

Cotswold and Vale Business Plan

Cotswold and Vale Primary Care Trust

Business Plan

Fourth draft 29th April 2005

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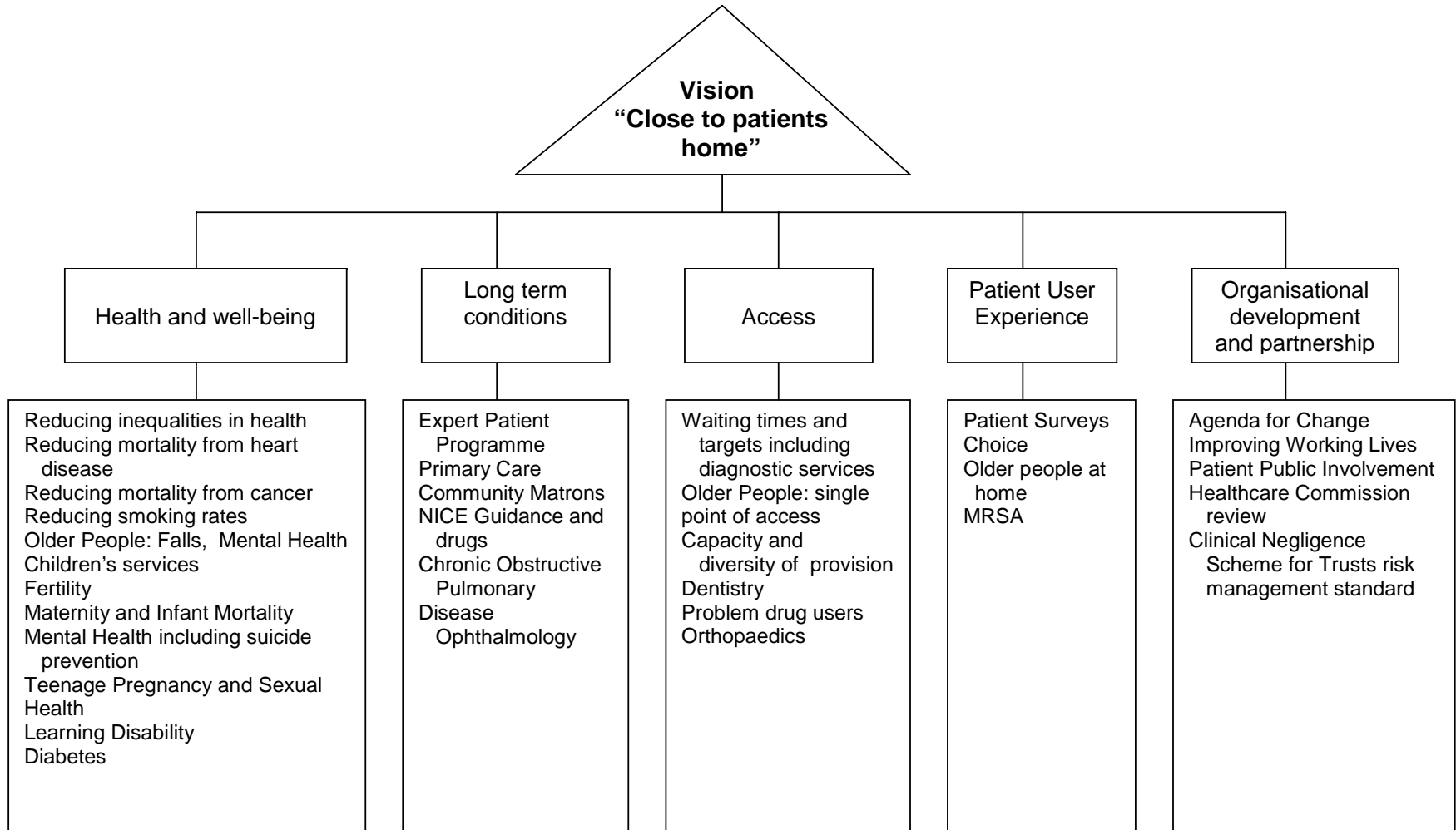
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Guide to the Plan



1. Introduction

The Trust

Cotswold and Vale Primary Care Trust covers an area of 627 square miles and is responsible for healthcare for a population of 192,000, of whom approximately 10,000 are registered with a Gloucestershire GP, but live outside of the county boundary. There are 123 GPs in 33 Practices; 40 community pharmacists; 80 dentists and 80 optometrists working within the Trust area. The Trust is a relatively large employer, with approaching 2000 employed staff working largely within the Trust area.

The Primary Care Trust's budget for 2005/06 is £205m. Of which, £123m will be spent on providing secondary and tertiary healthcare (acute hospital services, both inside and outside of Gloucestershire) and £82m on hospital and primary care services provided within the PCT area (largely from community based hospitals; community services and general practices).

Organisational Structure

In terms of governance the Trust has two key bodies. These are the Professional Executive Committee (PEC) and the Trust Board. The organisation is split into seven Directorates. These each have specific roles and responsibilities. These are Primary Care, Commissioning, Operations, Nursing and Learning, Public Health, Human Resources and Finance and Information. Along side this management structure we have set up four locality fora within the Cotswold and Vale area. This allows local communities and local professional groups to ensure that services are relevant to their communities. This locality focus is a key ingredient to the way we will attain our Trusts goals.

The Vision

This business plan for the Trust is underpinned by the Trusts vision. This is:

"to deliver a range of high quality local health services around the clock, as close to the patients home as possible, organised by integrated teams of health and social care staff based within local communities".

The Plan

This plan in five parts:

- Key strategic themes
- Our Financial position and Financial Recovery Plan
- Supporting strategies around Workforce and IM&T
- Reporting, Risk management and the Assurance Framework
- National Targets, PCT Targets and plans to meet them

2. Strategic Themes

Key References

The NHS Plan was published in 2000. This was the basis of significant change and modernisation for the NHS. The NHS Plan was supplemented by “The NHS Improvement Plan” and “National Standards Local Action” during 2004. These documents provided a more concrete vision of the future of the NHS and clarified targets for the next three years.

National Vision

The NHS improvement plan is clear about the future direction of services. The current changes for the NHS are to deliver services which are “responsive, convenient and personalised” This will involve offering an increased range of choice and a greater amount of personal attention and support both in the community and in peoples homes. There is also an increased emphasis on health and delivering much more prevention of ill health.

National Priorities

To deliver this ambitious change programme and to continue to deliver improvements in services the Department of Health has introduced four priority areas these are:

- Priority 1 Improve the Health of the Population – this covers health promotion and ill-health prevention, so that people are kept out of the care system wherever appropriate
- Priority 2 Supporting People with Long Term Conditions – supports health by promoting better self-care and treatment in a community setting or in people’s homes to avoid hospitalisation whenever possible
- Priority 3 Access to Services – ensures people have fair and prompt access to care to the point where waiting should no longer be an issue for the majority of service users
- Priority 4 Patient user experience – promotes maximum information and choice as well as a positive experience so that service provision is more consumer focused

Key Strategic Issues for the Trust

Cotswold and Vale PCT had assessed the Departments of Health’s priority areas and has constructed its plan for 2005/06 around them. However, despite being based on national priorities the Trust’s plan is a local plan. This Trust has choices about how it delivers the national agenda and about which local needs it

will prioritise and which local strengths it will incorporate in the plan. So, within the national context the Trust vision and objectives are vital.

The report of the Director of Public Health has looked in detail at the needs of older people, who are significant users of health care. This report indicates that in terms of needs we should expect that there will be a larger proportion of the population aged over 65. Whilst in general older people are healthier than they used to be, the number of people with chronic and long term conditions increases with age. This poses challenges in providing services for this population. This is specifically the case for the population in Cotswold and Stroud District Council areas, which already has a larger older population than the rest of England. This difference is expected to widen over the coming years. This must also be seen in the context of the largely rural nature of the PCT where service delivery is challenged by a dispersed population.

The Board and PEC have reviewed the national vision and priority areas and have identified the following key issues that we need to address to take the national plan forward in Cotswold and Vale and achieve recurring financial balance. These strategic issues that the PCT will develop in the coming year are:

- The need for a well-developed plan to engage the PCT's key stakeholders
- An understanding of how to manage demand
- An understanding of the dimensions of the choice agenda and how we would embrace it. This includes plurality of providers.
- An understanding of how PCTs may evolve organizationally with the advent of practice based-commissioning on the one hand and the need to build relationships with a plurality of providers (including the independent sector) on the other
- An assessment of the organizational capabilities that the organization would need to develop to flourish in the new operating environment
- A plan to develop sufficient financial headroom to allow us to fund the national priority areas

Building on discussion of these issues the Trust has been able to develop an overall plan to implement the vision, continue to meet key national targets and secure sustainable financial balance. This plan consists of the following threads.

- Improvement of clinical pathways to support more cost effective services closer to home
- Practice-based Commissioning
- Improving the way community hospitals and services work
- Expanding surgical activity
- Capacity planning approach

Clinical Pathway Development

The Trust intends to implement new pathways and approaches to care. This will both improve access to care and improve cost effectiveness. The Trust has already developed a range of community based options which offer alternatives to secondary care. These include General Practitioners with a Special Interest and Local Enhanced services in areas such as substance misuse. We have also introduced Orthopaedic Practitioners with Special Interest and introduced changes to orthopaedic pathways such as Physio Direct offering a fast and effective service to patients.

We wish to review other services in terms of access, closer to patients, cost effectiveness and clinical effectiveness. Service leads will be asked to make an assessment of:

- the best practice in their area
- the scope of change between current and best practice
- cost effectiveness of a new service model
- assessment of activity shifts and financial implications.

The service areas that will be considered include Ophthalmology, Dermatology, Urology, Neurology and Podiatry. Many of these areas appear as priorities elsewhere in the plan.

Practice Based Commissioning

The PCT actively worked on a version of Practice-based Commissioning before it became national policy. Meetings with General Practices are already underway, targeted at reducing expenditure in year and setting up the longer term arrangements. From April 2005, the PCT intends to delegate key aspects of its commissioning role to GP practices, grouped around the existing four localities.

We are already working with practices to design working and governance arrangements that fit new practice based commissioning guidance and help achieve our objectives. General practitioners will take the lead in decisions on where to commission patients' care. This new perspective on services and utilisation is expected to achieve improved value-for-money and better flexibility for patients. Using the experience we have already gained, and will build on in the later part of 2004/05, we feel the PCT is uniquely placed to take account of this major government initiative. The PCT, will in 2005/06, have Payment by Results (PbR) contracts valued at over £100 million with acute hospital providers, which practices will have the opportunity to review and shape.

Improving Community Hospitals and Services

The PCT not only commissions but also provides services. The most significant aspect of the PCT's service provision is its community hospitals and health services.

The PCT has 6 community hospitals (and a relationship with the charity, Tetbury Hospital Trust). The hospitals range from 11 to 94 beds with 265 in total. There are 125 medical beds under the direction of consultant physicians and 99 under general practitioners. There are 41 surgical beds under consultant surgeons.

Increased community and primary care provision is key in the delivery of the Government's agenda for health care. Such a change requires a radical review of provision to make sure it delivers modern cost effective health care, For these reasons, the PCT has looked further and in greater depth at the operation of its community hospitals and the relationship with community social and health services.

Recent work has audited the clinical condition and status of patients currently occupying community hospital beds and identified medically stable patients who could be cared for in other settings, such as at home, or in residential care. Throughout the PCT, the ratio was 56% unstable and 32% stable patients. There were 12% beds empty. Medically stable patients were reviewed at a Grand Round on 4 November 2004. It was clear that this group is elderly (83% aged over 70 years) with multiple medical diagnoses.

The highest proportions of medically stable patients were in Stroud, Berkeley and Cirencester Hospitals. They experienced long lengths of stay, extremely long in some cases. Delays resulted from internal factors (waiting for home assessments or ward rounds, for example) and external factors (waiting for a package of home care or a long-stay placement, for example). Most delay resulted from external factors.

The results confirm the areas of concern and cost to the PCT. They identify lack of capacity in services supporting patients going home, whether it is for home care or residential or nursing care. The long lengths of stay are creating blockages within the hospitals themselves and are bad for patients. The results also confirm that, were alternatives available, the community hospital bed complement could be reduced and patient care improved by reducing inappropriate stays in hospital.

The PCT's vision is of local services. In a dispersed rural population, there is significant merit in increasing local access to outpatient clinics, diagnostic services, day care, therapy, social and home care teams, anticipatory care and specialist clinics.

People now have to travel many miles for an outpatient appointment. There is a great deal the PCT will do to bring services closer to people. In addition, there are increasing numbers of clinics that could be undertaken locally by GPs with special training.

Increasing local outpatients, diagnostic and other services is both the right direction to take and also a positive message for communities. We shall need to

persuade these communities that change in the use of community hospital beds is required. To caricature the community hospitals now: they are serving a narrow group of mainly older people, mostly providing in-patient care. There is an opportunity to change from an emphasis on in-patient services to local access for outpatient and diagnostic services for a wide population.

The result of these changes is that the community hospitals will take on a much wider role in the care of local communities and receive much greater recognition of their role in the overall pattern of health care within the county. We will expect to see patients accessing a greater range and amount of out patient's appointments in their local hospitals which will provide services that the community currently relies on acute care to provide. This will mean that health care needs are met both quickly and locally.

Expanding Surgical activity

Surgical facilities are used to less than 50% capacity, a situation that has existed for a number of years. Gloucestershire Hospitals Foundation Trust owns the activity undertaken within the surgical facilities. Utilisation is inefficient and suggests an opportunity for change in the way that the facilities are used. For these reasons, the Trust has developed and is implementing a plan to increase surgical activity and take up vacant operating theatre capacity. We are supportive of the Independent Sector Treatment Centre initiative that will improve the utilisation of existing capacity rather than increase capacity. This will bring additional income in to the Trust and will also secure the future of these resources as providers of quality services into the future.

Capacity Planning, diversity and choice

The PCT has also developed a capacity plan which describes the impact of choice and decreased waiting times on the need for services. The capacity plan has been derived from using a model evaluating 2004/05 forecast outturn and the expected waiting list to predict future demand. The overall growth assumptions for 2005/06 are 1% non elective and 2% elective which is based on population and historical growth.

The PCT is working in a staged way towards the national targets around access including that by 2008 no patient waits more than 18 weeks from GP referral to hospital treatment. In this regard, we recognize the need to improve our understanding of diagnostic capacity and utilization within the health economy as a whole. We envisage that the planned partnership (see below) with the independent sector in management of our own operating theatres will assist with this.

The *NHS Improvement Plan* signals that independent sector providers will increase their contribution to the care of NHS patients and may provide up to 15% of surgical procedures and an increasing number of diagnostic procedures

by 2008. The PCT has begun to seek this capacity in several areas including IVF. At this stage we do not know what the outcome of our independent sector bidding process will be. However, we will be planning to access the capacity provided via GSUP and hope to use this in the early part of next financial year.

Diversity of provision and access is supported by the national Choose and Book programme, which combines choice of provider with the electronic booking of first outpatient appointments.

In line with the national policy, the PCT is developing commissioning principles so that the commissioned providers represent a real choice for our patients. A working group is evaluating the way in which patient flows are likely to change after December 2005 when the PCT will offer the choice of service provider at the time of referral to secondary care. The working group will complete its initial assessment within the next 2 months.

The PCT also plans to use referral data in tandem with the practice-based commissioning initiative to understand gaps in the provision of services to our local population. The referral information will be used to amend and develop new clinical pathways.

3. Financial Position

The PCT has been set Resource Limits of £213, £218 and £232m for the financial years 2205/06 – 2007/08.

To meet the statutory duty to break even the PCT needs to deliver a Financial Recovery Plan (FRP) as follows: -

	Recurrent £m	Savings Non recurrent £m	Total £m
2005/06	6.000	3.427	9.427
2006/07	1.890	0.000	1.890
2007/08	0.000	0.000	0.000

The programme is focussed around service changes linked to the following areas: -

- More focussed use of community hospital beds and community services.
- More outpatients and diagnostics available locally.
- Practice based commissioning.
- Treating patients, where appropriate, as close to home as possible.
- We are also undertaking a comprehensive review of the PCT admin and support arrangements.

We have initiated discussions within the health community on these issues with a view to commencing a full PPI process where required.

As part of the overall financing requirement the PCT will need to make investments to meet the required national targets. Significant areas of investment include: -

Access - £7.93m over three years
Cancer - £1.653m
Mental Health - £1.627m
IM & T - £1.155m

To manage this process we are adopting an “investment fund” approach where each investment is subject to a rigorous reassessment before any commitment is made.

Full detail of the financial position is outlined in Appendix 2.

4. Workforce

Improving community hospitals and services, clinical pathway development, building on current standards and responding to new targets will all have workforce implications. The Trust recognises that it needs to ensure it has a capable and committed workforce to deliver the plan and is currently developing a People and Organisational Development strategy to ensure our people are equipped to respond to the changing environment. This covers employees and all those working on behalf of the Trust in delivering primary care, e.g. GPs and practice staff.

It includes the following key areas:-

- We are reviewing the roles and number of staff employed in community hospitals. Inherently linked to this is a review of the roles and numbers of people employed in Community Service teams. If we are to achieve a reduction of beds, we are clearly going to want to reduce the former and increase the latter. This review will take into account current plans to introduce Community Matrons and increase the number of Community Care Workers in conjunction with Social Services. There will be opportunities for staff to be redeployed, with appropriate training; in fact this is already happening. We also need to effect an overall reduction in the number of people employed. We envisage managing most of this through normal staff turnover ~ i.e. retirement and resignations.
- Increasing local outpatient clinics, diagnostic and day rehabilitation services within the community hospital setting also provides an opportunity for redeployment of staff from more traditional ward based nursing and support roles. Indeed some of the new roles could provide career progression as we move towards Nurse-Led Diagnostic Services, e.g. in Sexual Health, and extend the role of Allied Health Professionals, e.g. in areas like Orthopaedics.
- We are looking at improving the utilisation of our operating theatres, including the transfer to private ownership. This could have workforce implications and will need to be kept under review.
- We are also reviewing medical models which will lead to more GP/consultant shared care and the PCT directly employing senior medical staff to work in community hospitals.
- Improving community support and extending the range of services available locally will have consequences and provide opportunities for people employed within practices. We are already encouraging GPs to utilise specialist skills or undertake training to offer dermatology clinics and have plans to do so for ENT and ophthalmology.

- We intend to make more extensive use of multi-discipline primary care teams, to improve patient care. The benefits of the MDAU in Cirencester will be evaluated with a view to extending new ways of working to other sites and services.
- In the main, we envisage changing the roles within the organisation and ensuring we have the skills and experience, largely by retraining/redeploying existing staff, to deliver the plan. Agenda for Change will provide a framework to facilitate this. There will be some specialist areas we need to recruit into but do not foresee any particular difficulties in filling the majority of posts.
- Notwithstanding the above, the need to support new Out of Hours services will continue to be a challenge. We are considering further use of salaried doctors to complement the services already provided by GPs and locums. We are also exploring the use of a consultant nurse and advanced nurse practitioners to reduce the service pressures. We also have challenges in dentistry, as the county lead, and are using national initiatives, such as employment of overseas personnel, to address the shortage.
- Although Agenda for Change does provide a framework for facilitating the redesign of roles and introducing the new ways of working envisaged, it presents its own challenges of improving pay and employment conditions without presenting further cost pressures within the Trust. A detailed plan exists which is closely monitored by a Steering Group. Similarly, the benefits of achieving the Improving Working Lives Practice Plus Accreditation are clearly understood, particularly in helping the Trust ensure it is able to attract and retain high performing staff. A prioritised plan exists which includes an analysis of the costs/benefits of any investment.
- It is vital that we raise understanding of the Trust's plan, to help people understand the contribution that they need to make, promoting involvement and securing engagement. This equally applies to managing partners and stakeholders to ensure we don't run into resistance during PPI.
- The National Programme for IT will fundamentally change ways of working, we are looking at the implications of this, particularly training.

We recognise the importance of working with the wider health and social care community to improve services, reduce waiting times, respond to plurality of provision, patient choice, etc. We have shared our plan with other PCTs, social services and our acute providers, particularly the intention to extend the range of patient services within primary care. We will need to work closely with them to consider and plan for any workforce implications arising, although these are not likely to be significant during 2005/06.

More immediately, we are mindful that across the county we are looking at the funding arrangements in two areas where we would anticipate additional resource to strengthen current services:-

- Mental Health – Crisis services, carers and early intervention teams
- Children’s Services – Maternity, School Nursing and Neonatal Intensive Care

5. Information Management and Technology

Overview

The Trust has an IM&T plan which assesses the current IT issues faced by Cotswold and Vale PCT and sets out an action plan covering 2004/05 and the following two years to address them, where possible with costs and timings. The Plan should be seen as a living document requiring on-going updating as priorities develop or become clearer. It starts by setting out an information vision for the PCT:

All staff and health care professionals should have appropriate access to the information and technology they need, at the time they need it, to perform their roles effectively in accordance with information governance standards

The plan

The National Programme for IT (NPfIT) is now being rolled out. This is a huge programme with a vision of easy access to up-to-date information for all clinicians and managers using standard care records and enabling systems.

Gloucestershire NHS organisations and Cotswold and Vale PCT in particular need to gear up for this world. Yet our starting point is one of fragmentation of systems and support functions. Steps are being taken to integrate support functions with the appointment of a new Director, IT for Gloucestershire to lead a unified approach.

The key features of our current situation are:

- Inter-connectivity – many of our systems particularly at community level cannot connect (for example, community systems and GP systems) and/or are different in the east and west of the PCT hindering exchange of information between professionals about the same patient
- Community systems – different in east and west of PCT; partially implemented; unused by some staff; poor quality data; hinders effective clinical and managerial planning at local and PCT wide level
- Out of county commissioning data – inaccurate and late exposing the PCT to contract risks as we move towards Payment by Results (PbR) for all contracts
- IT support to the community hospitals in the east – historical legacy that this is still provided by GHT, but service is problematic and not supported by an SLA
- Information sharing - data quality is good in GP practices, but data is not shared widely even on an anonymised basis with the PCT or other practices to allow easy understanding of key clinical practices and improved commissioning
- Training – staff have widely varying levels of IT skills; a training needs assessment is required for all staff groups to help prepare for
- We have significant unfunded plans that we need to take forwards to prepare for NPfIT

In addition, the in-house management of IM&T issues is very thinly spread. It consists of approximately 0.6 whole-time equivalent manager, plus director leadership when possible or necessary. This is only sufficient for “maintenance” level working and taking part in the county agenda. There is very limited spare capacity to take forwards challenging issues

Financial issues

The costs of gearing up for the roll-out of new PAS, PACS and choose and book system in 2004/5 is being assessed together with potential funding sources. The total cost of this could be as much as £5m in 2005/6 across the county. Taking into account AGW start-up and ‘loan’ funding, there is likely to be a shortfall of approximately £4m. Additional PCT funding is therefore expected.

In addition there are some specific cost pressures that the PCT will need to address in the coming year through the capital programme. The most significant of these are:

- Branch link replacement
- Assessment of community systems
- Training (immediate costing implications unclear)

6. Monitoring Arrangements

Performance reporting will be to both the Professional Executive Committee (PEC) and the Trust Board. Although the same or similar information may go to both groups the analysis will be different in each. The Trust Board will take a view from the perspective of business objectives. The PEC will take a clinical perspective. This will ensure that the organisation delivers on both the clinical governance and corporate governance aspects of its work.

Reporting will consist of short focussed information, which concentrates on progress against objectives and on risks. Where an issue or work area is covered in more than one report there will not be a requirement to produce multiple reports. Where risks are identified service leads will be required to assess the likelihood and severity of those risks and make recommendations for an action plan to keep the objectives on course. They will also be required to advise on the assurances in relation to the action planning. This will form the basis of the Trust Assurance Framework.

On a monthly basis the PEC and Board will receive:

Achieving Financial Balance Through Service Change (FRP Programme).

The Programme Director will provide this report by collating individual reports on each of the programmes A – D from the relevant Programme Sponsor. It will cover progress against targets and milestones and reference risks and the controls in place reported in the Assurance Framework Report (see below).

Activity report. This report will be provided by the Head of Purchasing and Information and will cover both contracted activity and activity from our provider services.

Management Accounts. This report will be provided by the Director of Finance and will concentrate on the current and projected financial position of the Trust.

On a quarterly basis in addition the PEC and Trust Board will receive:

Service area overview reports. Concise reports against each service area. This will cover progress to date, (successes and issues arising) risks identified and resource implications.

Assurance Framework report. The Risk Management Committee will oversee a report on risks and assurances that identifies the most significant risks facing the Trust and the controls and assurances in place in relation to those risks. .

7. Risk management and assurance arrangements

The Assurance Framework provides Board Members with a mechanism for identifying and understanding its principal risks to achieving the principal objectives and the key controls to manage those risks. In addition it provides evidence required for the Statement on Internal Control to demonstrate the Board are properly informed through assurances about the totality of the risks facing the organisation and have arrived at their conclusions based on all the evidence presented to them. The full Assurance Framework is attached at Appendix 1.

The Assurance Framework was developed by bringing together a number of separately developed areas of work undertaken over the past two years. For 2005/06 the Business Plan and the Assurance Framework will be further integrated as a single mechanism for setting out:

- the Trust's principal objectives (clinical, financial and generic)
- performance against objectives
- the principal risks that threaten the achievement of those objectives
- the key controls in place to manage those risks
- the assurances on the key controls in place
- the gaps in control and in assurance.

This will enable the Trust Board to monitor progress against objectives as well as monitor the assurances on the management of its principal risks in a co-ordinated and cohesive way. This will be underpinned by the Trust's business planning and project management processes which incorporate standardised risk management reporting as an integral part of their function.

The Assurance Framework risks will be reviewed and up-dated through reports to the risk management committee on:

- Quarterly Business Plan Performance Reports
- Monitoring of Standards for Better Health
- Clinical Governance Reporting Framework
- Internal and External Audit
- Reports of other external bodies, for example, Commission for Health Improvement, Health and Safety Executive, NHS Litigation Authority.
- Clinical Negligence Scheme for Trusts

The Risk Management Committee, with its representation drawn from the Trust Board, Professional Executive Committee, Management Team and Shared

Services will oversee an assurance report which combines the overall Trust risks, controls and assurances and it will present high level reports to the Professional Executive Committee and the Trust Board. This will enable priority to be given to routinely reporting the top risks and the effectiveness of the organisation's system of internal control.

At this time the most significant risks identified within the assurance framework are:

Service Area: Older People, Falls and Mental Health

Risk	Risk Management Plan	Controls
Implementation of enhanced community MH teams hindered by decisions to utilise Baunton Ward Older People monies to fund target related developments in Adult MH services.	Regular impact reporting from OPMH project group to the project board and C&V PEC/Directors.	Project Group led by W. Gloucestershire PCT

Service Area: Children

Risk	Risk Management Plan	Controls
Not controlling CAMHS Out of County spend and continuing health care spend.	Tight gate keeping of individual cases.	Scrutiny monthly by Chief Executives and PCT's finance departments.

Service Area: Learning Disability

Risk	Risk Management Plan	Controls
Mend Mayfield: Insufficient detail on service users needs and existing provision to allow a comprehensive tender specification to be drawn up.	a) Undertake full risk assessment and manage through Joint Commissioners group b) develop contingency plan	Tender and Oversight project group and sub project groups.

Project: New Pathways & Approaches to Care

Risk	Risk Management Plan	Controls
Commissioning units lack capacity to take forwards projects	Maintain flexible management support model to respond to gaps	Monitoring in programme B executive
Thresholds for admissions and	Ensure each new pathway developed has an action	Project impact monitoring, co-

referrals drift so that secondary care capacity released is still purchased “involuntarily”	plan tackle this – combining referrer awareness with hard contracting rules	ordinated at Programme B executive
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Project: Practice-based Commissioning

Risk	Risk Management Plan	Controls
Potential PBC practices are put off by having to use Choose and Book Tool	Share benefits realisation and engagement plan on referral management aspect and benefits of tool; ensure feedback from early adopters Run demos to show tool in practice	Choose and book PCT project board Programme B executive

Project: GP Engagement

Risk	Risk Management Plan	Controls
GP’s engaged on too many issues	Need to prioritise engagement and key messages and control communications	Programme Board and directors team develops prioritised communication plan

Project: Community Hospital Outpatient and Diagnostics

Risk	Risk Management Plan	Controls
Recharge project does not provide clarity to enable assessment of financial implications		PMS Board meet frequently Reports to Programme Board
GHT and/or consultants do not respond to our commissioning intentions	Develop links to alternative providers	PMS Board meet frequently Reports to Programme Board / DoF
Commissioning and operational leads lack capacity	Prioritise actively	PMS Board meet frequently Reports to Programme Board/ DoF

Project: ISTC

Risk	Risk Management Plan	Controls
GHT resistance to possible model		PMS Board meet frequently Reports to Programme Board / DoF

Legal process difficulties		PMS Board meet frequently Reports to Programme Board / DoF
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Service area: Problem Drug users

Risk	Risk Management Plan	Controls
Unable to recruit to Primary Care enhanced service in Stroud area	Explore potential for recruiting to clinical post outside of Stroud practitioners	Shared Care Monitoring Group

Service area: Choice

Risk	Risk Management Plan	Controls
Lack of clinical engagement	Dedicated work stream to provide primary care engagement strategy. GHT Booking Project manager responsible for consultant engagement.	Reports to Choose & Book Programme Board AGW seeking to foster engagement National incentives

Project: Recharges

Risk	Risk Management Plan	Controls
Inability to agree recharges with GHT	Continue to work closely with GHT and negotiate acceptable position.	Regular reports to programme and Trust Board.

Service area: Agenda for Change

Risk	Risk Management Plan	Controls
Insufficient budget to cover new pay arrangements	Consistency checks to ensure jobs not over-stated Pay modelling prior to assimilation	A4C Steering Group in place to monitor plans

Service Area: Quality Aspects of Foundation Trust Contract

Risk	Risk Management Plan	Controls
Lack of timely & effective information from Hospitals Trusts to Primary Care regarding patients discharged	Encourage reporting of all incidents & feedback to Foundation Trust Transfer & Discharge audits planned Work with Foundation Trust to improve	Discharge Schedule part of Foundation Trust Contract Countywide Foundation Trust Contract Clinical Governance Review Group Quality Schedules

8. Detailed Service Plans and Projects

Work Streams

The Trust's plan consists of five main work-streams. These incorporate the national priority areas and our own local issues. The work-streams are:

- Improve the Health of the Population
- Supporting People with Long Term Conditions
- Access to Services
- Patient user experience
- Organisational Development and Partnership working

This section considers the targets, outcomes and actions for each service area or project within these work-streams. These plans have been developed by service leads in conjunction with key stakeholders and partners from their service areas.

Programme Management

We recognise that to meet all of our objectives we will need to undertake significant changes in both what we do and how we do it. This type of organisational development and cultural change to complex systems of health and social care requires careful management. Because of this we have introduced a project management methodology to the Trust. We have also recognised that some projects are so vital to the Trusts Financial Recovery Plan that they need to be managed as a collection of programmes with a programme board to oversee the projects. The programme board has the support of a programme manager and together their role is to ensure that projects open and close in a timely and co-ordinated manner and that individual projects deliver their anticipated benefits. For the purpose of this plan the projects that make up the programme are not listed separately but are described as part of the main business plan. These projects can be found in Work-stream 3 Access and Work-stream 5 Organisational Development and Partnership

Work-stream one: Improve the Health of the Population

National Standards Local Action states the overarching aim of this area as being

“Improve the health of the population. By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.”

This work-stream consists of the following service areas:

- Reducing inequalities in health
- Reducing mortality from heart disease
- Reducing mortality from cancer
- Reducing smoking rates
- Older People: Falls, Mental Health
- Children’s services
- Fertility
- Maternity and Infant Mortality
- Mental Health including suicide prevention
- Teenage Pregnancy and Sexual Health
- Learning Disability
- Diabetes

Tackling Health Inequalities (Toni Smith)

Targets from NSLA:

- Reduce health inequalities by 10% by 2010 (from a 1997-99 baseline) as measured by infant mortality and life expectancy at birth.
- Reducing inequalities in health outcomes: all PCTs should work in partnership with LAs, using health equity audit, to demonstrate that effective interventions are provided for all groups in the population, targeting those with highest needs.

Tackle the underlying determinants of ill health and health inequalities by:

- halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole. (Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport); and
- reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health. (Joint target with the Department for Education and Skills.)

(Note: these targets are owned by the leads for smoking, obesity and teenage pregnancy with public health taking a supporting role)

Targets identified by service lead:

1% year on year reduction in proportion of women continuing to smoke throughout pregnancy, focusing particularly on women from disadvantaged groups (specific target of 1%).

2% increase in breastfeeding initiation rates focusing especially on disadvantaged groups.

Outcomes: what will we achieve over the next year?

- Smoking: Further reduction in smoking in line with national targets by targeting manual workers
- Infant nutrition: Increase breastfeeding initiation rates
- Develop plans to halt the year on year rise in obesity in the population in general and with U11s specifically.

Action plan: how will we achieve it?

Smoking: By specifically targeting C&V PCT, Cotswold District Council, and Stroud District Council and reviewing their smoking policies to encourage smoke free workplaces and help and advice for those wishing to stop smoking. Other work will include running smoke stop classes in business with a high percentage of manual workers (factories in Stonehouse etc).

Infant nutrition: Increase breastfeeding rates through the development of a county wide breastfeeding strategy which will have a local action plan for this PCT. As part of the local action plan, the Cotswolds Health and Well-being group funded the establishment of a breastfeeding support at The Churn Project, Cirencester. This will be the first support group in the Cotswold area. Similar support groups already exist throughout the rest of Gloucestershire and the Stroud Health and Well-being Group have helped fund one in Dursley.

Obesity: Halting the year of year increase in obesity through working through the LSPs, Crime and Reduction Partnership, and Health and Well-being Groups to develop an Obesity Strategy and action plan. As no funding was available through the PCT to address obesity, the Cotswolds Health and Well-being Group are currently seeking funding for a Healthy Villages

initiative, rewarding villages that introduce initiatives and create environmental changes to increase physical activity levels and encourage healthy eating within the resident community. This project will also help reduce CHD, Cancer, Diabetes, Hypertension, Cholesterol, improve mental health and increase physical activity.

Service area: Coronary Heart Disease. (Clare Louise Nicholls)

NSLA targets:

Substantially reduce mortality rates by 2010 (from the *Our Healthier Nation* baseline, 1995-97) from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole (NSLA)

Existing targets identified in NSLA:

Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.

In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and, by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.

Targets identified by service lead:

Maintain the 3 month maximum wait for PCTAs

By March 2005 achieve and maintain a 3 Month waiting time for CABGs, Angiography and Angioplasty.

Outcomes: what will we achieve over the next year?

We expect to see considerable improvements in care delivered in Primary Care, due to the new GMS contract, which focuses GPs to provide best care and treatment for patients with symptoms of coronary heart disease and at risk of stroke through the quality outcomes framework. (QOF). The QOF process is validating well-established practice based registers for CHD and there is high level achievement of this target already. An audit of primary prevention of CHD and stroke including hypertension is currently being undertaken by the Gloucestershire Primary and Community Clinical Audit Group. The audit is helping the PCT understand how many people are at the 15% threshold level of risk of CHD and early indications show progress is being made to monitor and treat these people. This will result in increased investigations – esp. Cholesterol levels, and therefore associated drug prescribing and expenditure in Primary Care, but is all evidence based, and should contribute to further reductions in CHD and stroke mortality. Mortality rates for CHD in Cotswold and Vale are lower than the Gloucestershire average and the PCT is at present confident of meeting the target by 2010.

The Heart Failure service will get completely up to speed, giving reductions in admissions for Heart Failure.

We will explore the scope to develop capacity within existing geriatric medicine clinics at Cirencester to provide PCT-wide rapid access for those with suspect TIA within 7 days of the event. Rapid management of TIA will minimise risk of progression onto stroke thereby improving mortality and primary/secondary prevention of stroke.

Action plan: how will we achieve it?

Working with practices on an individual basis, where the PCCAG audit results suggest lower than anticipated identification of those at risk of CHD through encouragement to achieve maximum points on CHD, hypertension and stroke indicators in nGMS Quality & Outcomes Framework. This has a strong financial incentive for practices to achieve! Use the audit results to inform clinical practice and treatment plans that improves the management of CHD and hypertension thereby continuing to reduce mortality from stroke and CHD.

Promotion of the countywide secondary prevention guidelines for stroke and TIA within primary

care teams with monitoring of use during practice visits and review of associated prescribing. TIA Clinic development will be managed and monitored through the PCT Stroke Strategy Group.

Service area – Cancer. Lead Sian Cole

NSLA targets

- ❑ Substantially reduce mortality rates by 2010 (from the *Our Healthier Nation* baseline, 1995-97) from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole
- ❑ Maximum two week wait (TWW) from urgent GP referrals to first outpatient appointment for all urgent suspected cancers (current target)
- ❑ Ensure a maximum waiting time of 31 days from diagnosis to treatment for all cancers by December 2005
- ❑ Achieve a maximum waiting time of 62 days from urgent referral to treatment for all cancers by December 2005
- ❑ 800,000 smokers from all groups successfully quitting at the 4 week stage by 2010
- ❑ National target of 80% coverage for cervical screening (current target)

NICE targets

- ❑ Implementation of the improving outcomes guidance (IOGs), monitor the progress as demonstrated by the number of MDTs for tumor groups – gynecology, upper GI, urology, head and neck, hematology and specialist palliative care.
- ❑ Bowel cancer screening – the percentage of eligible men and women 50-70 year olds should increase until optimum coverage rates are achieved (based on pilot/research finding, implementation by 2008)
- ❑ Supportive and palliative care for adults with cancer makes 20 recommendations; compliance will be measured as part of the peer review process (2005/6)
- ❑ National target of 80% coverage for breast screening, two view mammography, extension to breast screening programme for women aged 65-70 years (current target)

Local priorities

Local targets reflect the need to achieve and maintain financial balance, actively support the diversion agenda, the delivery of national targets, promote quality and responsiveness to local need. Targets are drawn from the views of local clinicians and stakeholders as expressed through C&V cancer and palliative care groups, each of which has user and carer representation.

- ❑ Explore cancer admissions to GHT, benchmark these against Gloucestershire PCT's and national data
- ❑ Disease management – clear specification and care pathways in secondary and primary care for the management of people with cancer
- ❑ To improve health promotion, prevention and self-management of people at risk or with diagnosis of cancer in primary care
- ❑ To have a well defined partnership arrangements with lead PCT, 3CCN and providers where roles and responsibilities are clearly defined
- ❑ Develop strong public involvement in the development and delivery of cancer services.
- ❑ Develop the skills and knowledge of local workforce to manage patients closer to home and ensure referral at appropriate time, via appropriate route.
- ❑ Develop supportive and palliative care strategy for C&V
- ❑ To improve end of life care by the use of Gold standards framework and care pathway for the last days of life

OUTCOMES

National Targets

- ❑ Further reduction in mortality rates
- ❑ Maintain current standards against the current TWW targets

- ❑ To achieve the national target of 31 and 62 day waits
- ❑ Continue the reduction in smoking
- ❑ MDTs for tumor groups will meet IOG recommendations (2008)
- ❑ Reduction in bowel cancer mortality by 15% in those screened (2008)
- ❑ To achieve compliance with cancer service measures (September 2005)
- ❑ Maintain achievements of national screening targets in cervical and breast screening

Local priorities

- ❑ To have robust data on cancer admissions, (compare cancer admissions across Gloucestershire) understand patient flows, including factors that influence admissions, ensure that robust arrangement on the monitoring of cancer admissions are developed
- ❑ Develop protocols, care pathways and where appropriate models of shared care for people with cancer between primary and secondary care clinicians
- ❑ Liaise and work with other agencies, users and carers to promote healthier lifestyles (particularly in cross over areas i.e. diet and obesity) to develop readily available patient information to raise awareness of symptoms and support self management in primary care setting
- ❑ Effective and efficient partnership working between Gloucestershire PCT's and 3CCN, with a clear commissioning framework within which the lead role operates, clarity on the role of the 3CCN in supporting C&V commissioning
- ❑ Active and vibrant user and carer involvement, ensure that PPI is integral to all areas of service review and development, C&V commissions services that have patients at the centre of decision making process
- ❑ Education and training programme that develops the workforce's skills, knowledge and competence. Raises the quality of care for people with cancer and palliative needs, supporting care closer to home and increasing the numbers of people dying in place of choice.
- ❑ C&V supportive and palliative care strategy that incorporates national and local priorities (summer 2005)
- ❑ All PHCT to be offered Gold Standard Framework (GSF) (June 2005) Audit and evaluation of current use of care pathway for last days of life (December 2005)

ACTION PLAN

National Targets

Health of the population - Mortality rates

PCT is taking a number of actions to support prevention and early detection

The Local cancer implementation group is in collaboration with health promotion and cancer user group looking at patient information that supports preventative strategies and early detection. The group is also considering health prevention information needs of health professional within C&V.

Working with primary care teams to ensure compliance with the TWW standards by providing feed back on referrals, examining the adherence to the TWW rule, benchmarking against local and national referral patterns.

C&V are working with county colleagues and 3CCN and the site specific cancer groups to develop clinical care pathways that reflect the role of primary care support appropriate referral and treatment pathways that maximise health gain with follow up in appropriate setting to agreed protocols.

Access -one month wait two month wait

Trajectories from GHT indicated PCT is on line to achieve the targets. Bottlenecks have been identified. The 3CCN service improvement team are working to support the delivery of targets such as supporting the work on radiology and chemotherapy treatment. C&V are working via the county service development groups. Gloucestershire PCTs, GHT and the 3CCN to explore each of the site specific groups identifying any issues that may prevent the deliver of targets. An example of this clinical care pathway is work is urology services by agreeing a protocol follow up care for appropriate patients is diverted to primary care this will support the release capacity in secondary care services.

NICE targets

- ❑ Work collaboratively with provider's organisations, Gloucestershire PCT's and 3CCN to develop designated specialist multi-disciplinary teams for tumour groups and on the implementation the national bowel-screening programme.
- ❑ Palliative care strategy developed via local and county group, that will reflect local need and outline C&V priorities for palliative care services.
- ❑ Breast screening – improve partnership working with breast screening service, address the health and safety issues with the mobile unit at Beeches Green Health Centre whilst maintaining local provision.

Local priorities

- ❑ Interrogate the numbers of cancer admissions for C&V, treatment pathways and length of stay of cancer patients in GHT compare in county and benchmarked against national data
- ❑ Ensure C&V participation at county service development group, review PCCL role and clinical reference group to ensure effective representation of primary care at county and network meetings and in the development of patient care pathways
- ❑ Cancer local implementation group to devise work programme to support health promotion, prevention and self management in primary care
- ❑ Support the C&V cancer involvement group via PCCL and service lead, working with the group explore ways to engage a wider cross section of the population on cancer and palliative care issues
- ❑ Work with C&V training lead, clinical academies and palliative care education group in Gloucestershire (PEGG) to develop a competence based training programme for cancer and palliative care staff
- ❑ C&V palliative care strategy group to develop local strategy in conjunction with key stakeholders

Service area: Reducing Smoking rates. Lead Phillip Bennett

NSLA targets

Tackle the underlying determinants of ill health and health inequalities by:
reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups¹ (from 31% in 2002) to 26% or less.

Existing targets identified in NSLA

800,000 smokers from all groups successfully quitting at the 4-week stage by 2006.

The PCT target for 2005/6 is 917 four week quitters

Outcomes: what will we achieve over the next year?

The required number of four-week quitters is likely to be achieved by continuing present activities. The longer term target of reducing smoking prevalence to 21% by 2010 is also likely to be achieved especially if controls on smoking in public places are introduced.

The specific reduction in manual groups to 26% by 2010, will require interventions to be targeted in workplaces with manual workers and this is being planned for. The introduction of controls on smoking would make this target easier to achieve.

Action plan: how will we achieve it?

Maintain provision of the Locally Enhanced Service for GP practices.

This provides a £250 sign up fee, £5 for each smoker setting a quit date, £10 for each four week quitter and £250 if the practice meets its population based target.

Maintain close links with the Gloucestershire Smoking Advice Service.

Continue to monitor activity of practice based support to stop advisers.

Take further action to assist PCT staff to quit smoking.

Workplaces, employing a significant proportion of routine and manual workers, are being selectively targeted by the Gloucestershire Smoking Advice Service workplace officer.

Employers are offered advice on introducing no smoking policies and are signposted to available services, (evidence shows that the creation of smoke free workplaces increases motivation to quit smoking). Smoking cessation help and advice is provided on site, during working hours where this is practical and acceptable to employers and employees. A specialist leaflet to promote this service has been prepared and will be produced and distributed to employers during 2005. In addition to commercial companies, smoking cessation help and advice will be offered to manual workers within the two local authorities within the PCT area and the PCT itself.

Plans are being considered to target families in rented accommodation with some type of smoke free homes scheme, however planning is at an early stage and no details have been finalised yet. Partners are likely to include the Fire and Rescue Service and housing associations.

Service area – Older People, Falls. Lead Clare-Louise Nicholls
Targets: Implementation of the PCTs falls action plan
Outcomes: what will we achieve over the next year? Development of a falls clinic in N Cotswolds locality utilising Primary and Community Development Scheme monies. Evaluation of Occupational Therapy services provided using Cotswold District Council second homes council tax income. Learning from ONI with Care Homes. Implementation of a falls risk assessment tool. Introduction of a pathway for fallers between acute and primary/community care. Consultant leadership for falls prevention. Portfolio of services that promote physical activity with benefits of reducing falls. IN 06/07 consider the development of a specialist falls clinic at Cirencester Hospital.
Action plan: how will we achieve it? <ul style="list-style-type: none"> • Project management approach working with the Falls Strategy group. • Promotion of physical activity and exercise in the community via Health and well-being Partnerships • Support to independent and voluntary sector providers in falls prevention initiatives and training, • Progression in developing model of falls services • Learning from osteoporosis nurse initiative, • Development and implementation of countywide falls risk assessment tool • Incorporation of falls risk assessment into management of long term conditions

Service area: Older People Mental Health
Local priorities: Commission services in line with the outcome of the countywide review of mental health services for older people that 1) Provide enhanced specialist community based services that: <ul style="list-style-type: none"> • prevent unnecessary admission to specialist beds for assessment and treatment and facilitate earlier discharge • support community hospitals care and manage patients with low level mental health problems • provide advice and support to primary care and the Independent Sector on patient management. 2) Provide specialist inpatient care for those with moderate and high level needs and for those with challenging behaviours. In partnership with social services and GPT commission and develop <ul style="list-style-type: none"> • improved day services, • improved support for carers, • community services within integrated teams including intermediate care provided by community care workers. Prepare for reimbursement in mental health beds. Consider how and where intermediate care beds can support meeting needs of older people

<p>with mental health problems. Appointment of 3rd consultant for PCT area to bring consultant numbers per head of population to within college recommendations. Develop enhanced local consultant led services.</p>
<p>Outcomes: what will we achieve over the next year?</p>
<p>Consultation on remodelled specialist mental health services and resources. Development of enhanced community mental health teams. Diversion of activity to community services that allows for remodelling of specialist inpatient services and resources to be reinvested in community teams. Evaluation of the intermediate care CCW service and plans for incorporation into mainstream services. Development of beds for challenging behaviour in continuing health care. Enhanced service plan delivered by 3 consultants.</p>
<p>Action plan: how will we achieve it?</p>
<p>Partnership working with social services and GPT under the leadership of the Older People's NSF standard 7 strategy group.</p>

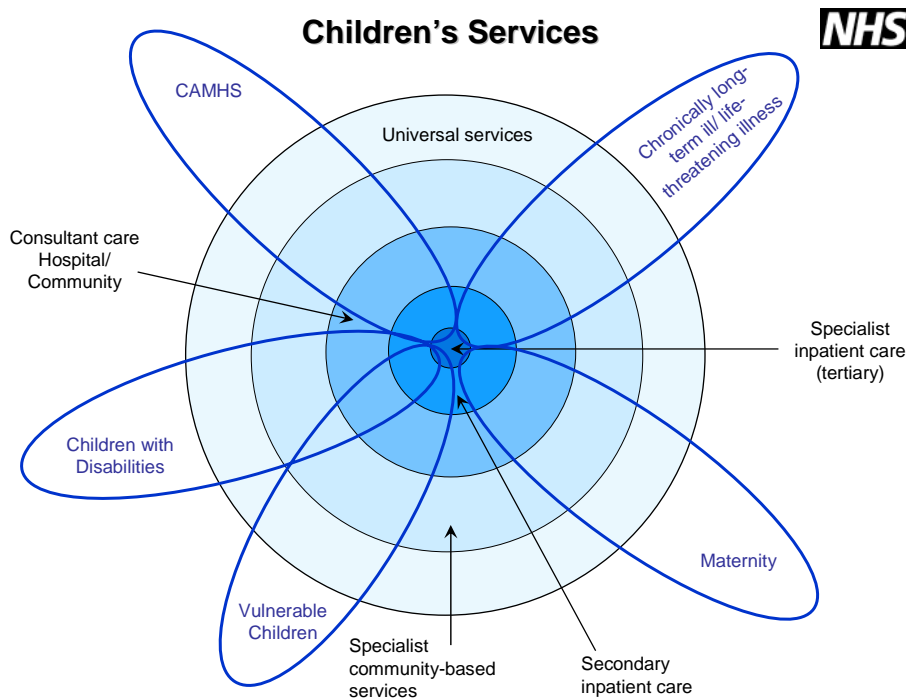
Service area: Children and young people. Lead Alison Melton

Existing targets identified in NSLA

Improve life outcomes of children with mental health problems by ensuring that all patients who need them have access to a comprehensive Child and Adolescent Mental Health service by 2006.

County perspective and figures

10 year plan for recently published NSF and Public Health white paper under construction together with Children's Trust discussions. Children's Trust to be in place by April '06 and firmly planned by April '05 that will be at the minimum a commissioning organisation. The NHS has a legal duty to co-operate with the County Council to progress towards pooled budgets. The flower diagram below represents the strategic direction of children, young people's and maternity services. It corresponds with both the Children Act and NSF to promote social inclusion, keep children with their families, local school and peers and provide quality assessed, evidence-based, easily accessible services close to children's homes integrated across agencies and organisations while ensuring high quality evidence-based specialist services. The Children's Health planning group that has representatives from the 6 NHS bodies, County Council, District Council and parents task is to push as much as possible to the outer rings of the flower while providing excellent services for the low volume, highly specialist services in the middle of the flower.



OUTCOME Shared outcomes from research with children and young people for all agencies in the Children Act are:

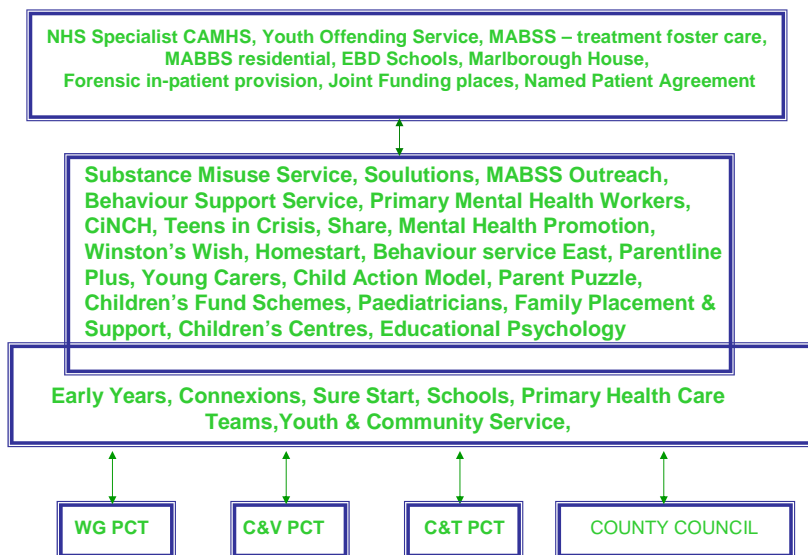
- Be Healthy
- Stay Safe
- Enjoy and Achieve
- Economic Well-being
- Make a Contribution

Starting a Comprehensive CAMHS

TARGET Improve life outcomes of children with mental health problems by ensuring that all patients who need them have access to a comprehensive Child and Adolescent Mental Health service by 2006.

Specialist services have received investment in both the NHS and County Council over the last 3 years. The model below has been both developed and agreed by the CAMHS partnership. This has members from nine of the organisations represented in the model and is led by C&V PCT. Process mapping and pathway development is underway for services below to provide single point of access from universal services to all levels of care across all agencies i.e. integrated services. A needs assessment for the psychological and emotional needs of the County's 125,000 children is being compiled by C&V's public health team and is near completion. Two principal papers have been prepared – one describing a Comprehensive CAMHS and a 10 year plan, the other about Primary Mental health Workers where this year's badged CAMHS money is mainly being invested. CAMHS accommodation for Cirencester and the North Cotswolds will be improved from the 900k capital secured.

Comprehensive CAMHS



OUTCOMES: The start of clear pathways between services. Primary Mental Health Workers (PMHWs) for children and young people across the PCT enabling schools, primary health care teams, early years and other universal services to access supervision, training and support quickly and easily to supporting 20% of children and young people with emotional difficulties close to home.

ACTION PLAN for '05 – '06 is establishing PMHWs, organising finance for Gloucestershire voluntary organisations, creating process maps for services.

NSF CORE STANDARDS

TARGET The bulk of the NSF is about core standards for all children available in universal services. Work is to begin in each of the 3 PCT groups in co-operation with County and District Councils to assess compliance against the standards.

Action plan: Plan to be developed for '05 – '08

OUTCOMES These were established for Gloucestershire children and young people during 2003 and 4:

- 1) Infants and Children thrive and meet key developmental milestones.
- 2) Children & Young People are ready for school; they are confident to separate from carers and able to exhibit age-appropriate behaviour.
- 3) Children and Young People succeed in school; both socially and academically.
- 4) Children and Young People grow up healthy and choose healthy lifestyles.
- 5) Children and Young People are brought up in safe and supportive families, family settings and communities.
- 6) Young People grow into successful adults.
- 7) Children and Young People are included in mainstream services and contribute to shaping these services.

CHILDREN AND YOUNG PEOPLE IN SPECIAL CIRCUMSTANCES

TARGET A shared target between NHS and Local Authorities to improve health and educational outcomes for these children and young people

OUTCOME Improve take up of health assessments and increase GCSE attainment

PLAN These children and young people no longer comprise a discreet section of the NSF as expected. A plan has been written since '02 but regrettably not secured recurring funding although non-recurring finance for a needs assessment was obtained '04 – '05. The CAMHS Primary Mental Health Worker plan has specialisms earmarked for the service improving access for emotional and psychological issues.

CHILDREN AND YOUNG PEOPLE IN HOSPITAL

LOCAL TARGET To concentrate high risk maternity, neonates and children's in-patients on one site

OUTCOME To ensure the safest and highest quality care by pooling highly specialist skills.

PLAN Outcome of Consultation published. Decision to be made by PCTs during February '05

CHILDREN AND YOUNG PEOPLE WITH DISABILITIES

TARGET To integrate services for children with disabilities across agencies

OUTCOME To improve access by providing local multi-organisational teams with single point of access

PLAN Multi-agency draft plan developed and to be progressed during '05 – '06

MEDICINES MANAGEMENT FOR CHILDREN AND YOUNG PEOPLE

TARGET To meet standards in NSF

OUTCOME Safe and efficacious care based on sound information about risk and benefit
PLAN To be developed during '05 – '07

UNDERPINNING THEMES

TARGETS Throughout the Children Act and NSF the Common assessment framework, Clinical networks, Information sharing, Information System's Options and Workforce Development are constant themes.

OUTCOME Non-recurring funding has been secured for all these initiatives to start 'Gloucestershireising' them for implementation.

PLAN To learn lessons from the pilots and include in progress towards a single point of access and shared core skills for all working with children and young people

Service area: Fertility. Lead Michelle Poole
<p>Targets:</p> <p>There is a discrepancy between John Reid's statement and NICE guidance. DOH John Reid " All PCT's will offer 1 cycle of IVF to all eligible couples by April 2005"</p> <p>The working group have a scoping document and will look at business plans for a minimum service, i.e. 1 IVF cycle, with the additional interventions of donor insemination and ovulation induction.</p>
<p>Outcomes: what will we achieve over the next year?</p> <p>We aim to achieve 1 IVF cycle, ovulation induction or donor insemination for eligible couples registered within county.</p>
<p>Action plan: how will we achieve it?</p> <p>Working with tertiary providers and other AGW PCT's to try and ensure consistency of criteria etc.</p> <p>Reviewing local provision for aspects of the treatments but capacity may be an issue. We would expect approx. 80 couples per year as a PCT to seek IVF. Applying specific criteria would reduce the number of couples eligible. [Treatment is approx. £3k per cycle of IVF].</p>

Service area: Maternity/Infant Mortality. Lead Michelle Poole
<p>NSLA targets:</p> <p>Reduce health inequalities by 10% by 2010 (from a 1997-99 baseline) as measured by infant mortality and life expectancy at birth. UK Rate is 5.7 per 1000births (1998) and Cotswold and Vale PCT was slightly lower than this at around 5 per 1000 births.</p>
<p>Local priorities:</p> <ul style="list-style-type: none"> • NICE: Antenatal care: Implemented October 2004 • NICE Caesarean Section: action plan being formulated by provider service (with maternity planning group) • Reduce under 18 conception rate by 50% by 2010. This is joint working with sexual health and social services. • Reduce smoking in pregnancy by 1% on previous year. This is currently at 21% in county • Maternity standard from children's NSF: Women have supportive, high quality maternity services designed around their individual needs and those of their babies • Effective antenatal care The women who are insulin dependent diabetics or have a multiple pregnancy should have nuchal translucency screening and this is an additional cost. • Increase in breastfeeding rate by 2% on previous year. • Improving nutrition of women who are pregnant or breastfeeding <p>The main priority is the shortfall of midwives in the community areas of Cheltenham, Cotswolds and Stroud. With additional resource it should be possible to reduce the number of antenatal admissions and day attendances to the acute units. The figure is for 6 midwives in the Cheltenham/Cotswold area and 2 in the Stroud area. This would benefit from the appointment of a midwifery consultant to promote normality and should include aspects of health inequalities.</p> <ul style="list-style-type: none"> • High risk maternity care is part of the current children's review consultation. • Midwifery staffing levels are a priority as they are below recommended levels (Birth-rate plus is an objective workforce planning tool) in Cheltenham and Stroud.

- Identify percentage of pregnant substance misusers to ascertain any future trends and service implications.
- Develop guidelines with respect to maternal mental health.

Outcomes: what will we achieve over the next year?

We aim to achieve smoking and breastfeeding targets.

All women will have antenatal care as outlined by the NICE Antenatal care guidance, including aspects of screening for Down's syndrome.

We aim to ensure issues around maternal mental health are reviewed to provide an effective service.

Action plan: how will we achieve it?

Smoking: Working with Gloucestershire smoking advice service (GSAS) and local practices to support women through smoking cessation.

Breastfeeding: implement Baby Friendly practice on all hospital sites and work towards community baby friendly to aid duration of feeding. Promote breastfeeding peer support groups working with public health and other services.

Work to promote effective maternity care to reduce infant mortality in county. This involves working with partners in education, social services, local councils and voluntary services.

<p>Service area Mental Health including reducing mortality from suicide</p>
<p>Targets from NSLA</p> <p>Substantially reduce mortality rates by 2010 (from the <i>Our Healthier Nation</i> baseline, 1995/97)– from suicide and undetermined injury by at least 20%.</p> <p>Reducing mortality from suicide: interventions which will help deliver this target are described in the <i>National Suicide Prevention Strategy</i>, and the <i>National Service Framework for Mental Health</i>. Unemployment and social isolation are important risk factors for deteriorating mental health and suicide. Information on how to help people with mental health problems gain and retain work, and improve community engagement, is set out in the report on mental health by the Government’s Social Exclusion Unit. PCTs should support access to assessment, treatment and care for all those at risk, paying particular attention to the needs of those from black and minority ethnic communities and other groups that may be hard to reach.</p>
<p>Existing targets identified in NSLA</p> <p>Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005.</p>
<p>Targets identified by service lead</p> <p>Establish Early Intervention Services and reduce the duration of untreated psychosis in 2005/06</p>
<p>Local priorities: are there additional targets or priorities?</p>
<p>The Trust has invested in Primary Mental Health Care Teams. These teams ensure that we meet our targets for Gateway and Graduate workers and contribute to the diversion agenda. The development is funded non recurrently from locality investment schemes. The Stroud service will receive mainstream funding from the start of 2005/06 with other teams coming up for funding in the latter stages of the year.</p>
<p>Outcomes: what will we achieve over the next year?</p> <ul style="list-style-type: none"> • Develop full coverage for Crisis teams by December 2005 • Consolidate Primary Mental Health care teams and carers services • Introduce a limited Early Intervention Service • Develop a suicide prevention strategy
<p>Action plan: how will we achieve it?</p>
<p>Crisis. With GPT Review current team and develop specification for coverage in Cotswolds area for December 2005.</p> <p>Primary Mental Health care. Review Stroud team and confirm structure and resource Early Intervention. Establish pilot in Stroud patch.</p> <p>Suicide prevention. A report has been commissioned and will recommend a strategy to take this forward.</p>

<p>Service area: Sexual Health and Teenage Pregnancy</p> <p>NSLA targets:</p> <p>Tackle the underlying determinants of ill health and health inequalities by reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health. (Joint target with the Department for Education and Skills.)</p> <p>Reducing teenage pregnancies: Choosing Health the Public Health White Paper details specific requirements for the delivery of sexual health services. The sexual health areas which will be particularly relevant for PCTs and their Local Authority partners to cover in their plans are: STI (and HIV) rates; holistic access times (covering both STI and reproductive health); and contraceptive and sexual health services provision.</p> <p>Targets identified by service lead:-</p> <ul style="list-style-type: none"> • To reduce the transmission of HIV & STIs, and to reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by the end of 2007 • To increase uptake of Hep B vaccine • To achieve agreed local teenage pregnancy conception targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets. • To increase the proportion of under 10 week abortions (Performance Indicator for Star Ratings) • 100% availability of appointments to be seen in GUM services within 48 hours of contact by end March 2008.
<p>Local priorities: are there additional targets or priorities?</p> <p>No specific targets, but a particular priority that will impact on all targets is the need to support development of sexual health service provision in primary care (and other community settings). This will improve access to services, which are currently concentrated in Gloucester and Cheltenham.</p> <p>Newly published national standards for Sexual Health and for HIV will influence service improvement and delivery.</p>
<p>Outcomes: what will we achieve over the next year?</p> <ol style="list-style-type: none"> 1. Further reduction in under-18 conception rates 2. Continued increase in the proportion of under 10 week abortions 3. Increase in nurse-led service provision within Sexual Health Services 4. Increase in capacity of Sexual Health Services 5. Increase in high quality STI testing & treatment in primary care 6. Greater integration of Contraception and GUM services on GRH site
<p>Action plan: how will we achieve it?</p> <ol style="list-style-type: none"> 1. Continue to implement the local Teenage Pregnancy Strategy, in particular the extension of school-based service provision and maintenance of the provision of free Emergency Hormonal Contraception (EHC) from community pharmacies, GP practices, MIUs etc.

2. Continued review and redesign of current service provision and increase nurse-led provision.
3. Speed up access to the abortion service by in particular using the DH non-recurring allocation for improving abortion services to train nurses to provide the medical abortion service.
4. Service capacity will increase as a result of increasing nurse-led services, thus optimising the skills and resources available within current budgets. In addition, capacity in the specialist services can be increased by supporting primary care providers to develop their level and standard of provision as appropriate and within national guidelines.
5. Offer training and support in STI diagnosis, treatment and partner notification and to use the learning from involvement in the NPDT Sexual Health Contracting Collaborative to inform the development of primary care based GUM services as a Local Enhanced Service.
6. Move of the Sexual Health Services on GRH site offers the opportunity to begin to integrate the GUM and Contraception Services. This will enable services to move nearer to the 'One Stop Shop' model outlined in the national sexual health & HIV strategy, again increasing capacity, improving the patient experience and developing new, extended career opportunities for staff.

Service area: Learning Disability. Lead Nicholas Breakwell
<p>Targets</p> <p>Learning Disability is not explicitly mentioned within the planning documentation. There are two outstanding targets for learning disability services that are monitored within the LDP. These are the number of people with learning disabilities who are registered with a GP and the number of people with learning disabilities who have a health facilitator. These have been picked up in the 'star targets' for 2004/05 along with a continuing reduction in long term NHS residence for people with Learning Disabilities</p> <p>However, all of the other targets listed need to be considered in relation to people with learning disability. The health inequality agenda is very relevant as people with learning disabilities are much more likely to have poorer health and poorer health outcomes. This means that other plans around issues such as access and long term conditions should ensure that they are fully inclusive and cater for the needs of people with learning disabilities.</p>
<p>Local priorities: are there additional targets or priorities?</p> <p>A commissioning strategy has been agreed by Social Services, the three PCTs and the Partnership Trust. This is wide ranging and the action plan covers:</p> <ul style="list-style-type: none"> • Organisational change • Purchasing changes • Re design of services • Operational changes
<p>Outcomes: what will we achieve over the next year?</p> <ul style="list-style-type: none"> • Agree specification and go out to tender for the services currently provided by Mend/Mayfield • Begin to manage the market – especially in relation to residential options • Reduce long term NHS residence • Develop integrated structure
<p>Action plan: how will we achieve it?</p> <p>The joint commissioning strategy includes a full multi agency action plan</p>

Service area- Diabetes. Lead Liz West

NSLA Targets

Priority 1: Improve the health of the population outlines several important targets that will impact on diabetes jointly with other services. These are reducing adult smoking rates and halting the year on year rise in obesity in children.

Priority 2: Supporting people with long term conditions outlines the need for comprehensive holistic assessment which corresponds to the NSF for diabetes and the nGMS contract around disease registers. This standard also states that there should be a systematic approach to care for people with chronic diseases. The NSF states that by 2013 all standards should be met. By 2006 all people with diagnosed diabetes should be identified in an up to date register.

By 2006 PCTs should ensure that systematic treatment regimes are in place for people with diabetes.

Existing target identified in NSLA

A minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy by 2006, and 100% by 2007.

Targets identified by service lead.

There are now many NICE publications around Diabetes including "Guidance on the use of patient-education models for diabetes" and "the Prevention and management of foot problems" The former recommends that structured patient education is made available to all people with diabetes at the time of initial diagnosis and that as a minimum any educational groups should be led by an appropriately trained nurse and a dietician. The latter states that on diagnosis of type 2 diabetes and at annual review thereafter all patients' feet should be examined to detect risk factors. Patients should be provided with foot care education and promptly referred to a foot protection team should they be deemed at high risk of ulceration.

Local priorities: are there additional targets or priorities?

In order to offer equitable access across the PCT for people with diabetes and to contribute to the diversion agenda the central local target is establishing a multi-disciplinary Primary care diabetes team. This is likely to be developed as part of a Local Enhanced Service and will be tied in with the updated integrated care pathway for diabetes. The team will include a Consultant, or GpWsl where appropriate, Nurse Specialist, dietician and Podiatrist. They will offer local access for patients supported by a robust care pathway. Patients will be seen quickly and efficiently at community based sites. There will be a reduction in unnecessary follow ups and patients will be supported through good quality information and education to manage their own condition where possible.

The second local target is to provide structured education to staff around the identification and management of patients with diabetes.

Outcomes: what will we achieve over the next year?

The PCT will evaluate the impact of the new roles created as part of the Primary and community Development Scheme. This will include a review of the level of diversion, access to services, patient satisfaction and outcomes.

Over the next year the PCT will review the implications of developing a Local Enhanced Service for diabetes.

Shared care plans will be rolled out across Gloucestershire and patients will continue to receive equitable access to education programmes.

Action plan: how will we achieve it?

A report will be developed by January that will provide an account of the impact of the locality scheme. This will be analysed in terms of continuing the service and spreading it to the rest of the PCT.

Work stream two: Supporting people with long-term conditions

National Standards Local Action offers the following guidance in this area:

Target: To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline), through improved care in primary care and community settings for people with long-term conditions.

This work-stream consists of the following service areas or projects:

- Expert Patient Programme
- Primary Care
- Community Matrons and Care Planning
- NICE Guidance and drugs
- Chronic Obstructive Pulmonary Disease
- Ophthalmology

Service area- Expert Patient Programme
<p>Target</p> <p>The Expert patient programme will be rolled out nationally by 2008 to enable thousands more people with long-term conditions to take control of their health.</p>
<p>Local priorities: are there additional targets or priorities?</p> <p>Locally we plan to hold four programmes a year in 2005/06. These programmes will take place in a variety of locations around the PCT to allow good access.</p> <p>The other major local development is the appointment of an EPP CO-coordinator (1 day a week). This role will ensure the programmes are adequately promoted in Primary care and with other partners and administered efficiently.</p>
<p>Outcomes: what will we achieve over the next year?</p> <p>We will hold 4 programmes over the next year. This will offer up to 60 people a place on a course. In 2006.7 we plan to expand the programmes further to accommodate 120 people and further expand in 2007/8 to allow for enough capacity for 250 people to attend</p>
<p>Action plan: how will we achieve it?</p> <p>The PCT agreed to fund the appointment of a co-ordinator and to support the programmes in regards to venues, transport and other consumables.</p> <p>The coordinator will ensure that the programme is promoted across the PCT and administrate the courses. Further investment in 2005/6 and 2006/7 will allow for the programmes to be expanded and offer improved capacity.</p>

Service area: Primary Care

NSLA Target

The *new contract for GPs* introduced in April 2004 will reward family doctors who deliver higher standards of care to patients;

Target identified by service lead

Access to Services: the 24 / 48 Hr access target will need to be maintained.

Outcomes: what will we achieve over the next year?

Smokers reduced. We have a target as a PCT to reduce smokers by a given number. This has been translated into practice based targets and a Local Enhanced Service set up to action an incentive scheme, to encourage practices to hit their specific target.

The target was exceeded last year, and we expect to meet if not exceed it again this year.

Practice based disease registers: These are being significantly upgraded as a result of the new GMS contract, which requires these as a baseline for the award of quality points and remuneration. The assessment process for the Quality Framework is focusing on validating these registers. 10 registers are in the Quality framework, including CHD, Diabetes and Hypertension.

Diabetes Screening: 2 year cycle under way, current results at about 20- 40% screened in last 15 months according to QMAS. Expect to meet 100% target by 2007 and 80% by 2006.

CHD Thrombolysis: Rolling out pre hospital thrombolysis in ambulances, expect to have all crews doing it within a year – thus will be getting towards 100% call to needle time in <60 mins. Can easily meet the 10% increase a year for a couple of years, once you reach 100% you fail this target the next year!

Action plan: how will we achieve it?

New GMS Contract is a strong financially motivated incentive to achieve these targets. Expect to get very high levels of compliance and thus target meeting.

Service area – Community Matrons and Care Planning

Target:

Patients with complex long-term conditions will be supported by *community matrons*, and by 2008 every PCT will be offering these services. (C&V PCT to have 10 Community Matrons by March 2007)

People with long-term conditions benefit from a comprehensive holistic assessment of their current and anticipated health and social care needs and wishes. The result will be a care plan for each person (and her/his carer(s)) which she or he has agreed with her/his lead care professional on behalf of the agencies involved. The plan will set out agreed health objectives and care needs and the contributions of the individual and of each agency. It will be reviewed regularly to evaluate outcomes and identify changes in the needs and wishes of the patient (and carers).

The level of support that people need will vary with time and the progression of their conditions. Many people with long-term conditions can manage their conditions well most of the time, with access to support in primary care and systematic and tailored disease management programmes when appropriate. There are some people (often those with more than one condition) whose needs are more complex, who require more proactive support with a key worker co-ordinating services.

The overarching target to reduce emergency bed-days has the following impact for Cotswold and Vale:

Baseline 2003/04 (FCE's). = 113,292 (DoH figure)

2005/06 112,159 (1%) - 1,133 bed days saved

2006/07 109,893 (3%) - 3,399 bed days saved

2007/08 107,627 (5%) - 5,665 bed days saved or 8% target reduction of current capacity for Cotswold and Vale PCT

Local priorities: are there additional targets or priorities?

The development of community matrons provides for a role that has the opportunity to work between health and social services to promote integration and the sharing of information that supports mutual and joint working.

Outcomes: what will we achieve over the next year?

Agree definition, with Public Health's help, of the population to be targeted.

Identify where resources can be recycled as part of community nursing services review.

Agree how to identify those patients meeting the definition with primary and community care services. This work being looked into by Public Health directorate as several models are already being used across S Cots and Stroud localities

Scope existing related services that fit with this role.

Scope admin, IT, budget, education and training support needs of community matrons.

Scope current and future clinical pathways / referral routes.

Scope Consultant lead

Scope GP mentors for CM's.

2005/06 Recruit 4 x Community Matron and Pilot within practice integrated teams (probably Stroud locality). CM's will need a lead in time to reach target caseload of 80 per CM.

2007 recruit additional 6 CM posts.

Action plan: how will we achieve it?

Project Manager to establish a multi-disciplinary implementation group led by Head of Community Nursing.
Develop Implementation Plan.

Service Area: Implementing NICE Guidance

Target: People with long-term conditions will benefit from the rapid implementation of NICE guidance on cost effective drugs and NICE guidelines, for example on MS and epilepsy.

The implementation of NICE Guidance will be overseen by a county-wide group that will report to the Strategic Commissioning Group.

The purpose of the group will be:

- To develop fair and transparent processes for the implementation of NICE guidance and Guidelines to ensure a timely response.
- To coordinate the assessment of the impact and resource implications of any guidance using service groups where appropriate or establishing ad-hoc groups.
- To ensure accurate and appropriate arrangements are in place to monitor the financial implications.
- To ensure appropriate arrangements are in place to review implementation.
- To develop a horizon scanning tool to inform the county group of forthcoming NICE guidance over the year to support forward planning and identify opportunities to comment on consultations.
- To understand impact of new national policy on implementation of NICE, e.g. PbR.

Service area: COPD

Targets

Service area is included under DOH Supporting People with Long Term Conditions policy area: awaiting DOH framework, due to be published Oct/Nov 04. PSA as listed which will be stepped:

- 1% reduction by Mar 2006
- 3% reduction by Mar 2007
- 5% by Mar 2008

against a baseline of admissions during 2003/04. Awaiting clarification as to whether this target is against all admissions or for conditions listed in the DOH Compendium of Chronic Disease.

COPD part of nGMS QOF.

PCT participating in NPDT “Managing Chronic Conditions” programme which supports practices in working towards QOF objectives for COPD and Diabetes. COPD target of reducing acute admissions for COPD exacerbations by 40% within 12 months. This target is unlikely to be achieved: evidence-base shows reduction of 1-2% within 12 months.

Link to smoking cessation targets: smoking main aetiological cause of COPD.

Local priorities: are there additional targets or priorities?

NPDT programme linked to PCT FRP.

Local priorities will be linked to PCT strategy for managing pts with LTC. Local issues identified have been:

- Spirometry – access/equipment/training
- Practice nurse training to manage COPD pts
- Absence of dedicated primary care specialist respiratory team (GPSI/Nurse/Physio)
- Access to pulmonary rehabilitation for pts with COPD
- Palliative care for end-stage COPD pts
- Access to pt education programmes

Outcomes: what will we achieve over the next year?

Participation in NPDT programme will lead to improved pt management at practice level and some cost savings against acute care admission.

Improved access to spirometry and setting of standards.

Access to training for practice and PHCT members.

Patient involvement: Patient satisfaction survey planned for Jan-Mar 05.

Action plan: how will we achieve it?

Participation in NPDT programme ongoing – runs till Aug 05. Dedicated project manager (Sarah Alvis) with up to 15 practices participating.
Pt satisfaction survey will take place.

PCT direction for broader management of LTC will impact on COPD service area.

Service area: Ophthalmology
Targets
None specific for ophthalmology except Choice of two providers from end of January 2005 and 4-5 providers by end December 2005 for cataract surgery. 3 month wait for cataract surgery to be achieved by November 2004.
Local priorities: are there additional targets or priorities?
Explore scope to provide ophthalmic primary care (OPC) outside of the hospital eye service (HES) using ophthalmic medical practitioners (OMPs) or OPC practitioners, to include diagnosis, investigate, treat and manage of key eye conditions, triage and prioritisation of referrals onto HES. The outcomes would be to reduce wasted or duplicated consultations in the HES, provide access to services more locally, improve the quality of referrals into the HES.
Outcomes: what will we achieve over the next year?
Close working between optometrists, primary care and hospital eye services to scope the development of local OPC services within Cotswold and Vale. Consider rollout of Glaucoma pilot being undertaken in the Forest of Dean once results are shared in the New Year.
Action plan: how will we achieve it?
Project team Partnership working

Work-stream three Access to Services

National Standards Local Action set the following overarching target:

“To ensure that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.”

This target applies to acute elective hospital care, but PCTs are encouraged to agree local plans to reduce waiting for other types of treatment. We would expect average waits in 2008 to be around nine weeks from GP referral to treatment, with waits for an outpatient consultation not normally exceeding six weeks. PCTs, in partnership with NHS and other provider organisations, are encouraged to set and achieve even more ambitious goals locally. PCTs will need to ensure they have robust plans to deliver the 2008 maximum waiting time target. PCTs' annual trajectories will be agreed with SHAs as part of the planning process and PCTs will hold providers to account for delivery through commissioning arrangements.

In addition to this there are targets relating to new capacity and diversity of provision: The NHS Improvement Plan signals that independent sector providers will increase their contribution to the care of NHS patients and may provide up to 15% of surgical procedures and an increasing number of diagnostic procedures by 2008. PCTs and their partners are encouraged to plan for significant plurality of provision, including Treatment Centres, to improve value for money and to benefit patients. PCTs should also have made contingency plans and have put in place adequate risk management strategies to address unforeseen capacity shortfalls.

This work-stream consists of the following service areas or projects:

Waiting times and targets including diagnostic services
Older People Single Point of Access
Dentistry
Problem drug users
Orthopaedics

In addition to this the Trust has significant plans for change in access to services and there are a programme of projects that fit in this area.

Programme B

Programme B represents the continuation and further development of projects (formally categorised as “Diversion”) that develop new pathways of assessment and care and improved services closer to home, delivered more cost effectively. The programme also integrates this work with the development of practice-based commissioning to ensure that incentives within PBC and the developing role of GPs as commissioners are aligned with the PCTs vision for services closer to home and achieving recurring financial balance. Almost 100% of GP practices are expected to go live in 2005/06.

Key Tasks/Milestones

Programme B		Programme Sponsor: Mike Adamson	
No.	Description of Outcome	Key Tasks/Milestones	Finish Date
	New Pathways & Approaches to Care To continue current projects and develop new pathways projects to reduce expenditure across all providers by a cumulative net £2.6m over 04 - 06	Pathways Scoped and Savings Projected Pathways for development confirmed Pathways developed Pathways implemented - phase one - phase two	15.02.05 01.04.05 27.04.05 30.06.05 30.09.05
	Practice-based Commissioning To reduce expenditure within primary care and by primary care (as commissioners), producing net savings of £800K over 05 - 06	Completed model for PBC Commissioning unit budgets completed Produce financial commissioning profile for each practice Finalize working arrangements by practice Implement from 01.05.05	18.02.05 16.03.02 30.03.05 29.04.05
	GP Engagement To secure the involvement in practice based commissioning of the GPs who have most scope to reduce commissioning spend and plan complementary changes to local services using a targeted approach.	Segment GPs Tailored messages and carriers for initial wave complete Complete engagement plan	17.03.05 17.03.05 31.03.05

Programme C

Description

Programme C involves the redevelopment of community hospitals and community and social care services in order to:

- Reduce avoidable admissions to community hospitals by strengthening services and early intervention where people live
- Run beds more efficiently, reducing length of stay and eliminating delayed transfers of care, and thereby reducing overall bed numbers
- Serve a wider proportion of local populations at different community hospital and clinic sites
- Provide a wider range and greater volume of outpatient, diagnostic and surgical services from community hospitals and clinics
- Maximise the utilisation of theatres in community hospitals
- Develop the workforce to deliver the new forms of service.

Key Tasks/Milestones

Programme C		Programme Sponsor: Richard Higgins	
No.	Description of Outcome	Key Tasks/Milestones	Finish Date
	Modernising care - Improving Efficiency in community Hospitals If the PCT thinks it is right to focus on	Plan and communicate new criteria for acceptance of transfers Factor in rehabilitation tariff as	31.03.05 31.03.05

	<p>action to improve care for patients who transfer from hospital care, then the following actions might be ones chosen. The aim would be to change services to improve and shorten the journey home and in doing so make a financial saving. The target financial saving would be £1,700,000 pa from 2006/07</p> <p>Local Health & social Care In a PCT-wide Framework In improving the efficiency of community hospitals it is recognised that community nursing and social care services need to change and that to link these changes to the development envisaged in project 10, below, a new model of service will be agreed for the PCT as a framework for locality service models.</p>	<p>contribution to rehabilitation service cost or to create surplus Implement criteria for transfer Implement realignment of rehabilitation care with transfers only to that service</p> <p>Fairford PPI Fairford Public consultation Close consultation and take decision Assess options for change at Tetbury Plan process for PCT-wide service model development in each locality Commence implementation</p>	<p>01.04.05 01.09.05</p> <p>31.05.05 31.10.05 25.11.05 15.02.05</p> <p>01.04.05 01.05.05</p>
	<p>Community Hospital Outpatient & Diagnostics Development and implementation of the plan for outpatient and diagnostic services that improves access and generates net income for the PCT of £250K in 05/06.</p>	<p>Establish specialties and activity levels for Tetbury business case and other main PCT sites</p> <p>Identify impact on secondary care providers and give notice</p> <p>Develop implementation plan Commence implementation from- 01.05.05</p>	<p>04.02.05</p> <p>11.02.05</p> <p>29.04.05</p> <p>TBC</p>
	<p>Community Hospital Theatres Plan, negotiate and implement the ISTC agreement for operating theatres, making a net savings/income contribution of £500K in 05/06. As a fall-back position – engage with private sector for the running of theatres at a financial premium to the PCT.</p>	<p>Agree with DoH application of national scheme to C & V PCT Assess viability of national or local route for C & V and select preferred route</p> <p>National ISTC route</p> <p>Local route</p>	<p>28.02.05</p> <p>31.03.05</p> <p>31.03.06</p> <p>30.09.05</p>

Service area: Waiting Times and Access

Targets from NSLA:

To ensure that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment.

Diagnostic Services: The maximum wait of 18 weeks by December 2008 includes diagnostic procedures and tests, encompassing all those diagnostic procedures and tests required for the consultation. There will be shorter waits for patients with suspected cancer – a maximum of two months from urgent referral to treatment from December 2005 and one month from diagnosis to treatment – again requiring faster access to key diagnostic services. PCTs and their partners will be encouraged to plan for early reductions in key areas of diagnostic waits, such as MRI, CT scans and endoscopy.

Existing targets identified in NSLA

Achieve a maximum wait of 3 months for an outpatient appointment by December 2005.

Achieve a maximum wait of 6 months for inpatients by December 2005.

Delayed transfers of care to reduce to a minimal level by 2006.

Targets identified by service lead:

Existing standards that must be maintained.

Elective care:

- Treat all in-patients within 9 months
- Reduce the number of over 6 month waiters by 80% of the 2003 baseline.
- Maintain CHD Targets
- Maintain no over 3 week waiters for cataract treatments
- Offer choice of second provider if originating trust has not offered date of treatment within six months
- Offer binding date within 28 days for appointment if operation cancelled for non clinical reasons

Emergency care

- Maximum 4 hour wait in A & E
- Maintain Ambulance Category A, B and C performance
- Maximum 2 week wait for Rapid Access Chest Pain clinics

Emergency Care

- Ambulance standards are currently being reviewed and will reflect rural and urban issues. Guidance is expected later this year.

There are additional core standards outlined in the fifth domain, these are c18, c19.

Developmental standard D11 requires the PCT to ensure that it offers equitable access to services and choice.

Local priorities: are there additional targets or priorities?

There are a number of key priorities that need to be addressed to ensure that the PCT is able to commission services for patients to these standards. These are:

Increase capacity

The NHS will offer access to treatment within the independent sector to ensure that sufficient levels of capacity are available to reach the 18 week target by 2008. Some of this capacity will be procured centrally. Local targets will be agreed with SHA's for IS use. Current local

capacity modelling suggests that 8% will need to be procured. This will be reviewed following the updated capacity model.

Improve Diagnostic performance

Poor access to diagnostic services, in particular MRI and Radiology, is seen as a key system bottleneck and a barrier to reducing patient throughput. A national initiative has secured additional mobile MRI capacity available locally to assess and diagnosis those who have been on the waiting list the longest. However, reform of the diagnostic pathway is needed to produce the increase in capacity required. This review needs to focus on key factors such as:

- Is the test needed? The need to critically examine the evidence for the diagnostic test and determine the added value this gives the clinician in either supporting or making the diagnosis.
- Can the test be carried out in a different setting? The need to shift, as part of the care pathway, simple diagnostic tests away from secondary care and provide these in a more local setting. This may involve increasing the capacity and competence within Primary Care through nGMS
- Can the test be carried out at initial assessment? The need to have access to “one stop assessment” that includes diagnostic tests and thus reduce the need for follow up appointments.
- Is existing capacity utilised effectively? The need to have a clearer understanding of demand and capacity both now and into the future.

Reduce unnecessary follow ups

There are a number of clinical services where national evidence suggests that there is scope to reduce secondary care follow ups; these are Orthopaedics, Dermatology, ENT and Ophthalmology. The PCT has developed services to reduce activity in Orthopaedics and is developing a primary care Dermatology service. Work needs to be completed in Ophthalmology and ENT.

Reduce DNA's & cancellations

It is envisaged that with shorter waiting times and full booking by December 2005 the percentage of appointments that are cancelled by patients or do not attend (DNA's) will fall, thereby increasing capacity. A series of local targets with providers should be agreed and monitored as part of the SLA process. Local provider trusts are currently working to review their patient access policies which will determine how they can meet the requirement for booking in advance

Outcomes: what will we achieve over the next year?

Existing standards and targets are monitored through the current performance arrangements. The PCT expects to maintain our current level of performance and ensure that we meet all the relevant national access standards.

Targets for 2005/6

Elective Care

The PCT expects to achieve the Dec 2005 targets in out-patients and in patients day cases.

Emergency care – Target is to maintain the requirement for Ambulance Trusts to respond to 75% of Category A calls within 8 minutes, to respond to Category B calls within 19minutes and to agree local arrangements for the response to Category C calls. The number of 999 calls has been rising by 8% per annum and the Gloucestershire Ambulance Trust has not been achieving the 75% Category A target. The targets have always been challenging in rural

areas across the PCT.

Targets beyond 2005/6

To reduce delayed transfers of care to a minimal level by 2006: Given current budgetary pressures within lead partner organisations our expectation of good performance would be in the region of the mid to high 20's unless additional investment is made available to create additional capacity across the health and social care community. This will be achieved by adhering to current partnership working arrangements between the PCT and SSD to identify, monitor and manage potential and actual patients delayed through joint working with the PCT capacity team, intermediate care services and SSD hospital, fieldwork, and home care teams.

18 week wait from referral to treatment: A detailed action plan will be produced by the PCT that will identify the system changes and increase in capacity need to reach this target. Early modelling of the demand and capacity assumptions has already started and will be refined during 2005/6. The modelling will ensure that there are sufficient clearance times for outpatient and inpatient waiting lists and, taking account of any diagnostic episodes, to achieve an overall maximum wait of 18 weeks from referral to hospital treatment. The modernisation/system changes required will be developed with support from key stakeholders and partners throughout the local health community.

Action plan: how will we achieve it?

Many of the actions outlined in this summary are cross cutting and will form part of the core business of every Directorate within the PCT. An agreed series of actions, milestones and outcomes will need to be agreed with lead managers and clinicians. It is envisaged that these will in part be monitored by the business plan review process, and by specific project monitoring developed as part of the PCT's Programme Board.

Emergency care:

An action plan has been agreed with AGW, to be monitored regularly, to urgently review systems such as control room procedures to raise the response rate. Part of the solution lies with joint working with the 3 PCTs to look at alternative methods of response, particularly in rural areas. These include telephone triaging of less urgent calls and queries and workforce changes such as the Emergency Care Practitioner and community responders. This also embraces the local response to non urgent Category C calls. The PCT will be working closely with the Ambulance Trust to help with system changes needed in the operating centre and to increase the number and range of staff with skills who can respond to 999 calls on behalf of the Ambulance service.

The Patient Transport Service (PTS) forms part of a separate contract and the Cotswold and Vale PCT is the biggest user in the county. This contract will be reviewed for 2005/06 with a view to targeting key journey times. A longer term piece of development work will also be initiated to explore options to create a more comprehensive and robust PTS which supports the PCT development plans.'

Service area – Older People, Single Point of Access. Lead Clare-Louise Nicholls
<p>Targets</p> <p>To have a more streamlined and coherent approach for professionals accessing urgently required health and social care services across the PCT to include all Intermediate Care, MDAU and beds by developing a single point of access available 7 days per week, 24 hours per day.</p> <p>This will prevent the duplication and scatter referrals, promote the most appropriate use of services and/or admission into hospital.</p>
<p>Outcomes: what will we achieve over the next year?</p> <p>By using resources and knowledge from the present year we will scope a fully and truly integrated single point of access for professional, urgent referrals to community services. This needs to be based centrally where clinical advice is available to CSOs.</p> <p>The single point of access needs to be manned at least 7 days a week and will need to be developed into a 24 hour service in line with PCT plans.</p> <p>The use of a single point of access will benefit referrers in that they won't be wasting time trying to decide where to refer patients to and finding a service with capacity. Consequent benefit is avoidance of inappropriate admissions through referrers giving up and taking the easy option of moving the patient on.</p> <p>Directory of services for use by the CSOs that includes service eligibility, contact details.</p>
<p>Action plan: how will we achieve it?</p> <p>Establish multi-agency project group and develop project plan.</p> <p>Explore potential links with other access/triage points.</p> <p>Development of Integrated Care Pathways between health and social services so that the processes by which referrals are made is clear across professional and organisational boundaries and disciplines.</p> <p>Access to additional professional support on MDAU to the CSOs to help screen referrals that can be quite medically complex and are difficult to place in specific services.</p> <p>Access to training for referral officers and clinical support.</p> <p>Marketing and process maps for referrers so that referrers are clear what information is needed and timescales for response times.</p>

Service area: Dentistry
National targets
<p>From April 2006 PCTs will be required to commission all NHS primary care dentistry. Under the Health & Social Care (Community Health & Standards) Act 2003, commissioning and contracting for NHS dentistry will devolve from the DH to PCTs, including the provision of a dental out-of-hours service for urgent treatment. The budget for General Dental Services (GDS) will be devolved to PCTs as part of their main allocations, subject to a spending 'floor', and will be subject to a significant growth, financed by a national increase in spending of £300m.</p> <p>From April 2005 PCTs will have the responsibility for providing Prison Dental Services and for dental public health, requiring the assessment of local need and commissioning services to meet the needs identified.</p>
Local priorities
<p>Cotswold and Vale PCT host and provide the Salaried Primary Care Dental Services (NHS provision) across Gloucestershire. These comprise the Community Dental Service (CDS) and the more recent Personal Dental Service (PDS).</p> <p>The aim during 2005/6 is to ensure that the services are performing to maximum efficiency and capacity to meet the needs of the 3 PCTs. This will be achieved by commissioning an external review of and integrating, the CDS and the PDS under strong clinical leadership which reflects the Chief Dental Officer's Report of December 2004.</p> <p>Developments to the Dental Access Centres in Southgate Moorings, (Gloucester) and St Paul's, (Cheltenham) planned during 2004/05, will be completed during 2005/06, maximising the service capacity within the existing financial envelope. The developments will be funded by transferring underspend on PDS revenue, to capital. The ongoing revenue consequences of these developments fall within the current resource limit allocation.</p>
Outcomes: what will we achieve over the next year?
<p>The key aims for PCTs will be to:</p> <ul style="list-style-type: none"> • improve access to NHS dentistry • convert 25% of GDS practices within the SHA area to early PDS contracts by April 2005 • increase the number of patients treated under the NHS • increase the w.t.e. number of NHS dentists • provide urgent dental treatment within 24 hours • improve oral health • integrate NHS dentistry within the wider NHS. <p>The new dental contract aims to radically change the way NHS dentistry is provided by requiring PCTs to have contracts with local dental practices. The emphasis will be on the provision of comprehensive care for a specified number of patients rather than the existing system based largely on a fee for item of service. As part of a wider modernisation programme across the NHS, the new dental contract should improve:</p> <ul style="list-style-type: none"> • access to services, • standards of care for patients, and • the working lives dentists and their teams.

However, some dentists believe that the new contract will not deliver real change, with a risk that it could herald an increased shift from NHS to private work. It is also unclear if the increased financial allocations will be sufficient to significantly improve and maintain greater access to NHS dental services.

Action plan: how will we achieve it?

A great deal of groundwork will need to be done during 2005/06 to put us in a position to be able to meet these targets, which will include:

- following up the introductory seminars run in 2004/05 with individual visits to each GDP
- Developing the working relationship with dentists, and PCT expertise in commissioning dentistry.
- clarification of the financial position in relation to existing and new budget allocations

Service area: Substance misuse

Targets from NSLA

Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

Target identified by service lead

There is an existing LDP target to increase the number of practices participating in shared care schemes.

Existing target to reduce the number of drug related deaths

Local priorities: are there additional targets or priorities?

The plan to increasing the number of drug mis-users accessing treatment is driving forward developments to expand activity in primary care

Outcomes: what will we achieve over the next year?

The priority is increasing the number of service users in treatment. There are significant problems in the Stroud patch where the waiting time is excessive. In the coming financial year we will need to establish additional capacity in substance misuse services. There is an expectation of a 9% increase in activity in this year. This will be achieved by consolidating the scheme developed in the Dursley area and by establishing new capacity in the Stroud area.

Action plan: how will we achieve it?

By establishing a new service to supplement existing activity. This service will be targeted at non-complex substance mis-users and will be based in primary care. Discussions are currently underway to identify the management arrangements for this service. At this time the preference for this PCT is for a hosted service.

Service area- Orthopaedics

NSLA target

Improve access times (by Dec 2005 no-one should wait more than 3 months for an outpatient appointment or 6 months for inpatients)

Local priorities: are there additional targets or priorities?

To contribute to the financial recovery plan by improving patient pathways and offering patients the choice of receiving a more local appointment by continuing to roll out the Orthopaedic Practitioner service. In 2005/6 the capacity within the service should more than double with additional investment.

To develop detailed plans around how we may offer orthopaedic minor surgery within primary care. This includes the project that has been developed recently around Carpal Tunnel surgery.

To review current gaps in the provision of the orthopaedic Practitioner service in particular focusing on shoulders, hands and feet.

Outcomes: what will we achieve over the next year?

We will extend the scope of the Orthopaedic Practitioner service in order to address the demand for consultations for shoulder, hand and foot complaints. We will establish a Primary care service for Carpal Tunnel Surgery. This will aim to divert around 90% of patients away from Secondary Care by offering a local service that can be accessed very quickly.

Action plan: how will we achieve it?

The Orthopaedic Practitioner Project will make recommendations on how we can extend the service in the future in light of new knowledge around the current referrals. The Interface Programme will address the issue of providing a Primary Care led Carpal Tunnel service.

Work-stream 4: Patient Experience

National Standards Local Action sets the following overarching target:

“Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by dependently validated surveys. The experiences of black and minority ethnic groups will be specifically monitored as part of these surveys.

Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:

- increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
- increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

This work-stream consists of the following areas or targets:

Patient Surveys
Choice
Older people at home
MRSA

Patient Surveys

Target

Patient experience: Survey results will be analysed and presented, at the national level, by different patient groups, including ethnic groups. Given that evidence shows relatively poor take up of services by people from black and minority ethnic communities, PCTs should work with local provider organisations to improve (a) the way people from black and minority ethnic communities are consulted about local health and health care issues and (b) the way their experience is monitored.

PCTs should ensure that adequate patient information and support processes are set up and, particularly, to provide targeted support for hard-to-reach individuals and communities, including black and minority ethnic groups. PCTs should be considering how to increase patient choice in primary care and for patients with long-term conditions.

The PCT participates in the National Primary Care survey, and for the last 2 years it has scored well above the national average on a significant number of indicators. This survey correlates to considerable work being undertaken in Practices around the Quality and Outcomes Framework, and a much more detailed survey taking place in practices, as part of this framework. Both these surveys will result in action plans in individual practices and indeed at the individual practitioner level, as the Practice QOF survey examines in detail the quality of care delivered by individual practitioners, and feed into the GP appraisal process. These are powerful tools for driving positive action and improvement in the quality of the patient experience in Primary Care.

The Quality & Outcomes framework assessment process reviews the practice based complaints processes and significant events processes, and will ensure that these are managed effectively in practices. This is supported by the Clinical Governance infrastructure, which is linked with the PCT complaints management process. These all feed into delivering a continuous quality improvement agenda in the PCT.

The outcomes from the 2004 PCT survey are very positive, showing the PCT to be better than the national average on 17 indicators and worse on only one. Compared with the previous years survey, significant improvements were seen in 2 indicators and in none was there a significant worsening.

The survey gives a number of areas where there is still opportunity for improvement, despite being better than the national average, from the results the key areas where actions are required are tabulated below:

Problem Identified	Fit with existing work programmes	Actions planned	Who responsible
Not told how long would have to wait in GP practice, would like to be told. 43%	Practice own surveys	Discuss with practices.	Practices C. Morton
Not always able to get through on telephone to Surgery. 35%	Practice own surveys	Ask practices to review own procedures	Practices. C.Morton

Not had Blood Pressure checked in last 12 months. 34%	Quality Outcomes Framework &	Currently 80% of >45 Yr old patients have been checked.	Practices
Had to wait more than 15 minutes to see GP. 29%	Access National Enhanced Services. Practice Surveys.	Practices to review	Practices. C.Morton
Have not been offered Flu Jab in last 12 months. 28%	NES Flu programme, currently exceeding 70% of >65's immunised	Manage patient perception.	Health Protection Agency. National programme, Practices.

Service area: Choice**NSLA Targets**

To deliver the choice element of the new national target, PCTs and their partners will be expected to plan so that from April 2008, patients requiring planned hospital care will have the right to choose to have their treatment in any health care provider that meets the Healthcare Commission's standards and which can provide care within the price the NHS will pay.

PCTs should ensure that adequate patient information and support processes are set up and, particularly, to provide targeted support for hard-to-reach individuals and communities, including black and minority ethnic groups. PCTs should be considering how to increase patient choice in primary care and for patients with long-term conditions.

Existing targets identified in NSLA

Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four to five different health care providers for planned hospital care, paid for by the NHS.

Targets identified by service lead:

National Choice Policy: 4/5 choices are to be given for elective care referrals. 1 choice is expected to come from a private provider.

Patient/User Experience: Patient and their user group's representatives are being consulted to make a more customer focused approach to the Choice Program. Their views and aspirations will be assimilated so as to help create and provide a framework that delivers the information patients want and in a format that is understandable. Development of a referral management service which will collate and disseminate feedback for service (choices) improvement

Long-term conditions: Through the revision of patient care pathways will be looking at providing choice options that where possible could offer initial consultation in a more local area.

Access to services: Provision of choices and the development of referral management services, which reflect customer aspirations and incorporating a contingency plan to identify non-booking will deliver a fair prompt more transparent service with shorter waits. Future mid term plans to progress to full electronic booking with release of edition 3 of the software for electronic booking will further enhance these targets.

Local priorities:

Local demography shows higher than average older persons in the population in some localities together with large rural areas distant from the countywide secondary care services. This is highlighted in the PCT's Business Development Plan, which highlights a special case for the development of more local services to improve access and the need to engage in patient involvement inline with the Standards Framework and patient focus. This is to be delivered by PCT to commission cost effective services that meet identified need and which improve health. These services will be provided as locally wherever possible, and will be delivered by partner organisations in the NHS, Voluntary & Independent sectors.

Local service provision does not necessarily mean within county, it may mean Swindon, Bristol,

Worcester, and Oxford etc. for customers living near county borders. Cotswold and Vale PCT are currently working with the other Gloucestershire PCTs to ensure a more effective service through better resourcing, planning and joint learning.

Outcomes: what will we achieve over the next year?

Choice Targets are to achieve 100% booking with choice by December 2005. It is recognised by the DoH that health communities such as Gloucestershire will not be able to implement the complete Choose and Book IT solution by December 2005. However, Choose and Book interim solutions are in development and we will be monitored on % utilisation of these national tools.

We will achieve:

- Implementation of a framework for booking and choice
- Development of principles to support the identification of commissioning 'choices'
- A minimum of two choices of cataract provider at the point of referral from January 2005
- A minimum of two choices of provider at the point of referral / listing for cardiac surgery from April 2005
- A menu of four to five choices of provider from the point of referral for elective hospital treatment from December 2005.
- Mechanisms to support patients and referrers through the Choose and Book process
- Quality information systems to be put in place to support (a) referrers undertaking Practice-based Commissioning, (b) patients exercising choice of provider and (c) pathway development.

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Action plan: how will we achieve it?

The Choose and Book programme is coordinated at county-level and reports to the county IM&T Programme Board. The Choose and Book programme has been divided into four work-streams as identified in the Local Health Community Assessment.

1. Delivering full booking with Choice
2. Developing new ways of working
3. Supporting Primary Care Referrers
4. Commissioning and Contracting for choice

Progress and risks will be monitored and managed by the Choose and Book Programme Board whose members represent Cotswold & Vale PCT, Cheltenham & Tewkesbury PCT, West Gloucestershire PCT, Gloucestershire Partnership Trust, Gloucestershire Hospitals Trust, Social Services, the GP community and patients.

<p>Service area – Older People, Independent Living at Home</p> <p>Targets from NSLA</p> <p>Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:</p> <ul style="list-style-type: none"> • increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and • increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care. <p>Additional targets identified by service lead:</p> <p>increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care, (Source IER)</p>
<p>Local priorities: are there additional targets or priorities?</p> <p>Initiatives to support older people living independently at home require partnership working between social care, health and local authorities and integrated working within health and social care teams that focus on their local population. Instrumental to successful integrated team working is the new community care worker role. Ongoing implementation of this role links with the Care at Home Strategy being led by Social Services.</p> <p>Services that underpin independent living at home include improved uptake of direct payments, improved and appropriate use of community equipment, the provision of a portfolio of intermediate care including beds and services delivered within people's own homes, support for carers, provision of day and respite services, use of Smartcare technology, support from home improvement agencies and housing options that meet needs in particular including extra care sheltered housing. Primary care will need to consider how underpinning services are supported and developed through its commissioning of local services and initiatives e.g. community therapy and nursing.</p>
<p>Outcomes: what will we achieve over the next year?</p> <p>Improved partnership working between health, social care and the district councils under the leadership of an older peoples partnership group.</p> <p>Submission of a bid to the DOH for capital monies for extra care sheltered housing.</p> <p>Evaluation of the community care worker pilots with plans for roll out of further teams.</p> <p>Improved use of Smartcare technology.</p> <p>Implementation of the Care at Home Strategy.</p> <p>Ongoing development of integrated health and social care teams.</p> <p>A review and remodelling of day care services.</p>
<p>Action plan:</p> <p>By working in partnership to agreed aims that support joint commissioning and working, by incorporating pilot work into mainstream services and roll out of the community model of care.</p> <p>By establishing Older People's Partnership Board undertaking a coordinating and monitoring role.</p> <p>Agree the Joint Health and Social Care Commissioning Strategy for Older People</p>

<p>Target: Reducing Methicillin Resistant Staphylococcus Aureus [MRSA]</p> <p>Achieve 20% year on year reductions in MRSA levels reported through laboratory systems. This is measured as a community wide target for Gloucestershire.</p>
<p>Outcome</p>

Improvements in:

Infection control; Surveillance; identification of risk; Bed management; Patient movement; Hospital cleanliness

Action:

14 point action plan in place and being delivered across the Trust as agreed through the work programme for infection prevention and control and monitored through the Community Infection Control Committee. Also review by AGW against the community MRSA action plan

Work-stream 5 Organisational Development and Partnership working

This work-stream consists of the following areas or targets

Agenda for Change
 Improving Working Lives
 Patient Public Involvement
 Healthcare Commission review
 Clinical Negligence Scheme for Trusts risk management standard

We also recognise the criticality of playing our role to improve the quality of partnership in the county. We intend to establish a steering group, including key partners, to provide strategic oversight of the PCT's change programme over the next 18-24 months.

In addition to this the Trust has significant plans for enabling changes and there are a programme of projects that fit in this area.

Programme A

Description

Programme A comprises a group of projects which have the potential for short-term gain and/or which clear the way for other projects to proceed.

Key Tasks/Milestones

Programme A		Programme Sponsor: Robert Knibbs	
No.	Description of Outcome	Key Tasks/Milestones	Finish Date
	Impact of Rehab Charges (transfers) Net £250k reduction in commissioning spend through the changes in the PbR regime relating to rehabilitation services.	a. Establish PbR regime under which Foundation Trusts will operate in 2005/06 b. Analysis of patients transferred to assess potential impact of new regime c. Monitor & review outcomes to	14.02.05 17.02.05 30.06.05
	Contract Reviews Net £50K reduction in out-of-county spend (Warks & Worcs) and a methodology to apply across other contracts to achieve further net savings.	Detailed review of Warks & Worcs contracts Agree activity within contracts Agree roll-out programme to other contracts Complete negotiation of contracts with providers to reflect savings/service change	11.01.05 14.01.05 20.01.05 31.03.05

	Admin Review Complete a review of administration services that will allow a £300K reduction in administration expenditure, by lowering costs to national average levels.	Confirm current admin staffing in Directorates (No.s, grades, roles etc.) Benchmark to similar PCTs/Validate Secta findings Sign-off new staffing levels Implement changes from 01.04.05	18.01.05 14.02.05 23.03.05 30.09.05
	Community Nursing Complete a review of community nursing that will allow a £500K reduction in expenditure, by lowering costs to national average levels.	Produce revised reference costs Validate Secta findings Report findings to Programme C for incorporation into new community/social care model, and workforce planning	17.03.05 30.03.05 31.03.05
	Car Parking Generate £150K of net income by implementing car-parking charges.	Develop and Appraise Options Identify preferred option Tender Service Negotiate Final Contract Implement Contracted service	22.02.05 23.02.05 30.02.05 31.03.05 01.04.05

Programme D

Description

Programme D comprises a number of cross cutting, enabling projects that support the rest of the projects in programme A to C. The most important of these, at this stage, are the communications plan including patient and Public Involvement (PPI), workforce planning for the new services, and recharges and ownership of activity.

Key Tasks/Milestones

Programme D		Programme Sponsor: Sue Donaldson	
No.	Description of Outcome	Key Tasks/Milestones	Finish Date
	Recharges Establish and operate a mechanism by which the PCT charges and is in turn recharged appropriate cash sums for the use of its facilities and services and it's use of the facilities and services of other organisations.	Revise internal costing model Agree recharges to/from GHT Establish risk mechanism	31.01.05 28.02.05 28.02.05
	Ownership of Activity As a result of completing the Recharges project, match potential PbR income against known costs and establish the viability or otherwise of owning activity undertaken in the PCTs facilities.	Revise internal cost model including recharges Identify and price PbR activity within provider arm Review results and confirm decision	28.02.05 28.02.05 31.03.05
	Communications (incl. PPI) Plan and implement the process by which stakeholders (internal & external) will have the information they need to influence and respond to proposed service changes, ensuring the PPI process and system is used effectively and appropriately.	Identify key internal & external stakeholder groups Produce high-level communications plan Create communications gateway Detailed communications plan Establish infrastructure Establish review mechanism	31.01.05 30.01.05 16.03.05 24.03.05 29.03.05 29.03.05

	<p>Workforce Planning Develop and implement a plan that ensures an appropriate workforce (numbers & skills) is in place to deliver the new services.</p>	<p>Complete LDP workforce submission Develop project scope for building detailed workforce plan Produce detailed plan for workforce requirements Complete workforce plan Implement workforce plan</p>	<p>28.01.05 28.02.05 28.02.05 30.06.05 28.10.05</p>
	<p>Improving Information & Performance Management Systems Identify and implement improvements to key performance management information and information flows so that the PCT has a system that allows it to understand efficiency in its commissioning & delivery of services.</p>	Work in progress	
	<p>Transport Complete an assessment of transport limitations and development issues in preparation for/in response to proposed services and site options.</p>	Work in progress	
	<p>Facilities Development and Planning Issues Complete an assessment of site constraints and planning consent issues in preparation for/in response to proposed services & site options.</p>	Work in progress	

Agenda for Change
What are the current trends or issues in this area which the actions seek to address?
<p>This is a national initiative primarily designed to: -</p> <ul style="list-style-type: none"> • Equalise pay to meet Equal Opportunities legislation • Harmonise terms and conditions of employment • Simplify pay and administrative support systems • Help with recruitment and retention of staff • Improve performance by linking pay and the Knowledge and Skills Framework (KSF) • Increase flexibility – clearer processes for role redesign/introducing new ways of working
Outcomes : What will we achieve over the next year?
<ul style="list-style-type: none"> • Develop and agree job descriptions and KSF outlines for all posts • Assimilate all staff onto new pay arrangements/terms and conditions of employment • Issue variations of contract so all staff know how they are personally affected • Ensure all staff go through a performance appraisal process and have a performance and development plan • Benefits realisation plans for all service areas to exploit the new structures and frameworks • Enhanced competencies in management community on core responsibilities
Action Plan : How will we achieve it?
A detailed project plan for this programme is in place. A high level project steering group exists to ensure the project is executed and is supported by appropriate resources
Risk Management : What are the risks and how will we manage them?
<ul style="list-style-type: none"> • This is a complex project and there are many risks. The project plan indicates milestones and dependencies, and this will be closely monitored by a Steering Group • Financial risk of not being able to implement A4C pay rates within the allocated budget ~ are reviewed on a regular basis by Director of HR and Finance. Resourcing plans will be flexed as necessary to ensure we do not exceed budget • This is a high-resource project ~ given the level of staff involvement. Again, the impact of this is regularly assessed • The project is being run also to meet SHA and D of H targets which are reviewed on a monthly basis • There is a risk to employee relations in implementing the project. By working in close partnership with staff side representatives this risk is minimised • Effective communication with all staff is also very important, and regular briefings are circulated

IWL ~ Achieving Practice Plus Accreditation
What are the current trends or issues in this area which the actions seek to address?
<p>This is a national initiative primarily designed to ensure the NHS is promoted as a model employer ~ thus helping with recruitment and retention of staff. It will also help promote: -</p> <ul style="list-style-type: none"> • Development of effective workforce planning • Development and maintenance of effective staff involvement and partnership working, leading to staff feeling recognised and valued • Development of more effective internal communication strategies and practices • Development of a training and development strategy • Development of flexible benefits • Promotion of a healthy/safe work environment
Outcomes : What will we achieve over the next year?
Practice Plus Accreditation
Action Plan : How will we achieve it?
<p>A comprehensive action plan has been developed ~ based on feedback during the IWL Practice assessment last year.</p> <p>This is regularly reviewed by a Steering Group ~ consisting of both management and trade union representatives.</p> <p>We have committed to Practice Plus assessment during December 2005, which means an initial self-assessment level to be undertaken by 31 March 2005 and submitted formally to AGW in October.</p>
Risk Management : What are the risks and how will we manage them?
<p>Finite resources ~ both staff and financial investment – pose a serious risk to achieving practice plus accreditation.</p> <p>The steering group and project co-ordinator are working hard to establish priorities in an endeavour to ensure the Trust focuses on the areas most vulnerable. We have also enlisted the help of the AGW IWL lead and are learning from best practice approaches across the county/country.</p>

Service area: patient and public involvement

Local priorities
Patient and public involvement: implement strategy and action plan Internal communications: review and develop good practice across the PCT
Outcomes: what will we achieve over the next year?
<ol style="list-style-type: none"> 1. Major staff and public involvement and consultation exercise around the future of services provided by the Trust 2. Raise awareness of patient/public involvement and good practice among our staff 3. Continue to develop strong working relationship with Patients' Forum 4. Increase the number of user (and carer) representatives working with the Trust 5. Formalise our relationship with the voluntary community and recognise its contribution to our work, in line with the Gloucestershire Compact 6. Further integration of PALS within the PCT 7. Develop more effective internal communications
Action plan: how will we achieve it?
<ol style="list-style-type: none"> 1. Initial letter to all staff; regular staff, public and media briefings; public and informal events (e.g. road shows for staff); feedback mechanisms (e.g. newsletters, posters, website) 2. 50+ staff across the PCT to receive training in PPI techniques (using joint NHS/Social Services training programme); PPI staff group to be re-established, chaired by Jonathan Duckworth 3. Cotswold and Vale Patients' Forum representatives to join our four locality forums 4. System for reimbursing travel and childcare expenses to be implemented for service user representatives (40ppm and £5 per hour, where relevant); explore options for providing relevant training for service user reps 5. First meeting with local voluntary organisations to explore implementation of Compact agreement 13 January 2005 6. Joint reporting (PALS/complaints/PPI) from Feb 2005; PALS 'hot desking' with front line PCT staff 7. Involve staff in developing internal communications by setting up cross-PCT working group (Dec 04) to share ideas and monitor existing mechanisms
Risk Management: what are the risks and how will we manage them?
<ol style="list-style-type: none"> 1. Risks: resistance towards change; cynicism about involvement and consultation process. We need to ensure excellence in communications with all staff, opportunities for multi-way dialogue, recognition of related stakeholders (e.g. Leagues of Friends) and a flexible approach that recognises staff experience and expertise in their area of work. 2. Risks: none identified. The costs of providing the training are currently being met by a grant from AGW that we hope will be renewed for the next financial year. 3. Risks: possibility of less open discussion by Locality Forum members in the presence of an external member. However, the Forums could still choose to conduct part of their meetings in private, where necessary. Plus, we are aiming to foster a more open, inclusive culture of planning and service delivery. 4. Risks: extra resource needed to meet user expenses and to deliver training. However, costs are likely to remain modest and have already been factored into the PPI budget. 5. Risks: raising unrealistic expectation within the voluntary sector; lack of resource to fund key projects delivered by voluntary sector. We need to be very clear about the PCT's financial situation and perhaps explore the opportunity of 'in kind' reward (e.g. training opportunities). 6. Risks: new PALS manager yet to be appointed (interviews 7 Jan); staff resistance to PALS support (e.g. among GPs). We need to brief identified staff on why we are setting up the 'hot desking' project and monitor its effectiveness.

7. Risks: may raise levels of dissatisfaction with internal communications and create demand for new service that we cannot adequately fund or staff. We need to be clear about the parameters in which we are working (e.g. we can't promise to provide computer access immediately for those who don't have it), but be creative within the resources we have available.

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Healthcare Commission Review

<p>What are the issues or trends in this area which the actions seek to address?</p> <ul style="list-style-type: none"> ▪ The Healthcare Commission are responsible for reviewing the performance of NHS organisations and awarding an annual rating of performance. The format of assessment is by measuring performance against Government standards published July 2004. Standards for Better Health consists of 7 domains, namely: <ul style="list-style-type: none"> • Safety • Clinical & Cost Effectiveness • Governance • Patient Focus • Accessible and Responsive Care • Care Environment and Amenities • Public Health ▪ Each of the domains is made up of a number of core standards, which establish the quality of care patients can expect now, and developmental standards, which are aspirational. ▪ During 2005/2006 the Healthcare Commission will concentrate on assessing compliance against core standards. The PCT will have to make a declaration of compliance against core standards ▪ Need to ensure Standards for Better Health framework reflected in commissioning arrangements
<p>Outcomes: what will we achieve over the next year?</p> <ul style="list-style-type: none"> ▪ The PCT will make a draft declaration of compliance October 2005 and final declaration of compliance April 2006 ▪ Declarations must take into account views of patients and other partners in local healthcare community ▪ Baseline assessment carried out November 2004, identified high compliance in 22 of the 24 core standards and lower compliance in 2 of the 24 core standards ▪ Each core standard further broken into component elements and their level of compliance assessed ▪ Lead Director identified for each of the 7 domains ▪ Lead Director and Manager allocated for each standard and component element
<p>Action plan: how will we achieve it?</p> <ul style="list-style-type: none"> ▪ Items scoring low compliance, i.e., 2 or below, will be identified and placed on the Assurance Framework and Risk Register, with action plans to achieve full compliance ▪ Progress reports against action plans will be part of Assurance Framework reporting arrangements ▪ Lead Director and Manager to develop and co-ordinate action plans to achieve full compliance for all component elements of standards and collect evidence to demonstrate compliance ▪ Develop systems and processes to ensure Standards for Better Health framework reflected in commissioning arrangements ▪ Determine how PCT will demonstrate compliance ▪ Promote compliance with standards with independent contractors
<p>Risk Management: what are the risks and how will we manage them?</p> <p>PCT unable to declare full compliance with standards resulting in weak rating by Healthcare Commission</p>

Clinical Negligence Scheme for Trusts – Risk Management standard

What are the current trends or issues in this area which the actions seek to address?

The PCT achieved Level 1A CNST risk management standards for PCTs in August 2004. The Level 1A assessment was principally concerned with ensuring that the organisation has developed key risk management documents. The PCT is now eligible for Level 1B assessment and is working towards this. Achievement of Level 1B will:

- Enable the PCT to have 10% discount from its scheme contributions for the following two financial years.
- Provide supporting evidence for Standards for Better Health assessment
- Contribute to the development and implementation of integrated governance
- Improve standards of care and the effectiveness of systems throughout the PCT
- Increase risk management awareness
- Help to embed risk management in the PCTs culture

Stroud Maternity Hospital achieved Level 1 CNST standard for maternity services in March 2003. The service is currently working towards Level 1 re-assessment.

Outcomes: what will we achieve over the next year?

The PCT will achieve Level 1B CNST Risk Management Standard for PCTs
Stroud Maternity Hospital will achieve Level 1 CNST Maternity Clinical Risk Management Standards

Action plan: how will we achieve it?

A CNST Steering Group will be formed and Leads identified for each of the criteria assessed. Each criterion lead will:

- Perform self-assessment of given criterion
- Identify people/services they need information from within their area
- Highlight gaps in evidence
- Actions needed to reach compliance
- Timescales
- Resource issues
- Feedback results of self-assessment to Steering Group

Steering Group to collate self-assessment and report back to Risk Management Committee/PEC/Board