

**Annual Operating Plan for  
NHS Brighton and Hove  
2011/12**

**Final Version  
2011/12**

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## 1 Introduction

The Annual Operating Plan (AOP) sets out the plans that NHS Brighton and Hove with its partners aim to deliver in 2011/12. The Annual Operating Plan has been developed in partnership with key stakeholders, including GP leads and Local Authority partners.

The plans outlined in the Annual Operating Plan for 2011/12 support the delivery of the 2010/14 Strategic Development Plan for Brighton and Hove and the Quality, Improvement, Productivity & Performance (QIPP) Delivery Plan for Sussex. NHS Brighton and Hove and its partners have achieved a lot in the last few years. 2011/12 will be a year where we consolidate what we have achieved in addition to making changes which will deliver improved services to the residents of Brighton and Hove.

We are preparing for a sustained period of no increase in funding during which we must deliver an even greater transformation of health and health care services with the same or reduced resources. In this different environment we must retain our focus on our commissioning goals and transformation programmes, on delivering improved health outcomes and maintaining a sustainable financial position.

The plans in the Annual Operating Plan are summarised in Sections 3 and 4 and are set within a financial plan in outlined in Section 2.

Section 3 provides a summary of the plans within each Priority Transformational Programme area (PTPs) that will be lead by the Transitional GP Consortia in Brighton and Hove.

Section 4 provides a summary of the plans within each Priority Transformational Programme area (PTPs) that will be lead by other commissioning groups within Brighton and Hove, eg. Public Health, the Local Authority, Sussex Specialist Commissioning Group.

More detailed information of the plans within each Priority Transformational Programme areas (PTPs) is available separately in the Delivery Plans.

Section 5 describes the enablers that need to be in place to support the delivery of the plans. These include the impact and implications on the workforce, information technology requirements and the estate.

Appendix B outlines the performance measures the PCT and its partners aim to deliver in 2011/12.

The performance measures included do not include the measures that relate to the delivery of the Local Area Agreement. The Local Authority and its partners will be discussing and agreeing the future LAA in the first half of 2011/12.

NHS Brighton and Hove is committed to continuing its statutory duties and its moral obligations to promote equality of opportunity, to eliminate discrimination and to promote good relations between communities, through all of its activities. It does this by ensuring the needs and experiences of local people from diverse communities are used to influence the services it designs and commissions.

The Annual Operating Plan contains commissioning plans and strategies which take into account the needs of local people to ensure that services are accessible and appropriate. They all further the PCT's commitment to meeting the requirements of the Equality Act 2010 and the Public Sector Duties contained within it. NHS Brighton and Hove ensures this by carrying out Equality Impact Assessments (EIAs) with key stakeholders on all of its functions and decisions. These EIAs are published on the Trust's website at

<http://www.brightonandhove.nhs.uk/about/community/eiapolicies/index.asp>. To see the EIAs for the plans contained within the Annual Operating Plan, and others that the Trust has carried out please visit the website or contact the Equality and Diversity Manager, Phil Seddon, at [phil.seddon@bhcpct.nhs.uk](mailto:phil.seddon@bhcpct.nhs.uk)

## 2 Financial Plan

The table over shows the additional funds available in 2011/12 and the current financial plan which identifies the use of those funds. Underneath are notes which explain the information and, in doing so, sets out the prudent assumptions we have made in the initial submission of our 11/12 plans.

Summary use of Growth 2011/12		£'000's 2011/12
<b>Note Source of Funds</b>		
Growth		8799
Prior Year surplus NR		4615
Public Health NR choosing health spend		698
Social Care Allocation		3285
Freed up resources		331
Underlying surplus R		0
<b>1.0 Total Source of Funds</b>		<b>17728</b>
<b>Inflation and Tariff</b>		
PbR		691
Non-PbR		-2264
Prescribing		2097
Capacity (@2.25%)		5946
<b>2.0 Total Inflation and Tariff</b>		<b>6470</b>
<b>3.0 LHE efficiencies</b>		
HIS		-1770
BSUHT LHE efficiency		-1000
SDH LHE efficiency		-300
		<b>-3070</b>
<b>4.0 Public Health choosing health spend</b>		<b>698</b>
<b>5.0 Social Care Allocation</b>		<b>3285</b>
<b>6.0 Other Cost Pressures</b>		<b>5042</b>
<b>7.0 GPCC PTPs (QIPP)</b>		
Investments		486
Savings		-235
<b>8.0 PTPs (QIPP)</b>		
Investments		4093
Savings		-13181
		<b>-9088</b>
<b>9.0 Contingency (1%)</b>		<b>4615</b>
<b>10.0 2% NR Reserve</b>		<b>3429</b>
<b>11.0 SHA lodgements</b>		<b>3911</b>
<b>Total use of funds</b>		<b>15543</b>
<b>12.0 Savings still to be found</b>		<b>-2430</b>
<b>13.0 PLANNED SURPLUS 1%</b>		<b>4615</b>

The PCT has received 2% growth for 2011/12 which needs to be adjusted for the impact in 2011/12 of a number of small amendments to our recurrent baseline allocation. We also have the carry forward of our forecast 2010/11 surplus of 1%.

Each year contracts and the funding of certain schemes within the Choosing Health budget comes to an end and this enable the redeployment of these ring-fenced funds into new initiatives (see note 6 below).

Within our allocations set out in the National Operating framework is £3.3m Social Care funding. Further guidance will be forthcoming but this is to fund joint initiatives designed for health benefit within the Joint Strategic Needs Assessment (JSNA). Although not intended to supplement existing services the extension or roll over of existing schemes is a possible use.

As we move into 2011/12 there is a residual amount of recurrently uncommitted 'Freed Up Resources' from 2008/09. This source of funds has been built into our AOP as has the current proposals for deployment of these funds (see note 7 below).

## 2 Inflation and Tariff

The National Operating Framework gave headline information on the construction of the 2011/12 PbR (Payment by results) tariff and non tariff changes.

For PbR tariffs (or prices) there is a 0.5% increase but this is following changes to the tariff construction which at a national level produces a 2% reduction in the tariff paid. This theoretically produces a net 1.5% reduction to the tariff paid. As this has been calculated on a national basis and will be highly dependant upon both case-mix and changes to the volume of activity between years we have not seen all of this benefit, although the amount being spent in the Acute sector has been suppressed.

We have not concluded the contract negotiations and therefore have retained some prudent assumptions, which should result in a reduction in savings requirements in the final version of our 2011/12 plan.

Inflation (both cost and volume) on Prescribing is assumed to be 5% although as in previous years we have set a savings target as part of our plans.

The inflation on activity levels has been retained at 2.25% but as we finalise negotiation of contracts this assumption will be amended to reflect the actual position.

## 3 LHE Efficiencies

In previous years this health economy has received pump priming monies to generate savings in both BSUHT and SDH. £1.3m is due back next year and this helps fund the lodgment to the SHA (note 12).

Within this section is the reduced contribution to a Sussex wide IM&T budget held by the Health Informatics Service (HIS). In future years we will need to ensure that there is sufficient allowance made for IM&T in the PTP costings and also funding secured from the SHA held transformation reserve.

## 4 Public Health Choosing Health Spend

Within the source of funds for the year there are the funds released as each year contracts and the funding of certain schemes within the Choosing Health budget come to an end. We are currently finalising the redeployment of these ring-fenced funds into new 'choosing health' initiatives. There is no intention of not reinvesting these funds and should there be a small amount of uncommitted funds these will be held in a Public Health reserve.

## 5 Social Care Allocation

Within our allocations set out in the National Operating framework is £3.3m Social Care funding. Further guidance will be forthcoming but this is to fund joint initiatives designed for health benefit within the Joint Strategic Needs Assessment (JSNA). Although not intended to supplement existing services the extension or roll over of existing schemes is a possible use.

Further guidance has been issued and we have clarified the process for transferring the funding to the City Council. This will be via a formal agreement under section 256 of the 2006 NHS Act. These funds will be used to address the social care budget shortfalls in the following areas:

- Eligibility for community care moved to critical only (rather than critical and substantial)
- Retain 6 posts around community care assessment activity
- Prevent closure of a resource centre
- Prevent reduction of third sector targeted prevention contracts.

## 6 Other Cost Pressures

This item contains a number of cost pressures the most significant of which are: -

- Chemotherapy
- IAPS (Improved Access to Psychological Therapies)
- Dementia
- GP Consortia support (£2ph)
- Horizon scanning – cancer drugs
- Diabetes – Insulin Pumps

The National Operating Framework contained a number of commitments to invest in service areas. As the source of the funding and the costs of these initiatives is unclear in the financial planning guidance there remains a risk that we have understated our cost pressures.

## 7 GP Commissioning Consortia (GPCC) PTPs (QIPP)

Included within the sources of funds is the uncommitted element of the recurrent practice based commissioning freed up resources. There are a number of schemes that have been proposed and these have been included in the AOP as a net spending commitment of £251k. These are not detailed in the document at present as there is to be further validation of a number of the proposals. From the 1<sup>st</sup> April we cease to have practice based commissioning and move to GPCC in shadow form. Therefore there is no longer a separate 'pot' of funding and these resources are now a small part of the overall commissioning budget.

## 8 PTPs (QIPP)

The Priority Transformational Programmes (PTPs) are the core of our AOP and constitute the QIPP plan for 2011/12. A full list of these programmes forms the main narrative of our AOP, the financial implications of these plans is in Appendix A.

## 9 Contingency

In 2010/11 we had no contingency reserve and we had to rely on non recurrent funds to cover cost pressures that arose during the year. Moving forward this is not sustainable and given that

the 2% NR Reserve will be held at the SHA we will have no local financial flexibility unless we create a recurrent contingency reserve within our plans.

Last year we aimed to set a contingency reserve of 1% and given the assumed level of risks we are potentially facing in 2011/12 we have created a reserve at the same level.

#### 10 2% NR reserve

As mentioned in note 10 above the National Operating framework stated that all PCTs will be top-sliced by 2% and that these funds will be held by the SHA and be released back to PCTs following the approval of a business case. The detail of how this fund will operate is not yet clear nor agreed by Cluster Chief Executives but it is assumed it will be along the same lines as to how the Regional Transformation Fund (RTF) was originally intended to operate in 2010/11. If that is the case we in effect relinquish the right to the funds and they are truly pooled across South East Coast. This would create a £136m budget enabling truly transformational changes to be made.

#### 11 SHA Lodgments

In previous years this health economy has received pump priming monies to generate savings in both BSUHT and SDH. £1.3m is due back next year and this helps fund the lodgment to the SHA.

We had agreed the profile of the replenishment of the Strategic Reserve held on behalf of PCTs at the SHA. That would mean that we should be lodging £2m in 2011/12. However, within the National Operating Framework there is a requirement for PCTs to ensure that all legacy debts are paid off prior to handing over the reins to GP Commissioning Consortia. For Brighton and Hove we are in setting our plan for 2011/12 ensuring that we move back into recurrent balance having needed to rely on non recurrently generated funds in 2010/11. The only other legacy debt is the balance of the replenishment to the Strategic Reserve which is a further £1.9m making £3.9m the amount needed to pay off the entire legacy debts in 2011/12.

#### 12 Savings still to be found

The above notes detail our plans for 2011/12 and in doing so confirm that we are some c£3m short on the savings target we set ourselves.

The Clinical Commissioning Executive have made good progress in identifying further savings proposals and these are being worked on. At the time of writing this report there is a likelihood that some of these savings will fall into 2011/12 but the majority will not be released until 2012/13. However, the assessment is that we can use non-recurrent resources to bridge the £2.4m shortfall shown in the table.

Once we have finalised our plans for 2011/12 a detailed risk assessment will be undertaken to confirm the risks within the plan and this together with assessing the use of the 2% NR Reserve is expected to reduce the level of savings we need to find.

#### 13 Planned Surplus

In 2010/11 the PCT is forecasting to deliver the control total surplus we were set of £4615k or 1%. We do not anticipate this being reduced (or increased) in 2011/12 and have therefore proposed that we set a plan with a 1% surplus again in 2011/12. The control total is actually set by the SHA and given the financial position of other PCTs in 2010/11 we may be asked to deliver

a higher surplus. This however would not be our preference and the early replenishment of the Strategic Reserve in any event has a positive impact on the overall SHA surplus in 2011/12.

### 3 Delivery Plans - Consortium

Section 3 provides a summary of the plans within each Priority Transformational Programme area (PTPs) that will be lead by the Transitional GP Consortia in Brighton and Hove.

Each of the following table shows the key deliverables and milestones and date of delivery along with the organisation/team responsible for implementing this plan. The key for the responsibility is:

- C= Commissioner /GP Consortia
- P= Provider
- PC = Primary Care
- BSUHT = Brighton Sussex University Hospital Trust
- SCT = Sussex Commissioning Trust
- LA= Local Authority
- CSU = Commercial Support Unit

In addition, the expected cost/saving of the deliverable is outlined. Each table also highlights the periods in which the GP Consortia for Brighton and Hove will need to ensure staff are available to resource the implementation of the plan. This will assist the consortia to utilise its resources in the right place at the right time.

#### 3.1 Long Term Conditions and end of life care

Summary								
<p>We aim to transform services in the city so that they are;</p> <ul style="list-style-type: none"> <li>• Equitable – patients will access to and receive the same level of care irrespective of where they live, where the care is delivered or the complexity of need.</li> <li>• Personalised – Patients and their carers will receive care that meets their needs and is articulated in a jointly co-produced care plan</li> <li>• Structured – Patients will receive the care most appropriate to their needs systematically</li> </ul>								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Recommendations of ICES review	Implement recommendations (already started)	LA/(C)	July 11	£65k				
Specialist neuro-rehab commissioning plan which supports Early Supported Discharge	Implement plan	C/P	Jun 11	£80k				
Unbundled tariff for patients admitted following a stroke	Develop unbundled tariff	Finance/CSU/P	On-going	None				
	Shadow	CSU/Finance	On-going					

	monitoring							
	Full implementation	CSU/Finance	April 12					
Review TIA service in-line with best practice tariff guidance		C	April 12	None				
Implement LTC teams across B&H	Implement teams	C/P/LA/PC	Dec 11	£100k				
	Implement supporting model	C/P/LA/PC	Dec 11					
Improved Oxygen service	Complete oxygen service procurement as part of national re-procurement	Regional Procurement Hub/PCT Alliance/C (tbc)	Mar 12	None				
	Implement oxygen assessment and management pathway	C/P/PC	April 12	£50k cost pressure				
City wide risk prediction tool to identify and stratify LTC patients within each practice	Implementation of risk prediction tool	C	Aug 11	None specific - £119k general reduction in admissions				
Implement insulin pumps		BSUH/C	April 11	Cost £235k				
Expert Patient Programme	Develop and deliver future programme	SCT	April 11	Cost £30k				
Housebound Project	Implementation of pilot	PC	April 11	Cost £69k Savings tbc				
Carers	Deliver strategy	LA	On-going	Cost £86k				
Physical Disability	Deliver strategy	C	On-going	Cost £118k				

### 3.2 Urgent Care

#### Summary

We will transform urgent care services in the city so that they are:

- simple to access – patients will know what services are available when, where and how to access them;
- responsive – patients will receive a timely response that meets their needs;
- consistent – patients will receive the right care whenever they need it and however they access the system;
- appropriate – patients will receive the right care most appropriate for their needs taking account of the urgency of the need and value for money

Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Implement new short term services model	Develop service model	C	July 2011	£350k PCT and £150k LA (reinvested)				
	Agree procurement route	C	July 2011					
	Procure services	C/CSU	July 11 – contract start April 12					
	Implement new medical model	C	April 12					
Implement long term model of community rapid response service/hospital rapid discharge team	Review phase 1	C	April 11	£318k				
	Implement long term model	C	Sept 11					
Triage of 999 calls	Implement local Directory of Services	C	Mar 11	C£100k tbc				
	Implement NHS Pathways	SECAM	April 11					
Continue implementation of ambulatory care model	Implement additional pathways	C/P	On-going	£592k				
Continue to improve hospital discharges		C/P	On-going	No new savings £42k cost				
Commence procurement or pilot for NHS 111		C/CSU	Pilot 11/12 or if not 12/13	None				
Review options for Urgent Care Centre and Out of Hours Service	Decision required. (Date dependent on publication of	C	Sept 11	None				

	new GP contract)							
Develop and implement plans for the use of reablement and social care monies		C	Ongoing	£109k reablement costs (local) £3.3m social care				
Pilot clinical dashboard (Urgent Care and LTC)	Implement clinical dashboard	C/HIS	Q1/2	£250k Primary Care cost Plus IT				
A&E Clinical Audit		Clinician/C	On-going					
A&E Primary Care	Social marketing campaign	C	On-going	£141k				
	Target A&E reattenders with mental health issues	C	On-going					

### 3.3 Planned Care

Summary								
<p>The following schemes will make services more accessible to patients whilst delivering improved cost efficiency and quality.</p> <p>In 2011/12 we will build on the successes of 2010/11 further reducing demand and moving more outpatient activity to primary and community settings. We will work with secondary, community and primary care providers to deliver solutions that are mutually beneficial and sustainable.</p> <p>We will also work with patients to ensure that they are fully involved with decisions relating to their care through informed choice and informed decision making. We will strive to involve patients in all commissioning decisions.</p>								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Referral management to be delivered by BICS from 1 <sup>st</sup> Jan 2011	Contract monitoring	C	On-going	£675k in contract to be delivered for calendar year 2011.				
	Audit of contract (contractual obligation)	C/CSU	30/6/11 – 31/8/11					
	Negotiation of new contract/contract extension	C	30/9/11					
Commission daycases as outpatient procedures	Work with CRGs to move daycases to outpatient clinics	C	Rolling programme	£699k (represents a third of maximum potential savings). To be split				
Outpatient services to be delivered as a	CRGs to identify pathways to be recommissioned	C	Rolling programme					

Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
one-stop shop				across the 3 areas.				
Telephone advice and appointments	Neurology and renal pilot is on-going	C to assess	31/3/11(?)					
	Further roll-out	C/P	tbc					
Enhanced Recovery Programme (QIPP)	MSK ICATS knee service Informed Decision Making service ready to be implemented by Primary Care.	Clinical lead/C	tbc	£72k cost				
Integrated Care Pathways	MSK	No further commissioning input required.	Fully implemented from 1/4/11	£931k				
	Dermatology – expand scope to include all day case activity	C	Revised contract with BICS to be in place 1/7/11	£77k				
	Expand approach to ENT, neurology, gynaecology and other high volume specialties	C	Phased from Q3	£142k				
Reduce ENT outpatients	BICS triage GPs to use Primary Care guidelines	BICS	From 1/3/11	£126k (includes some movement of procedures to community settings).				
Ophthalmology – develop an integrated Glaucoma service	Service in place with South East Health – local price agreed	SEH	From 1/4/11	£21k				
Restorative dentistry service	Establish consultant post at BSUH	BSUH	1/4/11	n/a – set-up funded by RTF (£92k)				
	Develop Primary Care workforce	PC	On-going	None				

### 3.4 Primary Care

Summary								
<p>General Practice: For high quality to be a consistent part of everyone's primary care experience.</p> <p>Pharmacy: To continue to improve the health of the City through its community pharmacies who are well placed to progress on local priorities for health improvement and reducing health inequalities.</p>								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
LES Review	Agree framework and services to target	C/PC	April 11	Currently being identified				
	Implement recommendations	C	April 12					
	Undertake further review including benchmarking of prices	C	Sept 11					
	Further implementation	C	April 12					
NHS Health Checks	Agree plan	C/PC	Jun 11					
	Progress implementation	C	On-going					
GP Balanced Scorecards	Publication of scorecards	C	April 11					
	Implement practice improvement plans	C/PC	On-going					
Estates Strategy	Implement strategy	C	On-going					
Access and Responsiveness of GP Practices	Continue to make improvements	C/PC	On-going					
Reduce the 'culture of dependency'	Roll-out of healthy living pharmacy programme	PH/C/PC	Dec 11					
	Support a Health Promoting Practice Scheme	PH/C/PC	Mar 11					
Primary Care Federations	Support development	C/PC	On-going					
Implement pharmacy assurance framework	3 year rolling visits programme starts	C	Jan 11					
Review pharmacy LES's	Review pharmacy LES's	C	Jan 12					
Pharmaceutical Needs Assessment	Published	C	Feb 11					

### 3.5 Mental Health

<b>Summary</b>								
<p>Four areas have been identified as priorities for transformation:</p> <ol style="list-style-type: none"> <li>1) Promoting Mental Health and Wellbeing</li> <li>2) Developing Community Pathways to support recovery</li> <li>3) Developing Care Pathways to treatment services</li> <li>4) Improving access to psychological services</li> </ol>								
<b>Deliverable</b>	<b>Milestone</b>	<b>Responsibility</b>	<b>Delivery Date</b>	<b>Net Saving 2011/12</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Dementia programme and sustainability plan	Memory Assessment service	C	Jul 11	RTF funding £1,159k				
	Dementia in-reach	C/P	May 11					
	Dementia crisis	C/LA	Jul 11					
	Dementia LES	C	Sept 11					
	MH liaison services (acute)	C/P(SPFT + BSUH)	Jun 11					
	Sustainability plan	C	Jan 12					
Implement re-designed secondary care/community MH services to support acute inpatient bed reductions	Intensive adult clinical case management service	P	July 11	None				
	Integrated Community Case Management Service	P	July 11					
	Implement reduced in-patient bed numbers - CAMHS	LA	April 11	£50k				
	Implement reduced in-patient bed numbers – WAMHS & OPMH	C/P	July 11	£100k				
Implement Urgent Response Service (BURS) and review impact upon A&E attendance and MH admissions.		C	Apr 11					
Design and implement community eating disorder service	Repatriate resources and align with PBC investment	C	July 11	None				
	Service	C	July 11					

	established								
Redesign of day services	Redesign and re-commission Allen Centre	C/P	Oct 11	£50k					
	Redesign remaining day service provision	LA/P/C	Jan 12						
Tender and implement new service models for primary care mental health, brief psychological therapies/counselling and day service (Allen Centre).	Tendering of primary care MH services	C/P	Jan 12	£225k					
	Tendering of IAPT services	C/P	Jan 12	IAPT cost pressure £1,170k					
3 <sup>rd</sup> sector re-commissioning	Develop a day services strategy with the LA	LA/P/C	Jan 12	None					
Develop youth services	Redesign care pathway for Looked After Children	LA/P/C	Jan 12	None					
	Provide outreach to young people 14-19 attending youth hubs	LA/P/C	Jan 12						
Review processes for specialist placements	LD/ABI etc – formalise process and funding for specialist placements	C	July 11	None					
	Secure and forensic – oversee financial recovery plan and transition to SCG (specialist commissioning group)	C/SCG/National Commissioning Group	April 12	None					
Continue implementation of MH promotion strategy and action plan		PH	On-going	None					

### 3.6 Maternity

Maternity								
<b>Summary</b>								
Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies.								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Commissioning of birth centre		P	Oct 11	None				
Reduce number of c section births		P	On-going	£267k				
Introduction of fibronectin testing		P/C	April 11	£54k				
Neonatal outreach service	Establish tariff	C/CSU/P	July 11	None				
	Commence pilot	P	Sept 11	None				

### 3.7 Childrens Services

Childrens Services								
<b>Summary</b>								
We aim to improve the lives and health of children and young people through delivering integrated, effective, evidence based and needs led services, as close to home as possible.								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Improve Urgent Care pathway for children	Phase 1 – minor head injury	C	April 11	£59k				
	Phase 2 – other high volume conditions	C	Sept 11 tbc					
Improve care pathways for children with asthma, diabetes, epilepsy and chronic fatigue syndrome (CFS/ME).	Employ therapist for children with CFS/ME	P	July 11	£65k cost Savings £29k				
	Phase 1 – reduce admissions to national average	C/P/PC	Sept 11(tbc)					
	Phase 2 – reduce admissions to top quartile performance	C/P/PC	April 12	£80k in 12/13				
Introduce insulin pump therapy for diabetic children		C/P	April 11	Cost £200k tbc				

### 3.8 Medicines Management

Summary								
<p>We aim to</p> <ul style="list-style-type: none"> <li>– improve the clinical and cost effectiveness of medicines management within primary care</li> <li>– ensure that medicines quality issues are addressed in the commissioning process</li> <li>– align the medicines management strategy with the strategy for the management of long term conditions</li> </ul> <p>Through this we will maximise patient safety and improve health outcomes.</p>								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Improve prescribing effectiveness in primary care	Agree Prescribing Incentive scheme targets with PBC	Prescribing advisor	April 11	Included in total saving of £1m				
	Monitor prescribing costs		Monthly					
	Monitor generic prescribing		Quarterly					
	Monitor use of specials							
	Monitor drugs misuse							
Monitor Better Care Better Value indicators								
Improve controls over PbR excluded drugs	Blueteq database for management of PbR excluded drugs active for rheumatology	Prescribing advisor	Apr 11					
	Blueteq database active for dermatology and gastrointestinal (GI)		Oct 11					
	Blueteq database active for remaining specialties		Mar 12					
Develop joint formulary and shared care guidelines (SCG)	Staged workplan agreed for formulary sections	Prescribing advisor /providers	Apr 11					
	SCG template and development agreed with providers		May 11					
	GI section of formulary complete and incorporated into Map of Medicine		May11					

## 4 Delivery Plans – Others

Section 4 provides a summary of the plans within each Priority Transformational Programme area (PTPs) that will be lead by other commissioning groups within Brighton and Hove, eg. Public Health, the Local Authority, Sussex Specialist Commissioning Group.

Annex A provides more detailed information of the plans within each within each Priority Transformational Programme areas (PTPs).

### 4.1 Cancer

Summary								
We aim to:								
<ul style="list-style-type: none"> <li>• Minimise people’s risk of developing cancer;</li> <li>• Encourage early presentation, detection and diagnosis;</li> <li>• Provide the very best cancer treatment including faster access;</li> <li>• Improve people’s experience of cancer care throughout the pathway.</li> </ul>								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
Deliver radiotherapy within 31 days	Commission 40k fractions per million pop	CSU	April 11	New local tariff to be agreed				
	Increase availability of LINACs within SCN area	P	Sept 12					
Chemotherapy	Increase capacity by developing Chemo at home service	CSU	Sept 12					
Breast screening program	Implement age extension	C	April 11					
	Make MRI scans available for those with high risk family history	C	April 11					
Colorectal cancer	Bowel screening age extension	C	April 11 (pending DoH approval)					
	Improve direct access to endoscopy and flexible sigmoidoscopy	CSU	April 11					
	Improve public and primary care awareness (NAEDI)	Public Health	Oct 11					

	Additional CTs to replace barium enemas	CSU	April 11						
Children and young people	Open POSCU leve3 at RSCH	CSU	Oct 11						
	Develop "survivorship" clinics	CSU	April 11						
Acute oncology	All patients admitted with cancer to be seen by member of oncology team	CSU	Sept 11						
	Implementation of IO Guidance on investigation of unknown primary	CSU	Oct 11						
PET Scanning	Increase availability of scans to equivalent of 925 per million	CSU	April 11						
Sarcoma	Develop local IOG compliant service	CSU	June 11						
Cervical screening	All patients to receive results within 2 weeks	Public Health	April 11						

## 4.2 Specialist Commissioning

### Summary

To effect smooth transition of robust commissioning arrangements for Specialised Services to 'the future state' in readiness for the planned establishment of the NHS Commissioning Board in 1 April 2012.

### Programme Plans (further detail in Annex A – delivery plan)

- Rare cancers
- Neurosciences
- Major trauma
- Critical care
- Renal
- Specialised paediatrics
- Specialised rehabilitation
- Specialised mental health
- Cardiac
- Bariatric surgery

### 4.3 Primary Care Contracting

Summary								
<p><b>General Practice:</b> For high quality to be a consistent part of everyone's primary care experience.</p> <p><b>Dentistry:</b> To improve oral health by providing access to high quality NHS dentistry that meets the needs of the local population in the most convenient and appropriate way.</p> <p><b>Optometry:</b> To ensure that everyone has an opportunity to minimise the impact of visual impairment through detection of disease at an early stage.</p>								
Deliverable	Milestone	Responsibility	Delivery Date	Net Saving 2011/12	Q1	Q2	Q3	Q4
PMS/APMS Review	Board approval	CSU/PC	Jan 11	(To be identified)				
	Recommendations implemented	CSU	April 12					
'Choice' of GP practice	Implement policy	CSU/PC	April 12					
Reduce GP list inflation	Programme agreed	PC	April 11					
	Implementation	External	April 12					
Review discretionary payments to GP practices		CSU	Jun 11					
Orthodontic review	Implement recommendations	CSU	Sept 11					
Specialist endodontic contract	Contract starts	CSU	Jun 11					
Procure out of hours emergency dental service	Contract starts	CSU	April 11					
Review sedation services	Pilot CBT service	PC	Sept 11					
	Develop referral guidelines	PC	Sept 11					
Restorative dentistry	Development of dentists with special interests – service starts	CSU/PC	Sept 11					
Improve access	Permanent investment in East Brighton	PC	Jan 12					
Improve Access	Contract management – minimise unnecessary recalls and split courses of treatment	CSU	On-going					
Dental balanced	Publication	PC	April 11					

scorecard	Full roll out	PC	Oct 11					
Promote improvements in children's oral health	Commission training to support oral health champions programme	PC	Jun 11					
Rapid needs assessment for primary eye care services		PH/PC	April 11					
Develop arrangements for monitoring optometry contracts	Plan agreed	CSU	April 11					
Improve access to NHS eye tests	Targetted communications	PH/PC	Jun 11					
Expand optometry LES	Expanded cataract LES starts	PC	April 11					

#### 4.4 Public Health

<b>Summary</b>
<p>These programmes contribute to the prevention and early detection of the major causes of morbidity and mortality and aim to reduce the gap in life expectancy between the least and most disadvantaged populations while improving the overall life expectancy of the local population.</p>
<p><b>Key Milestones</b></p> <ul style="list-style-type: none"> <li>• NHS Health checks support worker appointed (June 2011)</li> <li>• AAA screening bid agreed by national steering group</li> <li>• AAA screening programme planning begins (October 2011)</li> <li>• Support programme for patients undergoing bariatric surgery in place (Jun 2011)</li> <li>• Transfer those Practices running the Alcohol DES in 2010/2011 over to the re-specified Alcohol LES May 2011</li> <li>• Training for practices to run the Alcohol LES June 2011</li> <li>• Further 10 Practices to run the Alcohol LES March 2012</li> </ul>

#### 4.5 Sexual Health

<b>Summary</b>
<p>We aim to increase early detection and treatment of infections including Chlamydia and HIV. We will continue to improve access to services in community settings. Promotion of positive sexual health will ensure all local people have the information and resources they need and will lead to reduced rates of infection.</p>
<p><b>Key Milestones</b></p>

**GUM service**

- Receive GUM data report from BSUH by mid June 2011
- Negotiate appropriate volumes of level 3 and level 2 services to be provided at GUM by July 2011.
- Conclude service specification and contract negotiation by September 2011
- Commence new service model October 2011

**Chlamydia screening programme**

- Programme requirements for 2011/12 confirmed by DH by Feb 2011
- Service specification complete and included in Sussex Community Trust contract by May 2011

**HIV testing in primary and secondary care settings**

- Agree offer and uptake HIV screening targets for acute general medical admissions with BSUH by January 2011
- Specification for HIV testing in primary care is complete by June 2011
- 50% of general practices offer opt-out, point of care HIV testing by August 2011
- 25% of HIV LES general practices to offer point of care HIV testing by March 2012
- Target and timeline for remaining practices to be agreed

## 5 Enablers

### 5.1 Workforce

#### 5.1.1 Workforce Impact of QIPP

A high level analysis of workforce implications of the QIPP workstreams is provided in the following table.

Area of transformation	Workforce Impact
<b>Urgent care</b>	Reduced acute workforce and role substitution for primary care. Strengthened specialist community roles. Specific role for paramedics in areas such as stroke.
<b>Long Term Conditions</b>	<p>Different ways of work for consultants and GPs. Redesign of community workers including development of support workers.</p> <p>Training in personalised care planning and self care and intermediate care. Increased role for the primary care team including social care. Increases in staff relating to cancer services i.e. therapeutic radiographers.</p> <p>Increases productivity in screening services.</p>
<b>Out of Hospital Care</b>	Potential reduction in acute workforce, planned redeployment of workforce as services are re-commissioned or decommissioned. Develop expanded roles/extended roles of GPs and Allied Health Professionals.
<b>Planned care</b>	Reduced acute workforce. Increasing specialisms. Increased flexibility of workforce and roles that work across organisational boundaries.
<b>End of Life care</b>	Training and new ways of working implications for acute, community, primary care and care home staff.
<b>Children</b>	<p>Reduction in acute staffing in relation to the urgent care pathway. Implement effective skill mix in health visiting and school nursing/community teams. Further development in children's workforce in conjunction with social care.</p> <p>Increase in health visiting and school nursing in line with national policy.</p>
<b>Maternity</b>	Development of support work and re-profiling of workforce including ongoing recruitment and retention of midwives.

	Increasing consultant led workforce for labour wards. A number of training implications in adopting new ways of working and implementing productive ward.
<b>Staying Healthy</b>	Develop the wider workforce skills/competencies in prevention/staying healthy. Ensure supply of public health skills.
<b>Mental health</b>	Develop mental health skills in community settings/increase skills in dementia care. Reduction in acute Mental Health beds and a resultant reduction in the workforce. Approximately 35 Mental Health specialists to transfer to primary care. Continued recruitment of IAPT therapists to a total of 130 with further role substitution for access to psychological therapies. Training implications for memory assessment.
<b>Estates</b>	Reduction in the overall estate will require a reduced workforce.

### 5.1.2 Workforce Productivity – QIPP Programme

The workforce productivity programme focuses mainly on the generic aspects of workforce that can increase productivity. Those focused around staff engagement with the organisation which lead to greater loyalty, higher attendance and increased motivation.

The indicators we have agreed to use are sickness absence rates, agency spend, appraisal and performance development plan coverage and implementation of the productive series. A target has been set for all Trusts and at the next round of assurance meetings, trajectories will be set dependant on the Trusts current performance. Progress will be monitored individually and with the completion of a county wide QIPP tracker (a spreadsheet that monitors achievement of milestones and identifies risks to success. This is reported to the Sussex Performance Management Office. Progress to date is largely on track, however further work is needed around the finance side to ensure savings are achievable and not being double counted in other programmes.

## 5.2 Information Management and Technology

The Sussex health community has committed to the development of a Sussex information management and technology vision that will support and enable the large scale transformation to be delivered through the QIPP workstreams. Work is ongoing to specify further the developments needed to secure the benefits set out in each of the service transformation plans. All partners have agreed that this is essential to ensure that:

- Opportunities for leveraging greater value for money are achieved
- Good practice and excellence are delivered through joint approaches
- Patients clinical information can be transferred safely as they progress through the care pathway
- Clinical decisions about care are taken closer to the patient

- The work of clinicians is supported and enabled
- Opportunities to minimize the costs of collecting any unnecessary performance or cost data are realised
- Systems and data are managed in line with the aspirations set out in *An Information Revolution*

The future vision is centred on the principle of a core electronic patient record and will include:

- Improved and safe clinical communications between secondary and primary care
- Defined interoperability standards between systems and providers
- Robust decision support tools
- Systems which are resilient 24/7
- IT cost optimisation through procurement, cost reductions and process improvements
- Unified communications

The Sussex wide vision is not intended to constrain developments by individual Trusts or PCTs but rather to compliment these by being clear on what initiatives require collective working. Sussex organisations are also working collaboratively on a deployment plan for a community information system with Sussex Community NHS Trust.

NHS Brighton and Hove has some specific projects that it will progress in 2011/12 as follows.

- Summary Care Records (SCR)
- Electronic Prescription Service (EPS)
- Other Primary Care schemes

### **5.3 Estates Development**

The development of the primary and community estate is a key enabler to all the service transformation and QIPP plans for Brighton and Hove ensuring that we have the right environment for the strategic objectives to be achieved.

The PCT has developed an Estates Strategy and has completed an assessment of the primary and community assets in the city.

A review of the primary care estate in 2009 identified that there were 11 GP surgeries where the condition of the premises is poor. Of these, three surgeries moved to new premises in 2010/11, and a fourth closed. Sites have been identified for four new developments to replace five of the remaining sub-standard surgeries, with third party development companies engaged by the practices. Two of the developments are planned to complete in 2012 and two in 2013. One small surgery will close later in 2011, leaving only one small branch surgery needing to be replaced. There is potential for a new replacement surgery to be part of any larger site development at Brighton General Hospital; however there are no firm plans at this stage. A further review of the primary care estate should be carried out in 2012.

Additional NHS dental services are being commissioned across the city in 2010 and it is a requirement as part of the procurement process that these must be delivered in high quality accommodation that is fully accessible. The condition of the existing dental estate has not been reviewed since 2005.

Pharmacy and Optician premises have not been reviewed but are of generally good condition. NHSB&H will consider setting standards for new pharmacies (e.g. as part of third party developments) to ensure they include private consulting space and sufficient dispensing area.

In parallel, there are major plans for the development of the acute trusts estate via the “3Ts” (teaching, trauma and tertiary) strategy. The key investment objectives are to replace the Barry and Jubilee buildings, to transfer the Regional Centre for Neurosciences from Hurstwood Park to the RSC, to develop and expand the Sussex Cancer Centre, to develop the RSC as a major/level 1 Trauma centre for Sussex, and to strengthen teaching, training and research. NHSB&H will work with the Trust to assess the impact of the planned developed on local services and to ensure that any planned transfer of services into the community is fully understood and jointly managed.

A significant piece of work has recently been completed which has involved a detailed analysis of the estates requirements arising from the proposed service changes within each transformation programme to ensure there is real alignment with QIPP requirements. A detailed investment plan will be developed from this data.

A Sussex wide estates rationalisation group has been established to consider what could be done to optimise the use of the existing estate held by all organisations to deliver our collective plans and priorities. Alongside this there is potential to draw on additional external expertise to map assets and develop plans as part of a Kent and Sussex transformation plan.

Brighton and Hove have established a city wide property group which engages health together with all public sector partners to also consider how the estate within the city could be used to achieve our individual and collective objectives.

Below is a summary of the estates implications for each of the PTPs continue to be discussed and refined at the programme boards with commissioning leads and other key stakeholders.

#### Summary of the Estates implications of PTPs

PTP	Planned Developments	Estate Required			
		GP Surgery	Community Venue	Secondary Care	Not yet defined
<b>1. Urgent Care</b>	Procure Urgent Care Centre Introduce Rapid Access Assessment Services Introduce Short Term Services Introduce single point of access		• • •	•	
<b>2. Primary Care</b>	Procure additional dental services Replace GP surgeries	•	•		
<b>3. LTC and Case Management</b>	Establish LTC Teams		•		
<b>4. LTC and independence</b>	Establish specialist neuro rehab services Establish ICES		• •		
<b>5. Gateway and Referral Management</b>	Identify opportunities for referral and gateway management and implement service changes Extend range of triage services	• •			
<b>6. Acute Hospital Care</b>	Focus on improved efficiency at BSUH			•	
<b>7. Out of Hospital Care</b>	Develop pilots for MSK and Dermatology Implement the ENT pilot	• •	•		

	Transfer MSK, hearing aids and eye services Develop urology, nurse specialist and cardiology	•	•		
<b>8. Cancer</b>	Implement increased access to specialist services Implement age extension for screening services		•	•	
<b>9. Specialised Commissioning</b>	More local treatments			•	
<b>10. Transforming Mental Health</b>	Implement SMI LES Review community Services and implement new model Review psychological therapy service and implement new model Develop and implement new dementia model Develop and implement memory service	• • •		•	•
<b>11. Transforming Maternity Services</b>	Increase neonatal cots Implement MLU			• •	
<b>12. Transforming Children's services</b>	Develop improved prevention services Develop community-based alternative services to A&E/CASU Increase and improve transitional care provision and services	• •		•	
<b>13. Developing a Healthy Young City</b>	Develop a community sexual health service and assault referral service Develop alcohol harm prevention and expand suicide prevention work	•	• •		
<b>14. Adding Years to Life</b>	Roll out NHS Health Checks Commence new smoking cessation services Commence new adult obesity services Commence new AAA screening services	•	• •		•
<b>15. Targeted spend Review</b>	No estates implications identified at present				
<b>16. Use of system levers</b>	No estates implications identified at present				
<b>17. Corporate Efficiency</b>	No estates implications identified at present				

## 5.4 Risk

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

(CRxxx = risk number in Corporate Risk Register).

Key AOP risk	Current Risk level	Mitigation	Target Risk Level
Insufficiently well developed local health care market and procurement processes with resultant impact on the required	Medium	The PCT has standardised procurement processes in place. The Procurement and Market Management function is currently	Moderate

Key AOP risk	Current Risk level	Mitigation	Target Risk Level
shift of services into the most appropriate settings.(CR266)		being developed as part of Sussex Commissioning Support Unit implementation	
Significant medium term financial challenge to the PCT caused by a reduction in real terms funding and a lack of an underlying surplus resulting in potential reductions in services or budgetary overspend. (CR267).	Extreme	Medium term financial plans developed in partnership with local health economy partners to identify further potential savings opportunities. Development of a procurement and market management function to support improvements in the use of resources and value for money policy to support investment and disinvestment decisions.	High
Lack of robust plans to deliver the financial savings set out in the Integrated Plan for 2011/12 recurrently resulting in a financial pressure rolled forward into 2012/13 and a failure to achieve financial balance in either year. (CR376).	Extreme	A programme of work will be established in order to identify recurrent savings for 2011/12 and beyond. This will form a key part of the Transitional Consortium Commissioning Executive's agenda.	Moderate
Pressures on the Local Health Economy to meet its financial targets for 2011/2012, leading to consequential pressure on the PCT's year-end position.(CR457)	High	The PCT monitors provider Trust performance within Directorates and at Board level. Year-to-date and forecast positions will be monitored and actions implemented to address variances. A plan will be drawn up and implemented to address pressures and lead the PCT to a break-even position at year-end. There is also close liaison between PCT and Trust Director of Finance.	Moderate
Significant organisational changes lead to a potential loss of current relationships which have been established with local partners resulting in a lack of system leadership. (CR 468).	Extreme	Arrangements in place with Delivery Board, Performance and Quality Review Boards. Transitional arrangements with Brighton & Hove City Council re joint commissioning and the development of the Health and Wellbeing Board. The PCT Chief Executive has regular planned meetings with the Council's management team.	Moderate
PCT staff become distracted from managing delivery of current plans due to impending structural and	Extreme	Regular communications with staff through Joint Staff Committee, quarterly seminars, weekly e-bulletin	Moderate

Key AOP risk	Current Risk level	Mitigation	Target Risk Level
organisational changes and impact on individuals (with the potential for increased stress and sickness absence, lower morale and an inability to retain staff), resulting in potential failure to deliver the Integrated Plan in 2011/12. (CR 470)		and updates on the Extranet. Management cost target achieved for 2010/11. Restructuring to achieve target for 2011/12 taking place before financial year-end.	
Budget reductions put pressure on partnerships following transfer of financial and service risks. (CR 471).	High	Ongoing dialogue between the PCT and partners, specifically Brighton and Hove City Council. Relationships and influence maintained through Joint Commissioning Boards.	Moderate
The workforce implications in provider organisations may not be sufficiently understood or worked through as part of the development of proposed service developments in the Integrated Plan, which may lead to potential savings identified in the Integrated Plan not being fully realised with resultant financial pressure on PCT budgets (CR 488).	High	Developments are co-ordinated with the Commissioning Support Unit and the Sussex Workforce Hub. Commissioners use data from the Workforce Hub to inform their commissioning decisions.	Moderate

**Appendix A - Financial Savings & Investments**

	11/12 Cost (£k)	11/12 Savings (£k)	11/12 Net (£k)
<b>PTP QIPP SAVINGS</b>			
Diabetes		(74)	
Anti Coag	87	(249)	
End of Life - Education & Training	7		
Prevention of admission LTC		(119)	
Service Redesign - LTC Teams		(100)	
Service Redesign - ICES		(65)	
Service Redesign - Integrated Neuro Rehab Team		(80)	
<b>Total Long Term Conditions</b>	<b>94</b>	<b>(687)</b>	<b>(593)</b>
Reduction in the Number C Section Births		(267)	
Fibronectic Test	36	(90)	
Reduction in Paediatric A&E		(59)	
Paediatric LTCs		(29)	
<b>Total Maternity &amp; Children</b>	<b>36</b>	<b>(445)</b>	<b>(409)</b>
Decommission Access/ Commission PCMHS PYE Q3		(125)	
Decommission Adult I/P Beds PYE Q4		(100)	
Decommission CAMHS I/P Bed Q1		(50)	
Recommission Allen Centre (renegotiating) PYE Q3		(50)	
OPMH - Dementia	1,159		
<b>Total Mental Health</b>	<b>1,159</b>	<b>(325)</b>	<b>834</b>
Community - Dermatology	439	(516)	
ENT - phase 2 of project	50		
ENT		(126)	
Gynaecology	97	(121)	
Ophthalmology	86	(107)	
Neurology	57		
Neurology	547	(684)	
Glaucoma OP	352	(440)	
MSK	2,449	(3,380)	
Reduction in Out-Patients (Benchmarking)		(420)	
Enhanced Recovery	147	(75)	
Day Case to O/P Proc		(699)	
Theatres Productive Ward Programme	50		
Restorative Dentistry	70		
OPD large scale change programme	100		
Development of an Acute Oncology Service (AOS)	102		
<b>Total Planned Care</b>	<b>4,546</b>	<b>(6,568)</b>	<b>(2,022)</b>
Access & Responsiveness (LES one year only)		(250)	
Dental Access Centre & Community Services (SDH)- Recommissioned		(44)	

<b>Total Primary Care</b>	-	(294)	(294)
Reprovide Level II Sexual Health Services		(150)	
<b>Total Sexual Health</b>	-	(150)	(150)
GP OOHs		(110)	
Reduction in Ambulatory Care Admissions	(102)	(490)	
Hospital Rapid Discharge Team	42		
Reablement Money - Local Plan	109		
Phase 1 999 (NHS Pathways - SECAMB)		(37)	
Rapid Response and Assessment	67	(187)	
RTF additional RRS	161	(359)	
Primary Care A&E		(141)	
Readmissions Project	100		
RTF additional Roving GP	50	(65)	
FYE RTF	42		
<b>Total Urgent Care</b>	<b>469</b>	<b>(1,389)</b>	<b>(920)</b>
Prescribing Efficiencies		(1,000)	
<b>Total Prescribing</b>	-	<b>(1,000)</b>	<b>(1,000)</b>
Management Cost Savings		(1,958)	
SDH Corporate Efficiencies		(365)	
<b>Total Corporate Initiatives</b>	-	<b>(2,323)</b>	<b>(2,323)</b>
<b>SUB TOTAL (reduced investment reflecting RTF)</b>	<b>6,304</b>	<b>(13,181)</b>	<b>(6,877)</b>
RTF - Urgent Care	(293)		
EOL Funding - Urgent Care	(67)		
EOL Funding - Education & Training	(7)		
Reablement Funding	(109)		
RTF - Planned Care	(576)		
RTF - Mental Health	(1,159)		
<b>Total RTF</b>	<b>(2,211)</b>	-	<b>(2,211)</b>
<b>TOTAL INVESTMENTS</b>	<b>4,093</b>	<b>(13,181)</b>	<b>(9,088)</b>
<b>COST PRESSURES / SERVICE INVESTMENTS</b>			
Bowel Cancer Screening	80		
Breast Cancer Screening Services	240		
Horizon Scanning - Drugs	300		
IOG Compliant Services		(95)	
Chemotherapy - Drugs/Reprovision	1,356		
<b>Total Cancer Services</b>	<b>1,976</b>	<b>(95)</b>	<b>1,881</b>
Diabetes - Insulin Pumps	235		
Oxygen Review	50		
Carers	86		

EPP	30		
Physical Disability	118		
<b>Total Long Term Conditions</b>	<b>519</b>	<b>-</b>	<b>519</b>
Insulin Pumps (Children)	100		
Chronic Fatigue Syndrome	15		
Continuing Health Care - Children	50		
<b>Total Maternity &amp; Children</b>	<b>165</b>	<b>-</b>	<b>165</b>
Good mental health (IAPTs)	1,170	(100)	
<b>Total Mental Health</b>	<b>1,170</b>	<b>(100)</b>	<b>1,070</b>
Restorative Dentistry	92		
DA Chest Xrays	31		
<b>Total Planned Care</b>	<b>123</b>	<b>-</b>	<b>123</b>
Access to primary care (GP Led Health Centre)	150		
Premises rental increase	80		
Premises non recurrent costs	35		
SMI LES	159		
VAT increase from 17.5% to 20% - GP Rent Reimbursements	45		
<b>Total Primary Care</b>	<b>469</b>	<b>-</b>	<b>469</b>
NHS Health Checks	25		
AAA Screening	20		
<b>Total Public Health</b>	<b>45</b>	<b>-</b>	<b>45</b>
Clinical Dashboard	250		
<b>Total Urgent Care</b>	<b>250</b>	<b>-</b>	<b>250</b>
GP Consortia £2 per/head	520		
<b>Total HQ</b>	<b>520</b>	<b>-</b>	<b>520</b>
<b>TOTAL COST PRESSURES</b>	<b>5,237</b>	<b>(195)</b>	<b>5,042</b>
<b>GRAND TOTAL</b>	<b>9,330</b>	<b>(13,376)</b>	<b>(4,046)</b>

Appendix B - Integrated Performance Measures for 2011/13								
Headline Measures								
		Measure	Definition	How Performance will be Judged	Threshold (if appropriate)	Plan/Forecast required	PCT Plan	Contract Standard
Quality (Safety, Effectiveness & Patient Experience)	HQU01	HCAI measure (MRSA & CDI)	MRSA bacteraemia	Against plan	More than 1 SD away from plan	Yes	8	
	HQU02		CDI	Against plan		Yes	115	
	HQU03_01	Ambulance quality - Cat A response times	Cat A response within 8 mins	Against minimum threshold	75%	No		
	HQU03_02		Cat A response within 19 mins	Against minimum threshold	95%	No		
	HQU04	Patient experience survey	Outliers identified using NHS PF approach + narrative & results of local surveys			No		National CQUIN
	HQU05	RTT waits (95th percentile measures)	RTT - admitted 95th centile	Against max threshold	23 weeks	No		
	HQU06		RTT - non-admitted 95th centile		18.3 weeks	No		
	HQU07		RTT - incomplete 95th centile		28 weeks	No		
	HQU08	MSA breaches	Numbers of unjustified breaches	minimal breaches	tbc	No		Yes
	HQU09	A&E Quality Indicators (5 measures) <sup>1</sup>	Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	Against minimum threshold	>5%	No		Yes
	HQU10		Total time spent in A&E department - 95th centile		>4 hours	No		Yes
	HQU11		Left department without being seen rate		>5%	No		Yes
	HQU12		Time to initial assessment - 95th centile		>15 mins	No		Yes
	HQU13		Time to treatment in department - median		>60 mins	No		Yes
	HQU14	Cancer 2 week, 62 days (aggregate measures)	2 week wait services - % seen in 2 weeks of all urgent referrals & referrals for breast symptoms	Against minimum threshold	93%	No		Yes
	HQU15		62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme		>~86%	No		Yes
HQU16	Emergency Readmissions	Emergency readmissions within 30 days	System indicator	tbc	No		Yes	
Resources (Finance, Capacity & Activity)	HRS01	Financial forecast outturn & performance against plan	Financial forecast outturn performance against plan at organisational and regional level. In addition, no PCT forecast deficits are expected and no provider should plan for a forecast deficit unless part of an agreed recovery plan	Perf against plan and absolute performance by exception	In FIMS	Yes		
	HRS02	Financial performance score for NHS Trusts	Quarterly provider performance ratings to be given based on financial performance and position	System indicator		No		
	HRS03	Delivery of running cost targets	Actual running costs to be compared to target running costs at regional level. Definition of running	System indicator	In FIMS	tbc		

			costs to form part of planning guidance.					
	HRS04	Progress on delivery of QIPP savings	QIPP delivery (savings and re-investment) in 2011/12 and QIPP for 2012/13 to 2014/15	Perf against plan	In FIMS	Yes		
	HRS05	Acute Bed Capacity	G&A available beds	System indicator	recd for BSUHT for all PCTs	Yes		
	HRS06	Non elective FFCEs	Non-elective FFCEs	System indicator		Yes	28,921	
	HRS07	Numbers waiting on an incomplete Referral to Treatment pathway	Total numbers waiting at the end of the month on an incomplete RTT pathway	System indicator		Yes	13,952	
	HRS08	Health visitor numbers	Numbers of HVs	Perf against plan	tbc	Yes		
	HRS09	Workforce productivity	% Change in secondary activity compared to % Change in earnings weighted staff capacity	System indicator	tbc	No		
<b>Reform</b> (Commissioner, Provider & building capability and partnership)	HRF01	FT Pipeline	see SRF01 to SRF03					
	HRF02	Transforming Community Services successfully achieved	see SRF06					
	HRF03	GP consortia progress and transfer of relevant functions to NHS CB/LAs	see SRF07 to SRF10					
	HRF04	Establishment of PCT clusters						
	HRF05	Choice	SRF11 to SRF13					
	HRF06	Information to Patients	SRF14					
	HRF07	Competition	SRF13					
<b>Supporting Measures</b>								
		<b>Measure</b>	<b>Definition</b>	<b>How Performance will be Judged</b>	<b>Threshold (if appropriate)</b>	<b>Plan/Forecast required</b>	<b>PCT Plan</b>	<b>Contract Standard</b>
<b>Quality</b> (Safety, Effectiveness & Patient Experience)	SQU01	VTE Risk assessment	% of all adult inpatients who have had a VTE risk assessment	Improvement		No	90%	Yes
	SQU02	% deaths at home (inc care homes)	No reg deaths at usual place of residence/no. registered deaths	Perf against plan		Yes	41.7%	
	SQU03_01	Ambulance quality indicators (all othermeasures)1	Call Abandonment Rate	Improvement		No		Yes
	SQU03_02		Re-contact rate following discharge of care	Improvement		No		Yes
	SQU03_03		Outcome from Cardiac Arrest	Improvement		No		Yes
	SQU03_04		Service Experience	Improvement		No		Yes

	SQU03_05		Outcome from acute STEMI	Improvement		No		Yes
	SQU03_06		Outcome from stroke for ambulance patients	Improvement		No		Yes
	SQU03_07		Outcome from Cardiac Arrest- survival to discharge	Improvement		No		Yes
	SQU03_08		time to answer call	Improvement		No		Yes
Quality (Safety, Effectiveness & Patient Experience)	SQU03_09		time to treatment	Improvement		No		Yes
	SQU03_10		Ambulance calls closed with telephone advice or managed without transport to A&E	Improvement		No		Yes
	SQU04_01	A&E quality indicators (all other measures)	Ambulatory care	Improvement		No		Yes
	SQU04_02		consultant sign-off	Improvement		No		Yes
	SQU04_03		Service Experience	Improvement		No		Yes
	SQU05	Cancer waits (9 measures)	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	Against minimum thresholds	93%	No		Yes
			Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Against minimum thresholds	93%	No		Yes
			Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer	Against minimum thresholds	85%	No		Yes
			Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	Against minimum thresholds	90%	No		Yes
			Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	Against minimum thresholds	tbc	No		Yes
	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis		Against minimum thresholds	96%	No		Yes	
	Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery		Against minimum thresholds	94%	No		Yes	
	Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime		Against minimum thresholds	98%	No		Yes	
	Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course		Against minimum thresholds	94%	No		Yes	
	SQU06_01	Stroke indicator	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	Against minimum thresholds	80%	No		Yes
	SQU06_02		Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	Against minimum thresholds	60%	No		Yes
	SQU07	Community services	Indicator to be developed in 2011/12		WIP			
	SQU08	Carers breaks	Agree and make available to local people policies, plans and budgets to support carers	Through planning checklist	tbc			

SQU09	Access to NHS dentistry	Current 24 month measure	Perf against plan		Plans already collected	tbc	
SQU10	Staff engagement <sup>2</sup>	Overall Staff Engagement score is calculated from responses to multiple questions in the annual NHS staff survey	Improvement		No		
SQU11	PROMS scores		Improvement		No		Yes
SQU12	Maternity 12 weeks	% women who have seen a midwife by 12 weeks and 6 days of pregnancy	Against minimum thresholds	90%	No		Yes
SQU13	Mental health measures - EI	The number of new cases of psychosis served by early intervention teams year to date	Perf against plan for providers. Perf against envelopes for commissioners		yes	tbc	
SQU14	Mental health measures - CR/HT	Commissioner measure is number of episodes, provider measure is % of inpatient admissions that have been gatekept by CR/HT	Perf against envelopes for commissioners. Perf against threshold for providers	Provider threshold = 95%	no		
SQU15	Mental health measures - CPA	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the quarter (QA).	against threshold	95%	No		
SQU16	Mental health measures - IAPT	Proportion of people with depression referred for psychological therapy and proportion referred for therapy receiving it.	Perf against plan		yes	6.5% and 70%	
SQU17	Low value procedures	Number of identified low value procedures carried out			No	tbc	
SQU18	Smoking Quitters	Smoking quitters per 100,000 population	Perf against plan		Yes	2350	
SQU19	Breastfeeding at 6-8 weeks	Prevalence of breastfeeding at 6-8 wks after birth (also coverage?)	Perf against plan		Yes	69.2%	
SQU20	Breast screening	Extension of breast screening program to women aged 47-49 and 71-73	Improvement		No	tbc	
SQU21	Bowel screening	Extension of bowel screening program to men and women aged 70 up to 75 birthday	Improvement		No	tbc	
SQU22	Cervical screening test results	All women to receive results of cervical screening tests within 2 weeks	Against minimum thresholds		No	tbc	
SQU23	Diabetic retinopathy screening	Percentage of eligible people offered screening for the early detection (and treatment if needed) of diabetic retinopathy in the previous twelve months	Against minimum thresholds	95%	No		
SQU24	Referral to Treatment waits (median wait measures)	RTT - admitted median	Against minimum thresholds	11.1 weeks	No		
SQU25		RTT - non-admitted median	Against minimum thresholds	6.6 weeks	No		

				lds				
	SQU26		RTT - incomplete median	Against minimum thresholds	7.2 weeks	No		
	SQU27	Coverage of NHS Health Checks	% people ages 40-74 who have received a health check	Perf against plan		Yes	7.5%	
	SQU28	People with Long Term Conditions feeling independent and in control of their condition	% of people with LTCs who said they had had enough support from local services/orgs	system indicator		yes	78.8%	
	SQU29	Emergency admissions for Long Term Conditions	Number of emergency admissions to hospital for people who have a Long-Term Condition each month	system indicator	WIP	No		
	SQU30	Safeguarding	Indicator to be developed in 2011/12					
<b>Resources (Finance, Capacity &amp; Activity)</b>	SRS01	Total pay costs	Total costs of staff (to include cost of staff within provider contracts)	Perf against plan and in comparison to workforce	in FIMS	Yes		
	SRS02	Total workforce (FTEs)	All Hospital and Community Health Services (HCHS) workforce by FTE	Perf against plan	in FIMS	yes		
	SRS03	Year to date financial position	In year cumulative surplus/(deficit) position and how it relates to the forecast	Perf against plan	in FIMS	Yes		
	SRS04	NHS Trusts Breakeven duty	NHS Trusts three year break even duty	System Indicator		No		
	SRS05	Delivery of 2% recurrent headroom	All PCTs required to ensure that 2% of their recurrent funding is only ever committed non-recurrently. The 2% to be held by SHAs with PCTs accessing the funding through business cases	System Indicator	in FIMS	tbc		
	SRS06	PCT legacy debt position	PCTs with legacy debt issues (that arose prior to 2011/12) to be dealt with by the end of 2012/13. PCTs to work with developing GP consortia to ensure no new deficits in 2011/12 to 2012/13	System Indicator	in FIMS	Yes		
<b>Resources (Finance, Capacity &amp; Activity)</b>	SRS07	Underlying financial position of PCTs and NHS Trusts	Recurrent position of PCTs and Trusts as reported in FIMs	Perf against plan/system indicator	in FIMS	Yes		
	SRS08_01	Length of stay (Acute and MH)	Average spell duration for non-same day acute discharges	System indicator		Yes		Yes
	SRS08_02		Average spell duration for non-same day MH discharges	System indicator		Yes		Yes
	SRS09	Daycase rate	Proportion of elective FFCEs which are for daycases.	System indicator		Derived from SRS15		Yes

	SRS10_01	Delayed Transfers of Care (Acute & MH)	Delayed Transfers of Care (Acute) - Comm measure is no of delays per 100,000 population. Prov measure is no delays as a proportion of a count of activity or beds.	System indicator/use thresholds from PF	No		Yes
	SRS10_02		Delayed Transfers of Care (MH) - Comm measure is no of delays per 100,000 population. Prov measure is no delays as a proportion of a count of activity or beds.	System indicator/use thresholds from PF	No		Yes
	SRS11	GP written referrals to hospital	No of GP written referrals	Perf against plan & system indicator	Yes	61,598	
	SRS12	Other referrals for a first outpatient appointment	No of other referrals	Perf against plan & system indicator	Yes	33,103	
	SRS13	First outpatient attendances following GP referral	No 1st outpatient attendances after GP referral	Perf against plan & system indicator	Yes	50,739	
	SRS14	All first outpatient attendances	No of first outpatient attendances	Perf against plan & system indicator	Yes	73,691	
	SRS15	Elective FFCEs	No of elective FFCEs (ordinary adms & separately daycases)	Perf against plan & system indicator	Yes	32,744	
	SRS16	A&E attendances	Number of attendances at A&E departments in a month (total and type 1)	System indicator or	Yes	tbc	
	SRS17	Ambulance Urgent & Emergency Journeys	Number of urgent and emergency journeys via ambulance, monthly	System indicator or	Yes	tbc	
	SRS18	Community activity	Indicator to be developed in 2011/12				
	SRS19	Staff absences	WTE Number of days sick/WTE number of days available	Perf against plan / % reduction from baseline	yes	tbc	
	SRS20	Temporary staffing costs	Finance			tbc	
	SRS21	Clinical staff numbers	Clinical staff numbers (Medical & dental, Qualified nursing, ST&Ts, Ambulance staff, Clinical support)	Perf against plan	yes	tbc	
	SRS22	Management numbers	Numbers of HCHS FTE in the categories Admin & estates & Managers & senior managers	Perf against plan	yes	tbc	
	SRS23	Redundancy	Compulsory redundancy of NHS staff within NHS organisations	System indicator or	No	tbc	
<b>Reform (Commissioner, Provider &amp; building capability and partnership)</b>	SRF01	Progression of Trusts along the FT pipeline					
	SRF02	Assessment of risk to successful delivery of pipeline					
	SRF03	Assessment of progress along the pipeline of Trusts in category 4 (unsustainable provider classification)					
	SRF04	Uptake of Right to Provide					
	SRF05	Any Willing Provider					
	SRF06	Progress with Transforming Community Services Divestment					

SRF07	% of GPs (a) in pathfinder consortia and (b) in pipeline to become pathfinders	Indicators to be developed for 2011/12						
SRF08	% of PCT commissioning spend delegated to GP practices	Indicators to be developed for 2011/12						
SRF09	Running costs per head of pop. delegated from PCTs to consortia for start up costs	Indicators to be developed for 2011/12						
SRF10	Has SHA completed full analysis of current levels of staffing and arrangements for those region- wide (SHA and PCT) functions, which will transfer to the NHS CB?	Indicators to be developed for 2011/12						
SRF11	Choice of named consultant-led team							
SRF12	Choice Use of Choose and Book							
SRF13	Use of the independent sector							
SRF14	Percentage of patients with greater control of their care records							
SRF15	Leadership Capacity	Indicators to be developed for 2011/12						