Area : Health Informatics
a. Executive Lead
<ul style="list-style-type: none"> Pam Hobbs (Director of Finance) and Chris Day (Associate Director of IT)
b. Current Position & Reason Recovery Required
<p>1. <u>Summary Care Record (SCR)</u></p> <p>Work on upgrading GP Systems is on-going with 18 out of 27 of our GP Practices with systems that are now compatible with the SCR. However whilst the PCT is keen to see the results from the SCR demonstrator sites the trust is also investigating other avenues of public engagement such as the development of the Hampshire Health Record (HHR) as our local summary care record as this already provides a rich source of clinical information. More work is required in this area which includes an assessment of the current and longer term benefits of the SCR, development programme of the HHR and investigating possible data feeds from the HHR to the SCR.</p> <p>2. <u>Governance</u></p> <p>IM&T Programmes have traditionally been managed by the Local Deployment Board which is chaired by the PCT's SRO with direct reporting arrangements to the Trust Board. Although the Local Deployment Board is well established and includes PCT commissioners and representatives from our Local Authority partner, its main responsibility has been on the provision of systems to support mental health and community provider services. Whilst this approach has provided the necessary management and governance arrangements to successfully deploy local systems it does not provide the leadership and the governance required to enable the broader service reform agenda and support new models of care across the whole Local Health Community.</p> <p>3. <u>Capability and Capacity</u></p> <p>Following the agreement to merge the provider service of both NHS Portsmouth and Southampton City PCT, NHS Portsmouth has an agreed structure for Informatics that supports its current commissioning strategy and business objectives. However, as well as ensuring our commissioners and Informatics staff have the competencies required to drive the health agenda forward the PCT will also work closely with the Local Health Community to support and facilitate local development of</p>

project and operational staff and services in pursuit of the informatics agenda.

4. Information Governance

The PCT is committed to build on the high standards achieved in last year's submission of the Information Governance Toolkit with work continuing on the security and quality of data. The next step will be to focus on ensuring that all organisations, from which care is commissioned, including independent contractors and the third sector, are brought within the NHS Information Governance Assurance Framework.

5. NHS Number and Patient Demographic

Much work has already been done to ensure the widespread use of the NHS number for all patients, in all systems and in all correspondence. There are, however, areas where the NHS number is not being used which need to be addressed. The PCT is currently overseeing a review of all systems and processes that is being conducted by the Portsmouth Mental Health and Community Services (PMHCS) as part of the deployment of mental health and community systems. The purpose of this review is to identify the gaps where the NHS number is not being used and ensure its future use. The PCT is also working with Portsmouth Hospitals Trust where a similar work programme is underway covering secondary and acute care.

6. Pseudonymisation of patient data

Although plans are in the early stages of development there is some good work already underway with the Pseudonymisation of patient data (C&R and PCT's data warehouse). The PCT will continue to analyse local data flows and develop plans to ensure that organisations from which care is commissioned comply with the use of pseudonymised data for purposes other than the direct care of patients.

c. Planned Change

Section	Title	Programme of Work/Theme	Schedule of Work (High Level Plan)	Outcomes/Milestones	By When
1.	Summary Care Record Project	Summary Care Record and 'My Health Space' project	Assessment of current and longer benefits of the SCR over the HHR and preparation of an Options Paper and Business case	<ul style="list-style-type: none"> Options Paper Board approval of the Business case 	August 2010
			Subject to approval of the Business Case set up Project Board/Team (including Communications) and engage with GP Practices and system suppliers	Ensure sufficient project resources, and where necessary arrange backfill of staff.	September 2010
			Prepare Project Initiation Document	Project Board Approval	October 2010
			Prepare and plan communications strategy and campaign to include: <ul style="list-style-type: none"> Letters to patients Leaflets and posters Web-site pages Other media communication 	Establish patient list of those who wish to opt-in or out	October – February 2010/11
			Testing phase	Agreement to proceed	March 2011
			Implementation	Handover/go-live	April 2011
2.	Governance	Local Health Community IT-Enabled Change Programmes	The PCT has plans in place that will provide a Local Health Community wide approach to the management of the Informatics Programme. The PCT has established an IT-Enabled LHC Change Board to take the lead across the whole strategic IT-Enablement agenda for the local health community. The Board will be led and chaired by the PCT's Chief Executive.	<p><u>Purpose of the Board:</u></p> <ul style="list-style-type: none"> Starting point for collaborative change programmes across the LHC Resolve conflicts across projects and organisations Ensure Change Programme benefits are realised. <p><u>Membership:</u></p>	Mar 2010

				<ul style="list-style-type: none"> PCT Chief Executive (Chair) Clinical Lead Senior Management from LHC Provider organisations: <ul style="list-style-type: none"> PCT Provider Portsmouth Hospitals Trust Hampshire PCT Portsmouth City Council Public representative 	
			Responsibility for the programmes will be managed by the ICT Strategy Group which will be chaired by the PCT's SRO. The ICT Strategy Group is a sub-committee of the IT-Enabled LHC Change Board.	<u>Purpose of the Group</u> <ul style="list-style-type: none"> Provide support to the IT-Enabled LHC Change Board Develop IM&T strategic plans Develop cross organisation benefit realisation plans Derive IM&T requirements from the IT-Enabled LHC Change Board priorities Develop/Review IM&T Business Cases as requested by the IT-Enabled LHC Change Board Advise the IT-Enabled LHC Change Board on all IM&T related risks Advise the IT-Enabled LHC Change Board on training issues Advise the IT-Enabled LHC Change Board on IM&T capability and capacity. <u>Membership:</u> <ul style="list-style-type: none"> PCT SRO Chair Head of Strategy and Reform Associate Director of Communications and Engagement Associate Director of IT 	
3.	Capability and Capacity	<p>Commissioners need to identify the data they require, be able to analyse and interpret it and know when it is applicable and relevant and use it in informing their strategies and commissioning plans.</p> <p>The PCT's Commissioners also need to be able to consider the broader implications of their strategies that will be both informed by, as part of the enabling strategy, and integrated into their plans. To enable this to happen will require inclusion of Informatics team members in strategic planning sessions and day to day plans and contract performance management. Likewise the Informatics function will need to fully understand the commissioning aims of the PCT and be able to support and educate commissioners in the technology agenda.</p>	<p>This is a key competence that will be required of the PCT commissioning team and has therefore been built into the competence framework.</p> <p>The PCT recognises that the key to the successful outcome of change programmes, that underpins transformation, will be the capacity of available resources including staff with the necessary skills and knowledge supported by governance structures that ensure their effective use. Incorporate Informatics as an integral part of the commissioning strategic process and planning cycles.</p>		On-going
4.	Information Governance	IG Toolkit and Statements of Compliance	Ensure that all organisations, from which care is commissioned, including independent contractors and the third sector, are brought within the NHS Information Governance Assurance Framework. IG programmes and projects are managed by the PCT's Deployment Board and Governance Committee.	<ul style="list-style-type: none"> Produce local IG Assurance Framework Service Providers and Contractors Compliance Register IG Toolkit compliance 	Mar 2010 Jul 2010 On-going
5.	NHS Number and Patient Demographics	The PCT is working to secure the use of NHS number by all its providers in the LHC including Social Services. There is already agreement with Portsmouth City Council to use the NHS number for all patients' records held in their systems. However, more work is required to achieve 100% compliance particularly in respect of written correspondence to patients	Increase efforts to ensure that all systems use the NHS number (and where possible as the key identifier). This requires more work with our Social Care Partners. Project managed by the ICT	<ul style="list-style-type: none"> Review of all mental health and community systems and process (including all patient correspondence) Identify and ensure 'gaps' are filled NHS Number Project (Acute focused) 	May 2010 June 2010 Sep 2010
6.	Pseudonymisation of patient data	Pseudonymisation Project	Project sponsorship Establish Project Board and Team	Board approval Terms of Reference and PID	Feb 2010 Feb 2010

			Policies and procedures for identifiable data	Formulate and approve	Jun 2010
			Identify flows of identifiable data and repositories	Data maps	Apr 2010
			Users of identifiable data	User register	May 2010
			Organisation and awareness of the usage and IG	Design and implement regular training and awareness sessions	Jul 2010
			Data management	Review and modify	Apr 2011
			Pseudonymisation	Established Pseudonymisation function/process	Apr 2011
			Safe Haven	Established new Safe Haven and Back Office functions	Apr 2011
			Security	Establish Access Control functionality	Apr 2011
				Established User registration and authorisation processes	Apr 2011
			Software/application modifications	Applications reviewed and modified to support Pseudonymisation of patient data	Apr 2011
			Business process that support the use of pseudonymised patient data	Reviewed and modified	Apr 2011
			Log and audit trails	Establish audit trails that log the use of pseudonymised patient data	Apr 2011
			Hand-over/go-live		Apr 2011

d. Key Enablers and Links

With the establishment of NHS Portsmouth as a Commissioning only organisation the Informatics function is an integrated part of commissioning as the enabler service change and reform and provide support for new models of care.

e. Organisational Support Required

Section	Title	Organisations involved (Action By)	Supported/overseen By
1.	Summary Care Record Project	<ul style="list-style-type: none"> NHS Portsmouth 	<ul style="list-style-type: none"> SHA
2.	Governance	<ul style="list-style-type: none"> NHS Portsmouth Solent Provider of Mental Health and Community Services Portsmouth Hospitals NHS Trust Portsmouth City Council Independent Sector Treatment Centre Darzi Centre 	<ul style="list-style-type: none"> SHA NHS Portsmouth
3.	Capability and Capacity	<ul style="list-style-type: none"> NHS Portsmouth Solent Provider of Community Services Portsmouth Hospitals NHS Trust 	<ul style="list-style-type: none"> SHA NHS Portsmouth
4.	Information Governance	<ul style="list-style-type: none"> NHS Portsmouth Solent Provider of Community Service Portsmouth Hospitals NHS Trust 	<ul style="list-style-type: none"> SHA NHS Portsmouth
5.	NHS Number and Patient Demographics	Collaborative approach between: <ul style="list-style-type: none"> NHS Portsmouth Solent Provider of Community Service Portsmouth Hospitals NHS Trust Portsmouth City Council 	<ul style="list-style-type: none"> SHA NHS Portsmouth
6.	Pseudonymisation of patient data	Collaborative approach between: <ul style="list-style-type: none"> NHS Portsmouth Solent Provider of Community Service Portsmouth Hospitals NHS Trust Portsmouth City Council 	<ul style="list-style-type: none"> SHA NHS Portsmouth

f. Measures of Achievement

Section	Title	Management/Governance and Arrangements	Structures	Performance Process	Management	Measurable Output
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1.	Summary Care Record Project	<ul style="list-style-type: none"> Local Project Board reporting to the ICT Strategy Group 	<ul style="list-style-type: none"> Project Plan Information Governance Benefits realisation 	Planned targets set by: <ul style="list-style-type: none"> Primary Care Objectives Operating (Action Plan)
2.	Governance	<ul style="list-style-type: none"> Trust Board IT-Enabled LHC Change Board ICT Strategy Group Audit Committee 	<ul style="list-style-type: none"> Audit Reports and other inspection reports and plans Terms of Reference Board Agendas 	<ul style="list-style-type: none"> Trust Business Plan and supporting Strategies Operating Plan and associated action plans
3.	Capability and Capacity	<ul style="list-style-type: none"> ICT Strategy Group Programme and Project Boards 	<ul style="list-style-type: none"> Programme and Project Plans HR and Workforce Planning (Skills and Competencies Framework) Education and Training Needs Analysis Staff appraisals 	<ul style="list-style-type: none"> Education and Training assessments KSF Staff appraisal outcomes
4.	Information Governance	<ul style="list-style-type: none"> Integrated Governance Committee Audit Committee Information Governance Working Group 	<ul style="list-style-type: none"> IG Toolkit PCT Audits Internal Audit 	<ul style="list-style-type: none"> IG Toolkit Scores Audit Reports and Plans
5.	NHS Number and Patient Demographics	<ul style="list-style-type: none"> ICT Strategy Group Project Board 	<ul style="list-style-type: none"> Project Plans Review assessment 	<ul style="list-style-type: none"> Audit Report
6.	Pseudonymisation of patient data	<ul style="list-style-type: none"> ICT Strategy Group Project Board 	<ul style="list-style-type: none"> Project Plans 	<ul style="list-style-type: none"> Project milestones

g. Financials - Alignment of investment / disinvestment

Initiative Element	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Total	0	0	0

The objectives for informatics for 1011 can be summarised as follows.

Project	Target
Interoperability	<p>Support the Health and Social Care Economy in the use of National infrastructure (spine and SUS) to share data/information by aligning strategies and systems developments, e.g. care record, clinical and support service systems</p> <p>Provide E-technology to facilitate patient choice and social marketing</p> <p>Explore creation of a staging area to enable sharing across disparate systems providing a complete electronic care record, supporting care pathways and category management.</p>
Data Quality/Data Standards	<p>Enforce data standards in the transmission of data</p> <p>Enable effective use of data repositories (e.g. Hampshire Health Record)</p> <p>Enforce role based access controls</p>
Governance (Access and Security)	<p>Promote secure personal identifiable records through information governance action plans, information sharing protocols and pseudonymisation</p>
Capability and Capacity	<p>Plan and manage resources required to deliver the informatics priorities</p>
Technology Supporting Transformation	<p>Use technology in the transformation of care pathways, e.g. telecare, electronic prescribing, extranet, intranet</p>
Achieving Value for Money/Driving out Productivity	<p>Identify opportunities to realise the benefits of the historical and planned informatics improvement programme</p>

9 Performance Management

9.1 Performance Monitoring and Assessment

The PCT will continue to performance monitor and assure progress against national and local objectives, including; ensuring compliance with the NHS Performance framework and the CQC Annual Health Check, the Compliance Framework and World Class Commissioning Assurance Process. Our ambition across all of our performance areas is to move from good to great and aim to be identified as a high performer in the commissioning and delivery of high quality services.

Our internal mechanisms for performance monitoring are moving towards Programme Management Office. By the start of 2010/11 the PMO will be established and substantive recruitment taken place; this follows a period of using PriceWaterhouseCoopers to establish the mechanics and processes of the PMO from which we will grow the strength and capability of this function in house. This will ensure that all projects have consistency of approach and robust methodology ensuring that the projects have financial affordability and realistic and achievable milestones to support the delivery of demand management, CIP's, WCC outcomes and national targets. Local objectives set as part of the Compliance Framework will be consistent with the key areas of work and key objectives described in our Strategic Plan, Operating Plan and Organisational Development Plan.

Where we know we are falling behind on elements of the compliance framework and national targets, we are holding performance review meetings with the leads across the organisation to assure that actions are being taken to resolve issues with providers. These will be conducted by both Exec and Non-Exec Directors to ensure robustness, appropriate challenge and visibility to the board.

10 Corporate and Support Service Programmes

10.1 Communications and Public Engagement

Effective engagement is vital in ensuring the PCT makes sustained long term progress in developing as a commissioning organisation; it will support others' understanding of our role and responsibilities in an increasingly complex local NHS structure and it will help local people have a real say in the development and delivery of their local health services. Effective engagement will also enable us to promote the values and ideals of the NHS Constitution and ensure that we deliver on our responsibilities outlined within it, notably to help improve patients' experiences of the local NHS.

With this in mind the PCT has taken the opportunity to refresh its corporate Communications and Engagement Strategy and a revised document was approved by the Board in December 2009. Given the context of an evolving and developing NHS, both nationally and locally, it is important that the strategy is regularly reviewed to ensure the PCT engages appropriately with its key audiences.

This builds on the progress made to date in implementing the 2008/09 Communications and Engagement strategy whilst acknowledging that there is more to be done in terms of achieving all of the intentions and actions set out in that original paper.

It proposes an extension to the life of the existing strategy, with certain revisions, and a continuation of the work needed to achieve the action plan from last year. However, it also identifies ten key communications and engagement priorities for action over the next 12 months as the commissioning-focused PCT comes into form. These have been identified as being important in terms of supporting the PCT to meet its long term strategic priorities.

Meeting the aims and objectives set out in this strategy will support work to ensure that the PCT delivers its objectives, meet the demands of World Class Commissioning and the requirements of the NHS Constitution and develops local health care systems that are fit for the future of the NHS.

The revised strategy, rather than proposing wholesale changes to the PCT's overall approach to communications and engagement, recommends an incremental approach building on the achievements of the past 12 months and seeking to deliver on the areas of action not yet achieved. This offers a degree of continuity and stability in the way forward whilst, clearly, recognising the need to take account of organisational change and other developments within the NHS agenda locally and nationally.

The communications and engagement strategy will continue to support the business of the PCT, set out in its WCC strategy, Organisational Development and Operational Plans. It must also support the PCT in its partnership working, for example within the Portsmouth Local Strategic Partnership, and lead the health debate locally.

The 'Vision for Portsmouth' (April 2008) is the 10 year sustainable community strategy (2008-2018) for the city, to be delivered through the Local Area Agreement and Local Strategic Partnership work. As local leader of the NHS the PCT must ensure that communication and engagement is appropriate as this role is extended into effective cross-city partnership working, to ensure that what is important to Portsmouth people and organisations is reflected in service planning and development.

Alongside this, however, must be considered the national requirements on the PCT to demonstrate effective engagement, involvement and communication. These include the NHS Constitution, Vital Signs (VSB16 – public confidence in the NHS), several of the World Class Commissioning Competencies (and notably: recognition as local leader of the NHS; work closely with community partners; engage with public and patients; collaborate with clinicians; and manage knowledge and assess need. The Department of Health document '*The Communicating Organisation – Using communication to support the development of high-performing organisations*' (published in late 2009) will also be a fundamental support, and provides a valuable framework, for our future communications planning.

10.1.2 Measures of progress

There are four key areas to help measure how successfully the strategy and its objectives have been implemented to date.

ICM survey

ICM perception surveys are carried out twice a year by the Strategic Health Authority (SHA) on behalf of local PCTs. They are a useful indication of public awareness and opinion on a range of NHS topics and interests. With two years worth of data now in place, trends can be perceived more readily and action taken to address concerns. The PCT will look to take action on survey feedback where appropriate to do so and particularly in areas of 'low' performance.

Media analysis

Local and national media coverage remains a key influence in terms of building the PCT's reputation and people's perception of the organisation.

The Communications and Engagement team has worked hard to develop strong local relationships with all media partners in Portsmouth. This approach has been beneficial in

securing a greater, and to a large extent a more positive, media presence across the south coast.

From regular analysis undertaken by the SHA, media coverage in the Portsmouth area has been shown to have a high favourability indicator (balance of positive against negative coverage) as well as good performance in terms of impact and tone. This is particularly worth noting when set against the fact that The News in Portsmouth has the highest count of NHS articles in the SHA area of all regional newspapers.

Although the SHA is likely to continue to monitor media impact across the South Central area, it is fair to say that there is more the PCT can do locally in terms of regular media analysis.

Staff communications survey

Over 250 members of staff responded to a 40 question survey on communications conducted during the spring of 2009.

Around four out of every ten staff rate the PCT as good or excellent for the way it communicates with staff. However, nearly half (46%) described communications within the organisation as average - 4% described it as poor and 9% rated it as less than average.

The survey has provided valuable data on the success or otherwise of internal communications and engagement mechanisms and the results will be used to help establish effective systems for the new commissioning organisation.

Stakeholder perceptions and feedback

Although some work is carried out for the World Class Commissioning Assessment process the PCT needs to work more proactively in terms of testing stakeholder perceptions.

Progress is being made and a stakeholder mapping exercise has been undertaken, and a relationship management database system is currently being established. This will help the PCT secure much more meaningful insight into how well it engages with partners and stakeholders.

10.1.3 Moving forward - a ten step plan towards effective engagement

These are the ten critical 'must do's' for the year ahead as identified in the strategy.

1 Understanding stakeholders' needs

Delivering an improved system for stakeholder management that supports PCT stakeholder 'account managers' in engaging effectively with partner groups and organisations.

2 Fully rebranding as NHS Portsmouth

Implementing fully the new NHS Portsmouth branding with associated simpler visual identity (in line with national standards) to enable the organisation to present an effective, professional profile, with a consistent look and feel to printed and published materials that meet the core NHS corporate identity requirements.

3 Communicating the commissioning agenda

Helping each key audience develop a better understanding of the commissioning agenda by being open about priorities and the tough choices faced over the next few years is important. That means adopting a health economy wide approach to information sharing where possible and ensuring the channels of communication between the commissioners, the local community, partners, service providers and patients are in place and effective.

4 Managing knowledge in a way that promotes understanding

This is really about engagement at its broadest level - 'monitoring the heartbeat of the city'. Harnessing all the information that comes into the organisation from engagement activity (including intelligence from surveys, complaints and contacts through the Patient Experience Service, media and other organisational enquiries) into a regular report that is useful to commissioners will support them in their role, provide the organisation with a much deeper picture of trends and patterns across the city and enable more to be done in terms of sharing this knowledge more widely with partners and the local community.

5 Developing an annual cycle of engagement

As the level of scrutiny on the PCT's engagement practice will continue to be significant, this needs a structured approach that plans ahead and means that it can move towards meaningful, informed engagement on a cyclical basis. More can be done in promoting commissioning strategies in an accessible way.

Effective engagement must be led and valued by commissioners, but with support, monitoring and, where appropriate, coordination from the corporate communications and engagement team.

6 Working with others to ensure more effective engagement

It does not necessarily follow that the PCT should carry out all its local engagement work 'in house.' There will be times when other organisations (e.g. voluntary/third sector) will be in a much better position to undertake that work on behalf of the PCT. Many have effective means of targeting their own audiences and there may be opportunities to explore how the PCT might tap into these, or commission them to undertake the engagement work, where it may be appropriate to do so.

There will be particular benefits for PCT here in seeking the views of seldom heard or 'hard to reach' groups and individuals. This will be in addition to any work pursued in this field with the LINK, or the Portsmouth 100 (see item 10) – it remains important for the PCT to support the continued development of both of these engagement mechanisms.

7 Developing effective e-communications

Traditional means of communication and engagement are fast being caught, and overtaken, by e-communications and digital networking or engagement.

Whilst recognising that digital communications does not reach everybody, it is an effective way of engaging people and the benefits of this approach should be pursued, working with ICT teams to ensure access is in place but secure.

8 Delivering an annual public health/social marketing campaign plan

Greater structure and more forward planning over the PCT's public health advertising will result in better focused, higher impact campaigns sourced much more economically. An approach of four key campaigns a year (quarterly), funded from a central budget means that better deals for media advertising can be tied down across longer periods of time to deliver consistent and highly visible messages across the city.

The PCT will also explore social marketing initiatives further – there is scope to use the annual public health campaign plan to identify how and through whom public health messages are targeted, to ensure most impact and best effect.

9 Making a case for communications

Future bids, proposals and business cases for project/development funding must recognise the need for communications/engagement resources and should allow for these in their financial planning. A tightening financial position dictates the need to explore possible alternatives for securing funding for engagement/communications activity in future.

10 Embedding the Portsmouth 100

The newly formed Portsmouth 100 offers a valuable alternative to existing and traditional engagement routes by encouraging members of the public to sign up a scheme whereby they give their opinions routinely on aspects of the PCT's business that interest them.

The plan here is to continue to grow the Portsmouth 100 membership over the next 12 months, and identify, perhaps as part of the work on the annual cycle of engagement, particular areas of activity where people can be encouraged to participate.

The objectives for 1011 can therefore be summarised as follows.

Project	Target
Understanding our stakeholders' needs	Identify account managers for each of the organisations we engage with Develop a stakeholder management database
Rebrand as NHS Portsmouth	Promote our vision and values to strengthen and our identity as leader of the local NHS
Communicate the commissioning agenda	Enable the informed involvement of our key audiences and stakeholders
Manage knowledge in a way that promotes understanding	Harness information we receive from our engagement activity into something that is useful to commissioners
Develop an annual cycle of engagement	Ensure a planned, embedded approach to our engagement activity
Work with others to ensure effective engagement	Collaborative approaches to engagement, particularly with the 3 rd sector, for seldom heard groups
Develop effective e-communications	Utilise IT in our engagement activity (social networking and web technologies)
Deliver an annual public health campaign plan	Deliver four key campaigns a year (quarterly)
Make the case for communications	Proposals and business cases for project/development funding to include communications/engagement resources
Embed the Portsmouth 100	Encouraging members of the public to sign up to a scheme whereby they give us their opinions routinely on whatever aspects of our work interests them; continue to grow the Portsmouth 100 membership over the next 12 months

10.2 Workforce and Learning and Development

10.2.1 Experience, Satisfaction and Engagement (Employee)

We have created a People Strategy for NHS Portsmouth that aligns the needs of the business in terms of workforce, development, staff engagement, wellness and recruitment to the needs of the new organisation as it emerges. This document is focussed on a holistic approach to the workforce issues and the future needs for NHS Portsmouth. We have also worked to align this to the key issues highlighted in the NHS South Central Workforce Strategy (Shaping the Future). Our engagement work streams are very clearly linked to those in other areas of business such as Wellness, Learning & Development and Workforce; we believe that these areas contribute to the overall wellbeing of a person in the workplace, ensuring they have an element of control over their environment and the ability to progress. The key messages from this are grouped into the sub parts of the People Strategy, below.

10.2.2 Workforce

We are entering a period which is about workforce transformation against a backdrop of severe financial challenge; We will need to move away from traditional planning practices

and 'more of the same' and begin to build a workforce around the skills and competencies required to achieve outcomes (across all areas), this will transcend bandings and staff/professional groups.

In the next 12 months, operationalising the new NHS Portsmouth structures will be a key work stream. This will include the need to look at building a more flexible workforce to help deliver our business and ensure we remain sustainable for the future. From 2010/11 vacancies within the structure will be expected to be held or recruitment done on a fixed term or secondment basis. This will also help us to review the capacity of the organisation over the next 4 years in light of the 30% management cost reductions laid out in the operating framework, maintaining the degree of control we have over workforce growth that we have developed in recent years to help ensure a good financial position. These management cost controls are mirrored in the directive to cease the use of all management consultancy, interim and agency resources with effect from 1st April 2010, with exceptional cases only and with prior approval from the Chief Executive.

The majority of our additional staffing is within the Estates and FM function in terms of bank and agency usage, during 2010/11 we will be seeking to manage the current levels from approx 9.7% (% 'agency costs'; 3% in FTE's) reducing down to closer to benchmark levels. Work to look at how 'agency' is coded through the finance system will be carried out so that we are reflecting our usage accurately. Overtime and excess levels are approx 7.2%, with a plan to reduce this to approx 5.2% during 2010/11. We will continue to utilise excess hours in preference to overtime, bank or agency, as much as possible, as this is the most cost effective solution for this function.

Current sickness absence is 4.4% and this is right across the organisation, including Estates & FM which have remained part of NHS Portsmouth. We will be looking at managing this to the SHA benchmark levels of 3% during 2010/11. Arrangements to support this are in place via the PCT's policies and regular monitoring via our internal systems and quarterly reporting. Action plans will be created per service where appropriate, supported by the HR advisor and Wellness Lead, in conjunction with the manager. Greater management and speedier resolution of cases are key to bringing down our long term absences as we hope to resolve cases before they move into half or no pay situations.

Although not benchmarked, our current turnover levels are around 9.6%, as per last year we will be seeking to have turnover levels of around 10% across the organisation.

We will be looking at how we can reduce the back office and support functions of the PCT by around 3% per annum over the coming 4 years; we will examine a mix of FTE and SLA/productivity efficiencies. The management reduction challenge faced by the SHA will be supported by each organisation, including NHS Portsmouth; our proportion of the aggregate 30% reduction in management and agency costs by 2013/14 will be worked through in our plans each year.

Our current unit labour costs (cost per FTE) is approx £33k, this is below the SHA average of approx £41k. We are anticipating an increase in the workforce once the new structures are implemented, but we believe that we will remain below the SHA average.

To support robust workforce planning for our organisation, we will continue to monitor and maintain the data quality in ESR; we are currently number 1 in the NHS Information centre rankings.

We will also continue to develop a commissioning centred appraisal process linked to both our organisational values (ABLE) and the Commissioning Development Framework and matrix (emerging from work across SHIP, led by NHS Portsmouth).

10.2.3 Learning & Development

High Quality Care for All, the NHS Constitution and QIPP are all defining drivers for the development of staff in the NHS, both nationally and locally. The need to support staff to deliver Quality, Innovation, Productivity and Prevention through Co-production, Subsidiarity, Clinical Leadership and System Alignment means that staff need to have not just the capacity but the capability to make change happen for patients in Portsmouth.

Talent at all levels of the organisation will be supported to reach their potential, and the Skills Pledge continues to ensure all staff have the essential skills to deliver to the highest level of competence, through targeted support to achieve level 2 qualifications, with apprenticeships building capacity for the future across the organisation.

Research clearly demonstrates the value of investment in staff development, and current financial projections mean that resources will be increasingly limited in coming years. It will therefore be essential to use resources wisely. The internal faculty development across the organisation will provide staff with access to a range of expertise and developmental interventions. These will be complimented by those available through the city collaborative – an informal partnership of public sector organisations in Portsmouth.

People Development will need to meet the varied needs of staff in Estates and Facilities as well as Commissioners. With staff spread across sites in Hampshire, there will need to be intelligent solutions to ensure all staff feel they belong to the organisation and have a shared identity. Induction at the start of their career will set the standard for ongoing support and development, whether a part time cleaner or a consultant.

The Organisational Development plan lays out several workstreams which involve learning & development, not least the progression of the Commissioning Development Matrix across SHIP and culture change and knowledge management.

10.2.4 Wellness

We continue to work to implement our wellness strategy across the organisation, and have a dedicated resource within the new NHS Portsmouth structures to support this critical workstream. A recent scoping of the key messages arising from Boorman review identified that we already have a number of workstreams and initiatives running that support many of the key recommendations. Our strategy and our approach in general, looks at both the needs of the individuals and the needs of the business, with our guiding model being 'Well staff, Well Managed = Well Organisation'. We will continue to develop both the appraisal and development systems in place to support staff; this will focus now on the needs of commissioning staff, although as Estates and FM remain within NHS Portsmouth solutions for their needs are also being developed.

We continue to be committed to delivering fast-track solutions for staff such as fast track back and a physiotherapy self referral service, as well facilitating a number of preventative services and initiatives to encourage healthy lifestyles such as the running group and locally negotiated discounts for gym memberships.

We will continue to update and provide Wellness training at both staff and manager level to ensure that responsibilities are clear, and we will run wellness days across the organisation which are both fun interactive sessions for all levels of staff but also provide a serious message about taking both personal and professional (workplace) responsibility for all types wellbeing.

We have a Board level Director responsible for this area of work, and in the reorganisation this has meant that the Wellness Coordinator reports directly to the director. The work with Wellness will continue to link closely to the work of both the workforce and learning and development teams as well as forging close links with Public Health to ensure that the messages we deliver publically are replicated for staff so that we are 'walking the talk'.

As part of moving this agenda forward, we will be developing a range of wellness related SLA's specifically for NHS Portsmouth as a consequence of the commissioning and provider separation.

10.2.5 Staff Engagement

We are working to ensure that our workforce is engaged with NHS Portsmouth and committed to acting in a way that is consistent with our values (ABLE) and aims. We are working hard to achieve an open and honest dialogue with staff and gaining their respect and engagement through the way we act and conduct our business, thereby becoming an employer of choice. To this end we should be an organisation that **Listens**; to staff in both their concerns and their suggestions for improvements, **Learns**; from staff experiences and feedback and from the mistakes that occur at all levels, with an emphasis on sharing the learning that comes from this, and **Leads**; is an employer of choice, is a respected organisation and one that makes staff proud to work here and is an organisation that understands that staff are a valuable asset that has an major impact on the way in which the core business is delivered.

There are three levels with responsibility for engagement with staff: Corporate responsibilities, Line manager responsibilities and Staff. There are currently a number of methods in place across the organisation to help increase engagement with staff, and we must make full use of the processes we already have in place. In addition we are looking at where there might be gaps, including the things we should ensure happen as a matter of course but may not be effective in all areas, i.e. good job design. We have an excellent opportunity as new structures are put in place to ensure that roles are varied and attractive and keep staff engaged and motivated.

From a business perspective, engagement and satisfaction is about attracting and retaining the right staff, increasing productivity and reducing absence and turnover. For the individuals, this is about increasing wellbeing, increasing the feeling of involvement and control and having ones' needs met on a daily basis – having a positive work experience.

For 2010/11 Staff Survey, NHS Constitution and staff forums will be at the forefront of engagement initiatives, ensuring we have both a consistent message and two-way dialogues with staff.

10.2.6 Recruitment

Working collaboratively across the region we have been designing a new recruitment toolkit and attraction messages for NHS Portsmouth (alongside CLEAR). It is intended that this will support the ongoing needs of this organisation and the need to work closely with our neighbouring PCT's to ensure that there could be smooth transition across organisations where needed. This will also allow a streamlining of efforts with regard to recruitment; we intent to implement this fully within 2010/11.

There will be some workstreams in 2010/11 that will involve collaborative working, especially within the SHIP boundaries. Work will be undertaken to ensure that a new induction process for NHS Portsmouth is put in place and that this is sufficiently sensitive to SHIP working, to create consistency and enable smoother working across organisations for staff. This is

especially important to those coming into roles like category managers or provider relationship managers, where they will be working right across SHIP.

10.2.7 Workforce Risk Assessment

The focus is on the PCT's strategic commissioning priorities for 2010/11 but also beyond this time frame, if for instance the supply of a particular staff group has a longer lead in time.

This has been produced as a separate document for Commissioning staff to use in their Darzi workstream commissioning plans. The assessment has been done by looking at the key themes and work areas emerging from each of the Darzi groups, and looking at the general themes for those staff groups affected. This is simpler for some areas such as Planned Care and less so for areas such as Staying Healthy where the staff groups affected can be very wide spread. Even End of Life for example, touches a large range of staff groups as well as the training and development needs of NHS, voluntary sector staff and carers. To this end some of the larger workforce impacts will be around the design and implementation of the right development for staff working across a number of areas and parts of a pathway.

In terms of workforce savings, our top down schemes bottom line figures of approx £25m would equate to approx 609.75 FTE's, if all of the savings were to be achieved through staffing reductions. However, mapping only the savings that could apply to workforce (i.e. not tariff or drug based savings) this figure comes down to approx 212.43 FTE's based on average FTE costs. This figure may still reduce as not all schemes will require a reduction in the workforce numbers; for some areas there may be higher losses than others and .in some schemes the money saved in one setting may need to increase workforce in another (i.e. saving money on ECR's within Mental Health). There may also be a transfer of staffing or skills across the locality provider; this however may retain some hidden costs in the form of re-training of staff.

This workforce risk assessment is about our knowledge and strategic intentions, our assurance role will inform us of any local issues that are impeding delivery of particular workstreams as we will then be seeing provider specific work plans. The figures represented in the locality assessment relate to what we believe could happen as a result of these savings, our Demand Management schemes may produce further opportunities for workforce reconfiguration and as such we will be working with our providers to understand how our schemes track through to their workforce plans and broader CIP's.

With regard to the locality, we are working with our local acute and community provider to try and minimise the impact that the financial climate is having. Where possible we are working collaboratively to look at how we can most effectively avoid redundancies by committing to facilitate access to our vacancies for staff at risk within the acute trust, our provider and commissioner functions. This is happening within the SHIP locality to maximise opportunities for staff. For example, moving from acute settings to other acute settings would be a smoother transition than acute to community for example. We are aware that there may still be the need for some job losses, particularly within our local acute unit, however, we will continue to work with them to try and minimise this during 2010/11.

On assuring ourselves of workforce planning processes happening within provider organisations, our aim is to equip contracts with the right level of detail to see that this is happening. We will also be monitoring and assuring ourselves of provider performance via their KPI's (FIMS returns) in order to understand and monitor progress against plans and issues, we have requested, and been in receipt of provider FIMS returns for the last few months and expect this level of reporting to continue.

As commissioners this is our method for monitoring and evaluating the effectiveness of services, by inserting workforce information into the contracting process will help us create a fuller picture of the variables that can affect the quality outcomes we seek. We will also be assuring ourselves that the equality and diversity of provider organisations is representative of their local communities; currently within Portsmouth we are happy that the statistics coming from both the Acute and Community provider are currently meeting these requirements as compared to the Portsmouth City census data.

A summary of the key objectives for this area for 1011 are as follows.

Project	Target
Professional Development	Continuing professional development of clinical and all staff
Mandatory Training	100% of staff maintain competence in all statutory and mandatory training identified for their role
Staff Survey & Satisfaction	Staff Survey action plans for any scores, or response rate for organisations, in lowest 20% of average; action plans for those in bottom 20%
Staff induction	100% of new staff receive 90 day induction programme appropriate to their role
Skills for Life Pledge	100% of staff in bands 1 to 4 have qualifications mapped and are offered support to develop to at least a level 2 qualification
Talent Management	A strategy for succession planning and supporting talent throughout the organisation is developed and implemented
Productivity	Reduce back office and admin functions by 3% per annum (2011+) Reduce Acute spend by 1% through better data validity and challenge and use of CES and SHIP
Project & Programme Management	Programme of e-learning achieves qualification for all identified staff by end of 2010.
World Class Commissioning Competencies: training needs analysis	Using the Commissioning Development Framework, all staff complete annual review of development needs to inform commissioned interventions.
New organisation structure (NHS Portsmouth)	New structure for NHS Portsmouth in place
Workforce Locality Risk Assessment	Assess 9 Strategic Programmes for impact on locality workforce
Workforce Assurance	Supporting and monitoring all provider workforce plans
Development of e-learning	NLMS will support a range of courses that enable staff to maintain development in a flexible format, recorded on OLM.

10.3 Leadership

The work undertaken in collaboration with the University of Portsmouth, Portsmouth Hospitals Trust (PHT) and Portsmouth City Council (PCC), as well as colleagues from NHS South Central (NHSSC), to develop a Masters Programme have bolstered our leadership development agenda, this is now operational and within the next year we will have the opportunity to assess content and outcome to ensure that as we move forward this is meeting the needs of all parties.

The competency framework designed especially for commissioning roles (PCT and Atos) has been implemented and the TNA arising from this has led to further developments in learning and development. We are working across the SHIP boundaries to establish a framework, or matrix, to support the needs of commissioning staff arising from this.

The PCT Enabling Excellence, Leadership & Management framework, compliments the work that is progressing with the University. With the changes to the organisation this will be reviewed and refreshed to support the needs of the commissioning organisation more. This will continue to be made available to a wider range of staff so that we will have greater knowledge of where our leaders are and what their needs are to enhance their skills within

the organisation; this will give us greater management of talent, and fits within our strategic OD plan for the PCT.

In response to the High Quality Workforce, the PCT are developing workforce planning and will continue to do so throughout 2010/11, in a way that is consistent with the 6 core principles outlined in the report and that fits with the changing structure of this organisation. A PCT wide 5 year People Strategy and key within this is the need to ensure that planning is joined up with the education commissioning cycle and that our commitment to the Skills Pledge is maintained, with tangible results. As in previous sections, this will also be developed in line with our new responsibilities for workforce planning; in assurance of provider plans and assessment of workforce risks created by commissioning decisions.

Clinical leadership will also be high on the agenda, and is a core part of the OD Plan for the PCT. This is to ensure that we have effective leadership and input to commissioning decisions, that we are able to engage with a wide range of clinicians across a number of services to empower them to be part of the decision making process.

10.4 Medicines Management

Medicines Management is a system of processes and behaviours that determine how medicines are used by patients and by the NHS. The medicines management function cuts across PCT business with links with commissioning and service development, governance and regulation, financial management and public health. It also cuts across all of the Darzi groups.

Medicines are increasingly being advocated in earlier stages of disease to prevent more serious complications and death in the longer term. As people live longer and the number of older persons in the population increases, so the number and complexity of medication-related problems and issues increases. National research suggests that:

- Half of all patients with chronic conditions do not use their medicines as intended.
- Medication problems are implicated in 5-17% of hospital admissions
- Medication errors have been estimated to cost the NHS £500 million a year in additional days spent in hospital.
- People who could benefit from medicines are not all receiving them

High quality care for all – NHS Next Stage Review raised a number of implications for medicines management services.

- a) Local services should meet specific needs of the local population and efforts should be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health. In all of these areas medicines will be an element of the service strategy.
- b) Pharmacists both in the community and potentially practice setting have a potential role in undertaking vascular risk assessments now known as NHS Health Check. (see Staying health strategy)
- c) Everyone with a long term condition (LTC) should have a personalised care plan to improve patient outcomes and underpin the partnership between patients and healthcare professionals or volunteers that care for them.
- d) Ensuring that clinically and cost effective innovation in medicines and medical technologies is adopted. This will require horizon scanning, e.g. for new drugs and involving industry in a systematic and transparent manner.
- e) Patients should have access to the most clinically and cost effective drugs and treatment. Patients should receive drugs approved by the National Institute for Health and Clinical Excellence (NICE) if recommended by the clinician.

Within Portsmouth the Medicines Management Team aims to:

- Support the improvement of patient safety through high quality prescribing
- Improving clinical use and cost effectiveness of medicines, particularly in relation to Long Term conditions
- Provide specialised input to the development of clinical pathways and personalised care planning
- Reducing health inequalities and improve access to medicines
- Further develop joint approaches between hospitals and GPs with respect to medicines.
- Supporting the Accountable Officer to ensure safe management of Controlled Drugs across the PCT

Medicines are a significant financial and clinical risk to the PCT but the safe and effective use of medicines also has the potential to significantly improve outcomes for patients.

The work of the NHS Portsmouth Medicines management team can be broadly divided into:

- a) Commissioning medicines in primary care e.g. from GP practices.
- b) Commissioning medicines as part of services provided by secondary care.
- c) Commissioning medicines management and health related services from community pharmacists

10.4.1 Medicines and Primary care

The SHA have identified a number of indicators/ areas to support Demand Management around prescribing. The areas relevant to PCTs include:

- Regular prescribing reports to PCT Board/ PEC
- Prescribing benchmarking data shared with all practices.
- Action plan to deal with "outlying" GP practices
- Forum to resolve primary / secondary care interface prescribing issues.
- GP practice access to prescribing advice
- Prescribing targets included in practice based commissioning plans or prescribing incentive schemes.
- IT prescribing solutions such as script switch/ practice formularies.
- PCT plan to reduce waste associated with repeat prescribing such as repeat dispensing.
- Mechanisms in place to monitor non medical prescribing
- Met NAO checklist for reducing prescribing costs in primary care (NAO May 2007)
- Audit practices under 'excessive and inappropriate prescribing clause' from GMS contract

Where appropriate all of these issues are already being addressed in Portsmouth. This PCT has invested in practice based prescribing support over the years and this combined with effective incentive schemes and a significant level of GP engagement in the prescribing agenda has ensured that prescribing spend has remained within budget.

Financials – Medicines Managers - Investment			
Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Developing Medicines Managers	47	(20)	27

Total	47	(20)	27
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The PCT performs well against a number of national comparative prescribing indicators such as Better Care Better Value prescribing indicators. For quarter 4 2008/9, Portsmouth City was the only PCT in South Central where there were no savings identified against these indicators.

In addition the SHA has recently circulated a prescribing benchmarking document which compares prescribing across a range of additional indicators which demonstrate value for money in GP prescribing. The document highlights that, on average, practices in Portsmouth have the highest LISI score in the SHA, which is a measure of deprivation based on exemption from the prescriptions, charge on the ground of low income. At PCT level it is a crude indicator of deprivation but helps to identify the PCTs where deprivation has a significant impact on prescribing. Areas worthy of further attention in Portsmouth include:

- Increasing the proportion of all diabetes medication prescribed as metformin (first line agent for obese patients)
- Volume of antibiotics prescribed
- Volume of coxibs prescribed

The PCT also has one of the highest levels of uptake of repeat dispensing within the SHA which has the potential to reduce waste.

There is good evidence that medicines are often prescribed and administered inappropriately within care homes (see Quality and Safety in Health Care 2009; 18: 341-346). This has been previously identified as an area of risk with the PCT and it had been the intention to commission a care home review service from local community pharmacists. This has not been possible due to a lack of capacity. However this remains a priority.

10.4.2 Medicines and the interface with secondary care

Population-level decisions about the use of medicines will usually be made by the Portsmouth and South East Hampshire Area Prescribing Committee (APC), these decisions have to be made in accordance with the principles in the NHS constitution, but also ensure value for money for the NHS. Collaborative working arrangements with other local NHS organisations on the introduction of new medicines and guidance have been strengthened during 2009-10 and processes are in place to take account of guidance from NICE, South Central Priorities Committees and the Cancer Drug and Therapeutics Committee in terms of impact on the Portsmouth District Prescribing Formulary and local prescribing guidance. The introduction of an interface pharmacist post has led to improved relationships with secondary care and great engagement in the managed entry of new drugs

The District Formulary will continue to be developed, and is the key vehicle for managing the entry of new drugs via the Area Prescribing Committee. Adherence to the formulary for specific drugs or groups of drugs will be monitored and included in primary care prescribing targets for future years.

NICE have published guidance on process of Medicines reconciliation and recently the Care Quality Commission have published their review of performance in managing medicine after discharge. This confirmed the following that many of the processes required when patients transfer between primary and secondary care are not in place and this may result in a number of avoidable hospital admissions. Anecdotal feedback from both GPs and Acute trusts would indicate that many of the problems found within this review are present locally and need addressing. Included within this document are a number of recommendations for

PCTs including reviewing the work of the medicines management team to focus on medicines management after discharge, to improve patient safety and efficiency

10.4.3 Medicines and community pharmacy related services

Community pharmacies operate within an NHS contractual framework to deliver three levels of services:-

- **Essential services** offered by all contractors, which includes dispensing, disposal of unwanted medicines, public health promotion, signposting to other health related services, support for self care and clinical governance.
- **Advanced services**, requiring specific accreditation, and is currently limited to the pharmacist offering a concordance centered medicine use review with the patient. This is offered by 37 of 38 pharmacies within NHS Portsmouth
- **Enhanced services** which are commissioned locally by PCTs based on need and capability of contractors. Within NHS Portsmouth the following services are commissioned:-
 - Stop Smoking Service
 - Weight Management Service
 - Provision of Emergency Hormonal Contraception
 - Chlamydia screening and treatment
 - Supervision of substances given for misuse of drugs
 - Minor Ailments service
 - Concordance Support Service.

The medicines management team currently supports and facilitates the development of the enhanced services. The team gives professional advice and support to the by the Head of Dentistry, Pharmacy and Optometry across several areas of work including the Contract Monitoring Process, the review of the Pharmacy Needs Assessment and the control of entry to provide pharmaceutical services process. The team also gives professional support to the informatics team responsible for the Connecting for Health agenda; this includes the encouragement of uptake and role of the electronic prescription service. The team gives dedicated support to the clinical governance aspects of the contract and this includes the support of multidisciplinary audits, regular bi-monthly clinical governance newsletter and professional support for any critical incident or error reporting investigation that may involve community pharmacy.

The DH published its vision for Community Pharmacy in the Pharmacy White Paper “Pharmacy in England: Building on Strengths – Delivering the Future” in April 2008. Community pharmacies are offering an ever-expanding range of clinical services, and are involved in roles to support the safe use of medicines, promote the health and wellbeing of individuals and communities and reduce health inequalities.

NHS Portsmouth has been asked by the Department of Health to lead on developing a framework for ‘Healthy Living Pharmacy’. This model was described in the Pharmacy White Paper and has been further supported by the requirements described in World Class Commissioning: Primary Care and Community Services: Improving Pharmaceutical Services (DH April 2009)

In the summer of 2008 the PCT undertook a review of pharmacy services to provide a baseline of service provision and to gain an insight into the capacity and capability issues within community pharmacy. Many community pharmacies in Portsmouth already provide accessible, consistent and high quality services, commissioned to meet the needs of the local population and contribute to our vision of a healthier population. The PCT has facilitated a number of stakeholder events to gain greater understanding of the opportunities and barriers

to developing the Healthy Living pharmacy. In partnership with some of these stakeholders the PCT we are producing a prospectus which outlines how the Healthy Living pharmacies may develop in Portsmouth, provides insight into our commissioning aspirations for the future and highlights the requirement to link the needs of the population with the commissioning of services.

Financials – Healthy Living Pharmacy - Investment			
Initiative Elements	Spend required 1 year 2010/11	Savings generated 1 year 2010/11	Net 1 year investment (disinvestment)
Healthy Living Pharmacy	34	-	34
Total	34	-	34

At the heart of healthy living pharmacies is the commissioning of enhanced services which are evidence based, in line with the needs of the population and which delivery high quality accessible care to the people of Portsmouth which support the PCTs objective of improving health and reducing inequalities. Commissioning from a range of providers builds in capacity and system resilience. Initially the PCT will need to work with community pharmacists to support performance and quality improvement within the pharmacy workforce as well as investing in local pharmacy leadership to deliver consistent high quality services. However where the criteria of quality, outputs, capability and need are consistently not being met then the PCT will cease to commission enhanced services from these contractors.

As the PCT increases the range of service it commissions from community pharmacies it will become increasingly important to ensure effective use of technology for communications, performance management and reporting purposes. Access to NHS email will be vital as we move forward with more patient centred delivery of care involving community pharmacies. Use of the Pandemic Flu web based portal has shown the benefits of web-based systems to capture daily activity and reporting information. Similar technology would benefit pharmacy contractors to submit financial claims, activity reports and WCC outcome data in a consistent format that meets the needs of the PCT.

Summary objectives for this area for 1011 are as follows:

Project	Target
Community pharmacy services	Continue development of community pharmacy services in line with the emerging framework for 'Healthy Living Pharmacies' within NHS Portsmouth Every HLP contractor to evidence targeted medicines use reviews for at least 15 patients per quarter for the priority long term conditions which have been indicated by the PCT
Support GP practices to maintain prescribing costs within allocated budget.	Develop annual work programme for prescribing support team and cost efficiency plan for prescribing savings and refresh each year. Maintain prescribing incentive scheme Ongoing review of Scriptswitch profile and roll out to all compatible practices
Clinically and cost effective medicines and treatments across primary and secondary care	Maintain APC meetings every 2 months Update District Formulary and ensure publication of shared care guidance Impact of NICE, CDTEC and SCPC recommendations to be considered by APC within 3 months of publication Review of primary care compliance with APC recommendations each quarter
Staff within GP practices	Increase year on year the number of staff within GP practices nominated as "Medicines Managers" to assist in supporting practices in safe, cost effective and quality prescribing
Medicine management support of care home residents and vulnerable patients	Develop specific targeted pilot project, engaging GPs, care homes, and their pharmacies and complete evaluation.

10.5 Estates and Facilities

The PCT has previously had a very good record of cleanliness and in 2010-11 we intend to further improve upon this with the introduction of a new soft fm (facilities management) contract for City properties. In order to continue to monitor achieving these high standards, a new soft fm, web-based audit and monitoring tool is also being introduced to support the process across all of the NHS Portsmouth premises.

Estates & Facilities will continue to provide professional and technical support to Primary Care colleagues in the improvement and development of the Primary Care premises and estate, therefore enabling improvements to primary care access in the City, e.g. through Primary Care Development Funds and third party developments (3PD).

The improvements of access to NHS Dental Services are being led by NHS Portsmouth and again Estates & Facilities will support commissioning colleagues in the delivery of this vital service (e.g. H.L.C.).

As an integral part of NHS Portsmouth, Estates & Facilities will provide professional and technical support and expertise to commissioning colleagues to ensure that provider organisations are complying with and have plans for compliance with the requirements for a quality care environment, e.g. elimination of mixed sex accommodation, DH Cleaning Standards, Health & Safety etc.

Climate change effects and in particular NHS Portsmouth's organisational carbon footprint is constantly monitored, especially around the long-term threat of flooding to parts of the City of Portsmouth. The energy efficiency and effects of waste management are also constantly under review and improvements continue to be made to energy consumption and consequential reduction in CO2 emission by reducing travel, food miles and linen miles through local purchasing.

Capital and non-recurring revenue programmes will continue to be delivered based upon an informed and risk based methodology supported by robust locally sourced information to achieve a reduction in backlog maintenance and the delivery of an estate which is safe, warm and comfortable for clients, patients, staff and visitors.

The whole health experience for clients, patients, staff and visitors is facilitated by the work of Estates & Facilities in enabling the delivery of healthcare. We undertake regular customer satisfaction reviews of our services to ensure we meet customer expectations and will continue to do this in 2010-11.

2010-11 will see NHS Portsmouth begin to operate as the landlord of a fully managed property portfolio within which providers, as selected by the Commissioners, will be able to operate to provide services within a lease arrangement, as set out within the Transforming Community Services document. Estates & Facilities will continue providing the professional and technical input and reviewing with Primary Care and other commissioning colleagues the CIAMS submission and will be monitoring the process for its strategic delivery.

There are a number of local priorities for Estates & Facilities Services the main focus of which will be the efficient and effective development of the recently transferred land and buildings at St Mary's Hospital which will be remodelled, refurbished and reconfigured to provide the City with a 21st Century Community Healthcare Campus.

The Directorate is actively working with the City Council to develop initiatives around asset management for both organisation and regularly meets with Council colleagues to explore planning and development opportunities.

The new 5 year Board approved Estates Strategy document (2009-2014) supports the philosophy of maximising opportunities which can be derived from best use of the estate and the consequential reduction of operating costs associated with best practice in ownership and operation of land and property.

In managing, operating and using premises there will be CO2 generated along with waste (clinical healthcare, domestic and commercial) all of which contributes to the organisation's Carbon Footprint. As stated above this measure of environmental impact is constantly monitored and is on target to be both achieved and is forecast to exceed the 2015 target.

The Organisation and Estates & Facilities takes very seriously its impact upon the environment and has developed a Sustainable Development Management Plan and the Associated Action Plan, both of which have been approved by the Board.

1011 objectives for Estates and Facilities can be summarised as follows.

Project	Target
Accessible Access to Health Services	To plan and implement a hub and spoke network of Estates across the City in order to enable local access to a range of services in a Community setting. Individual developments are set out in the Estate Strategy, key targets being: <ul style="list-style-type: none"> - The delivery of St Mary's Healthcare Campus - Improved premises of Independent Practitioners - Provision of Outreach Dental School with the University - Provision of other community facilities
Quality of Premises Used to Deliver Healthcare	To ensure that premises are safe and meet statutory compliance standards, such as asbestos registers, legionella, electrical testing. Ensure that NHS Portsmouth has a prioritised programmed to reduce backlog maintenance To focus on sustainability agenda reducing the carbon footprint of the PCT and its energy consumption. Promote through its contracts with Providers and by implementation of a non-recurring programme for its own premises, an environment which is of good quality and meets standards in relation to cleanliness, comfort, dignity and respect
Promote the Attainment of Value for Money	Ensure that premises used in the provision of NHS care are well utilised and are cost effective.

10.6 Emergency Preparedness

To support the requirements in the Civil Contingencies Act (CCA) the Department of Health produced a number of guidance documents which outline the health emergency planning responsibilities of NHS trusts, these documents include:

- NHS Emergency Planning Guidance, and associated supplements (Department of Health, 2005, 2007)
- Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007)
- The NHS Resilience and Business Continuity Management Guidance (Department of Health November 2008)
- Strategic command arrangements during a major incident
- Heatwave plan for England (Department of Health 2009)

- NHS guidance on planning for disruption to road fuel supply: strategic national guidance for NHS organisations (Department of Health November 2008)

NHS Portsmouth is deemed a category one responder under the Civil Contingencies Act 2004. As a category one responder NHS Portsmouth are subject to a full set of legal duties. These duties fall into six specific areas:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency

As such the PCT has the statutory duty to have a Lead Director and an Emergency Planning Liaison Officer in place to support the discharge of these duties.

10.6.1 Local Resilience Forum (LRF)

A Local Resilience Forum, based on the Hampshire and Isle of Wight police force area is established to provide all the category one responders with an opportunity to meet, share ideas, discuss risks and create and test emergency plans together.

The forums are attended by all Category 1 responders and as many Category 2 responders as possible.

The broad structure of the LRF is:

- an Executive group directing work,
- a Coordinating Group taking this forward
- subject or task specific sub groups delivering the detailed work

All agencies are represented at the Executive and Coordinating groups, and only those relevant to specific work at the sub-group level. NHS Portsmouth is represented by NHS Hampshire at the Executive and coordinating group.

A Hampshire and Isle of Wight Local Resilience Forum Health Emergency Planning Group constitute one of the subject sub groups of the LRF. To support this group NHS Portsmouth Chair a Portsmouth and South East Hampshire Joint Health Emergency Planning Group.

Details of the arrangements of the LRF are outlined in the "Hampshire and Isle of Wight Local Resilience Forum Strategic Plan 2009-2012"

10.6.2 Supporting forums

In addition to the LRF and subgroups NHS Portsmouth holds a bimonthly internal Emergency Planning Group.

A Hampshire and Isle of Wight Health Emergency Planning Leads Group provide a forum for health emergency planning professionals to share and work collaboratively.

10.6.3 Staffing arrangements

The Director of Public Health and Wellbeing acts as the lead Director for Emergency Planning. An Emergency Planning Liaison Officer is in post to support the discharge of the CCA duties.

10.6.4 NHS Portsmouth Plans

To ensure NHS Portsmouth is prepared for emergencies the following plans are in place:

- NHS Portsmouth Major Incident Policy
- NHS Portsmouth Major Incident Plan
- NHS Portsmouth Managing Disruption to Road Fuel Supply Emergency Plan
- NHS Portsmouth Heatwave Plan - Protecting Health and Reducing Harm from Extreme Heat and Heatwaves

10.6.5 Arrangements for responding to a major incident

NHS Portsmouth has 24 hours a day 7 days a week on call Director available to be notified of a major incident. A major incident control room is available if required to support the response.

10.6.6 Short term plan for next year

The main aims and objectives for 1011 include:

- Continue our response and recovery from the H1N1 swine flu outbreak. Review, test and update plans based on lessons learnt including the development of a range of vaccination delivery strategies relevant to pandemic influenza.
- Raise awareness and improve major incident induction training within NHS Portsmouth
- Improve communication resilience between category one responders, including the adoption of National Resilience Extranet (NRE)
- Continue activities to meet the requirements of the civil contingency act and emergency planning guidance. In particular ensure the following strands of an effective response are in place and are able to be deployed at short notice should the situation demand it:
 - Robust and tested command and control arrangements
 - A strategy covering escalation of the service response to an emerging situation, including triggers, bed management, equipment and stock, staffing implications and communications
 - Systematic, embedded and resilient approach to mutual aid
- Focus attention on putting in place and testing plans and arrangements to deliver an effective response to chemical, biological, radioactive and nuclear (CBRN) threats, conventional terrorism, fuel and supplies disruption, flooding and public health incidents, and any impact from climate change in conjunction with other category one and two responders through the Local Resilience Forum.

10.7 Governance

The introduction of Integrated Governance and the Healthcare Commission's Annual Health Check has placed the onus firmly on boards to assure themselves of compliance and continuous improvement.

Integrated Governance includes:-

- Corporate governance

- Clinical governance
- Risk management
- Financial governance
- Research governance
- Information governance
- Staff governance

The Integrated Governance Handbook (2006) describes 8 elements which constitute the high level governance framework:-

- Resources – be financially sustainable (probity, regularity, balance at year end), sufficient human resources, estate fit for purpose, appropriate information technology
- Efficiency and Economy, Effectiveness and Efficacy (4Es) – the organisation can be run effectively, efficiently, economically and challenged – why are we doing this activity, could someone else do it and do it better?
- Compliance with authorisations – will be compliant at all times with its authorisation to operate (Monitor, Health & Safety, Drug and Research management)
- Compliance with national targets
- The duty of quality as reflected in clinical governance – continue to improve services for patients and be governed in accordance with current best practice
- The duty of partnership – cooperate with local healthcare economies
- The duty of patient and public involvement (Section 18 of the NHS Act) – have a growing and representative membership to which it is response and accountable, in particular in the planning of services
- The ongoing development of the Board

10.7.1 NHS Portsmouth – Supporting the Operational Framework.

NHS Portsmouth will ensure

- clear, robust systems of **accountability and assurance** for all aspects of integrated governance, closely linking with performance management
- robust systems to ensure sound **financial management**, effective use of resources and value for money
- sound systems of **Internal control**, supported by the Board Assurance Framework and underlying processes of risk management
- processes to ensure NHS Portsmouth complies with all current and future **national standards**, regulations and legislative requirements
- strong **governance of the commissioning framework**, including PBC
- systems and processes for **holding providers to account** for the quality of their services and commissioning for patient safety

10.7.2 Key Governance Areas

- Assurance Framework

The Assurance Framework will continue to provide focus on systems of internal control against identified strategic risks and will continue to be supported by the combined Risk Management and Assurance Strategy. The PCT has consistently maintained an 'A' score (as scored by the SHA) and will maintain this score through the revised scoring arrangements using the Head of Internal Audit's opinion.

- Complaints/Compliments

NHS Portsmouth values all comments and concerns regarding any aspect of its business. The PCT will continue to work to a robust process for dealing with and monitoring complaints it receives regarding any and all of its services including primary care.

There is an additional responsibility for the PCT to ensure that it actively identifies all complaints regarding the services or organisations from which it commissions, or partners with. The use of national or local complaints information will inform decision-making.

- Risk Management

The PCT will continue to foster and promote a risk-aware culture where risk management is recognised to have an essential and positive impact on meeting organisational objectives. The combined Risk Management and Assurance Strategy will continue to ensure engagement and individual responsibility for the identification and management of risk in all PCT business including risk identified by those organisations we commission from, and partner with.

- Business Assurance

NHS Portsmouth will continue to meet national requirements by ensuring appropriate and robust internal control mechanisms are in place and provide transparency on the decision-making and workings of the Board and its sub-committees.

- Policy Development

NHS Portsmouth will ensure that it is served by relevant, up-to-date and robust policy systems and processes along with individual policies by further reviewing and developing existing mechanisms in order to meet the needs of a the changing organisation.

- Strategy Development

NHS Portsmouth currently has a range of strategies and plans detailing governance arrangements (systems/processes for the management and accountabilities etc) of individual aspects of its business. The development of an Integrated Governance Strategy for NHS Portsmouth will combine these individual aspects to provide a greater degree of assurance and transparency.

- Regulation

NHS Portsmouth will continue to meets any and all regulation requirements for all assessments through robust governance processes.

The PCT will continue to work to achieve, monitor and report standards/targets set by regulatory bodies including the NHS Litigation Authority, Audit Commission, Department of Health etc. Whilst, at the same time, utilising national information on services and organisations from whom it commissions to assist in its decision-making.

Appendix A – Operating Plan Summary Table

1011 Initiatives										
Staying Healthy	Improve alcohol education and awareness (P) - PCT	Increase access to improved treatment and support services (P) - PCT	Tackle alcohol related crime and anti-social behaviour (P) - PCT	Breast Screening (Age Extension) (P) - NHS/SC/PCT	Bowel Cancer Screening (Age Extension) (P) - NHS/PCT	AAA Screening Programme (P) - NHS/COM/SC/PCT	Chlamydia Screening (P) - PCT	National Health Checks Programme (P) - PCT	CVD LES (P) - PCT	Physical Activity Care Pathway - Lets Get Moving (LGM) (P) - PCT
	Reduction in 4-weeksmoking quitters (P) - PCT	Reduction in smoking prevalence amongst pregnant women (P) - PCT	Increase referral of a patients with established health conditions to smoking cessation services (P) - PCT	To ensure provision of work based smoking cessation services (P) - PCT	To continue the implementation of the Action plan associated with the Smoke Free Portsmouth Strategy (P) - PCT	Fluoride Varnish - (P) - PCT	Glaucoma Locally Enhanced Service (P) - PCT	Public Health Advertising / Advertising Campaigns (P) - PCT	Under 18 conception rate (R) - PCT	
Planned Care	Procedures of Low Clinical Priority (P) - PCT/COM	18 Week Access (R) - PCT	Reduction in Elective Admissions (P) - PCT/COM	Hip Pain Pathway (P) - PCT/COM	Shoulder Injections (P) - PCT	Podiatric Surgery (P) - PCT	Treatment Centre Contract Re-Tender (R) - PCT	Readmission rates within 7 days (R) - PCT	Reducing GP referrals (P) - PCT	
Acute Care	Community Healthcare (P) - PCT/COM	Reduce non-elective admissions (P) - PCT/COM	Health and Social Care Partnership Project (P) - PCT	Reduce Paediatric Non-Elective Admissions (P) - PCT/COM	A&E - 4 Hour Target (R) - PCT/COM					
Maternity & Newborn	Reducing Caesarean Section Rates (P) - PCT/COM									
Children & Young People	Autism Waiting Times (P) - PCT									
Long Term Conditions	Managing Respiratory Conditions in Primary Care (P) - PCT/COM	Diabetes Intermediate Care (P) - PCT	Home Oxygen (P) - PCT	Implementation of a Joint Carers Strategy (P) - PCT						
End of Life	Dedicated End of Life (EOL) Commissioner (R) - PCT									
Mental Health	Memory Assessment (P) - PCT	Needle Exchange (P) - PCT								
Other	South East Hampshire Sustainability Programme (P) - COM	Health Informatics (R) - PCT	Healthy Living Pharmacy - (P) - PCT/NHS	Developing Medicines Managers (P) - PCT						

Key: Type (P) Priority
Type (R) Recovery
Level (PCT) Local
Level (COM) Sub-regional
Level (SC) Regional
Level (NHS) National

Appendix B - Glossary

3PD	Third Party Developments	HIC	High Impact Change	PAS	Patient Administration System
A&E	Accident and emergency	HIDS	Health Improvement and Development Service	PASCOM	National Audit Tool
AAA	Abdominal Aortic Aneurysm	HLC	Healthy Living Centre	PBC	Practice based commissioning
ABLE	Achieving, Bold, Leading, Engaging	HLP	Healthy Living Pharmacies	PbR	Payment by results
ACES	Aware, Committed, Equipped, Safe	HO	Home Oxygen	PCC	Portsmouth City Council
ACS	Ambulatory care sensitive	HOS	Home Oxygen Service	PCMHS	Portsmouth Community and Mental Health Services
ADHD	Attention Deficit Hyperactivity Disorder	HPA	Health Protection Agency	PCT	Primary Care Trust
AIT	Alcohol Intervention Team	HR	human resources	PDS	Personal Demographics Service
AMH	Adult mental health	HRDS	Health reform demonstration site	PEC	Professional Executive Committee
APC	Area prescribing committee	HRG	Healthcare resource group	PHT	Portsmouth Hospitals NHS Trust
ARCSCG	Adult respiratory care strategy group	IAPT	Improving access to psychological therapies	PID	Patient Identifiable Data
BBV	Blood Bourne Virus	IBA	Identification and Brief Advice	PMO	Programme management office
BME	black minority and ethnic groups	ICM	Government social research unit	PMS	Personal Medical Services
BMI	Body mass index	IDU	Injecting Drug User	PNNP	Procedures not normally purchased
BPPC	Better Payment Practice Code	IM&T	Information management and technology	PPI	Patient and public involvement
BSP	Build, Share, Procure	IMD	Index of Multiple Deprivation	PRM	Provider relationship management
CAF	Common Assessment Framework	IP	Inpatient	PROMS	Patient Reported Outcome Measures
CAMHS	Children and adolescents with mental health illness	IST	Intensive Support Team	PSA	Prostate Specific Antigen
CASH	Contraceptive and sexual health service	ISTC	Independent sector treatment centre	QAH	Queen Alexandra Hospital
CAU	Children's Assessment Unit	IT	Information technology	QIPP	Quality, Innovation, Productivity, Prevention
CCA	Civil Contingencies Act	JSNA	Joint strategic needs assessment	QOF	Quality and outcomes framework
CDTEC	Cancer Drug and Therapy Evaluation Committee	KPI	Key performance indicator	RA	Registration Authority
CEC	Clinical Executive Committee	KSF	Knowledge skills framework	RIP	Referral Incentive Model
CES	Commissioning enablement service	LAA	Local area agreement	RO	Responsible Officer
CHC	Continuing Healthcare	LAC	Looked After Children	RTT	Referral to treatment
CHC	Community Health Campus	LARC	Long acting reversible contraception	SAR	Standard Admission Ratios
CHD	Coronary heart disease	LBHU	Locally Based Hospital Unit	SAVO	Service Agreement Variation Order
CHP	Community Health Practitioners	LD	Learning Disabilities	SBOT	Short Burst Oxygen Therapy
CIAMS	Commissioner Investment and Asset Management Strategies	LES	Local enhanced service	SCAS	South Central Ambulance Service
CIP	Commissioning Cost Improvement	LGM	Let's Get Moving	SCPC	South Central Priorities Committees
CO	Childhood Obesity	LHC	Local health community	SCR	Summary care record
COIN	Community of Interest Network	LINK	Local Involvement Networks	SHA	Strategic Health Authority

COM	Collaborative operating model	LISI	Low Income Scheme Index	SHIP	Southampton, Hampshire, Isle of Wight, Portsmouth
COPD	Chronic obstructive pulmonary disease	LMC	Local Medical Council	SIF	Staff involvement forum
CQC	Care Quality Commission	LoS	Length of Stay	SIRI	Serious Incidents Requiring Investigation
CQUIN	Commissioning for quality and innovation	LPC	Local Pharmaceutical Committee	SLA	Service level agreement
CRS	Care records service	LRF	Local Resilience Forum	SMH	St Mary's hospital
CRS	Cancer Reform Strategy	LSP	Local strategic partnership	SPA	Single Point of Access
CS	Caesarean Section	LTOT	Long Term Oxygen Therapy	SPP	Safer Portsmouth Partnership
CVD	Cardiovascular disease	MATS	Memory Assessment and Treatment Service	SRE	Sex and relationships education
CYPP	Children and Young Peoples Plan	MAU	Medical Assessment Unit	SRO	Senior responsible officer
D&C	Dilatation & curettage	Max Fax	Maxillo Facial Surgery	SUHT	Southampton University Hospitals Trust
DAT	Drug Action Team	MMR	Measles mumps and rubella	SUI	Serious untoward incident
DC	Day Case	MSK	Musculoskeletal	TAT	Turn Around Time
DESMOND	Diabetes Education and Self Management for Ongoing and Newly Diagnosed	NAO	National Audit Office	T&O	Trauma and orthopaedics
DH	Department of Health	NCG	National Commissioning Group	TB	Tuberculosis
DM	Digital Mammography	NESC	NHS Education South Central	TNA	Training Needs Analysis
DM	Demand Management	NHS	National Health Service	TOM	Target Operating Model
DOH	Department of Health	NHSBSP	NHS Breast Screening Programme	VBAC	Vaginal Birth After Caesarean
DPT	Diphtheria, Polio and Tetanus	NHSSC	NHS South Central	VOP	Voice Over IP
ECIST	Emergency Care Intensive Support Team	NICE	National Institute for Clinical Excellence	VSA	Vital Sign A
ED	Emergency Department	NIMM	NHS Infrastructure Maturity Level	VSB	Vital Sign B
EET	Education, Employment and Training	NIS	National Indicator Set	VSC	Vital Sign C
ENT	Ear nose and throat	NLMS	National Learning Management System	VTE	Venous thromboembolism
EOL	End of Life	NPSA	National Patient Safety Agency	WCC	World Class Commissioning
EPS	Electronic Prescription Service	NRE	National Resilience Extranet	WiFi	Wireless Infrastructure
ESR	Electronic staff record	NRT	Nicotine Replacement Therapy	YOT	Youth Offending Team
FIMS	Financial Information Management System	NST	National Support Team		
FTE	Full Time Equivalent	NTA	National Treatment Agency		
FV	Fluoride Varnish	OCD	Obsessive Compulsive Disorder		
GMC	General Medical Council	OD	Organisational development		
GMS	General medical services	OH	Oral Health		
GP	General practitioner	OHAG	Oral Health Action Group		
GUM	Genito-urinary medicine	ONS	Office of National Statistics		
H&IOW	Hampshire and the Isle of Wight	OOH	Out of hours		
HaSP	Health and Social Care Partnership Project	OP	Outpatient		
HCAI	Health Care Associated Infection	OPD	Outpatient Department		

HHR	Hampshire health record	OPMH	Older people's mental health		
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