

Operational Plan 2009/10

31st March 2009

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1. Introduction

The PCT's Operational Plan sets out the key priorities, actions and underpinning financial plan to ensure that the PCT meets national, regional and local health expectations in 2009/10. It is one of the three main plans for the PCT and is accompanied by our:-

- 5 Year Health Strategy 2009-14 which sets out the plans for achieving our ambition to improve the health and well being of local people
- World Class Commissioning (WCC) Development Plan which sets out how we will improve and develop our knowledge, skills, behaviours and characteristics to achieve our mission of becoming a 'World Class' Commissioner

2. Strategic Context

The expectations for this local operational plan are drawn from the following main strategies which forms the PCT's agenda for 2009/10. Our challenge is to meet the national and regional health objectives whilst ensuring that the local health needs are addressed within our allocated resources.

2.1 Nationally

High quality care for all: the NHS Next Stage Review Final Report¹ was published in 2008. This sets out a new foundation for a health service that empowers staff and gives patients choice. It ensures that health care will be personalised and fair, include the most effective treatments within a safe system and help patients to stay healthy.

*The DH Operating Framework for 2009/10*² sets out four challenges for 2009/10:-

- continue to deliver on the national priorities which are confirmed to be the five national priorities established in 2008/9:-
 - improving cleanliness and reducing HCAs;
 - improving access through achievement of the 18-week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services;
 - keeping adults and children well, improving their health and reducing health inequalities within which there are four areas where particular attention is required:-
 - *cancer* – implementing the reform strategy, including meeting new targets for access to radiotherapy and ensuring that (where necessary) recovery actions to meet Improving Outcomes Guidance standards are taken
 - *stroke* - implementing the national stroke strategy

¹ *High quality care for all:* NHS Next Stage Review Final Report – 2008 – Department of Health

² Operating Framework 2009/10 - DH

- *maternity and neonatal* – ensuring that by the end of 2009 women have choices about how to access maternity care, what type of antenatal care they receive, choice in the place of birth and place of postnatal care, as well as increasing the numbers of midwives in line with regional targets
 - *children* – focus on obesity, increasing breastfeeding rates and on safeguarding children
 - improving patient experience, staff satisfaction and engagement; and
 - preparing to respond in a state of emergency, such as an outbreak of pandemic influenza
- invest the additional resources wisely in order to prepare for a tougher financial climate from 2010/11
- begin to deliver the regional visions
- develop new ways of working and leading

The Operating Framework also outlines 8 areas that PCTs will need to consider when determining local priorities with partners, many of which will be reflected in the LAA. These are:-

- alcohol
- dementia
- end of life care
- mental health
- military personnel, their dependents and veterans
- mixed sex accommodation
- people living in vulnerable circumstances
- people with learning disabilities

The DH's *Informatics Planning 2009/10*³ guidance sets out the DH's expectations in respect of informatics planning to ensure that local planning incorporates the components from the National Programme for Information Technology (NPfIT) and other solutions to underpin the delivery of the information needs of service plans.

2.2 Regionally

*The East of England Commissioning Framework for 2009/10*⁴ sets out the East of England (EoE) expectations for PCTs for 2009/10. It provides the main priorities and specifies the actions that PCT's will need to take across a range of topics, as well as outlining financial assumptions for 2009/10. The EoE's vision as set out in *Improving Lives; Saving Lives*⁵ of *We will be the best health service in England* has the following outcome based pledges:-

³ Informatics Planning 2009/10 DH 2008

⁴ East of England Commissioning Framework – 2009/10 – NHS East of England

⁵ Improving Lives; Saving Lives – 2008 - East of England Strategic Health Authority

Pledge 1	We will deliver year on year improvements in patient experience
Pledge 2	We will extend access guarantees to more of our services
Pledge 3	We will ensure GP practices improve access and become more responsive to the needs of the patients
Pledge 4	We will ensure NHS primary dental services are available locally for all who need them
Pledge 5	We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer
Pledge 6	We will make our healthcare system the safest in England
Pledge 7	We will improve the lives of those with long term conditions
Pledge 8	We will work with our partners to reduce the differences in life expectancy between the poorest 20% of our communities and the average in each PCT
Pledge 9	We will ensure healthcare is as available to marginalized groups and 'looked after' children as it is to the rest of us
Pledge 10	We will cut the number of smokers by 140,000
Pledge 11	We will halt the rise of obesity in children and then seek to reduce it

The EofE's clinical vision *Towards the best, together* provides a vision which is clinically led, evidence based and patient centered. The implementation plans provide the key actions that will need to be taken in respect of the following clinical pathway groups (aligned to Darzi) which will support the delivery of the pledges.

- Staying Healthy
- Mental Health
- Maternity and Newborn
- Children's Health
- Planned Care
- Acute Care
- Long term conditions
- End of life

2.3 Locally

The PCT's 5 year health strategy *Making healthy choices, Our Commitments to you*⁶ 2009-2014 is based on a comprehensive health needs assessment and has three main priority areas:-

- Reducing health inequalities
- Improving mental health
- Optimising opportunities for children and young people

Our commitments are:-

⁶ Making healthy choices, Our Commitments to you – 2008 - North East Essex PCT

Commitment 1	We will increase life expectancy, in particular for those people who die prematurely in our population, and improve your health and well-being
Commitment 2	We will tackle certain diseases to reduce levels of illness
Commitment 3	We will improve the health and well-being of children and young people
Commitment 4	We will provide better access and choice and care closer to home
Commitment 5	We will improve mental health services
Commitment 6	We will improve premises and make them suitable for modern healthcare
Commitment 7	We will improve patient safety and make our healthcare as safe as possible
Commitment 8	We will excel in the way that we purchase care on your behalf
Commitment 9	We are committed to the principle of patient and public involvement and to making real improvements to the patient experience

2.4 World Class Commissioning

During 2008, the PCT has been embracing the WCC assurance process which will help us to develop a more strategic and long term approach to commissioning services, with a clear focus on delivering improved health outcomes through developing in the following competencies:-

- Be recognised as the local leader of the NHS
- Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities
- Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health
- Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation
- Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
- Prioritise investment according to local needs, service requirements and the values of the NHS
- Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes
- Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
- Secure procurement skills that ensure robust and viable contracts
- Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and values for money

Our assessment has informed our WCC Development Plan to become a 'World Class' commissioner.

3. Targets

This section focuses on the targets that the PCT are set to achieve in 2009/10. The full detail of the targets, together with the associated trajectories are in the embedded documents at the end of the section.

3.1 Local Area Agreements

The PCT is a key partner in delivering the LAA2 with the Director of Public Health chairing the Community Wellbeing and Older Peoples Thematic Partnership.

PCT officers lead across Essex with the Year 6 obesity target and the mortality rate target. The PCT have regard to and are actively involved in delivery on a range of LAA2 targets including:-

LAA Reference	Area
NI 51	CAMHS
NI 56	Childhood Obesity
NI 112	Under 18 conception rates
NI 134	Emergency Bed days
NI 135	Support for carers
NI 141	Vulnerable people living independently
NI 120	Reducing mortality in most deprived quintile
LI 3.1	Mental health and employment
NI 123	Smoking prevalence
NI 39	Alcohol related admissions
N 115	Substance misuse in young people
NI 8	Adult sports
NI 57	Children sports
NI 7	Thriving third sector
NI 98	Children travelling to school
LI5.1	Access to services

3.2 Vital Signs

This is the second planning year since the vital signs were introduced. The Trust has selected the following tier 3 vital signs for focus -

Vital Sign Reference	Description
VSC15	Proportion of all deaths that occur at home
VSC20 (LAA 2 target)	Emergency bed days
VSC26 (LAA 2 target)	Hospital admissions for alcohol-related harm
VSC27	Patients with diabetes
VSC32	Patient and user reported measure of respect and dignity in their treatment
VSC34	NHS estates energy/carbon efficiency

The trajectories set in last years operational plan have been revised to ensure that all our plans reflect revised national guidance and take into account better achievement to date than predicted. Predictions of patient activity levels have been revised to reflect the most recent forecasts where relevant. The vital signs that are affected are:-

Vital Sign Reference	Description
VSA01	MRSA number of infections (trajectory for PCT reduced from 15 per annum to 13 per annum)
VSA03	Incidence of Clostridium difficile (trajectories for PCT reduced from 232 for each year to 132 in 2009-10 and 126 2010-11)
VSA05	Activity data to support 18 weeks
VSA08	Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral
VSA12	Proportion of patients waiting no more than 31 days for second or subsequent treatment (radiotherapy)
VSA14	Implementation of the stroke strategy
VSB05	Smoking prevalence among people aged 16 or over and, aged 16 or over in routine and manual groups
VSB06	Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy
VSB11	Percentage of infants breastfed at 6-8 weeks
VSB12	Effectiveness of Children and Adult Mental Health Service (CAMHS)
VSB13	Prevalence of Chlamydia (increased coverage of screening programme to 25% in 2009/10 & 35% in 2010/11)
VSB15	Self reported experience of patients and users (increased trajectory to score 80 in 2010/11)
VSB16	Public confidence in local NHS

3.3 World Class Commissioning Local Outcome Measures

The following are the WCC local outcome measures that have been selected by this PCT.

- % individuals with a Personal Health Plan compared to the number of people on the 19 LTC QOF registers
- % of Stroke Admissions given a physiotherapist assessment within 72hours

- CHD controlled cholesterol (The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the last 15 months) is 5 Mmo/l or less)
- Diabetes controlled blood sugar (The percentage of patients with diabetes who have a HbA1c of 7.5 or less)
- Managing variations in emergency admissions calculated for a suite of 19 long term conditions
- Proportion of children who complete MMR immunisations by 2nd Birthday (see VSB10)

3.4 Public Service Agreement Targets

A number of the Vital Signs contribute to delivery of Public Service Agreements (PSA). The targets this applies to are in the embedded document in this section.



P:\Plans Baseline P:\Summary of Key E:\PSA targets.doc
NEE PCT Post Refresh\Targets by 2010-11(v

4. World Class Commissioning Actions for Specific Care Groups/Services

This section brings together the actions that are required in 2009/10 to achieve the goals and targets set from the three strategic levels.

4.1 Health Inequalities

“We will implement actions outlined in the commissioning framework for health and wellbeing to reduce health inequalities in adults.

We will preferentially invest in deprived populations to reduce inequalities in childhood obesity, breast feeding, smoking in pregnancy and teenage pregnancies”

Parts of the PCT population suffer from considerable deprivation with shortened life expectancy. The PCT are committed to preferentially investing resources to address these issues. We are using an evidence based approach to deliver on “Scarf” interventions largely targeted at reducing cardiovascular disease in all ages through primary care interventions supported by additional community resources. We will invest an additional £400k in 2009/10 in targeted interventions to improve life

expectancy in specific electoral wards with resources going to primary care teams serving more than 10% of the wards population.

Key Actions in 2009/10

Specifically for the populations in the worst 20% of MSOAs we will:-

- participate in the regional lifestyle survey as well as additional local social marketing work
- improve secondary prevention of CVD in deprived wards by 15% increase in coverage of use of effective treatments in 35-74 age group. This has been piloted in the 3 lowest life expectancy MSOAs and lessons learned will inform roll out
- improve primary prevention of CVD hypertensive's under 75 with improvement in ascertainment in at risk population to 60% with pharmacological interventions as appropriate including statins and hypertensives
- improve primary prevention of CVD in hypertensive age 75 and above with target of 80% ascertainment of blood pressure
- introduce "Reach Out" project in Pier and Golf Green wards within 12 months and expand subject to evaluation funded jointly with Essex County Council
- have specific primary care based focussed interventions targeted at deprived geographic and other vulnerable populations to improve life expectancy using interventions defined in *Commissioning Framework for Health and Wellbeing*
- target CVD identification & intervention & prevention through social marketing and outreach screening
- establish the Multi Agency Centre at Clacton
- achieve a 5.5%- point increase (Tendring 10.5% to 16%; Colchester 6.5% to 12%) in number of smokers accessing the service and achieve a 2.5%- point increase (Tendring 4.8% to 7.3%; Colchester 3% to 5.5%) in quitters from deprived areas over three years from 2006-7 baseline

We will in addition address health inequalities in older people by:-

- achieving minimum flu uptake of 80% in all deprived practices
- increasing the uptake of the level of winter warmth payment
- having a system in place to ensure health need impacts on priority for "Warm Front" within 1 year by 2009/10
- invest with Essex County Council in ensuring optimal uptake of benefits. Up to 12,000 local people do not currently access all their entitled benefits

We will reduce health inequalities in children and young people through:-

- reduction in Teenage Pregnancy rates in worst areas (average 15 worst wards = 52.1/1,000) towards average (34.1/1,000) with a reduction of 5% over the next year against 2005 data baseline
- reduction over the year of the level of obesity and overweight within the 12 worst schools in each borough by 1%

- reduction of levels of smoking in pregnancy in deprived areas to at rate at least similar to the rate of reduction of the NEE average (baseline to be defined)
- increased breast feeding initiation rates from the 2007-8 Annual Health Check of 73.8% to 75.8% by 2009/10 and 6-8 week rates of 47% in 2005 survey, to a target of 50% by Q4 in 2009/10

Partnership Working

- in addition to the above we will continue to work in close partnership with Essex County Council, Colchester Borough Council and Tendring District Council to deliver LAA and LSP's with a focus on addressing broader determinants of health locally. The longer term gains to improve health secured through partnership will compliment the shorter term interventions previously stated
- we will specifically focus on Jaywick including the 3rd most deprived LSOA nationally working with Tendring District Council, Essex County Council and GO East as part of the Jaywick Strategy Group

4.2 Children's Services

“We will ensure that all children and families have access to high quality universal services.

We will ensure that children identified with additional needs are safeguarded and supported by seamless care pathways”

We will work together with our partners through the Essex Children's Trust Approach to ensure that services are designed for children and take account of their needs. Our priorities in the next year are to ensure all children and their families can access a high quality universal service from 0-19, with children identified as having additional needs being safeguarded and supported through seamless care pathways. In particular we will:-

Key Actions in 2009/10

- continue to work with partners to strengthen the Children and Young People's Strategic Partnership and develop the joint commissioning framework
- implement 'You're Welcome' standards to ensure young people's views inform future planning and commissioning
- implement the Child Health Promotion Programme (CHPP) to support the delivery of:-
 - an increase in the percentage of infants with breastfeeding being initiated at birth and at six to eight weeks. We are currently completing

our local market research (report due end of March 2009). The report will include a 2 year action plan on how and which areas will need to be targeted and this may include a mix of deprived and less deprived areas.

- a reduction in obesity among primary school age children - actively promote the Change4Life Programme to tackle childhood obesity with LAs and regional partners. It will include logos on future obesity programme; leaflets and actively distributing the programme literature at events and through the Healthy School Network
- an increase in the completion of immunisation programmes (see Immunization and Vaccination section 4.4.5)
- earlier identification and referral of children and families requiring enhanced services, for example, the planned perinatal mental health pathway

To achieve this we shall review the current universal prevention and early intervention services to identify the changes required to fully implement the CHPP and:-

- work with providers and stakeholders to develop a service specification for the CHPP including monitoring arrangements
 - ensure that workforce plans include the necessary competencies for staff to deliver both the universal and enhanced elements of the programme
 - promote the leadership role of health visitors in delivering the CHPP together with multi-agency partners through Children's Centres and general practice
 - commission additional services as identified through the local joint strategic needs assessment and family health needs assessments to tackle health inequalities
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- undertake a review of the PCT safeguarding arrangements and implement the recommendations
 - improve the experience of services for children with disability and long term conditions by implementing comprehensive care pathways
 - reduce the numbers of children and young people attending A&E and those readmitted to hospital
 - increase the range of short break provision for children with complex needs in accordance with Aiming High for Disabled Children
 - improve support for children requiring palliative and end of life care by increasing service to 7 day working
 - strengthen the CAMH service by contributing to the Essex review and implementing plans to enhance the Tier 1 and 2 provisions locally
 - increase in Breastfeeding prevalence by having dedicated breastfeeding resources for co-ordination including breastfeeding peer supporters to support the agenda and ensure training for all relevant staff including primary care
 - develop an extensive social marketing approach to better understand barriers and facilitators to breastfeeding

4.3 Mental Health

“We will improve Children’s and Adolescent Mental Health Services enhancing provisions locally

We will improve access to services, increase choice and provide care closer to home through improvements in the mental health services”

Mental Health services are a key priority for the PCT with improvements planned for the Children and Adolescents, Adults and Older People services.

January 2009 proved a land mark in Primary Care mental health as the new local Improving Access Psychological Therapies (IAPT) service called *Health in Mind* commenced after a rigorous procurement process in 2008 fulfilling our 08/09 operational plan target. This provides a step care model for access to therapy in Primary Care for people with mild to moderate depression and anxiety.

Key Actions in 2009/10

- improving Access to Psychological Therapies (IAPT):
 - implementation of IAPT through the newly commissioned Health in Mind service led by Rethink commencing fully in April 2009
 - monitor the new service as it is implemented following NICE and national guidelines ensuring that a quality service is provided and the KPI targets are achieved
- ensure implementation of legislation: MHA 2005, Mental Capacity Act, Deprivation of Liberties safeguarding:
 - PCT has local lead for DoL – in post
 - Work with LA and PCTs to produce regional policies - ongoing
 - Identify and train BIA assessors – ongoing
- Dementia Services. The national Dementia Strategy is due to be published shortly and we will work with our partners to plan and implement recommendations.

Locally we will improve the memory assessment services through a local initiative Pilot scheme due to run for 12 months due to commence July 2009.

The PCT is working with the Local Authority to implement the proposals of the *Pan Essex Strategy Reviewing and re-positioning older adult mental health services*. We will work with the key stakeholders to agree the commissioning plans for dementia services, to be delivered in 2010/11 or in year, subject to availability of reserves to be utilised for this purpose.

- deliver improvements in equitable access - the *Delivering race equality in mental health care action plan* will be used to improve direct clinical care through:
 - use of e training for Equality and Diversity for clinical staff
 - data collection arranged with providers
 - equality and diversity in contracts

These will be implemented in line with the host commissioner's time table in negotiation with service provider.

- improve Children's and Adolescent Mental Health Services (CAMHS) enhancing provisions locally:
 - increase CAMHS staff (18 WTE in North East Essex)
 - scope number of 17 year-olds accessing service
 - commission integrated service for children with severe Learning Disability
 - introduce Brief Child and Family Phone Interview

These will be implemented in line with the host commissioner's time table in negotiation with service provider.

Locally we will:

- Work in conjunction with the Local Authority to increase local TASC teams. Finances agreed and service currently being implemented.

- deliver recovery orientated services

The recovery-based approach encourages self-determination and self-management. In North East Essex the introduction of the IAPT service offers people who are suffering with mild to moderate mental health problems of anxiety, depression and mild compulsive disorders the opportunity to use self-determination and self-management. They are offered choices of treatment from self help, cCBT, counseling and individual CBT. They are also being given the opportunity to return to work, gain training or gain employment which is also a vital component of recovery.

In North East Essex, the PCT is working in conjunction with Mid Essex PCT through the host commissioning arrangements to ensure the local mental health service provider, North Essex Partnership Foundation Trust (NEPFT) is incorporating the Principles of Recovery as laid out in the Sainsbury's Centre for Mental Health report '*Making Recovery a Reality*'. We will work together with regional initiatives to develop recovery outcome measures.

Key Performance Indicators within the contract specify that CRHT should supply the number of urgent assessments (within 4 hours) and the number of non-urgent assessments (within 24 working hours). The 4 hour target is being met.

- introduce work to achieve the national target to reduce waiting times from referral to treatment to 18 week by utilizing maximum waiting times trajectories agreed with the SHA. At a regional level we will work with our partners to:
 - agree benchmarking of data capture
 - agree timetable of implementation
 - draw up plans to show how compliance with target will be achieved
 - ensure commissioners discuss local interpretation during contract negotiations

Locally we will:

- review waiting times for CAMHS through data collection and monitoring effect of increased workforce to meet 18 week target
 - review waiting times for psychotherapy and complex psychotherapy through data collection. Monitor effect of introduction of IAPT service
- work with local Mental Health provider (NEPFT) on specific projects to improve local provision of services, the specific projects will be determined through the Local Delivery Plan prioritization process (schemes will be added if approved)
 - develop comprehensive, locality wide Peri-Natal Mental Health Service
 - support people with mental ill health with primary prevention of CVD working with NEPFT
 - support people with mild-moderate mental ill health to gain or retain employment or meaningful activity (from 2009)
 - establish plans to ensure that by April 2010 no 16-17 year olds are treated on adult psychiatric wards unless such an admission is in accordance with their needs.

The local Mental Health service provider, NEPFT have an operational policy in place '*Emergency admission of young people under 17 to adult in-patient units*' and a '*Transition Protocol Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS)*' which states that all young people aged 17 and above (regardless of educational status) will be treated by adult services, except in exceptional circumstances. The Transition Protocol expires in April 2010. Instructions for the full assessment of the young persons needs, their capacity to consent, their wishes, their management and safeguarding are incorporated in the policy to ensure admission in accordance with their needs.

- maintain the number of Early Intervention cases and demonstrate how the length of care provided to individuals will be considered

The yearly target of 36 new cases has been met in each of the past two years and the Early Intervention (EI) team are on target to meet the accumulative target of 108 in the first three years. The anticipated length of care for each individual is three years but is dependant on the need of the individual and will vary accordingly. Early discharge is frequently due to people moving away and

extended treatment to 5 years has been considered for some cases dependant on the individual's need.

4.4 Staying Healthy

4.4.1 Reduce number of Smokers

“We will achieve higher levels of smoking quitters moving towards the best nationally”

Key Actions in 2009/10

- provide dedicated community-based clinics and improved marketing of existing services to meet additional target
- introduce new initiatives to reduce smoking during pregnancy following social marketing research (to be completed in March 2009) and evaluation of voucher incentive scheme – up to £100 of food vouchers will be made available to a small pilot group of pregnant women in January - March 2009 to encourage them to quit smoking. We aim to achieve a 5% reduction of the 20.73% baseline in 2007/8 which includes a reduction of 1.5% in 2008/9
- develop subject to funding agreement
 - extra interventions in 20% most deprived MSOAs
 - information collation from GPs re: prevalence
 - specialist smoking champions in local communities
 - social marketing to reduce uptake
- deliver a four-week quitter target for 2009/10: 2,662 four-week quitters (50 per 1,000 smokers, compared with SHA target of 40.7 per 1,000 smokers). We will have 60% (1,587) of our quitters coming from the 16 MSOAs with the highest smoking prevalence (25% and over). This includes the additional stretched target of 395 quitters

Geographical areas with highest estimated prevalence will have higher targets than other areas for numbers of smokers accessing service and numbers quitting.

Existing provider services are performing well and have good working relationships with key partner organisations, e.g. local authorities, which enhances service delivery and facilitates targeting of priority groups/communities. We would therefore not wish to procure this service elsewhere. The Contract with Provider Services includes the recording of postcode and occupational codes. Marginalised groups have also been clearly stated including people with learning difficulties, those with mental health problems, the unemployed and young disaffected people.

- Plans to promote health at work through workplace health initiatives to be launched as part of Health Trainers. We currently support staff at the PCT,

CBC & TDC on smoking cessation and physical activity

- other ongoing services and initiatives include:-
 - stop smoking services in wide range of settings e.g. town centre clinics; primary care, pharmacies, community centres, workplaces
 - systems for contacting “lost to follow up” clients
 - education and peer led activities in schools
 - specialist smoking in pregnancy advisers who work with maternity services dedicating their time in supporting pregnant women who
 - targeted face-to-face marketing campaigns e.g. in supermarkets
 - Stop before the Op – scheme aimed at supporting smokers quit the habit before surgery
 - regularly reviewing all data collection methodology to validate performance

4.4.2 Alcohol

“We will introduce a range of services to reduce the level of harm caused by alcohol misuse”

We will work with partners to deliver the LAA targets for admissions due to alcohol through:-

- pilot of LES in primary care for identification and brief advice (IBA) for hazardous and harmful drinkers (pilot begins 2008-09, roll-out to all practices by April 2010).
- extend IBA to health trainers, pharmacists and other non-NHS potential service providers from 2009-10
- use social marketing to increase awareness of the risks of excess consumption of alcohol and the links between alcohol and poor sexual health
- support the establishment and continued service provision through the Crime and Disorder partnership of the Colchester SOS bus (from Oct 08)
- have schools liaison workers (1 per locality) from 2009 to address the increase in consumption of alcohol by young people and the age at which young people start to drink alcohol. PRG funding sought for majority of cost, PCT contributing.
- establish alcohol pathway in line with DoH commissioning guidelines, identifying areas for further investment especially in relation to tiers 3 and 4, and appropriate outcome measures for services in tiers 2 and 3 (from 2009, additional revenue required from 2010 to be determined)
- commission extended Brief Interventions service in line with alcohol commissioning guidelines

4.4.3. Halt Rise in Obesity

“We will continue to develop a range of services to address obesity in all age groups”

Key Actions in 2009/10

- **Continue with the specific adult programmes and interventions which are already underway and include:-**
 - Shape – up weight management courses delivered across the PCT locality (8 per year) for people with BMI over 28
 - Weight Watcher voucher schemes available through all GP practices (818 per year)
 - dedicated telephone contact point for weight management services
 - exercise referral schemes (GP ERS) and walking for Health programmes available in the PCT locality - 8 led walks per week
 - Health Trainers working within communities and workplaces across the district promoting Healthy Lifestyles and advice. (Commence April 2009)
 - opportunistic health checks held within the community (12 per year)

- **Continue with the specific child and family interventions that are already currently underway and include:-**
 - delivery of MEND programme (7 programmes per year)
 - Child Health Improvement sessions (5 sessions per week)
 - healthy eating and physical activity road shows (34 per year)
 - Take Ten (40 schools per year – 1,600 places)
 - Healthy Schools (124 schools involved out 129, 67% achieved validation)
 - community rugby scheme (40 schools per year)
 - Body care programme (twenty schools per year – 800 places)
 - Healthy Together programme (4 programmes per year – 80 places)

- **Provide additional interventions to achieve target of halting the rise in obesity with additional resource requirements:-**
 - community nutritionists to work with local partner agencies and schools
 - development of food cooperatives and networks across the PCT including the appointment of a community chef
 - training of local volunteers for community development including cookery classes, targeting areas of need
 - extend Child Health Improvement sessions (CHIMPS) focusing on areas with high prevalence of overweight children – 720 places

- actively promote the Change4Life Programme to tackle childhood obesity with LA and regional partners. It will include logos on future obesity programme; leaflets and actively distributing the programme literature at events and through the Healthy School Network
- support the local authorities with free swimming for all over 60's and under 16's in the locality
- expand MEND and introduce mini-MEND – total 84 places
- expand Shape up and Weight Watcher voucher scheme
- market and improve the uptake of existing schemes, including GPERS.
- develop dedicated awareness and education campaign for healthy eating and physical activity in workplaces
- moreover, we plan to improve our child height and weight measurements in schools to monitor the prevalence of overweight and obese children - we will aim to collate 86% of Year 6 (16.1% prevalence) and 89% of children in Reception Year (7.3% prevalence) during 2009.

4.4.4 Sexual Health and Chlamydia Screening

“We will develop a robust and sustainable screening programme for Chlamydia in North East Essex”

“GUM clinic consistently meeting access targets – 100% offered an appointment within 48 hours and 95% seen within that time”

We will improve the uptake of Chlamydia screening with a target of 11,765 tests for 2009/10: representing 25% of target population (rising to 35% 2010-11). Working towards having at least 75% screenings undertaken as part of core contraceptive services by 2012.

Key Actions for 2009/10

- continue with the recent developments that include:-
 - improved access across PCT area to contraception and other services from range of providers and venues e.g. Chlamydia testing, free pregnancy testing kits & free emergency contraception for under 18s through pharmacies; Barrier Protection Scheme with GPs; C-Card; dedicated young people's clinics; school drop-in clinics; condoms on SOS bus
 - locally agreed targets and joint working with local authority partners to establish and promote accessible services in wards with the highest teenage pregnancy prevalence

- close working with schools e.g.support to improve SRE policy; development and implementation of SRE schemes; (e.g. APAUSE, SENSE); School Road Shows
 - improved access to terminations with providers of abortion services to provide contraception advice and services after an abortion has taken place as per the standard contract for 2009/10
 - various information resources for schools & partner agencies
- implement the following service developments:-
- call-recall service to ensure high level of Chlamydia screening through existing family planning and sexual health clinics across all settings. We will also increase local capacity to undertake more 'street and evening' activities
 - improve access to LARC among young people as well as free access to condoms
 - develop and sustain local training the trainers programme and sexual health awareness training for all relevant agencies front-line staff, including support for teenage mothers:-
 - new local information and improved signposting services, including dedicated training for partner agencies' front-line staff
 - research and plan an integrated sexual health service (for development 2010-11)
 - developing school nursing team and role in service delivery
 - school-based annual Chlamydia screening
 - increased provision enabling 100% access to terminations before 10 weeks (for those presenting on time) including counselling support
 - expand and sustain current school road shows from sexual health perspective. This would increase capacity of staff on road show programme to have more in depth input around STI's, contraception and
 - expand support services for teenage mothers to improve life opportunities and reduce consequential health inequalities.

4.4.5 Immunisations and Vaccinations

“We will ensure high levels of vaccine uptake through offering a convenient service informed by user views”

Currently our:-

- coverage is slightly lower than anticipated for pre school vaccinations
- the uptake of the flu vaccination for over 65 years old - 73%; under 65 years in at-risk group – 46.9%. This is an increase in the at risk group since last year

- nearly 100% of practice nurses & school nurses attended for HPV immunisation training in the autumn of 2008
- the close working with Essex County Council has led to a Mobile Immunisation Unit being jointly funded to target areas of low uptake of the MMR vaccine
- HPV vaccination programme is offered to all 12 – 13 year olds & 17 – 18 year olds
- parents are encouraged to have their children vaccinated with the MMR
- community engagement work has identified areas of concerns expressed by parents of pre-school children

Key Actions for 2009/10

- achieve an MMR immunization rate for 2009/10 of 90% with 95% in 2010/11
- ensure accuracy of immunisation data on the Child Health System
- review the commissioning process for the provision of immunisations
- create a rolling programme of training to ensure all health care practitioners involved in immunisations
- raise the importance of immunisations with healthcare workers & people who work with children
- commence an ongoing process of community involvement
- increase patients, parents & employees access to the immunisation service
- ensure system is user focused with easy access to appointments, advice and support by appropriately trained professionals

4.4.6 Screening

“We will introduce bowel cancer and abdominal aortic aneurysm screening”

Currently:-

- coverage of cervical screening is 80.6% (Standard 80%). We are the only PCT in Essex meeting the target.
- 96.4% of women are offered an appointment for breast screening within 36 months (target 90%).
- 82.7% of women attend for breast screening (target 80%)
- 96% of babies are offered newborn bloodspot screening (target 100%)
- 96% of babies are offered newborn hearing screening (target 99%)
- full implementation of liquid based cytology, & all sample takers now have unique identifiable number to enable audit
- bowel screening commenced in March 2008, & offered to 60 – 69 year olds men & women
- combined screening for Down’s Syndrome implemented & offered to all ante-natal women

- successful QA visits for newborn hearing, cervical & breast screening
- business case submitted to the SHA regarding the Abdominal Aortic Aneurysm Screening Programme

Key Actions for 2009/10

- implementation of the abdominal aortic aneurysm programme for all men aged 65 years old
- continue the roll-out of the bowel cancer screening programme
- develop robust monitoring of all screening programmes to ensure a high quality service is offered & maintained
- increase patient access to screening services through signposting so they can easily access screening
- increase uptake of cervical screening, especially non attenders & 25 – 34 year olds

4.4.7 Marginalised Groups

“We will reduce the risk of heart disease in people with learning disabilities”

Our targets:-

- we will reduce the risk of CVD for LD clients through better management and assessment in primary care with 90% being assessed by end 2009/10
- increased support and direction to carers to enable them to support their learning disability clients in behaviour changed to improve their lifestyles

Key Actions for 2009/10

- continue with existing initiative of primary prevention of CVD LES for adults with Learning Disability. We will aim to have assessed 90% of people known to have learning disabilities by 2010
- supporting carers of adults with learning disabilities with primary prevention of CVD

Homeless people:

“We will ensure that people who are homeless have access to basis healthcare services, including health promotion, where they wish to access these”

Key Actions in 2009/10

- develop additional services at Beacon House clinic for homeless people in Colchester to include Outreach to the soup run, smoking cessation advice and day-bed rest project (aimed at reducing admissions), provide flu and pneumococcal vaccinations, all operating from 2008.
- by March 2009 have evaluated the need for a primary care clinic for homeless people in Clacton and planned for service if appropriate
- from 2009 provide specific dental service and dental health promotion for homeless people
- secure specific GP support to Beacon House for Colchester area maximising access to appropriate and specialist support

Substance Misuse

“We will improve access to treatment for people who misuse drugs and alcohol and seek to retain people in treatment for improved outcomes”

Key Actions in 2009/10

- continue funding clinical staff to support needle exchange provision within Open Road bases in Colchester and Clacton
- continue funding extension of welfare support to 2 practices on a regular basis and 6 practices on a peripatetic basis across NE Essex providing Shared Care following the pilot in one practice
- improve access to blood borne virus screening for at-risk groups, determine need for outreach Hepatitis C provision
- assess current pathway for opiate users, identify bottlenecks in current provision of shared care and specialist services, and identify potential for increased provision within primary care (assessment to be completed during 2008-9)
- provide specific dental provision and dental health promotion for substance misusers
- engage with Essex DAAT in treatment redesign process and ensure additional PCT resources focus on same outcomes

Looked After Children (LAC)

“We will improve the health and well-being of Looked After Children with dedicated support”

Key Actions in 2009/10

- recruit Designated Doctor and additional administrative support to increase LAC health team
- work to improve uptake of statutory health assessments from 74% (05/08) to 80% (09/10) with dedicated health advisor for LAC
- pilot targeted dental provision in Colchester to improve access to services & dental health promotion for carers (roll-out to Tendring tbc)
- undertake healthy care programme audit Sept 2008 to identify opportunities for improving access to health services - focused for 14-19 yr olds including incentives

4.5. Maternity and Newborn

“We will open a Midwife Led Birthing Unit in Colchester

We will increase the staffing levels in maternity and neonatal services to improve care for women and babies”

Our priorities in the next year are to increase the staffing of the maternity and neonatal services to improve the care of women and babies and to open the midwife led birthing unit at Colchester Hospital University Foundation trust.

Key Actions in 2009/10

- ensure ongoing contribution and involvement in the EoE Neonatal group, continuing to confirm roles and responsibilities in establishment of units in NEE
- outline steps to offer pre-conception care to women with pre-existing health problems and lifestyle issues
- consult on the current options for giving birth including the coastal unit in 2009/10
- ensure that by the end of 2009 women have choices about how to access maternity care, what type of antenatal care they receive, and the place of birth and postnatal care
- outline steps being taken to implement Maternity Matters, including direct access to midwife care, choice of type of antenatal care they receive and the place of birth and postnatal care, and progress towards providing 1:1

midwifery care in established labour. The first step will be to agree the local commissioning specification in relation to Maternity Matters by September 2009. Specifically therefore the Maternity Matters deliverables will be:-

- all women will have the choice of direct access to maternity services through their Midwife or GP – this is in the service specification and will be achieved through increased publicity and promotion
 - all women will have a choice of antenatal care delivered by a Midwife or GP
 - all women will have choice of place of birth
 - one to one midwifery care will increase by 1/3rd through increase of investment to fund an additional 8 wte midwives.
 - Increase choice of place of postnatal care from current choice of home, antenatal clinic in health centres and GP surgeries and the Children's Centre in Tendring to also include Children's Centres in Colchester for 2010-11
- review workforce commissioning plans to ensure 1:1 midwifery care in established labour, as well as increasing the numbers of midwives in line with regional targets – numbers will be determined as part of agreeing the commissioning specification
 - ensure that the obstetric unit remains with the newly established co-located Midwife led birthing unit located at Colchester Hospital University NHS Foundation Trust, and that this unit is operational and its use monitored
 - confirm appointment of consultant presence on labour ward to 60 hours per week by September 2010

4.6 Acute Care

“We will review Clacton and Harwich Minor Injury Units with a view to deciding whether they can be turned into Urgent Care Centres in the future”

We will deliver new Admission Avoidance Schemes with another significant reduction in admissions to acute hospitals”

We will continue to implement the urgent care strategy to develop high quality services closer to home delivered at the point of need. This strategy provides value for money through reduced costs and less acute hospital admissions and excess bed days.

Key Actions in 2009/10

- review of Harwich and Clacton Minor Injury Services with a view to development of a single point of access for GP urgent referrals by March 2010
- developing Urgent Care Centres at these two sites by March 2010

- Supporting the development of 24/7 primary percutaneous coronary intervention (PPCI) model of service for all Essex patients
- implementation of admission avoidance projects, as summarised below

The Admission Avoidance Projects

Projects	Specialty
LTC – Cardiac	
Rehabilitation	Cardiology
LTC – Pulmonary	
COPD further developments	Respiratory Med
Rehabilitation	Respiratory Med
LTC – Other	
Telecare	COTE
Health Inequalities	
Tending Health Centre and other initiatives	General Medicine and COTE
Smoking Cessation schemes	Respiratory Med
Obesity Schemes	General Medicine
Alcohol Schemes	General Medicine
GP Care Advisors	General Medicine and COTE
Urgent Care / AA schemes	
Intermediate Care (review with LA)	General Medicine
Direct Admissions to Clacton Hospital	COTE
Community Matrons	Med/Eld
Falls Prevention - service expansion	Med/Eld
Out of Hours District Nursing	Med/Eld
Single point of access for end of life care – scoping stage	COTE
North Colchester Health Centre (Jun 09)	A&E

Admissions avoidance schemes will deliver a further 334 spells avoided in 2009/10, resulting in disinvestment in acute sector and marginal extra investment in intermediate and primary services.

The PCT supports the proposal by the Essex Cancer & Stroke Network for a twenty four hour seven day a week primary percutaneous coronary intervention (PPCI) model of service for all Essex patients. The PCT will ensure that the agreed model of care is implemented by the agreed timeline once notification is received. The PCT will work with the Network and ambulance service to develop patient pathways in order to deliver PPCI. The PCT will measure the impact of PPCI on the ambulance service in order to address financial implications.

The PCT will review Urgent Care services, and determine the need to develop urgent care centres within the current minor injury/illness led units within the coastal areas, and to develop a single point of access to urgent care services.

The urgent care review will involve determining and scoping the development of Urgent Care Centre's within our coastal hospitals in Clacton and Harwich. The health needs of the population and current urgent care referrals will determine what the

needs of the local population are; this will include the need to enhance current provision to provide health promotion and other targeted services.

The Urgent Care Centre's will provide a whole systems approach to managing urgent care avoiding the need for patients to access secondary care facilities and admission avoidance. Care will be brought closer to home, available to all at a time and place of their choice. The Urgent Care Centers will support other services to achieve their national standards such as ambulance response times and turnaround, advanced access primary care targets and will contribute to a reduction in winter pressures to the secondary care services such as the Emergency Department.

The single point of access will provide an opportunity to further develop care pathways that ensure that patients are seen in the right time at the right place by the best person able to meet their individual needs. It will ensure admission avoidance is co-coordinated thus improving effectiveness and efficiency of community teams by being able to refer direct to SPA to co-ordinate care packages essential for the patient to receive care in a timely manner. The SPA will provide high quality information to the PCT which will identify any gaps in current service provision, which will enable evidence, based future commissioning intentions to be prioritized. By developing urgent care, the priority will be to provide high quality care closer to home utilising existing services to their full potential that will enable services to meet targets in relation to urgent care, e.g. 4 hr A and E, and ambulance turnaround times.

We will also scope the feasibility to provision of a separate area and service for children within the Urgent Care Centre to address their particular needs with access to appropriately trained pediatric staff to deliver high quality safe care within an urgent care setting.

4.7 Planned Care

“We will deliver new Demand Management Schemes with another significant reduction in outpatient referrals to acute hospitals

We will have a maximum waiting time of 18 weeks for all services from referral to treatment by March 2010”

The PCT will develop and sign off a PbC Service Improvement Plan which will ensure NEE PBC is;

- Fully engaged in the Practice Based Commissioning network
- PBC is reinvigorated and clinical engagement is secured across all practices including broadening the range to other clinicians
- Part of the Practice Based Commissioning Framework

Key Actions in 2009/10

Improving waiting times and access

From December 2008, Colchester Hospital achieved the minimum targets for admitted (90%) and non-admitted (95%) PTLs that no one should wait more than 18 weeks from the time they were referred to their hospital treatment.

An audit of all patients in the backlog cohort has been undertaken which established some patients had breached 18 weeks due to systems/service failures. As a result the PCT will work with CHUFT to put in place systems to monitor that the standards are achieved across all service specialties along with a process to ensure that all patients who fall within the 0.5 week churn numbers are not waiting for any other reason than choice or clinical exception.

In collaboration with our PBC colleagues, the PCT will refresh and further develop its current diagnostics strategy to extend access and provision in primary and community settings and improvements in direct access to diagnostics, as well as pathology and radiology.

The demand management schemes in 2009/10 will be

Projects	Specialty
LTC – Cardiac	
24/7 ECG Service	Cardiology
Cardiology Tier 2 Service	Cardiology
LTC – Renal	
Chronic Kidney Disease LES	Nephrology
LTC – Pulmonary	
COPD Identification (Spirometry LES)	Respiratory Med
CVD LES	Respiratory Med
LTC – Diabetes	
Diabetes Care Pathways	Diabetes
Insulin Initiation within Primary Care	Diabetes
LTC – Other	
DVT Pilot	Heam non cons
Tier 2 schemes	
Community Pain Service	Pain Management
Digital Photography	Dermatology
Dermatology Services / Community Skin Cancer	Dermatology
Doppler and Vascular Assessment (LES)	General Surgery
Minor Surgery Training & Clinical Support	General Surgery
ENT GPwSI	ENT
Gynaecology GPwSI	Gynaecology
Gastroenterology - IBD nurse	Gastroenterology
Urology Pathways	Urology
Musculo-Skeletal Services - Manual Therapies	Orthopaedics, Pain Management, Rheumatology
Other	

Implementation of Diagnostics Strategy e.g. Ultrasound and Plain Film X-Ray access	Outpatients
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Demand Management schemes will deliver a further 7,011 outpatient attendance and 87 spells avoided in 2009/10, resulting in disinvestment in acute sector and marginal extra investment in intermediate and primary services. There will be a 3% shift in outpatient setting from acute to primary/community care during 2009/10.

We will ensure that we have a maximum waiting time of 18 weeks from Referral to Treatment for all services by end March 2010.

Community Waits

The PCT will commission services to provide high quality, timely access to care. Waits for all community services will be reduced to 18 weeks from referral to treatment by 2010/11. During 2009/10 the PCT will work with local providers to ensure that services are able to deliver this commitment and develop and implement local appropriate solutions to ensure that accurate and timely reporting is available.

The PCT will encourage providers to incorporate new service models including self-referral to improve patient outcomes and satisfaction and therefore reduce demand elsewhere in the system. The PCT will consider alternative models for AHP and community services to improve health outcomes and reduce health inequalities.

Each service will be required to record the maximum waiting time for treatment and will have agreed trajectories during the year to work towards. Monitoring of the performance will be through the contract monitoring process. Referral to treatment data will be mandatory.

Services identified as key challenges in delivering the new standards are:-

- Orthodontics
- Orthotics/wheelchair services
- Clinical psychology
- Complex psychotherapy
- Child and adolescent mental health services

4.8 Military Personnel, Their Dependents and Veterans

“We will improve family planning and sexual health services available offering service close to the Garrison

We will implement a Long Term Condition protocol for wounded warriors with prosthetics retained in service”

Local primary care services should not disadvantage military personnel, their dependents and veterans in terms of their ability to access timely health care or dental services. The PCT has developed an Armed Forces and Families Strategy which has been agreed and signed by two Colonels at the Colchester Garrison. This strategy aims to maintain a fit and healthy service population by means of effective health promotion, injury prevention policies and provision of prompt and effective diagnosis, treatment and rehabilitation.

By consolidating services available at the Garrison Medical Centre, there shall be improved access offered to patients accompanied by a greater health service programme.

Through communication with the Regional Clinical Director and clinical healthcare providers at the Medical Reception station, supported by public health, the criteria for delivery shall be structured to ensure services commissioned are customised to reach the needs of the Armed forces and their dependants in the most effective way year on year.

Key Actions in 2009/10

- ensure that military personnel and their dependants are provided with information on the availability of local health services and how they can be accessed
- provision of a Genito-Urinary Clinic within the Garrison Medical Centre, which offers Chlamydia screening, sexual health education and advice, cervical screening, a family planning clinic and a weekly community midwifery clinic
- implementation of a Long Term Condition (LTC) protocol for wounded warriors with prosthetics retained in service
- review current access to NHS dental services for military personnel, their dependents and veterans and develop plans to meet any shortfall in provision

4.9. GP Access

“We will open the new North Colchester Health Centre in June 2009

We will ensure up to two thirds of GP Practices offer extended hours by March 2010”

Improving GP access continues to be a key national and SHA priority as set out in the 2009/10 EoE Commissioning Framework.

The revised National GP Patient Access Survey which will be undertaken quarterly in 2009/10 will allow us to regularly review and identify where targeted action is needed with specific practices to improve their performance.

An Access action plan will be produced for 2009/10 which sets out these actions in more detail. Practices who fall below the average for the EoE SHA in the national patient access survey will be supported to develop an action plan to improve access and responsiveness to patient needs; for example: increased use of internet appointment bookings and/or email consultations. If necessary external support will be commissioned to work with these practices; if practices fail to respond to offers or support and/or demonstrate a year on year improvement in patient satisfaction through the national surveys the PCT will consider taking action through existing contractual routes for improving performance.

The PCT will continue to commission a LES for extended hours and Access LES to ensure continuous improvement by all practices in improving access to primary care. The PCT will invest £1.7M in improving access to primary care through these LES in 2009/10.

Currently 63% of NE Essex GP practices provide extended hours to their patients; we will aim to increase this to 70% by March 2010.

The PCT has now signed an APMS contact with Harmoni to provide an Equitable Access Health Centre from the Colchester Primary Care Centre from June 2009; this will be available from 7am to 10pm 7 days a week and will also incorporate the existing nurse led Walk In Centre service. The OOH service will also be relocated to the PCC during 2009.

The PCT will review the impact of the Health Centre on existing primary care services and as part of the work on developing its 5 year Primary Care Strategy will consider whether additional capacity needs to be commissioned within Tendring to meet the needs of local people.

During 2009/10 we will market test the two remaining PCT managed practices, Frinton Road and Epping Close, in Tendring and expect to have appointed providers under an APMS contract from April 2010.

The PCT is currently reviewing the range of enhanced services commissioned from primary care and will be extending the existing LES for the homeless during 2009/10 to ensure that these enhanced services are available across NE Essex.

4.10 Dentistry

***“We will provide additional capacity in dental practices to ensure we meet the current needs of patients, including extended hours provision*”**

We will ensure we meet the 18 week pathway for orthodontics treatment in primary care

The increase in dental ring fenced funding will not be confirmed until Spring 2009 and will be determined by 2008/09 increase in activity.

The outcome of the Dental Health Needs Assessment (due Spring 09) and the 08/09 Dental Access Survey will determine 2009/10 and 2010/11 dental commissioning and investment decisions for adults and children in areas in NEE currently experiencing poor access provision. It is already apparent that there is an identified lack of dental capacity in the Tendring area and addressing this need will be a priority in 09/10.

The commissioning of an additional 53,007 UDAs with a spend of £1,375,906 in 08/09 to increase access is expected to be recurrent in 09/10 to maintain patient access. To increase patient access year on year it is anticipated that an additional 10,000 UDAs will need to be commissioned across NEE to continue providing a service for those patients identified through the 08/09 dental initiatives.

The PCT will commission extended hours provision in dental practices to improve patient access and provide equitable access for those patients that find it hard to access dental services during normal opening hours. This was an issue highlighted in the recent MORI survey commissioned by the PCT to better understand access issues and potential barriers to access for people in NE Essex.

Following the 2008/09 Orthodontics service review and 18 week pilot scheme, additional service provision will be commissioned to meet the 18 week pathway. The PCT provided 200 new case starts from 700 assessments in 08/09 and the remaining case starts/reviews and/or treatment will continue and be completed in 09/10 to meet the 18 week target. The 4750 UOAs currently being commissioned, at a cost of £273,125 for 08/09 will continue in 09/10 with a possible increase following waiting list reviews during 08/09.

The PCT will scope and provide dental access, in partnership with public health colleagues and other stakeholders, for hard to reach groups including the homeless & 'stop smoking' for pregnant mothers. Commissioning considerations will include the provision of a mobile dental unit to give the homeless opportunity and access to dental services.

During 2009/10 the PCT will review and scope the current services within the Salaried Dental Service and a new service specification will be developed to commission and expand current service provision and provide greater access to special needs patients in 2010/11.

In 08/09 the PCT commissioned a new domiciliary service in Colchester. The scoping and provision of a fit for purpose domiciliary service in Tendring will take place in 09/10.

The PCT will increase prevention activity and oral health education awareness by commissioning screening campaigns in local schools.

The PCT will provide dental access for patients who have not seen a dentist within 24 months and will sustain the 2008/09 initiative to identify and provide for those patients year on year.

4.11 Long Term Conditions

“We will pilot personal health plans for Chronic Obstructive Airways disease, Coronary heart disease and Diabetes”

Our Long Term Conditions (LTC) plans will deliver the following five key outcomes:-

- people have improved quality of life, health and well-being and are enabled to be more independent
- people are supported and enable to self care and have an active involvement in decisions about their care and support
- people have choice and control over their care and support so that services are built around their needs
- people can design their care around health and social care services which are integrated, flexible, proactive and responsive to individual needs
- people are offered health and social care services which are high quality, efficient and sustainable.

Key Actions in 2009/10

- prioritise the three new LTCs of CHD, heart failure and COPD – pulmonary rehabilitation
- increase the number of patients who have hand held personal health plans and personal health budgets, by expressing an interest in the Personal Health Budget pilot that has been launched by the Department of Health
- increase the emphasis on self care by making information for individuals and their carers more accessible. Develop support networks and access to self care tools and monitoring equipment and assistive technologies. Improved self management through the installation of 40 telehealth units. These units will help to stabilize or improve vital signs, improve medication compliance, and reduce the number of crisis situations.
- develop integrated working between health and social care, with multi-disciplinary teams
- facilitate partnership working between primary and secondary care, therefore reducing the number of appointments individuals have to attend

- explore IT systems to support information sharing, therefore reducing the number of times individuals have to give the same information to health care professionals
- work with Practice Based Commissioners and joint commissioning for outcomes
- commission a comprehensive programme of Expert Patient Programmes including disease specific courses.

For patient education programmes there were 100 hundred people who will attend during 2008/9 which will increase to an additional 380 during 2009/10 as there are 30 courses of 16 people per course over 2008/9 and 2010/11. Up to 15% of the population will classify as having a LTC, a proportion of these will be eligible for the patient education programmes if they so choose to participate. There is currently (March 2009) no waiting list but course numbers can be flexed to meet increased demand.

For Personal Health Plans our intention is that all individuals with a LTC will have a Personal Health Plan by 2010/11. During 2009/10 we will be developing agreed Personal Health Plans for three conditions which will be:-

- chronic obstructive airways disease
- coronary heart disease
- diabetes.

The development of personal health plans will be led by a Task and Finish Group. The priorities of the group will be to:-

- implement personal health plans currently as developed by EoE SHA
- involve all stakeholders in the planning, implementation and evaluation of personal health plans
- produce pathways for the disease areas chosen as defined by the task and finish group
- collection of the monitoring of all key metrics as agreed by the Task and Finish Group to monitor delivery
- work towards defining further conditions by September 2010

4.12 Cancer

“We will plan the future of Radiotherapy Services at Colchester Hospital University NHS Foundation Trust , working alongside the Cancer Network

We will deliver the new cancer targets, as outlined in the Going Further With Cancer Waits national policy”

Key Actions in 2009/10

- support the EoE networks in developing centres of excellence compliant with national and local standards. The PCT will also support networks as appropriate in terms of clinical quality and patient safety
- work with Colchester Hospital University NHS Foundation Trust (CHUFT) in delivering “Going Further With Cancer Waits” and in developing its Radiotherapy services to ensure they are re-located and modernised to meet national standards and Network targets

A robust action plan has been developed to ensure the implementation of the New Cancer waiting standards which includes compliance to the recommendations made by NRAG and the National Radiotherapy Advisory Group Report. The PCT are undertaking weekly meetings with CHUFT to review the agreed actions for the compliance of the new cancer wait standards.

We are also working with Essex Cancer Network to develop capacity plans. The Radiotherapy Cross Cutting Working Group has identified a range of options that key stakeholders are working through to agree the Essex wide solution to meet December 2010 standards which includes no patients waiting more than 31 days for radiotherapy.

- For cancer waiting standards
We will continue to work with the Network and CHUFT to ensure that the future provision of radiotherapy services across North East Essex are developed to meet raising demand and long term predications.

The PCT and Trust leads meet on a weekly basis. Any areas identified as a ‘risk’ in relation to achieving the Cancer Waiting Times are recorded and actions are agreed to ensure that the identified ‘risk’ is addressed and remedial action is taken. The Trust has functionality within their new cancer waits data collection system for PTL monitoring. The Trust has provided reassurance to the PCT that a robust management system is in place to monitor PTL and appropriate action is taken where required.

The PCT will monitor identified poor performance through the Acute Contract. The Contract Monitoring Review Group will develop remedial plans where improvements in performance are required. If appropriate the PCT will initiate formal Contract performance controls (e.g. performance notice) in accordance with the Contract.

- The Supportive and Palliative Care Cancer IOG (NICE Improving Outcome Guidance) will be fully implemented by December 2009.

The PCT supports the EoE Cancer network proposals for Head & Neck services to be delivered from Broomfield Hospital and Upper GI services to be delivered at Broomfield Hospital. The PCT will work with the Cancer Network in determining

the Cancer Drugs and Medicines strategy. The PCT will introduce community skin cancer services by April 2009.

4.13 Heart Disease

“We will improve cardiac rehabilitation, including development of heart failure and angina cardiac rehabilitation services”

The PCT will support the EoE networks in developing centres of excellence compliant with national and local standards. The PCT will also support networks as appropriate in terms of clinical quality and patient safety.

Primary Prevention and Vascular Checks

The PCT has established a working group to look at implementation of the vascular check schedule.

We will ensure a 20% year on year rolling programme of assessment. We would expect all practices to increase coverage by 20% over the year 2009/2010.

Elements include:-

- a range of service providers including outreach services to tackle hard to reach populations.
- development of a call recall system
- agreement around risk stratification
- agreed interventions.

We are clarifying resources required by each practice to deliver on this. We are aware of central resources but as yet unclear how these will be allocated.

Targets

- for 2008/9 minimum target is for 80% of practices to sign up for Prevention LES of having a validated at risk CVD register; with trajectory for 2009/10 to be 90% and for 2010/11 to be 98%
- for 2008/9 minimum target is for 20% of practice eligible patients (40 – 74 with no vasc hx) to have CVD risk score calculated (as per NICE Rol and Cost Effectiveness model); with trajectory for 2009/10 as 50% and for 2010/11 as 70%.
- for 2008/9 minimum 20% of those with CVD risk \geq to be seen by healthcare professional and offered lifestyle advice/pharmacotherapy to reduce risk with trajectory for 2009/10 as 50% and for 2010/11 as 90%
- data to be collected for 2008/9:-
 - A – number/percentage of practice signed up to LESs
 - B – number of patients aged 40 – 74 with no vasc hx

- C – Number of B) with CVD risk score calculated
- D – Number of C) with CVD risk score recorded of 20% and above
- E – Number of D), who have a reduction in cardiac risk after 12 months intervention
- for 2009/10 the target is to achieve a 20% increase on 2008/9 baseline number of patients with a reduced cardiac risk

Secondary Prevention

Optimal management of people who have angina or a heart attack is vital to prevent recurrence. We have chosen cholesterol management in this group as a WCC local outcome measure. We will work with Primary Care to move towards 95% of patients whose total cholesterol is below 5 m.mol/litre (baseline 79.6% in 2006-07). We will aim to achieve 85% controlled by the end of 2009.

- QOF (CHD10) measures the percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)

The QOF maximum target is 60% and the PCT achievement for 2007/8 was 72.6%.

- The 2008/9 QOF Indicator HF3 measures the percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication.

The QOF maximum target is 80% and the PCT achievement for 2007/8 was 91.7%.

- There is a change in the Heart Failure indicators for 2009/10. A new indicator HF4 will measure:
 - the percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers. This will have a maximum QOF target of 60%.

Cardiac Rehabilitation

Cardiac rehabilitation is a set of services that enables people with coronary heart disease (CHD) to have the best possible help, physical, psychological, and social to preserve or resume their optimal functioning in society. There is evidence that cardiac rehabilitation reduces the risk of total and cardiac related mortality, subsequent revascularization and occurrence of non-fatal myocardial infarction.

Key Actions in 2009/10

- actively identify people who would potentially benefit from cardiac rehabilitation
- commission the following episodes of cardiac rehabilitation:-
 - Phase 1 – 575
 - Phase 2 – 675
 - Phase 3 – 631 + 50 Heart Failure & 75 Angina Patients (and for 2010/11 631 + 200 Heart Failure and 150 Angina Patients)
 - Phase 4 - 80
- explore increasing choice for patients
- ensure that through our commissioning process we improve clinical outcomes be enabling people to become active self managers of their condition
- reduce inequalities and improve access for those groups less likely to access cardiac rehabilitation services, including people from black and minority ethnic groups, women, people from rural communities and people with mental and physical health co-morbidities

4.14 Stroke

“We will develop a 24/7 stroke centre at Colchester Hospital University NHS Foundation Trust by the end of September 2009”

The PCT will support the EoE networks in developing centres of excellence compliant with national and local standards. The PCT will also support networks as appropriate in terms of clinical quality and patient safety.

In 2009/10 the PCT will be working with Colchester Hospital University NHS Foundation Trust (CHUFT) in delivering its 24/7 Stroke Centre by the end of September 2009.

The PCT will be working with CHUFT to deliver a stroke service that ensures that by end 2009/10:-

- 45% of people are treated for their whole stay on a stroke unit – an increase from the 2008/9 baseline of 16%
- 45% of high risk TIAs assessed within 24 hours of symptom onset – an increase from the 2008/9 baseline of 11%
- 60% of low risk TIA scanned in 7 days – there is no baseline for 2008/9

- 95% of patients with suspected stroke accessing brain scan within 60 minutes – there is no baseline for 2008/9 as service did not commence until Q4 of 2008/9
- 95% of eligible patients receiving thrombolysis within 3 hours – no baseline for 2008/9 as service did not commence until Q4 of 2008/9

The Essex Stroke Clinical Advisory Group and Network Board have undertaken an informal peer review of CHUFT in December 2008, prior to the accreditation review by the Royal Collage of Physicians.

The peer review assessed CHUFT's state of readiness has been extremely useful as it has highlighted areas of service for development in order to meet the standards required. Particular areas the PCT and CHUFT will now focus on developing are:-

- workforce (numbers required to enable 24/7 thrombolysis)
- national sentinel audit score (assesses progress against implementation of national recommendations)
- capacity (number of beds and links to current rehab arrangements at Clacton)
- imaging availability (Radiology services)

Workforce and capacity are the priority areas to be addressed as they are key enablers to delivery of enhanced stroke services (both 9-5 and 24/7 thrombolysis) which we aim to progress for our residents.

The 24/7 thrombolysis, originally planned to be operational from July 2009 has now been deferred until January 2010.

4.15 COPD

“We will ensure there is sufficient capacity to treat all patients requiring pulmonary rehabilitation”

Chronic obstructive pulmonary disease (COPD) is the fifth biggest cause of death in the UK, the second most common cause of emergency admissions to hospital and one of the most costly in-patient conditions treated by the NHS. With effective services and treatment, exacerbations of COPD can be shortened, so reducing the need for hospital admission, reducing lengths of stay and improving the outcomes and quality of life for patients.

The National Chronic Obstructive Pulmonary Disease Audit of 2008 recommended that work is done to identify resource and organisational factors that may account for observed variations in outcome, facilitate improvement in the quality of care, and develop integrated COPD services across primary and secondary care.

There were a number of key findings as part of the clinical case audit which would support a review of the current service provision.

Key Actions in 2009/10

- during 2009/10 we will undertake a review of the current COPD service to determine the areas that require development.
- we will invest in developing services to improve health outcomes
- we will reduce the number of emergency admissions to hospital for COPD related issues
- we will develop pathways of care that integrate services primary and secondary care

- we will commission 520 sessions of pulmonary rehabilitation during 2009/10. By commissioning effective pulmonary rehabilitation services for patients with COPD the PCT will:
 - improve the health related quality of life
 - reduce the number of length of hospital stays
 - improve the patient experience by commission pulmonary rehabilitation at times and venues suitable for patients

During 2009/10 the current provision of COPD service will be reviewed as part of the overall long term conditions strategy

4.16 Diabetes

“We will develop a Local Enhanced Service to improve the management of people in primary care and reward exemplar practice”

Following undertaking a comprehensive review of all service provision in 2008/9 the following developments will be made in 2009/10.

Key Actions in 2009/10

- raise awareness and understanding of the symptoms and management of diabetes
- implement a LES to improve management of people in primary care and reward exemplar practice
- strengthen Paediatric Diabetes Specialist services through the appointment of a new Paediatric Diabetes Specialist
- ensure continued professional education and training is rolled out across all professionals and disciplines
- strengthen and support the local Diabetes Network
- measure patient experience through surveys and working with Diabetes UK

Management of Diabetes especially control of blood pressure, cholesterol and HbA1c are key areas to improve health locally.

Improved management of HbA1c to 90% of diabetics which is a local target within our WCC strategy.

Over the next year we will work to improve levels of control from our baseline of 59.2% to 65% using LES.

The PCT have a poor record of use of ACEI and management of microalbuminuria.

QOF indicator DM15 measures the percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists).

The QOF maximum target for this indicator is 80% and the PCT achievement for 2007/8 was 83.7%. This however covers an unacceptable variation in the percentage of diabetics with this pathology. The PCT will work to improve ascertainment recognising a likely short term fall in the above indicator.

The LES is with the Professional Executive Committee for scrutiny. Practices will have assessment visits to identify level of care a Practice is providing and agree what level they aspire to/need to reach. Practices already at the advanced level will be able to receive payment per patient from April 2009. Once this work has been completed, the PCT will know level of investment which may be required in Community Services to support Practices in the future. Guidelines and protocols are currently being adapted for NEE area to support this work.

There is also an exciting pilot project underway entitled '*In Pursuit of Excellence Initiative*' initially for 12 months. Under this Initiative practices would be able to access a range of support options from a "menu" to improve the management of diabetes and heart disease in primary care. This may include access to external specialist nursing support and/or funding to support additional capacity within the practice to implement this LES.

Examples of support requested by practices include:

- near patient testing machines in practices
- additional dietetics support
- specialist nursing support
- telemedicine support
- patient education programmes
- access to weight management and exercise programmes (ie Shape Up programmes and others commissioned by PCT)
- additional Podiatry service in some Practices

13/43 practices have registered their interest in this initiative to date.

4.17 Renal

“We will develop a renal dialysis satellite of 10 stations in Clacton, aiming to get the service operational in 2009/10”

The PCT has worked closely with the EoE Specialist Commissioning group during 2008/9 to ensure that capacity within NEE is secured and expanded to ensure that our patients can be treated locally. Despite lack of capacity within the existing unit the PCT has secured capacity out of area along with a commitment to develop a satellite service in the Tendring area. It is planned that the new satellite service will be up and running in 2009/10.

4.18 End of Life

“Patients can expect to see an increase in the scope of services available including a 24 hour help line to offer timely support to patients and a specialist team to support during crisis situations to avoid unnecessary hospital admissions.

There will be a comprehensive campaign to increase awareness of end of life issues which will be launched along side a programme of education for staff, carers and support staff.”

During 2009/10 the PCT will complete their End of Life Care Strategy incorporating the recommendations from the *End of Life Care Strategy – promoting high quality care for all adults at the end of life* and the identified needs of the local population following stakeholder consultation, and deliver the following improvements.

Key Actions in 2009/10

➤ **Increasing Hospice at Home capacity for care**

Increased investment over the next 12 months to improve on existing capacity to deliver flexible, quality care for those more complex patients at end of life. A scoping exercise will be undertaken during the first quarter of 09/10 in order to make decisions about longer term provision of care.

➤ **Provision of a single point of access to care at end of life**

It is anticipated that as a result of consultation planned for March, stakeholders will want us to commission seamless access to care provision which is less fragmented and confusing for staff and patients alike.

A 24 hour help-line could be included in this provision as a means of providing timely support and advice to patients with acute symptom control problems.

➤ **Specialist rapid response for crisis situations**

We will commission a 24 hour specialist rapid response team for crisis situations that have a high risk of unnecessary admission to hospital.

➤ **Raising public awareness of end of life care**

We will ensure involvement of patient groups in the consultation process currently underway as part of the end of life strategy

A co-ordinated approach will be required to ensure that the population are aware of the service by utilising hospital premises, written material, radio, local newspapers.

There are 2 key outcomes we are looking to achieve through putting these services in place:

- reduction of hospital admissions and readmission due to inadequate symptom control
- increase in percentage of patients who are given the opportunity to die at home to the vital sign target of 30% by 2011

Patients can expect to see an increase in the scope of services available including a 24 hour help line to offer timely support to patients and a specialist team to support during crisis situations to avoid unnecessary hospital admissions. A comprehensive campaign to increase awareness of end of life issues will be launched along side a programme of education for staff, carers and support staff.

4.19 Carers

“Support will be tailored to meet the individuals’ needs, enabling carers to maintain a balance between their caring responsibilities and a life outside of caring, whilst enabling the person they support to be a full and equal citizen.

The action that needs to be taken over the next 10 years to make this vision a reality needs to start now.

By a process of engagement we will identify the needs of carers.”

The Vision of the National Strategy is:-

By 2018 carers will be universally recognised and valued as

being fundamental to strong families and stable communities.

During 2009/10 the PCT will work in partnership to raise the profile of the needs of carers and their role in providing health and social care support.

We will improve access to information regarding support and services available to carers.

Key Actions in 2009/10

➤ **Consultation**

- commitment to the production of a joint carers strategy.
- provide a dedicated lead to ensure a local joint strategy is in place and raise the status of carers.
- establish ways of working in partnership to provide joined up services with Adult Health and Social care services at Essex County Council, creating a shared database of carers.

➤ **Information and Advice**

- explore availability of 24 hour access to information and support, with particular attention to streamlining bureaucracy
- establish a system for early identification of carers involved in hospital discharge and provide good access to information and support
- provide a flexible way by which Carers are supported to participate through training, peer support, preparation for meetings
- provide high quality convenient, personalised information, education and advice to enable them to care well. In this respect their needs are similar to those of trained staff
- provide access to a dedicated service of support /advocacy workers
- provide 24 hr core information and advice services and improve access to them, including how to deal with emergencies
- develop independently managed consultation schemes

➤ **Short Breaks**

- use partnership working to ensure short notice sitting services through out North East Essex
- commission emergency home based support for carers in crisis for 72hours from health professionals and Adult social carers

➤ **Carers Assessments**

- create a process to ensure a seamless friendly process with well trained staff (performance managed)
- initiate care packages that include short breaks
- raise the profile of carers health needs and advice on healthy living, particularly carers over 75

➤ **Equity**

- develop a joint strategy is in place for young carers and minority groups and address the needs of parents of disabled children

➤ **Employment**

- support the promotion of flexible working and carer friendly employment practices

4.20 Learning Disabilities Services

“We will provide better access and choice to Learning Disability services”

Learning Disabilities services in North East Essex are currently undergoing a self-assessment exercise. The PCTs priority for 09/10 is to implement recommendations from *Healthcare for All* (DoH 2008) using the findings from the services self-assessment as a baseline for improvements.

Key Actions for 2009/10

- **Improved Access to Health Services (Primary Care)** - the DH has made available £22M nationally for PCTs to implement a new Directed Enhanced Service to incentivise **all North East Essex GP practices** to:
- identify people on their lists, cross referenced to the Local Authority LD register with a learning disability and;
 - carry out an Annual Health Check in the prescribed format

The PCTs allocation of funds is expected to be in the region of £175k for 2009/10.

The DES will commence in April 2009 and will build on the work already achieved through the LES. We are conducting audits to identify the People with Learning Difficulties (PLD) population with financial incentives to GPs to ensure the records of PLD are accurate and up to date. We are cross checking with the LA records to ensure accuracy for identifying PLD. We are ensuring that practices are given training and undertaking benchmarking to improve the accessibility and improve the environment for PDL. We are increasing speed of access to the GP practice through offering appointments within an hour for PLD in relevant circumstances.

We will meet the 50% uptake target.

- **LD Performance Self Assessment**– Findings from the ‘Health Big Day’ held in December 2008 will be used to help with the ongoing development of the LD

performance self assessment and identify the baseline, which is to be presented to the SHA during Q4 08/09. Attached is the completed self-assessment.



P:\NHS North East
Essex LD summary re

- **Response to the *Healthcare for All*** – The lead commissioners (West Essex PCT) are considering bids to recruit additional Acute Liaison Nurse capacity, and to appoint local health access support staff, both nurses and support workers. The PCT will continue to work in partnership with the lead commissioner as contracts with acute Trusts and local providers will need to reflect the requirements that creating equal access will place on the way they deliver services and the additional expectations that will be made to conform to Disability Equality Directives.

4.21 Mixed-Sex Accommodation

We will work with our Providers to ensure that specific plans are agreed and published to reduce areas of mixed sex accommodation unless clinically necessary eg in intensive care, A&E etc.

We have also agreed plans to undertake an independent review and agree an action plan with CHUFT by June 2009 that achieves compliancy with the mixed sex accommodation requirements by end March 2010.

Locally we have agreed remedial works with NEE Provider Services to reduce areas of mixed sex accommodation in Clacton Hospital and in our LD units.

NEPFT do not have any mixed sex bays. They are conducting privacy and dignity audits with patients/clients to address the issue of day areas. Some work has been done to widen availability of women only day areas. This is being discussed in contract negotiation with NHS Mid Essex as host commissioners.

NEPFT do not admit 16 year olds to adult wards. Plans are in place to increase the age to 17 in 2009 to meet the legal requirements by 2010.

4.22 Emergency Preparedness

Partnership Working

- The PCT has in place a robust Major Incident Response Plan (MIRP) which provides a comprehensive, tested and audit compliant mechanism for the Trust to mount an effective response to major incidents. This Plan and the contingency and response actions contained therein have been developed in partnership with a wide range of internal and external partners

- The PCT's Influenza Pandemic Plan has been extensively revised in January 2009 and improvements have been based on, amongst other sources, the outcomes and lessons learnt from past exercises, including:
 - Operation Fancied Plum (Regional exercise, October 2008)
 - Operation Spring Fever (County exercise, Feb 2008)
 - Operation Bless You (Trust exercise, Nov 2007)

The DH assessment of the Plan took place in January 2009 and indications from the SHA at the time of producing the Operational Plan is that the PCT scored a satisfactory 89%. A subsequent one-to-one assessment of the PCT's influenza Pandemic Plan by the SHA, taking into account the aforementioned score, confirmed that the PCT has a robust and commendable Plan. A fresh set of action plans for enhancement of the Plan are being produced and will involve practically all functions in the PCT. These will include taking into account the national requirements related to pandemic flu planning. Further exercises will be undertaken during 2009/10, possibly in conjunction with the Lead PCT (Mid Essex) and the Essex Health Emergency Planning Manager. Exercises to test the PCT's Business Continuity Plans, which includes contingency streams for pandemic flu, are to take place on the 24th April 2009. The lessons learnt from these will also be fed into the Influenza Pandemic Plan.

The PCT has also appointed a temporary Project Manager for 2009 who, with the PCT's EPLO, is dedicated to the continued improvement and development of the Plan.

5. World Class Commissioning Enablers

5.1. Commissioning for Quality

Launched alongside the 2009/10 Operating Framework, the DH has initiated a major work programme 'Commissioning for Quality and Innovation (CQUIN). Appendix 2 summarises what has been agreed with each Provider.

The DH Patient Reported Outcome Measures (PROMs) guidance has now been issued which will support the NHS in the collection of patient feedback on the success of their operations. From April 2009, all licensed providers of hip replacements, knee replacements, groin hernia surgery and varicose vein surgery will be expected to invite patients undergoing one of these procedures to complete a pre-operative PROMs questionnaire. In year 09/10 this is nationally collated, in 10/11 local collation will take place. In NEE the PROMS form part of the CQUIN framework demonstrating achievement levels as stretch targets.

The PROMs guidance sets out in detail:-

- procedures for which PROMs data should be collected
- details of the national PROMs questionnaires

- roles and responsibilities of the different organizations involved in the delivery of the PROMs programme
- a step-by step guide to the administration of PROMs questionnaires

NEE are working with the acute provider to demonstrate a joint approach to administration and implementation.

5.2 Patient Experience

Patient experience is a high priority for the PCT and will influence all our commissioning decisions, through a range of approaches. We will be focusing highly on discovery and listening activities, adapting our approach to the patient groups. Building on existing local incentive schemes and partnership working with patient and public involvement, we will develop patient experience indicators which will inform commissioning decisions, predominantly focusing on privacy, dignity and respect.

All areas of CQUIN's have been agreed between providers with further work to determine absolute thresholds for implementation of CQUIN's from April 2009. We will be explicitly linking payments (in the first year up to 0.5% of contract value) to the achievement of agreed quality targets, stimulation of innovation or the development of relevant metrics.

Our commitment to patients will be shown through the implementation of systems that respond to their views and experiences, We are working in partnership with mental health, ambulance and community providers, combining the key elements of safety, effectiveness and experience to influence the joint development of quality improvement plans for 2009/10.

The CQUIN approach for both community and mental health providers will be to create a quality development plan. This plan will establish baselines where they are not known of CQUIN's for 2010/11, the PCT will be enabled in negotiating local targets with providers that are meaningful to both patients and the public and therefore achieve patient-centred care. In addition to the development plan, patient experience will have a high focus in the CQUIN framework.

As part of our ALTO approach to patient experience we will be measuring patient experience through a 'real time' patient tracker, (Netbuild) responding and adapting services to the needs of patients, carers and the public. Tracking performance over time will enable benchmarking against other or similar organisations and inform local improvement.

These approaches will also form part of the quality improvement plans with providers and future CQUIN plans for 10/11.

Through partnership working with all providers we will determine and agree local incentive schemes through a patient experience work programme throughout 2009/10 linked to CQUIN payments, the outcomes will determine patient experience indicators for 2010/11. The quality development plans for 2009/10 will determine baseline and target areas to improve patient experience in 2010/11.

A group has already been established under the chairmanship of the Director of Nursing with terms of reference and membership agreed to progress the implementation of CQUIN's and PROMS and to report on the outcomes. Four nationally agreed surgical interventions will be a requirement in the standard acute contract, knees, varicose veins, hernia and hips. Within 09/10 and learning from the national PROMS we will begin to negotiated local PROMS for 10/11.

A Joint Clinical Review Group is in place for both CHUFT and Provider Services, this is led by the PCT and includes CHUFT clinicians, we are an associate commissioner for the Mental Health contract and have senior manager representation on the contract group.. The focus of the meeting is to achieve compliance to contract requirements and discuss and debate, patient safety, clinical effectiveness and patient experience issues in the context of quality and safety in the delivery of care.

There are also opportunities to have Joint Clinical Investigations where areas of improvement are required, or a significant area of learning and improvement can take place, this may result form a significant event or a failure to meet needs.

A Local Incentive Scheme has also been completed which has resulted in a payment and subsequent action plan which will be monitored by the clinical review group for CHUFT. The action plan has been incentivised to achieve the whole incentive amount as part of the CQUIN framework.

Both PROMs and CQUINs are discussed at every contract clinical review monthly meeting for CHUFT and ALTO.

Releasing Time to Care, Productive Series

The two Community Hospitals and CHUFT can evidence productive ward series and releasing time to care. We will be monitoring the outcomes of this initiative and will include this information in the quality development plan for 2009/10. Areas of poor performance will inform the 2010/11 CQUINs and may generate patient experience reviews.

Explicit Commitment to Reporting Patient Experience to Boards Monthly

In April 2009 the Board Development Day will include a Patient Experience Workshop with Essex University and Ambulance patient experience interviews shown through a DVD after the workshop. We are currently considering how patient stories can be facilitated within the bi-monthly Board meetings and the Board Development Days

Our 5 year strategy highlights priority areas for patient experience, predominantly 09/10 will focus on establishing a suite of patient experience indicators, a methodological framework for accessing patient experience feedback and building meaningful external relationships with partners to improve the delivery of our

commission services. This will be achieved through the development of a WCC patient experience team linked closely to the Research Department.

5.3. Patient Safety

The contract for CHUFT includes contributing to the national databases listed as listed in Annex 3 of the EoE SHA's Commissioning Framework.

The venous thromboembolism (VTE) risk assessment requirements are included in the CQUIN schedule within the CHUFT contract.

CHUFT has an HSMR above 100 and the PCT will work to address this in two ways as part of the CQUIN framework. Firstly, the issue will be a regular agenda item on the Quality Performance meetings with the trust with updates against an agreed action plan. Secondly the Director of Public Health will be attending the acute trust's internal working group to add public health input to this issue and to ensure all is being done to understand and remedy this situation. We will work to regularly monitor HSMR on a quarterly basis and take action as required.

Our 5 year strategy highlights priority areas for patient safety - confirmed initiatives are to reduce HCAI, reduce antibiotics prescribing, reduce high risk medication namely opiates and anticoagulation and implementing the national patient safety campaign in primary care.

HCAI

"We will continue to reduce levels of HCAs with introduction of a community based MRSA decontamination team

We will continue to work to reduce levels of antibiotics use to below the national average"

Targets

For 2009/10 the target is to reduce HCAI to a maximum of 132 cases within the PCT area with 84 cases in the local acute trust and a maximum of 13 cases of MRSA for the year.

For 2008/9 we aimed to reduce levels of antibiotic use to national average levels. We have achieved a reduction to date as follows, and we will continue to work to reduce inappropriate use further in 2009/10.

Antibacterials Per STAR-PU/Quarter

	Q2 2007/8	Q2 2008/9
National	0.051	0.051

Regional	0.053	0.052
PCT	0.054	0.052

Key Actions for 2009/10

- continue with the roll out of the development of MRSA registers in primary care
- commence a pilot of a Community decolonisation team to manage identified MRSA carriers in the community
- reduce the number of people colonised with MRSA living in the community
- try to reduce the number of people colonised with MRSA identified on admission screening at CHUFT
- introduce screening of all elective patients on the 1st April 2009
- complete ongoing work to establish the feasibility and way forward for screening of all emergency admissions with the plan to introduce screening if required by December 2009
- establish database of patients with indwelling devices (catheters etc) on SystemOne
- explore inputting patients infection/ colonisation status using SystemOne to ensure all health care professionals have up to date information
- continue to work with practices to ensure optimal use of antibiotics

Key Actions 2009/10

- Establish CQUIN programme 10/11.
- Establish PROMS programme 10/11.
- Establish quality development plans with acute, community and mental health providers 09/10.
- Develop a patient experience work programme 09/10.
- Implement patient experience board and development 09/10.
- Develop meaningful patient experience indicators 09/11.

5.4 Commissioning Primary Medical Care

“We will implement a profiles of excellence approach to performance management of primary (medical) services

We will agree a 3 year "Enhanced Services" basket for 2009/10 to allow practices the opportunity to plan and recruit additional staff resources to deliver these services in future with some certainty rather than have to plan on a year to year basis only.”

The PCT is committed to the development of more robust primary (medical) commissioning in 2008/09 and we have begun this journey as illustrated by:-

- development of a 5 year Primary Care Strategy informed by a series of facilitated workshops with clinicians held during October 2008 and a stakeholder conference involving local people, statutory and voluntary organisations held in November 2008. We are seeking to involve “hard to reach” groups in influencing the strategy for example, local teenage mothers groups and teenage school health educators directly
- development of “Profiles of Excellence” (balanced scorecard) indicators for general practice including web based performance management system is being developed with CHKS Ltd in discussion with local PBC Clinical Leads, Practice Managers, PEC and LMC representatives
- review of GP capacity by newly established working group with primary care and Local Medical Committee involvement. The aim is to develop additional local health needs formula for future investment in primary care and develop enhanced services “basket” of services to be commissioned on a 3 yearly rather than annual basis from April 2009. This will encourage practices to plan ahead and invest in additional staff to deliver services effectively
- development of performance management process for general practice for implementation from April 2009 incorporating annual review and agreement of objectives/action plans with practices. Annual contract review processes are already in place for dental and pharmacy contracts

The EoE’s ‘how to’ guide for commissioning primary medical care will be published in early 2009. This will set out three stages of a process which the PCT will be taking forward and detailing within the final Operational Plan. The “how to” guide will be incorporated into the commissioning process, to cover the following:-

Stage 1 – establishing where we are now – including local needs assessment and a detailed baseline mapping exercise

Stage 2 – where do we want to be – our ‘offer’ to patients and the service models that we intend to implement

Stage 3 – what are the tools that will help us get there – including formalizing performance and contract management mechanism, the transparent use of information, introducing additional capacity and practice based commissioning

The application of the guide will help us to consider the capacity and capability requirements for primary care commissioning which shall be reflected in the WCC Development Plan.

The key objectives in 2009/10 are therefore:-

- agree a methodology for a local health needs funding factor relating to life expectancy

- map the existing Enhanced Services currently available to practices (both DES, NES, LES including Public Health and PBC LES) and agree a 3 year 'Enhanced Services' basket for 2009/10 to allow practices the opportunity to plan and recruit additional staff resources to deliver these services in future with some certainty rather than have to plan on a year to year basis only.
- review the impact of proposed national changes to the MPIG for GMS practices and review of QOF prevalence and consider whether practices who are adversely affected and not identified as a high needs practice should be offered a form of local top up to address specific practice issues
- take forward the balanced scorecard called 'profiles of excellence' from preparation and planning phase to implementation and use in exception and performance management
- incorporate the EoE's 'how to' guide for commissioning primary medical care into the PCTs commissioning approach

5.5 Contractual Portfolio

The contracts where the PCT is the co-coordinating commissioner are:-

- Colchester Hospitals University NHS Foundation Trust

The contracts for which the PCT is an associate to are:-

- Mid Essex Hospital Services NHS Trust
- Cambridge University Hospitals NHS Foundation Trust
- Ipswich Hospital NHS Trust
- Southend University Hospital NHS Foundation Trust
- Basildon & Thurrock University Hospitals NHS Foundation Trust
- Norfolk & Norwich University Hospital NHS Trust
- Barking, Havering and Redbridge Hospitals NHS Trust
- Royal Free Hampstead NHS Trust
- Royal National Orthopedic Hospital NHS Trust
- Barts & The London NHS Trust
- Moorefields Eye Hospital NHS Foundation Trust
- Independent Sector - Spire (formally Roding) Hospitals
- East of England Ambulance Services NHS Trust
- North Essex Partnership NHS Foundation Trust
- those contracts for which the EoE Specialist Commissioning Group lead

The contracts that are/will be in place between service Providers and the PCT are:-

- North East Essex Provider Services (community services)
- Local Independent Sector contracts – The Oaks (Ramsey), Colchester
- Vasectomy providers (x 2 Colchester & Clacton)
- ENT Providers (x3 GPs with a special interest)

- Alliance Medical – MRI Scans
- Manual Therapists – (x 15 new service from April 2009)

All contracts are on a cost and volume basis. 99.7% of the secondary and community care budget will be under the new NHS Contract by the end of February 2009. Remaining contracts have a timeline (up to September 2009) to move to the new NHS Contract and Providers will have arrangements in place until then.

Ambulance

The main issues for the emergency ambulance service in 08/09 and 09/10 are:-

- supporting East of England Ambulance Service NHS Trust (EEAST) to achieve and maintain call-connect targets
- supporting the development of a regional service, with regional performance targets, whilst striving to commission the delivery of the best response times and services to local population of North East Essex
- supporting the implementation of the national contract for Ambulance Services, and contribute to the development of a robust Ambulance Contract covering;
 - a. developing, with EEAST, sustainable demand management and efficiency programmes, to support admission avoidance and provide appropriate services and/or sign-posting to patients to avoid unnecessary conveyance to hospital. An initial focus will be developing the business case to demonstrate the need for extended hours for the Essex Clinical Triage Service.
 - b. ensuring the Ambulance Trust are fully linked into the Primary PCI and Stroke service developments

The Call Connect performance standard will require substantial investment to both implement and maintain, but will deliver an improved quality of service.

The implementation of call-connect is based on a resource led, front-loaded model that essentially needs more vehicles available to be deployed to hit the target 8 minutes across all areas – both urban and rural. To ensure this model is deployed in the most effective way will require, over a three year period, fundamental adaptation of workforce and the development of more resource efficient deployment and patient care models.

The full financial impact of call connect was originally estimated at approximately £7.725m across East of England but, as with many other areas in the country, this has increased significantly to a figure currently estimated at around £26m-£31m.

Patient Transport Services

In addition to emergency ambulance services PCTs will assume responsibility, from 2009/10, for the commissioning of non-urgent Patient Transport Services (PTS) for their resident population. This was previously the responsibility of acute trusts, with the costs included in national tariff prices.

Locally, the existing contractual arrangements will require these services to be tested in the market for a new contract starting no later than April 2010. This is a significant project, the outcome of which is vital to ensure appropriate mechanisms to support the transportation of eligible non-urgent patients throughout the locality, and beyond.

5.6 Activity

The PCT fully embraces the opportunities of Choice, Payments by Results and Practice Based Commissioning and ensures that all of these factors are taken into account when forecasting activity and demand. The other key driver is the PCT's Public Health Needs Assessments, in terms of predicting annual demand and influencing demand management and admission avoidance schemes.

For services which fall into the Specialised Commissioning category, the PCT's requirements are included within the EofE's Specialised Commissioning activity and financial plans for which the PCT funds its proportionate part of the delivery programme.

Modeling processes

The PCT has used Checklist (modeling tool) to forecast the activity requirements, alongside historic trends analysis for smaller contracts. Once the baseline model, or Public Health model, is completed, the next step is to adjust it for known strategic planning changes, including secondary to primary care schemes covered in sections 4.6 and 4.7. This model is then called the order book.

The PCT and Practice Based Commissioners will be continually assessing services and pathways for delivering the new ways of working. Activity and Demand Models will be updated to reflect new in-year initiatives through the normal contractual process.

Choice

The PCT advocates Choice and Choose and Book and will actively seek to manage the markets to ensure patients have a real choice of a range of providers.

The PCT needs to really understand what matters to patients, public and staff and what influences the choices they are making. In ensuring our primary care clinicians and patients understand freedom of choice and make informed decisions, it is expected that historical commissioning patterns / trends will be changed. Funding/activity will follow the patient therefore the PCT must consider and establish robust monitoring systems to capture people's choices and support the development of responsive providers to meet local health care needs.

We have a 2008/9 to 2011/12 contract with CHUFT, with an agreed target that 90% of appropriate slots are available electronically for Choose and Book. This is the locally agreed standard that ensures a proportion of slots are held back to account for manual referrals received. Given the national target is 90% of referrals are completed via Choose and Book, it is good governance to ensure CHUFT still have

the capacity to deal with the manual referrals. This will be reviewed on an annual basis.

Basic modeling assumptions – baseline model

Modeled maximum waiting times

2007/08	2008/09	2009/10	2010/11	2011/12
Outpatients (weeks)				
5	4	4	4	4
Inpatients (weeks)				
11	8	6	6	6

Annual Demand:-

- 2004 ONS predictions for population growth for Colchester and Tendring were combined in the following age groups 0-14; 15-34; 35-64; 65+ to produce a table of % growth year on year from 2007
- Activity data (2006-07) by Specialty for Daycase, Inpatient Non Elective, Inpatient Elective, OP (Cons) and OP (Non Cons) were assigned into proportions by age groups as above
- Activity data percentages were then multiplied by the growth rates each year to yield a percentage growth rate for each specialty in each age band.

Outpatients Upstream:- The Checklist model, as part of the forecasting methodology, calculates these and they are factored into the process

Clinical Prioritisation:- Outpatient urgents seen in 2 weeks and routine patients seen in turn during 2 weeks before breach date. Inpatient urgents seen in 4 weeks and routine patients seen in turn during 4 weeks before breach date.

Follow up attendances:- assumptions are made with regard to improving the discharge planning process

Sense Check:- For all specialties and all models, a sense check has been applied throughout. If something seems like an outlier, this has been looked into.

Diagnostics:- Modeling work is taking place to cost the impact of moving to reduced waits. The options modeled are “no waits” through to 4 weeks maximum waiting time. To achieve shorter Referral To Treatment waiting times, there will be need to further improvements on current access times for diagnostics within the four key clinical areas; Imaging, Pathology, Physiological measurement and Endoscopy.

Scenario Planning:- Alternative models will be produced to forecast

- differential impact of Choice
- casemix changes relating to the health needs assessment analysis

The accuracy of the activity projections are dependent on a number of factors, including the impact of new national and regional guidance, changes to Practice

Based Commissioning plans and the pace of change in the development and improvement of key services such as diagnostics.

Summary of activity and demand forecasts and implications

The following principles are reflected within the activity and demand forecasting:

- Non elective growth (annual demand) will be mitigated through secondary to primary care schemes
- On a “like for like” basis, secondary care Outpatient activity will be reduced year on year as tier 2 community schemes increase in number. This is often difficult to track due to PbR recording changes
- Improved discharge planning will mean more patients have routine follow ups in primary care via schemes such as Enhanced Services
- As the market is developed more activity will take place in the Independent Sector to ensure there are genuine Choice options

Summary of activity plans

The activity plans for 2009/10 are now confirmed as the final version as all co-ordinating commissioning contracts have been agreed. The activity plan is an embedded document in this section.



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5.7 Practice Based Commissioning

“We will have an agreed PbC Framework that strengthens PbC involvement in commissioning and conforms to national guidance”

The PCT will continue to work to the DH publication ‘*our vision for primary and community care*’ commitment which states ‘redefine and reinvigorate practice based commissioning’ through taking forward the following actions:-

- increased autonomy for the most capable PBC consortia, and explicit ‘entry criteria’ that all must meet
- incentivising a broader range of clinicians to engage in PBC
- provide greater clarity on the difference between practice based commissioning and practice based provision

A PBC Operational Plan will be developed with PBC Groups which will be informed by the shortly to be published narrative from the DH on PBC. This will also set out the local PBC Charter outlining the rights and responsibilities of both PBC groups and the PCTs.

Within the PBC Framework, the PCT will develop a PBC Implementation Plan for 2009/10 which sets out our approach to implementing national guidance when published. This will also set out our approach as follows

- adopt the EoE and Network's disputes resolution procedure which will be devised. This will give PBC consortia and PCTs a 'right of appeal' if either party considers that it has been treated unfairly, or if the terms of the Charter have been breached
- commission a PBC Academy module course through Humana/NHS Alliance in partnership with Suffolk PCT to develop PBC commissioning expertise and capability within both the PCT, PBC Groups and primary care
- continue to review progress and improve understanding and involvement of local GP practices with PBC through quarterly meetings with PBC Clinical leads from every practice
- continue to build on good local working relationships between PCT and primary care as evidenced in quarterly national MORI PBC Surveys; currently NE Essex PCT is one of the highest performing PCTs in the EofE based on this survey

We will use the DH's PBC 'call off framework' that PCTs and consortia can use to bring in expert support on a range of topics, including information, management, governance and incentives. The PCT has already been working with Catch On consulting, one of the DH approved PBC Framework suppliers, during 2008 to facilitate improved communication and joint working across the PCT and PBC Groups.

Within the PBC Framework, the PCT and PbC will also agree:-

- the indicative commissioning budget available to consortia for 2009/10
- the approach to moving towards fair shares for PBC budgets
- Freed Up Resources (FUR) and Demand Management service improvement plans
- changes to budget and activity monitoring
- Local Incentive Scheme

5.8 Sustainable Development

NHS North East Essex recognises that it has a duty to protect the environment through energy conservation, the control of pollution, the prudent use of resources, and the safe disposal of all types of waste.

NHS North East Essex accepts that it must take all reasonable practicable steps to conserve energy, control emissions and dispose of waste safely in premises owned or operated by the NHS North East Essex.

In order to ensure the health, safety and welfare of employees and the Public, an understanding of energy conservation and safe handling and disposal of hospital waste is regarded as a basic requirement of all employees.

The PCT will maximise the use of resources by minimising material and energy wastage and increasing the use of recycled materials in accordance to the Good Corporate Citizen model.

To meet these objectives an Environmental Policy has been developed. The appropriate financial and personnel resource will be made available to implement this policy, and all necessary steps, including auditing compliance, will be taken to ensure that the policy is understood, implemented and maintained at all levels.

We are also party to the Local Authority Green Travel Plans and we are implementing this in respect of the North Colchester (Darzi) Centre.

The PCT can make a significant contribution to reducing the NHS carbon footprint. In so doing the PCT will work with providers to seek assurance that they are taking appropriate action in the:-

- monitoring and improving performance in key areas such as energy, efficiency, waste production and recycling
- developing sustainable transport plans
- building sustainability into procurement
- completion of the good corporate system self assessment and to work with us to address the results

5.9 Stimulating the Local Market

Shaping and managing the local market

- **Service areas that will be subject to tender or any willing provider arrangement**

The PCT has developed a draft commercial plan for 2009/10, which is subject to refinement as the detailed market analysis and scoping work determines the most appropriate commercial strategy. The Commercial Plan is a mix of schemes where the contestability will be concluded within the next financial year, and preparatory work to prepare for contestability or revised strategy for supplier relationship management in 2010.

The PCT is reviewing the way in which it currently procures the various public health initiatives to ensure that best value can be driven from existing contracts, to give synergy with new developments. The draft commercial plan is provided here as an embedded document.



E:\Draft Commercial
Workplan 09-10 v3 Jc

- **Key service areas in which new providers will be sought**

As part of the response to the changing economic position, the PCT is reviewing all planned activity and financial processes to ensure that it can continue to promote the use and viability of Small and Medium enterprises where possible. This includes a number of facilities management arrangements and the annual review of Approved Contractors List for Building and Maintenance, plus invoicing and payment arrangements.

For clinical services the PCT anticipates that we will be seeking to encourage new market entrants to the locality during 2009 for provision of complex domiciliary care, for management and delivery of immunisation programme(s), and for complex primary care optometry services.

The PCT will extend the range of providers in mental health through use of Any Willing Provider for accredited counselling services, and will continue to work with the IAPT provider to consider how the consortia approach within this tender can provide a platform for 3rd sector organisations to develop areas of specialist provision and extended primary care access.

- **Key organizational policies and processes outlined in the checklist will be in place**

The System Management Checklist (embedded) includes a position statement for each element and the anticipated timescale for implementation or review. The PCT has an established Board subgroup called the Procurement Panel, with Non Executive Chair and Vice Chair. The terms of reference for this subgroup were revised in October 2008 to ensure that there was a systematic approval and review process for all policies and procedures which related to the commercial activities of the PCT.



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Management Checklis

To highlight the red and amber actions that are being taken, an extract of the checklist is provided as follows:-

- **Process to ensure that the PCT Board signs off all decisions not to tender services and reports this to NHS East of England** – current SFIs and guidance on waivers is to be reviewed
- **Process for monitoring promotional activity and escalating process for resolving breaches and complaints established. Policy developed and available for external scrutiny** – to be completed by June 2009

- **Process for ensuring all breaches of the promotional code are documented and reported to the NHS East of England Director of Communications** – to be completed by June 2009
- **Application of Promotion code is evident in strategic and operational plans** – to be completed by
- **Escalation process for competition disputes established** – to be further discussed with SHA
- **PCTs conducted analysis of patient demand and service provision (e.g. market analysis)** – working with external agencies to develop market analysis and plans
- **Strategic plans incorporate outputs of market analysis work (specific changes to provider capacity and gaps in provision addressed)** - to be completed by end of March 2009
- **Application of the Principles and Rules of Cooperation and Competition is evident in strategic and operational plans** – assurance to be provided via Procurement Panel with retrospective review to complete PCT assurance
- **Progress and policy for ensuring that any transactions (mergers, acquisitions and joint ventures) are consistent with the transaction manual**
- **Gap analysis conducted against the Principles and Rules of Cooperation and Competition** – scheduled for March 2009
- **PCT system development plan is a key component of the WCC Development Plan** – the WCC Development Plan will be completed by the 5th May 2009 which will include the system development plan which is scheduled for completion by July 2009

The draft Commercial Workplan as previously embedded, shows the specific services that will be subject to greater contestability during 2009/10, how they will be contested and the approximate scale of funding of each service to be contested.

5.10 Future of PCT Provider Services

The PCT is preparing to divest itself of its Provider function and the Board has agreed to support the establishment of a “stand alone” enterprise. A PCT wide transitional group will ensure that the Provider is “business ready” to make the next step to be an independent and autonomous organisation. A number of agreed workstreams will ensure that implementation of the separation will deliver the outcomes that enables this and frees the PCT to concentrate on becoming a WCC

organisation and to focus on developing and implementing the WCC Development plan to deliver this.

The development of this separation will be informed by the recent publication *Transforming Community Services* and the need to develop and agree a Community Services strategy.

The PCT has also established Transition Board to ensure achievement against the SHA assurance framework which will report back to the Board the milestones of achievement.

From April 2009 the PCT will adopt the National standard contract for Community services and will, with PbC, commence service reviews and a complete market analysis of these services so that by October 2009 we will be able to determine a procurement plan and have an agreed organisational model for divestment.

Implementation of this will take account of the Principles and Rules for Cooperation and Competition.

Service reviews will take into account the provider services audit and the benchmarking of services, recently completed and presented to the January 2009 Board. Commissioning intentions have already stated that the following services will be reviewed and/or market tested:-

- All existing PCTMS Practices
- Salaried dental
- Falls service
- Community matrons
- Digital retinal screening
- Chlamydia screening

5.11 Establishing Fair and Transparent Procurements

The PCT has in place a Procurement Strategy and Policy which details the rigorous processes that have to be adhered to when dealing with procurements. These documents outline the steps to enable a fair and transparent procurement system. The PCT currently utilises "Supply 2 Health" which acts as a portal for all advertising. During 2009/10 the PCT will be introducing "E-Bravo" which will allow better management of the procurement process and provide increased governance arrangements.

5.12 Competition Dispute Resolution

The PCT has in place an agreed documented competition dispute resolution process. This is monitored by the Procurement Panel.

5.13 Equality and Diversity & Equality Impact Assessments

NHS NEE is mindful of its obligations, as a public body, to commission and provide services that reflect the diversity of the population we serve. To this end we have commissioned further work in ensuring equality and diversity is appropriately embedded into how we will commission and provide services and assist in the reduction and prevalence of health inequalities in its various forms.

Three key components of this will be to undertake a stocktake of where we are in relation to compliance with our obligations, the development of a Single Equality Scheme and the implementation of Equality Impact Assessments (EIA) to underpin commissioning and service delivery.

We are working with consultants to develop an EIA toolkit and a programme of awareness raising and implementation of EIA.

NHS NEE will take cognisance of the EIA recommendations for PCTs as part of the DH's EIA of the WCC assurance framework namely:-

Primary Care Trusts

- the robust collection of quantitative and qualitative data is central to the PCTs' ability to commission world class health services. PCTs should prepare to invest in the necessary systems and expertise to enable effective identification and segmentation of their local populations by healthcare needs. Performance data should be disaggregated by ethnicity, disability, gender wherever possible, in order for PCTs to monitor the impact of its commissioned services on the corresponding population groups
- through their organisational plans, PCTs should ensure that they have sufficient equality and diversity capacity to support the commissioning function. This should include both training and development for commissioning managers (with particular emphasis on conducting Equality Impact Assessment) and specialist/dedicated support
- the criteria used by PCTs to prioritise investment should encourage the equitable allocation of resources according to need, and avoid exacerbating existing health inequalities. This is particularly important when considering the healthcare needs of smaller, hard to reach communities or groups, where local data and intelligence may be more difficult to obtain
- promotion of equality and diversity should be considered throughout the procurement process, from the initial stages of identifying service needs through to contract monitoring. The equality duties relevant to the provider need to be explicit and clearly stated within PCT's contract conditions
- PCTs should consider the unique strengths of third sector providers when developing strategies to increase choice of healthcare provision. Voluntary sector organisations can often provide cost effective and culturally appropriate services tailored to the needs of specific groups or communities
- PCTs are strongly encouraged to assess the impacts of their strategic plans and individual programmes of work ('initiatives') on key equality groups
- promoting equality and tackling health inequalities should be a 'golden thread' running through all WCC board support programmes; PCTs should ensure

that training and development providers possess the necessary expertise to deliver in this area

5.14 Informatics Plan

Using the national expectations contained in the DH *Informatics Planning 2009/10* guidance, the PCT is leading the re-focusing of the Local Health Community's (LHC) IM&T Plan to form a new Informatics Plan. This will be information led as opposed to systems development led but will require the full exploitation of the solutions available under NPfIT contracts to underpin the delivery of the information needs of service plans.

Supporting the revision of the Informatics Plan will be:-

- the confirmed content of the Operational Plan which will provide the service changes that inform the development of knowledge, skills, resources and technical infrastructure to enable informatics to respond to and better support the delivery of the annual plan
- the requirements of data and information systems that are essential to support the achievement of becoming a world class commissioner as will be identified in the WCC Development Plan
- the outcome of the Informatics Review that the PCT has commissioned on quality metrics. This is a data and information audit to document the flows of data/information throughout the organisation. Within the new PCT structure there is greater emphasis on the transformation of data into information for knowledge, and as such the information team is being expanded and will be headed up by an Assistant Director of Information. The production of a Knowledge Information Strategy will be delivered as part of this enhancement in information services
- the completion of the LHC IM&T Self Assessment Tool (LISA) where the gap analysis will be addressed by the LHC's Programme Board
- the strategic direction of our providers and their informatics developments

Along with the benefits realization programme, the governance structures, identification of the resources required to support the implementation of the Informatics Plan, the plan will also contain the further deployments of the NPfIT programme which include:-

- **Summary Care Record (SCR)**
An outline project plan has been developed for SCR implementation which will commence with the organizational readiness preparation from May 2009. This concentrates on four of the SystemOne practices, and will be the template plan developed as further information is forthcoming. This project plan spans a two year period following the organizational readiness preparation. The development has a number of dependencies which include the need to receive and learn from the reports from the pilot areas; Connecting for Health's formal confirmation that the change can take place and that the governance arrangements are fit for purpose.

Further waves will be determined during this roll out for SystmOne practices following the lessons learned from the first wave and will be progressed with non TPP practices depending on when their systems are upgraded for SCR.

Part of the SCR roll out will also include the preparation for and promotion of Healthspace.

- **Electronic Prescription Service (EPS)**

EPS will enable electronic prescriptions to be sent, patients will be able to nominate the preferred pharmacy, electronic cancellation of prescriptions can take place so to electronic repeat dispensing.

The national and local milestones for Release 2 during 2009/10 is contained as an attachment in this section. A Project Group is already established and is making very positive progress through all the tasks but speed of implementation may be constrained if national direction and guidance is delayed. Project milestones as per embedded document.



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- **NHS Choices**

Patients will be provided with clear information on the quality of care. Easy to understand, service specific, comparable information will be available online on many aspects of service quality.

The PCT will have in place mechanisms for gathering, validating and maintaining information on all local health and social care services and promote awareness of the NHS Choices website including availability of 'Your Thoughts' as a mechanism for capturing patient experience.

- **GP to GP Record Transfer**

GP2GP enables the safe and timely transfer of general practice electronic health records, providing the general practice clinician with access to the patient record at the first consultation with a new patient.

The PCT will ensure that GP2GP will be deployed to all eligible practices as suppliers deliver new implementations of GP2GP and will work with clinical supplier training teams in order to ensure practices receive high quality GP2GP training.

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

GP Systems of Choice is a framework of existing suppliers of GP clinical IT systems, through which these suppliers will rollout National Programme services and provide resilient hosted services to general practice.

The PCT has fully implemented GPSoC and practices are expected to comply with the terms of the agreement in respect to their use of the systems provided. Likewise ESSA are expected to perform to the GPSoC SLA which is matched to the PCT/SLA. The SLA is monitored regularly by the PCT and exceptions dealt with. The agreement is also subject to annual review.

The GP IT Infrastructure specification is embodied in the terms of the PCT practice agreement and is managed according the PCT IT equipment refresh Policy and general IM&T strategy

Refinement of policy and strategy for managing GPSOC business cases in light of growing pressures for simply upgrading legacy clinical equipment versus the desire to move to remote hosted solutions through the GPSOC replacement options.

NHS Infrastructure Maturity Model.

The NHS Infrastructure Maturity model will be used to benchmark our infrastructure capability in order to create a roadmap for improving our IT infrastructure and to inform the Informatics Enablement Plan.

- **Implementation of Lorenzo**

The LHC has been deploying National systems extensively across the economy when functionality which meets requirements has become available. Primary care has benefited from a number of solutions which has enabled one shared record to become reality. Focus has now turned towards the acute setting and community hospitals, commencing with a feasibility study to look at the current functionality of the PAS systems mapped against Lorenzo Regional Care, in addition to mapping tactical systems in use to a replacement roadmap and deployment timescale. This study is already underway and is expected to be complete by April 2009 for discussion.

A roadmap for the implementation of Lorenzo will be developed within the LHC with the priority considerations being given to consideration of the Community Hospitals as early adopters for Lorenzo and determining recommendations regarding Lorenzo releases in relation to the PAS replacement at Colchester Hospital University Hospital Trust

In addition 2009/10 will also see the delivery of:-

- a newly negotiated SLA with ESSA
- provision of Active Domains for GP practices with remote infrastructure management facilities and managed encryption for desktops and laptops
- completion of 3 more GP practices transferring to SystemOne making a total of 15 with the new health centre provision in Colchester providing for 16 practices in total on SystemOne
- GP clinical system encryption installment
- streamlining the electronic discharge summary process

- data warehousing solution
- voice over IP telephony
- mobile working solutions for GP practices when accredited under GPsOC
- a number of TPP SystemOne service exploitation projects
- applying our agreed benefits methodology to identify the cost savings of technology

Informatics Enablement Plan

To achieve the delivery of the Informatics Plan, the PCT will also be developing an Informatics Enablement Plan. This will be informed by the NHS Informatics Review Implementation Report and by local discussion across the LHC with providers of services and practice-based Commissioners to determine the enablement factors that need to be addressed to ensure that the right support is provided to successfully achieve the service transformation requirements. Some of this work will be facilitated by the SHA at the strategic review/alignment workshops.

An initial, outline Strategic Informatics Enablement Plan will be submitted with the Informatics Operating Framework Plan for 2009/10 at the end of March 2009 with the final Strategic Informatics Enabling Plan, supporting our 5 year strategic plan and including details of leadership, governance and funding, submitted to the SHA in mid June 2009 to the SHA.

Technical Infrastructure

The LAN and WAN infrastructures are robust to support clinical applications and the performance of the network is reviewed to ensure levels are maintained. WI-FI services are not the norm but would be installed where strategically beneficial

Data Quality and Information Governance

The PCT aims to achieve Level 2 of all Statement of Compliance standards of the NHS Information Governance Toolkit March 2009 with the remaining standards of the toolkit being achieved at level 2 by March 2010.

By the 1st April 2009 all GP practice action plans for the achievement of Level 2 of the Statement of Compliance will be completed.

The PCT will be concentrating their facilitation of the community pharmacists, dentists and optometrists in their achievement of the Statement of Compliance using national guidance on availability of appropriate toolkits.

NHS Number and Patient Demographics

The NHS should improve patient safety by enabling consistent use of the NHS Number to reduce the number of data quality issues due to mis-associated records and by making effective use of the Personal Demographics Services.

The PCT in its commissioning role will be setting out plans which ensure that by the 18th September 2009 all NHS organizations that are commissioned by the PCT use the NHS Number as the national patient identifier and will put processes in place to ensure that patients can know their own NHS Number.

5.15 Estates

The PCT's direction for Estates is contained within the Estates Strategy in which the over-arching objectives are to:-

- Pro-actively manage the estate portfolio and associated resources to ensure best utilisation of the resources. This includes investment and divestment, as appropriate.
- Improve premises and make them suitable for modern healthcare.
- Ensure the capacity and facilities are appropriately located to deliver specific service developments and initiatives, whilst helping to meet the objective to bring services closer to patients' homes.
- Facilitate delivery of specific commissioning plans where the PCT has a lead role in supporting the provision of estate, such as for GP premises.

The pressures and performance issues identified were those which were collated through the 6 facet survey undertaken early in 2008 and through discussions with current occupants where required.

The desired location for premises developments and potential opportunities are driven by the strategic commissioning plans for community and primary care service locations. In some instances, this will highlight where current premises no longer match service requirements, which premises may not be required in the longer term and where expected population growth or unmet need requires new facilities.

The PCT will also ensure, in accordance with *Transforming Community Services* that its community estate is fit for purpose and reflects future commissioning intentions. This will be addressed through the Estates strategy and will also consider the future management arrangements of the overall estate stock.

6. Financial Framework

6.1 Financial Plan

The PCT has received an increase to its recurrent baseline funding allocation of 5.5% for 2009/10, this equates to £25.5m. The PCT will also have the recurrent effect of the £4.8m deposit given up in 2008/09; overall this will give the PCT an increase of just over £30m from 08/09.

In addition to this, the first installment of our deposit of £2.4m is due to be returned in 09/10, this will be non recurrent funding.

The PCT's total allocation for 2009/10 will be £485,349k, this includes a reduction of £17.6m in respect of a transfer of funding from the PCT to ECC in respect of Learning Disability Services.

The PCT will deliver cash releasing efficiency savings of £6.6m during 2009/10.

The following details the source and application of this additional resource.

	£'000
Growth	25,534
Recurrent effect of 08/09 deposit	4,800
Non Recurrent Deposit returned	2,400
CRES	6,600
Underspend from 08/09	500
Reprovision of 08/09 funding from SHA	481
TOTAL`	40,315
Inflation	12,711
Additional funding to move contingency to 1%	1,000
Full Year Effects of 08/09 LDP investments	2,830
CQUIN (quality payments)	1,370
Aiming High Respite Care	280
HRG V4	1,500
Capacity Plan & Other Contracts	8,982
Loss of funding due to campus reprovision	500
Dental initiatives commenced 08/09 (NR)	500
Cost pressures b/f (net effect)	5
WCC Structure	2,000
Initiatives	7,976
IM&T Development	180
WCC Development	481
	40,315

The introduction of HRG V4 has identified an impact due to Out Patient Attendances to the PCT of £5.1m over and above that allocated above. The detail of this is being worked through and a local tariff suggested to reflect an appropriate increase.

The Initiatives identified above align to the first year of the PCT 5 year strategy, and cover such areas as Health Inequalities, Mental Health, Children's Services etc. The impact of any further cost pressures not yet identified will reduce the amount of funding available for in year initiatives and thus this figure will reduce.

The PCT will hold a reserve of £4,870k, which equates to 1% of total funding.

The embedded document provides the total resources of the PCT split into budget headings. The full 5 year financial plan will go to the PCT Board in March 2009.



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6.2 Prioritisation of Investment

There is limited funding for new investments and as such the PCT has undertaken a process of prioritisation in order to determine the optimum investments to be made. In order to ensure long term financial stability this process has looked at all initiatives to be undertaken by the PCT within its 5 year strategy. Phase one of this process involved scoring against priority criteria, this was quality assured by Directors. Appropriate weighting was applied to each of the criteria in order to gain an overall score. These weightings were determined in conjunction with stakeholders, which included PbC and patient representatives. The following details the weighting applied to each criterion.

Prioritisation Weighting		
Key Priorities	Health inequalities	15
	Children	7.5
	Mental health	7.5
Total Score for Key Priorities		30
Performance	WCC	6.5
	Vital signs	6.5
	Local target	4
	LAA target	13.5
Total Score for Performance		30.5
PCT's Commitments		9
SHA Pledges		11
Towards the Best, Together		8
Total Score for Commitments*		28
Total Weighting		98.5

Phase two looks at the year the initiative is due to commence versus the lead in time. The rationale for this is as follows:

- if an initiative is due to commence in 09/10 it attracts a higher score than an initiative that is scheduled to commence in 13/14
- the later the scheme starts the less risk is presented in terms of achievement and deliverability, hence the lower score

- if an initiative is currently underway, expenditure for the initiative has already begun
- there would therefore need to be a compelling reason to stop this initiative from continuing
- as such initiatives currently underway or with a greater lead in time have a higher score than initiatives with a shorter lead in time

This represents the risk in terms of ability to deliver within the stated year

This attachment details the scoring utilised for assessing phase two of the prioritisation process.



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This score is then multiplied by the weighted score from phase one.

Phase Three then sorts further by identifying those schemes which are deemed 'must do'. The criteria for this must meet the following:-

- National guidance
- Regional guidance
- Commissioning Framework
- Operating Framework

Phase Four is the sense/reality check which ensures that the prioritisation methodology applied has demonstrated appropriate results.

Available funding is then allocated according to priority. Should any further funding become available in year then schemes can be brought on line quickly.

The PCT is keen to develop prioritisation further and is currently working on developing a "QALY" type measure which will allow a cost benefit analysis to be undertaken, so that the benefit of investments can be measured.

As a result of this process, the 2009/10 investments have been determined as provided in the attached embedded document.



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6.3 Productivity

The PCT achieved its demand management and savings plans for 2008/09 and believes it has set itself a further challenging target for 2009/10. The PCT works closely with the procurement hub and plays a proactive role in the delivery of the hub workplan. The embedded document details the productivity targets for 2009/10.



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appendix1-31st Jan.c

The table below shows the movement on the Better Care Better Value PCT indicators from 2007/08 Q1 to 2008/09 Q1.

Productivity Metrics Q1 08/09	National Position out of 152	Relative level	Change in Relative Level Q1 08/09 on Q1 07/08	Change
Managing Variation in Surgical Thresholds	35	89	(2)	Improved
Managing Variation in Emergency Admissions	6	50	(35)	Improved
Managing Variation in Outpatient Appointments	N/A	N/A	N/A	N/A
Increasing Low Cost Statin Prescribing	70	76	0	Steady state

The PCT has improved its relative position for the management of variation in surgical thresholds and for the management of emergency admissions, where it is now shown as the 6th best performing PCT.

With regard to managing variation in outpatient appointments, NEE PCT has undergone comprehensive transactions validation in outpatients, with over £1m of queries successfully adjusted for in 2007/08. We do not commission/ contract with CHUFT on the basis of SUS data, rather we use a local payment dataset that is definitive in terms of contracting and Payments by Results.

The following spreadsheet shows the different between SUS submissions, and what we actually paid for under our contract with CHUFT.

	Q1 0708	Q4 0708
SUS Recording of 1st Outpatient Attendances	27176	28927
Actual Chargeable 1st Outpatient Attendances	24967	25339
SUS Overestimate of Costs	£1,316,564	£2,138,448

SUS Directly standardised 1st Outpatient Attendance Ratio (per 10,000 pop'n)	791	845
Actual Directly standardised 1st Outpatient Attendance Ratio (per 10,000 pop'n)	742	759

The analysis shows that the national indicative information is significantly over-estimating outpatient activity and the cost benefits of reducing referrals. The PCT continues to develop its tier 2 programme, as outlined in the section entitled "Improving waiting times and access".

The PCT will continue to monitor the Better Care Better Value indicators to ensure that there is a continued efficiency gain.

With regard to outpatient follow ups, consultant to consultant referral rates, day case rates, emergency bed days and high cost drugs, the PCT will use the contractual route to agree targets.

The Professional Executive Committee has signed of the process for agreeing consultant to consultant referral rates and this is included within the contract.

The PCT has an Efficiency, Effectiveness and Value for Money (EEV) Group which is headed by the Director of Finance and reports directly to the Directors Group. This group will lead a review of best value across the PCT, linking into the work to be done around programme budgets.

6.4 Disinvestment

The PCT will use its commissioning arrangements to achieve productivity, whether in acute, primary care or community services. The PCT is committed to working with NHS East of England in the development a set of key indicators to pursue to achieve increased productivity. The proposed disinvestment areas are:-

- Primary PCI Service Impact (can you provide the name in full)
- Gastroenterology Pathway Redesign
- Urology Pathway Redesign
- ECC Collaboration of service overlap

The PCT will commence several streams of work from 2009/10 in order to highlight those areas where possible disinvestment can occur from 2010/11 onwards. These streams of work will be:-

- a) Evaluation of total PCT spend by programme budget category to understand where the PCT spends more than comparable PCTs. Where the level of investment is deemed inappropriate a case for disinvestment will be drawn up.
- b) Use of national benchmarking (NHS Institute for Innovation & Improvement) – highlight areas for potential disinvestment.
- c) A system of formal annual contract evaluation will be brought in for all contracts. The documented evaluation will include an assessment for value for money, quality and outcomes. Where contracts are not delivering appropriately plans for contract cessation will be undertaken.
- d) Evaluation of 08/09 investments to ensure outcomes achieved. Where investments failed to provide the necessary outcomes an exit strategy will be determined and actioned.
- e) Identify areas for pathway/service redesign that will achieve efficiencies/overlap e.g. LTC. Collaboration with local authorities to reduce duplication.
- f) Alignment of Strategy across current services. Long term planning is required so that service redesign and transformational change can be pump primed to allow more effective future service delivery and potential disinvestment.

- g) Benefits realisation of developments in technology to identify where possible long term disinvestment could be enabled.
- h) Assessment of long term estates need, estate rationalisation.
- i) Assessment of treatments that don't produce effective outcomes, cease commissioning of those treatments.

Currently, the existence of indicators, and data collection arrangements which could inform indicators, are less well developed in primary care services and community services. We will be developing data collection arrangements, linking new data requirements to the national intentions for the improvement in primary and community productivity.

The EEV Group has shared their work with staff at organisational staff workshops to spread good practice, seek ownership of the concept of EEV and to apply developed toolkits to their respective areas – thereby maximising the potential of our total capacity on achieving EEV. The group has focused on:-

- the development of a robust business planning tool (Gateway process) to ensure that investments and any reviews of services defines the outcomes of what the organisation needs
- reviewing the adequacy of internal support services and developing robust Service Level Agreements with customers
- a process of reviewing all support service functions within the PCT
- undertaking an opportunity assessment to determine contract owners and outcomes of contracts in order that best value reviews can start taking place at the end of March 2009

The PCT is an active member of the Procurement Hub and has engaged the hub to assist with its own procurement function. It has also started to play a proactive role in the delivery of the workplan.

6.5. Savings Schemes

The following saving schemes for 2009/10 have been identified:-

Saving Schemes

Scheme	Director	Total Savings
Prescribing	MG	1,500
Provider Services	MB	1,028
Estates Rationalisation (Octagon)	AM	125
Back Office (IA&LCFS)	JH	50
Hub	JH	50
First Dressings Initiative	MG	100
Demand Management Schemes	MB	2,000
PCTMS fye 08/09 tender	MB	125
North Colch HC/WIC	MB	325
Efficiencies from Block element	MB	795
Capital charges	JH	502
Total		6,600

3% to be achieved

6,600

7. Performance Management

The delivery of the Operational Plan will be one of the PCT's 11 Principal Objectives for 2009/10. The plan will be performance monitored within the Assurance Framework. Progress on implementation and actions to mitigate against any risks of non achievement will be reported to the Board on a quarterly basis which will be in addition to the monthly reports via the Finance and Performance Committee to the Board.

8. Stakeholder Engagement

We have proactively worked with some of our key stakeholders in designing the prioritisation of investment process for application against the funding proposals to meet our commissioning priorities for 2009/10. This has involved the Chair of our

Patient and Public Involvement Panel, the two Practice Based Commissioning clinical leads with their joint Executive Lead and the Chair of the Professional Executive Committee.

We will be sharing our Operational Plan during the final development phase with as many of our forums as possible, for example the Patient Commissioning Forums; the Patient and Public Involvement Panel, the Local Strategic Partnerships. This way of working with our stakeholders builds on the robust consultation arrangements that were in place during the development of our 5 Year Strategy which informs the first year's delivery requirements for year's Operational Plan.

9. World Class Commissioning Organisational Development Plan

The PCT's WCC Development Plan is a separate plan which sets out our organisational developments to rapidly achieve the fundamental shift from the baseline position of the 2008/9 to becoming world class commissioners. This plan includes:-

- how skills gaps will be filled, identifying functions that will be merged, pooled and outsourced
- how and when commissioning capacity will be increased and what plans we have for talent and leadership
- what structural changes will be required and when these will be implemented
- how the PCT will divest itself of 'non-core' activities to enable us to have a sharper focus on commissioning

The plan will be formally assessed by the SHA and form part of our performance reviews.

10. Workforce and Talent & Leadership Plan

NHS NEE will continue to develop its capacity throughout 2009/10 and will aim to finalise and recruit to a fit for purpose WCC organizational structure. The development of this has been informed by our own analysis of areas for enhancement and improvement and the feedback from the WCC panel evaluation.

We have already recognised the need to develop a commercial strategy and be more robust and innovative in market management and have been out to advert unsuccessfully to appoint a Director of Commercial Services and we are further considering the capacity needs as a consequence in order for us to make a step change in this area of the WCC competencies.

In the meantime NHS NEE has played a full part in the Essex County Workforce group and has successfully received funding for a number of initiatives on its own and Essex PCTs behalf linked to key priorities and Darzi and related workstreams.

We have and will continue to develop plans for the separation of Provider Services in accordance with the need to demonstrate "business readiness" and the Board have

now agreed the further development of a full business case for a stand alone organisation with associated workstreams one of which will focus on senior management capacity, competence and structure.

We submitted our workforce plan to the SHA Workforce Directorate aligned to the Darzi workstreams and the emerging needs of Commissioning staff to achieve WCC.

Key workforce performance indicators will continue to be reported to the Board and these indicators will illustrate how effectively the PCT is able to meet its business plans through its workforce. The Better Care Better Value indicators will also be used to track comparative performance and highlight areas for particular action.

The emphasis of workforce planning will be on having a clear clinical vision to inform workforce planning and to ensure that all providers of services to the PCT have linked workforce, finance and service plans to support existing and emerging models of care. This will include compliance with the European Workforce Time Directive by August 2009 on which we are currently working with CHUFT.

Training and Development to support new structures and competencies required is vital and the PCT has increased its resources and expenditure on Training and Development and a new structure following appointments is now bedding down. We are part of a national pilot for E – learning and we are evaluating the efficacy of this approach with the SHA looking at ways of delivering training more efficiently through a blended E learning approach. The future delivery of training will be linked to workforce priorities and developing the agreed clinical outcomes for service provision.

The principal objective of developing the workforce capacity and capability identified in 2008 remains appropriate for this coming year through:-

- identifying and utilising available talent and providing personalised support to staff to equip them to deliver the PCT's objectives. This development includes staff in the provider arm, both for the management and delivery of services within the Service Level Agreements and in the development of new ways of working in an ALTO whilst preparing to move to a new Provider organisation.
- working with external providers and partners to develop and maximise overall capacity and skills available in the local healthcare economy.
- Relaunch of the KSF to ensure workforce priorities reflect service and operational ones.

As part of the Operating Framework for this year (08/09) there is a requirement to produce a Talent and Leadership Plan by the end of March 09 for which we have begun the process of mapping and development. We are working with CapGemini to develop and implement the plan which will be incorporated into the WCC Development Plan.

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Reference for Actions on the 2009/10 National and Regional Targets

Issue	Rationale	Content to be included	Action Recorded in Plan	Section -Page Reference
Financial Plan	Balanced plan	<ul style="list-style-type: none"> Budget head template attached, covering 2008/09 budgets, increments for 2009/10 and planned 2009/10 budgets 	✓	6.1 Financial Plan
Productivity	Maximising value	<ul style="list-style-type: none"> Outline of quantified productivity targets for 2009/10, including (but not limited to) BCBV indicators Confirm contractual approach to outpatient follow up and consultant to consultant referrals rates, day case rates, emergency bed days and high cost drugs 	✓ ✓	6.3 Productivity
Disinvestment	Maximising value	<ul style="list-style-type: none"> Outline of work planned to highlight areas where investment may be withdrawn or reduced from 2010/11 	✓	6.4 Disinvestment
Activity	Balanced plan	<ul style="list-style-type: none"> Summary of referrals and activity, using the attached template 	✓	5.6 Activity

Contractual portfolio	Key enabler and WCC competency	<ul style="list-style-type: none"> Confirm which contracts (NHS and IS) the PCT is the co-ordinating commissioner for, and which it is an associate to 	✓	5.5 Contract portfolio
Operating Framework requirements	National requirement	<ul style="list-style-type: none"> Confirm coverage of national priorities set out in Chapter 2 of the DH Operating Framework that are not covered elsewhere (military personnel their dependents and veterans, people living in vulnerable circumstances) 	✓	4.4.2 - Alcohol 4.3 - Dementia 4.18 – End of life 4.3 Mental health 4.8 - Military 4.21 – Mixed sex accom. 4.4.7 - Marginalised 4.20 – LD
Patient Experience	<i>EoE Pledge 1</i> We will deliver year on year improvements in patient experience	<ul style="list-style-type: none"> Clarify which measures of satisfaction, experience and clinical outcomes will be used – including in contracts – to drive improvements in the patient experience Plans to specifically to address mixed sex wards Identify which areas of poor patient experience will be addressed in 2009/10 	✓ ✓ ✓ (described process)	5.3 Patient Experience 4.21 Mixed sex accom. 5.3 Patient Experience

Access to services	<p><i>EOE Pledge 2</i> We will extend access guarantees to more of our services</p>	<ul style="list-style-type: none"> • Confirm which, if any, services will have a waiting time from referral to treatment of greater than 18 weeks • Set out a clear plan (including milestones), for reducing maximum waiting times in relevant services to 18 weeks by April 2010 	<p>✓</p> <p>✓</p>	<p>4.7 Planned care</p> <p>4.7 Planned care</p>
GP access	<p><i>EOE Pledge 3</i> We will ensure that GP practices improve access and become more responsive to the needs of patients</p>	<ul style="list-style-type: none"> • Identification of poorly performing practices in GP survey, and outline of action being taken to address • Target for extended opening hours (i.e. above and beyond the 50% baseline) • Clear “pipeline” of practices (e.g. PCTMS or retirements) that will be tendered in 09/10 • Actions planned to improve responsiveness (e.g. internet booking, email consultations) • Outline of investment in LES/incentive schemes to improve access and 	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>4.9 GP Access 5.4 Commissioning primary medical care</p> <p>4.9 GP Access for all</p>

		responsiveness		
Dentistry	<i>EoE Pledge 4</i> We will ensure that NHS primary dental services are available locally to all who need them	<ul style="list-style-type: none"> • Details of additional capacity that will be commissioned in 2009/10 (£s and UDAs) and anticipated impact on patient numbers • Identification of geographic areas that currently experience poor access/fall outside agreed standards, and plans to remedy • Confirmation of when access portal will be operational, and how it will work 	<p>✓</p> <p>✓</p> <p>Already in place</p>	4.10 Dentistry

Heart disease, stroke and cancer	<p><i>EoE Pledge 5</i> We will ensure that fewer people suffer from, or die prematurely from, heart disease, stroke and cancer</p>	<ul style="list-style-type: none"> • Action on any remaining areas of non-compliance with IOG standards • Action on new cancer wait standards, including radiotherapy • Confirmation of CVD primary prevention plans and targets, including existing and planned percentage of practices and population on a CVD register and how this will be achieved • Confirmation of CVD secondary prevention plans and target, including percentage of individuals on heart failure registers who are on beta blockers • Confirmation of plans and targets for the number of people receiving cardiac rehabilitation • Confirmation of baseline and planned improvement in the percentage of people treated on a stroke unit >90% of their stay; percentage of people assessed as high risk TIA being scanned within 24 hours and low risk within 7 days; percentage of patients with suspected stroke accessing brain scan within 60 minutes; percentage of eligible patients receiving thrombolysis within 3 hours 	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>4.12 Cancer</p> <p>4.12 Cancer</p> <p>4.12 Cancer</p> <p>4.13 Heart disease</p> <p>4.13 Heart disease</p> <p>4.14 Stroke</p>
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Patient safety (CQUIN)	<p><i>EoE Pledge 6</i> We will make our healthcare system the safest in England</p>	<ul style="list-style-type: none"> • Confirmation that contributing to national databases listed at Annex 3 will be included in contracts with acute providers • Confirmation that VTE requirements included in CQUIN proposals to acute providers • Confirmation whether any hospital for which the PCT is the co-ordinating commissioner has an HSMR above 100 and, if so, what the PCT plans to do to reduce the mortality rate • Confirmation of MRSA and C. Diff contractual targets for 2009/10 • Confirmation of CQUIN approach in MH and community services 	<p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p>	<p style="text-align: center;">5.2 Patient safety</p> <p style="text-align: center;">5.2 Patient safety</p> <p style="text-align: center;">5.2 Patient safety</p> <p style="text-align: center;">5.1 Commissioning for quality</p>
Long Term Conditions	<p><i>EoE Pledge 7</i> We will improve the lives of those with long term conditions</p>	<ul style="list-style-type: none"> • Clarify the three LTC groups for which personal health plans will be agreed and for which services will be formally reviewed and (where necessary) recommissioned • Confirm that the key metrics agreed by the Task & Finish group to monitor delivery will be collected 	<p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p>	<p style="text-align: center;">4.11 LTC</p> <p style="text-align: center;">4.11 LTC</p>

		<ul style="list-style-type: none"> • Outline of plans to further develop patient education programmes, including volumes 	✓	4.11 LTC
		<ul style="list-style-type: none"> • Outline of plans to develop services to ensure appropriate and accessible access to services for people with a learning disability; and ensure sign up of practices to the DES from March 09 	✓	4.20 LD
Carers	TTBT theme	<ul style="list-style-type: none"> • Outline of plans to improve support to carers 	✓	4.19 Carers
Health inequalities	<i>EoE Pledge 8</i> We will reduce unfairness in health by working with our partners to reduce the difference in the life expectancy between the poorest 20% of our communities and the average in each PCT	<ul style="list-style-type: none"> • Outline of initiatives being undertaken in 2009/10 in the poorest 20% of MSOAs, including SMART deliverables 	✓	4.1 Health inequalities

Marginalised groups	<i>EoE Pledge 9</i> We will ensure healthcare is as available to marginalised groups and “looked after” children as it is to the rest of us	<ul style="list-style-type: none"> • Confirmation of groups being targeted • Outline of initiatives being undertaken to target identified groups, including SMART deliverables 	<p>✓</p> <p>✓</p>	4.4.7 Marginalised groups
Reduce smokers	<i>EoE Pledge 10</i> We will cut the number of smokers by 140,000 across the East of England	<ul style="list-style-type: none"> • Confirmation of the PCT’s planned 4 week quitter target for 2009/10 • Confirmation of the proportion of quitters that will come from priority MSOA areas and targeted marginalised groups • Outline plans to develop greater contestability in the provision of quitting services, including the use of any willing provider contracts 	<p>✓</p> <p>✓</p> <p>✓</p>	4.4.1 Reduce number of smokers & 4.1 Health inequalities

Halt rise in obesity	<i>EoE Pledge 11</i> We will halt the rise in obesity in children and then seek to reduce it	<ul style="list-style-type: none"> Outline the PCT's planned actions, including numbers of MEND (or equivalent) places, healthy schools etc, underpinned by SMART objectives 	✓	4.4.3 Halt rise in obesity
		<ul style="list-style-type: none"> Planned data capture and prevalence rates for 2009/10 	✓	4.4.3 Halt rise in obesity
Staying healthy	TTBT commitment	<ul style="list-style-type: none"> Planned uptake of Chlamydia screening 	✓	4.4.4 Sexual health and Chlamydia screening
		<ul style="list-style-type: none"> Planned improvements in immunisation rates where rates are currently poor 	✓	4.4.5 Immunisation & vaccination
		<ul style="list-style-type: none"> Plans to promote health at work in partnership with employers and employees 	✓	4.4.1 Reduce numbers of smokers
Mental health	TTBT commitment	<ul style="list-style-type: none"> Clarification on which elements of the dementia strategy will be implemented in 2009/10 	✓	4.3 Mental health
		<ul style="list-style-type: none"> Clarification on which elements of a recovery approach to MH will be implemented in 2009/10 	✓	
		<ul style="list-style-type: none"> Confirmation that maximum waiting times for psychological 	✓	

		therapies, early intervention in psychosis and crisis resolution will be met		
Maternity and newborn	TTBT commitment	<ul style="list-style-type: none"> Plans for a co-located midwife led unit (where relevant) Outline steps being taken to implement Maternity Matters, including direct access to midwife care, choice of where to give birth and in postnatal care, and progress towards providing 1:1 midwifery care in established labour 	<p>✓</p> <p>✓</p>	4.5 Maternity and newborn
Children's	TTBT commitment	<ul style="list-style-type: none"> Plans for strengthening CAMH services Outline of how the child health promotion programme will be fully implemented 	<p>✓</p> <p>✓</p>	4.2 Children's Services
Planned care	TTBT commitment	<ul style="list-style-type: none"> Clarification of the planned shifts required to delivery care closer to home, particularly for outpatient and diagnostics Plans to increase direct access to pathology and radiology 	<p>✓</p> <p>✓</p>	4.7 Planned care
Acute care	TTBT commitment	<ul style="list-style-type: none"> Confirmation of any plans to establish urgent care centres Timeline for introduction of PPCI services Timeline to establish 24/7 stroke thrombolysis services 	<p>✓</p> <p>✓</p> <p>✓</p>	4.6 Acute care 4.14 Stroke
End of life	TTBT commitment	<ul style="list-style-type: none"> TBC – likely to be refresh of the operational plan 	<p>✓</p>	4.18

				End of life
Stimulating the market	Key enabler and WCC competency	<ul style="list-style-type: none"> • Clarification of which service areas will be subject to tender or any willing provider arrangements. • Confirmation of the key service areas in which new providers will be sought • Confirmation of when key organisational policies and processes outlined in the checklist will be in place • Inclusion of the system management checklist as an Annex to the Plan (draft attached) 	<p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p>	5.9 Stimulating the market
Practice Based Commissioning	Key enabler	<ul style="list-style-type: none"> • Confirm the indicative commissioning budget available to consortia for 2009/10 	Can this be confirmed yet	5.7 PBC

Learning Disabilities	TTBT and CPB priority	<ul style="list-style-type: none"> • Confirmation that transfer of social care funding completed • Outline percentage of practices taking up the LD DES • Planned actions to ensure providers are adhering to Disability Equality Duty • Confirmation that LD self assessment benchmark data is being utilised in the PCT • Complete the attached self assessment and include as an annex to the plan 	<p>This is confirmed</p> <p>TBC following national issue and local take up but will be at least 50%</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p>	<p style="text-align: center;">4.20 LD for all</p>
LAA	Delivery of shared goals	<ul style="list-style-type: none"> • Confirmation of which targets have been agreed with local authority partners, and how they will be met 	<p style="text-align: center;">✓</p>	<p style="text-align: center;">3.1 LAA</p>

Vital signs refresh	National requirement	<ul style="list-style-type: none"> • It is anticipated that there will be national requirement to refresh the following lines, and these will need to be submitted by 20 January: <ul style="list-style-type: none"> ❖ VSA 03 – C.Diff ❖ VSA 05 – improving access ❖ VSA 08 and VSA 12 – cancer ❖ VSA 14 – stroke ❖ VSB 06 – maternity ❖ VSB 11 – breastfeeding ❖ VSB 13 – Chlamydia ❖ VSB 16 – public confidence ❖ VSC 15 – end of life (TBC) 	✓ for all	3.2 Vital signs
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Commissioning for Quality and Innovation

Contracts Plan for 2009/10

Colchester Hospital University Foundation Trust			
Linking payments (up to 0.5% of contract value) to the achievement of agreed quality targets, stimulation of innovation or the development of relevant metrics	Local Targets	Indicators of effectiveness, safety and the patient experience	Introduction of Patient Reported Outcome Measures (PROMS)
1. Electronic and manual discharge 2. Patient experience 3. Quality plan 4. HSMR reduction 5. VTE 6. National Databases 7. PROMS			<i>KNEES VARICOSE VEINS HERNIA HIP</i>
North Essex Partnership Foundation Trust			
Linking payments (up to 0.5% of contract value) to the achievement of agreed quality targets, stimulation of innovation or the development of relevant metrics	Local Targets	Indicators of effectiveness, safety and the patient experience	Introduction of Patient Reported Outcome Measures (PROMS)
Quality Development Plan including			<i>n/a</i>
North East Essex Provider Services			
Linking payments (up to 0.5% of contract value) to the achievement of agreed quality targets, stimulation of innovation or the	Local Targets	Indicators of effectiveness, safety and the patient experience	Introduction of Patient Reported Outcome Measures (PROMS)

development of relevant metrics			
Quality Development Plan Patient Experience scheme			n/a
Ambulance Trust			
Linking payments (up to 0.5% of contract value) to the achievement of agreed quality targets, stimulation of innovation or the development of relevant metrics	Local Targets	Indicators of effectiveness, safety and the patient experience	Introduction of Patient Reported Outcome Measures (PROMS)
Other Contracts			
Linking payments (up to 0.5% of contract value) to the achievement of agreed quality targets, stimulation of innovation or the development of relevant metrics	Local Targets	Indicators of effectiveness, safety and the patient experience	

Glossary

A&E	Accident and Emergency
AAA	Annual Area Agreement
AAACM	All age all cause mortality
ALTO	Arm's Length Trading Organisation
APMS	Alternative Provider of Medical Services
BASQ	British Association for the Study of Community Dentistry
BMI	Body Mass Index
BP	Blood Pressure
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CHD	Coronary Heart Disease
CHIMPS	Child Health Improvement Sessions
CHUFT	Colchester Hospital University NHS Foundation Trust
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPG	Care Pathway Group
CPNS	Community Psychiatric Nurses
CRHT	Crisis Resolution Home Treatment
CVD	Cardio vascular disease
CYPSP	Children and Young People Strategic Partnership
DARG	Drug and Alcohol Reference Group
DDA	Disability Discrimination Act
DH	Department of Health
DPH	Director of Public Health
ECN	Extended choice network
ENT	Ear, Nose and Throat
EoE	East of England
EPS	Electronic Prescribing Service
EQUIP	Education and Quality in Primary Care
FT	Foundation Trust
GDPs	General dental practices
GP	General Practitioner or General Practice
GPwSIs	General Practitioners with Special Interests
GUM	Genito Urinary Medicine
HCAI	Healthcare Aquired Infection
HNA	Health Needs Assessment
HRG	Health Resource Group
HSMR	Hospital Standardised Mortality Ratio
IAPT	Improving Access to Psychological Therapies
IM&T	Information, Management and Technology
IMD	Index of Multiple Deprivation
IOG	Improving Outcomes Guidance
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreement

LAC	Looked after Children
LD	Learning Disabilities
LES	Local Enhanced Services
LIFT	Local Improvement Finance Trust
LINKs	Local Involvement and Knowledge Network
LLTI	Limiting Long Term Illness
LSOA	Lower Super Output Area
LTC	Long Term Condition
MAC	Multi Agency Centre
MH	Mental Health
MMR	Measles, mumps and rubella
MRSA	Methicillin Resistant Staphylococcus Aureus
MSOA	Middle Super Output Area
MUS	Medical Unexplained Symptoms
NACS	National Administrative Codes Service
NEPFT	North Essex Partnership Foundation Trust
NHS	National Health Service
NHS NEE	NHS North East Essex
NICE	National Institute of Health and Clinical Excellence
OD	Organisational Development
ONS	Office of National Statistics
OP (Cons)	Out-patient consultations
OT	Occupational Therapy
PARR	Patients at Risk of Re-hospitalisation
PbC	Practice Based Commissioning
PbR	Payment by Results
PCC	Primary Care Centre
PCT	Primary Care Trust
PEC	Professional Executive Committee
PID	Pelvic Inflammatory Disease
PLD	People with Learning Difficulties
PPIF	Patient and Public Involvement Forum
PPIP	Patient and Public Involvement Panel
QOF	Quality Outcomes Framework
SHA	Strategic Health Authority
SIP	Standardised item for patient
SPA	Single point of access
STAR-Pus	Specific therapeutic group age-sex related prescribing units
STI	Sexually transmitted infection
TASCC	Terms Around Schools, Children and Communities
TIA	Transient Ischaemic Attack
VSA	Vital Signs A
VSB	Vital Signs B
VTE	Venous Thromboembolism
WCC	World Class Commissioning