

**Priority Transformation Programme
Delivery Plans**

Final Version

2011/12

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1. Priority Transformation Programme Delivery Plans

| 1.1 Long Term Conditions and end of life care |
|--|
| <p>Summary</p> <p>We aim to transform services in the city so that they are;</p> <ul style="list-style-type: none"> • Equitable – patients will access to and receive the same level of care irrespective of where they live, where the care is delivered or the complexity of need. • Personalised – Patients and their carers will receive care that meets their needs and is articulated in a jointly co-produced care plan • Structured – Patients will receive the care most appropriate to their needs systematically |
| <p>Programme Plans</p> <ul style="list-style-type: none"> • Implement recommendations of ICES review • Implement specialist neuro-rehabilitation commissioning plan which supports Early Supported Discharge • Develop and shadow monitor unbundled tariff for patients admitted following a stroke for full implementation in 2011/12/13 • Review TIA (transient ischaemic attack) Service in line with best practice tariff guidance • Implement LTC teams across city and supporting LTC model • Complete Oxygen service procurement as part of national re-procurement • Implement oxygen assessment and management pathway • Implement a city wide risk prediction tool to identify and stratify LTC patients within each practice • Implement GP Consortium Commissioning Housebound Project • Implement insulin pumps as per NICE guidance • Develop and commission future Expert Patient Programme |
| <p>Key Milestones</p> <ul style="list-style-type: none"> • Recommendations from ICES review fully implemented Jul 11 • Fully implemented specialist neuro rehabilitation pathway Jul 11 • City wide roll out of LTC teams and supporting model Dec 11 • Home Oxygen Service awarded via national and regional procurement process Mar 12 • Home Oxygen Service assessment and management position Apr 12 • Implement risk prediction tool Aug 11 • Implement GP Consortium Commissioning Housebound Project on-going • Implement insulin pumps as per NICE guidance Apr 11 • Develop and commission future Expert Patient Programme Apr 11 • Carer Strategy ongoing • Physical Disability Strategy ongoing |
| <p>Linked QIPP Programmes</p> <p>Improving stroke pathway; end of life care; respiratory programme, LTC , Urgent Care</p> |

| Outcome measures | |
|---|---------------|
| Measure | Target |
| Emergency re admissions 25% reduction (but still to be defined what re admission is locally) | 25% reduction |
| Emergency admissions for people with long term conditions | n/a |
| Proportion of deaths in usual home (including care homes) | 41.7% |
| Carers Breaks (agree and make available to local people policies, plans and budgets to support carers). | Local plan |
| The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call | TBC |
| Quality Stroke indicators -proportion of people who have had a stroke who spend at least 90% of their time on a stroke unit | 80% |
| - proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours | 60% |
| | |
| Quality metrics | |
| Measure | Target |
| CQUINS under development | |
| People with Long term Conditions feeling independent and in control of their condition (% who said they had had enough support from local services/organisations) | 78.8% |
| | |
| Principal changes in activity | |
| Anticoagulation local items | -9,908 |
| Anticoagulation outpatients | -336 |
| Diabetic medicine outpatients | -510 |
| LTC short stay | -154 |
| Implications for workforce | |
| <p>With the reconfiguration of existing teams and focus and shift to generic team based models of care the existing community workforce is likely to experience the most change.</p> <p>Teams will move from nursing only to multi disciplinary teams working across a number of organisational boundaries.</p> <p>Aspiration to train non-qualified staff to take on a range of roles including assessing for and prescribing equipment and therapy support.</p> | |
| Commentary on financial requirements | |

| | 11/12 Cost | 11/12 Savings | 11/12 Net |
|--|---------------|------------------|--------------|
| Savings Plans | | | |
| Diabetes | | (74) | |
| Anti Coag | 87 | (249) | |
| End of Life – Education and Training | 7 | | |
| Prevention of Admission | | (119) | |
| Service Redesign – LTC Teams | | (100) | |
| Service Redesign - ICES | | (65) | |
| Service Redesign – Integrated Neuro Rehab Team | | (80) | |
| Total Savings | 94 | (687) | (593) |
| Service Investments | | | |
| Diabetes – Insulin Pumps | 235 | | |
| Oxygen Review | 50 | | |
| Carers | 86 | | |
| Expert Patient Programme | 30 | | |
| Physical Disability | 118 | | |
| Total Investments | 519 | | 519 |
| Procurement and market management implications | | | |
| Oxygen service national and regional service | | | |
| Equalities Impact | | | |
| Plans have been assessed as part of the Primary and Community Care Strategy. | | | |

1.2 Urgent Care

Summary

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

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

Programme Plans

- Implementation of new short term service model
- Implementation of new medical model for short term services
- Implement long term model of community rapid response service/hospital rapid discharge team
- Full implementation of local Directory of Service to support NHS Pathways
- 3 digit number (SEC wide)
- Continue implementation of ambulatory care model
- Implement findings of social marketing report
- Improving hospital discharge work programme
- Review options for Urgent Care Centre and Out of Hours Service
- Develop and implement plans for the use of reablement and social care monies
- A&E Primary Care development

Key Milestones

- Develop service model for short term services July 11
- Agree procurement route for short term services July 11
- Procure short term services to have service in place April 12
- Implement new medical model for short term services April 12
- Review phase 1 of community rapid response service/ hospital rapid discharge team April 11
- Implement long term model Sept 11
- Implement local Directory of Services Mar 11
- Implement NHS Pathways April 11
- Implement additional pathways for ambulatory care model – on-going
- Continue to improve hospital discharges – on-going
- Commence procurement or pilot for NHS 111 – during 11/12 if pilot
- Decision re Urgent Care Centre and Urgent Care Centre Sept 11
- Develop and implement plans for the use of reablement and social care monies – on-going
- Implement Urgent Care clinical dashboard
- Social marketing campaign
- Pilot clinical diagnosis tool
- Target A&E reattenders with mental health issues

Linked QIPP Programmes

Ambulatory Care, 3 Digit Number

| Outcome measures | |
|---|--|
| Measure | Target |
| Cat A response within 8 minutes Category A 19 Minute Transportation Call Abandonment Rate Re-Contact Rate Following Discharge of Care Ambulance calls closed with telephone advice or managed without transport to A&E | 75% 95% |
| Unplanned re-attendance at A&E within 7 days of original attendance Total Time in the A&E Department A&E left without being seen rate | A rate below 5% Less than 4 hours Less than 5% |
| Ambulatory Care Percentage of A&E attendances for cellulitis and DVT that end in an admission Number of admissions for cellulitis and DVT per head of weighted population | |
| Emergency readmissions Total number of non-elective FFCEs in a month Average length of stay for hospital spells Number of A&E attendances in a month Number of urgent and emergency journeys via ambulance, monthly | <i>TBA</i> Improvement against 10/11 baseline |
| % of all adult inpatients who have had a VTE risk assessment | |
| Delayed transfers of care | |
| Quality metrics | |
| Measure | Target |
| Ambulance Service Call Abandonment Rate Re-contact rate following discharge of care Service Experience Outcome from acute ST-elevation myocardial infarction (STEMI) Outcome from cardiac arrest Outcome from cardiac arrest – survival to discharge Outcome from stroke Time to answer call Time to treatment | |
| A&E time to initial assessment A&E time to treatment A&E Consultant sign off – high risk patient groups Service experience (A&E) | A rate below 5% All patients assessed within 20 mins of arrival Continuous improvement |
| CQUINS for providers to be agreed | |

| Principal changes in activity | | | |
|---|------------|----------------|--------------|
| Ambulatory Care Admissions | -268 | | |
| NHS Pathways - SECAMB | -149 | | |
| Primary Care A&E | -1,433 | | |
| Community Rapid Response | -718 | | |
| Implications for workforce | | | |
| <p>We will need to develop certain core roles and challenge current workforce behaviours, requiring some staff to work differently and more flexibly.</p> <p>We will expect a blurring of the boundaries between primary and secondary care with hospital doctors performing outreach work in the community and rotations between primary and secondary care staff. We also expect a range of staff including nurses, therapists, generic care workers and doctors to come together in a genuinely integrated way in some of the new services we are developing such as the UCC or the RRAS. This may mean staff working under new management arrangements or even for a new provider.</p> <p>We expect services to be delivered in different locations. All existing bed-based services will be brought back into the city and delivered from fewer sites. Services may be expected to work on a locality basis supporting clusters of practices and working much more closely with primary care. We will expect the operating times of some services to change so that they are configured to meet demand. Some services may be required to operate 24/7.</p> | | | |
| Commentary on financial requirements | | | |
| | 11/12 Cost | 11/12 Savings | 11/12 Net |
| Savings Plans | | | |
| GP OOHs | | (110) | |
| Reduction in Ambulatory Care Admissions | (102) | (490) | |
| Hospital Rapid Discharge Team | 42 | | |
| Reablement Money – Local Plan | 109 | | |
| Phase 1 999 (NHS Pathways – SECAMB) | | (37) | |
| Rapid Response and Assessment | 67 | (187) | |
| RTF additional Rapid Response Service | 161 | (359) | |
| Primary Care A&E | | (141) | |
| Readmissions Project | 100 | | |
| RTF additional Roving GP | 50 | (65) | |
| FYE RTF | 42 | - | |
| Total Savings | 469 | (1,389) | (920) |
| Service Investments | | | |
| Clinical Dashboard | 250 | | |
| Total Investments | 250 | | 250 |
| Procurement and market management implications | | | |
| <p>Options for procurement of new short terms services model likely to be decided post JCB approval in July. Market development required to explore likelihood of potential alternative providers with appropriate estate within city.</p> | | | |
| Equalities Impact | | | |
| <p>Plans have been assessed as part of the Primary and Community Care Strategy.</p> | | | |

1.3 Planned Care

Summary

The following schemes will make services more accessible to patients whilst delivering improved cost efficiency and quality.

In 2011/12 we will build on the successes of 2010/11 further reducing demand and moving more outpatient activity to primary and community settings. We will work with secondary, community and primary care providers to deliver solutions that are mutually beneficial and sustainable.

We will also work with patients to ensure that they are fully involved with decisions relating to their care through informed choice and informed decision making. We will strive to involve patients in all commissioning decisions.

Programme Plans

Referral management

Reducing GP referrals for elective care and ensuring quality of referrals are key priorities for NHS Brighton and Hove. Over the past few years NHS Brighton and Hove (BHC) and the NHS as a whole has learnt a great deal about referral management and how to maximise its impact. Based on local findings and national intelligence such as the Kings Fund report of October 2010 a new gateway management contract has been negotiated and commences in January 2011. The focus of the contract has changed from blanket triage to a much more targeted approach. Greater emphasis has been placed on GP feedback and education. To support this aspect of the contract we have engaged PBC in agreeing the content of the service specification, performing a contract monitoring role and assessing the success of the contract at 9 months (September 2011) with a view to PBC taking full contract responsibility for any subsequent contract.

The impact of the new contract is to reduce outpatient activity by £420k in 2011/12.

Cost effective commissioning

As well as reducing demand for planned care services we will also look at delivering some services in the community or primary care and some within a hospital setting but delivered in a different way:

Outpatient Procedures - A group of 55 procedures which are currently undertaken primarily as day case could be safely and efficiently delivered in an outpatient setting. Through CRGs we will work to move many of these procedures to outpatient clinics.

One stop shops - We will also task CRGs with identifying which procedures could be delivered as a one stop shop (i.e. without the need for an outpatient appointment in advance of the procedure date).

Telephone follow up - Providing more advice and support to GPs to reduce routine referrals that result in patients being seen in outpatients. Both in terms of providing re-assurance and advice to GPs for management of certain conditions to keep patients in primary care and also to reduce unnecessary referrals to secondary care (directing referrals to a more appropriate service).

In certain circumstances as a result of these discussions, investigations could be organised in advance, either negating the need for patients to be physically seen, or facilitating the subsequent consultation - allowing patients to be prioritised and provided with a 'one stop' opinion based on necessary investigations.

Such a system may be particularly helpful for patients that are already known to the department allowing longer term plans for management to be made and reducing the number of follow-ups. We are piloting this approach in neurology and renal.

Enhanced Recovery Programme

In 2011/12 we will expect the MSK ICATS Knee service, which is due to commence from late

February 2011, to provide a full Informed Decision Making service for patients with osteoarthritis of the knee. This will involve supporting patients to use the NHS Direct patient decision aids service around having surgery. The NHS Direct IDM service will be free and open to all from mid-January 2011, and includes an online patient decision aid plus telephone support. There is good evidence that Informed Decision Making leads contributes to better outcomes for patients, whilst at the same time reducing demand for surgery by up to 20% for some conditions. As this will be our first step in this direction we are making a conservative estimate that it will reduce the demand for total knee replacement by 5%. We funded 273 knee replacements in the 09/10 financial year at a cost of £1.5m. A 5% reduction would deliver a saving of £75k. We do not envisage any requirement for investment to achieve this, since IDM is an existing requirement of the MSK ICATS service and the NHS Direct inputs are free of charge.

Speciality specific projects

Integrated Care Pathways

During 2010 NHS BHC commissioned two integrated care pathways, dermatology and MSK. This approach brings about a change in clinical skill-mix, treatment pathway and in the setting of care. It presents a unique opportunity to bring gateway and service provision functions closer together, eliminating duplication of triage, maximising opportunities to manage demand and ensure that only those patients who really need a specialist service are referred into secondary care. In 2011/12 we will continue with this approach in MSK and dermatology and expand it further in other specialities:

- MSK – continue with the roll out – full implementation from 1st April 2011
- Dermatology – expand the scope to include all day case activity
- Explore integrated approach for ENT, Neurology, Gynaecology and other high volume specialities.

During Q4 of 2010/11 a feasibility study will be undertaken to explore the lessons learnt so far and to assess how we expand this approach in the future.

Preliminary figures show this approach could reduce OP spend by £920k in 2011/12

In addition to the integrated care approach we are looking at a number of discrete areas within specialities for improvement and redesign:

ENT

The annual demand for new ENT outpatient appointments will be reduced in 2011/12, to yield a 20% net reduction in cost. This will be achieved by;

1. Primary Care Guidelines: guidelines have been developed for several common ENT conditions which often result in premature referral. The purpose of these guidelines is to clarify what primary care management is expected of GPs and the thresholds at which it is appropriate to refer on for specialist assessment. These guidelines will be used by BICS triage GPs as a tool to peer review referrals received for ENT. Where necessary, this will facilitate a conversation with the referring GP about management options. This will be supported by the publication of the guidelines on the Map of Medicine and, where appropriate, using the guidelines in education sessions.
2. Improved pathways for patients who require referral to specialists. Opportunities have been identified to treat more patients in community settings, particularly where these are co-located with Audiology services.

The expected impact of these two schemes is a net saving of £76k.

Ophthalmology

The main focus of service improvement in Ophthalmology in 2011 - 2012 is the development of an integrated Glaucoma service, delivered by a consultant-led multi-disciplinary team including

Community Optometrists, Ophthalmic Nurses and Orthoptists. The service development is planned to be phased, with non-medical staff seeing more complex patients as their competencies increase. The proposal is for a service to be delivered in existing premises at the SEH rather than in a community setting in order to maximise cost efficiency. Appointments for patients with suspected or diagnosed Glaucoma constitute approximately one third of outpatient services in Ophthalmology. It is also proposed that the PCT actively encourage Optometrists to exercise their right to refer directly to secondary care rather than referring patients via their GP. Net savings for glaucoma and ophthalmology are £109k.

Restorative Dentistry

Establishment of a consultant post in Restorative Dentistry to: a) achieve IOG compliance (0.3wte) b) to provide a specialist restorative dentistry service in Brighton and Hove and c) to develop the primary care dentistry workforce. The cancer element of the post will be funded by repatriating work from other providers, as will the secondary care specialist service over time. The provision of clinical leadership and training to primary care practitioners will initially take more time than service provision and £70k of RTF funding is to fund this element of the post during the first year. Development of the primary care workforce will allow more work to be retained in primary care by General Dental Practitioners. It will also facilitate the development of Dental Practitioners with Special Interests who would be able to take referrals from other General Dental Practitioners. Development of GDPs and DPwSIs will reduce the number of referrals to other secondary care providers. Currently local dental services are inequitable as poorer people are less able to pay to be treated privately.

Key Milestones

- Referral management – review of BICs contract Jun 11
- MSK fully implemented April 11
- Dermatology ICO expanded to include day case July 11
- Implement IDM for knee surgery tbc
- Trial telephone follow up April 11
- Roll out integrated pathways phased from Oct 11

Related QIPP Programmes

All projects are covered under planned care QIPP programmes

Outcome measures

| Measure | Target |
|--|--|
| RTT (referral to treatment waits) | Admitted 95 th centile – 23 weeks Non-admitted 95 th centile – 18.3 weeks Incomplete 95 th centile – 28 weeks 11.1 admitted median 6.6 non-admitted median 7.2 incomplete median |
| Acute bed capacity | |
| Average spell duration for non-same day acute discharges | |
| Elective FFCEs | <ul style="list-style-type: none"> • Proportion of elective FFCEs which are for daycases • No. of elective FFCEs |

| | |
|---|---|
| Referrals | <ul style="list-style-type: none"> No. of GP written referrals No. of 1st outpatient attendances after GP referral |
| No. of first outpatient attendances | |
| Numbers waiting at the end of a month on an incomplete Referral to Treatment pathway | |
| People offered screening for the early detection (and treatment) of diabetic retinopathy in the previous 12 months | 95% of eligible people |
| Improved access for advice and treatment | Measure to be developed |
| Quality metrics | |
| Measure | Target |
| Onward referral rate | Measure to be developed |
| Reduced surgical interventions | Measure to be developed |
| Patient satisfaction and PROMs | Measure to be developed |
| Reduced length of stay | Measure to be developed |
| Choice | <ul style="list-style-type: none"> Choice of named consultant-led team Choice: use of Choose and Book |
| Use of the independent sector | |
| Mixed sex accommodation | Numbers of unjustified breaches to be minimal |
| Principal changes in activity | |
| Reductions in activity | |
| Dermatology OP | -15,219 |
| ENT OP | -1,294 |
| Gynaecology OP | -991 |
| MSK OP | -36,834 |
| Ophthalmology OP | -1,510 |
| Increases in activity | |
| DA Chest Xrays | 1,761 |
| Restorative dentistry | 388 |
| Implications for workforce | |
| To deliver the vision of greater primary and community provision of services a significant amount of development is required by the existing workforce. In view of this RTF monies have been set aside in 2011/12 to support primary care workforce development specifically in relation to the delivery of | |

planned care service

Commentary on financial requirements

The below table shows the financial costs and associated savings related to the schemes outlined above:

| | 11/12 Cost | 11/12 Savings | 11/12 Net |
|--|--------------|----------------|----------------|
| Savings Plans | | | |
| Community – Dermatology | 439 | (383) | |
| ENT – phase 2 of project | 50 | | |
| ENT | | (126) | |
| Gynaecology | 97 | (121) | |
| Ophthalmology | 86 | (107) | |
| Neurology | 57 | - | |
| Neurology | 547 | (684) | |
| Glaucoma OP | 352 | (440) | |
| MSK | 2,449 | (3,380) | |
| Reduction in Out-Patients (Benchmarking) | | (420) | |
| Enhanced Recovery | 147 | (75) | |
| Day Case to Outpatient Procedure | | (699) | |
| Theatres Productive Ward Programme | 50 | | |
| Restorative Dentistry | 70 | | |
| OPD large scale change programme | 100 | | |
| Development of an Acute Oncology Service | 102 | | |
| Total Savings | 4,546 | (6,568) | (2,022) |
| Service Investments | | | |
| Restorative Dentistry | 92 | | |
| DA Chest Xrays | 31 | | |
| Total Investments | 123 | | 123 |

Procurement and market management implications

Sussex Orthopaedic NHS Treatment Centre – contract award May 2011
 Patient Transport Services – contract award January 2012

Equalities Impact

Plans will be assessed as required.

1.4 Primary Care

Summary

General Practice: For high quality to be a consistent part of everyone's primary care experience.

Dentistry: To improve oral health by providing access to high quality NHS dentistry that meets the needs of the local population in the most convenient and appropriate way.

Optometry: To ensure that everyone has an opportunity to minimise the impact of visual impairment through detection of disease at an early stage.

Pharmacy: To continue to improve the health of the City through its community pharmacies who are well placed to progress on local priorities for health improvement and reducing health inequalities.

Programme Plans

General Practice

- Implement recommendations of PMS/APMS contract review
- Implement recommendation of LES review
- Undertake further LES review including benchmarking of prices and implement recommendations
- Progress implementation of the NHS Health Check programme in a way that positively contributes towards reducing health inequalities.
- Full roll out of the GP Balanced Scorecard including publication of the scorecards and the implementation of practice improvement plans
- Implementation of the Estates Strategy
- Continue to make improvements in the access and responsiveness of GP practices
- Implement the policy of "Choice" of GP Practice
- Implement a programme to reduce GP list inflation
- Review of Discretionary Payments to GP Practices
- Reduce the "culture of dependency" by promoting self-care, and supporting a Health Promoting Practice Scheme.
- Target resources to reduce health inequalities
- Support the development of Primary Care Federations

Dentistry

- Implement recommendations of the orthodontic review
- Tender specialist endodontic contract
- Procure an out of hours emergency dental service – with the PCT boundaries
- Review sedation services
- Develop an integrated restorative dental service including the development of Dentists with Specialist Interest.
- Continue to Improve Access to Dentistry
 - Make more permanent investment in East Brighton
 - Effective contract management of dental contract – minimise unnecessary recalls and split courses of treatment
- Full roll out of the Dental Balanced Scorecard
- Work with dentists and other agencies to promote improvements in the oral health of children
- Implementation of the Oral Health Champions Programme.

Optometry

- Undertake rapid needs assessment for primary eye care services.

- Develop arrangements for monitoring optometry contracts including patient feedback
- Improve access to NHS eye tests by targeted communications
- Expand Optometry LES where cost effective and more convenient to patients.

Pharmacy

- Implement the new pharmacy assurance framework together with the three year rolling visit programme.
- Review all pharmacy LESs and implement any changes to ensure that the services provided continue to deliver high quality outcomes.
- Publish the Pharmaceutical Needs Assessment.

Key Milestones

General Practice

- Board approval of recommendations of APMS/PMS review – Jan 11
- Agree framework and services to target – LES Review – April 11
- Agree plan to target NHS Health Checks towards reducing health inequalities – June 11
- Publication of GP Scorecards – April 11
- Programme to reduce GP List Inflation agreed – April 11

Dentistry

- Recommendation of orthodontics review implemented – September 11
- New specialist endodontic contract starts – May 11
- New out of hours emergency dental contract starts – April 11
- New integrated restorative dental service commences – June 11
- Agree investment plan to improve dental access in East Brighton – Feb 11
- New Contracts for East Brighton dental access commence – Jan 12
- Publication of Dental Balanced Scorecard – April 11
- Training commissioned to support oral health promotion champions programme – June 11

Optometry

- Rapid needs assessment for primary eye care services complete – April 11
- Agree plan for monitoring of optometry contracts – April 11
- Expanded cataract LES commences – April 11

Pharmacy

- Start new pharmacy assurance framework visits – January 11
- Review all pharmacy LESs – January 12
- Publish PNA – Feb 11

Related QIPP Programmes

- Primary Care Contracting

Outcome measures

| Measure | Target |
|--|-----------------------------|
| Improved and increased access to GP services | At least at existing levels |
| Dental Access | Improve from current 58% |
| % of patients with greater control of their care records | tbc |

| | | | |
|---|------------------------------|------------------|--------------|
| NHS Healthchecks | Year on year increase | | |
| Quality metrics | | | |
| Measure | Target | | |
| Improved quality of GP services | Improve from existing levels | | |
| Improved patient experience of GP services | Improve from existing levels | | |
| Increase in premises which are fit for purpose | Per estates strategy | | |
| Improved quality of dental services using dental balanced scorecard | tbc | | |
| Principal changes in activity | | | |
| Not applicable. | | | |
| Implications for workforce | | | |
| <ul style="list-style-type: none"> ▪ Development of enhanced services – requires more specialist skills in primary care ▪ Integrated Restorative consultant service – will require the development of Dentists with Specialist Interest | | | |
| Commentary on financial requirements | | | |
| | 11/12 Cost | 11/12 Savings | 11/12 Net |
| Savings Plans | | | |
| Access & Responsiveness LES (1 year only) | | (250) | |
| Dental Access Centre & Community Services (SDH) - Recommissioned | | (44) | |
| Total Savings | | (294) | |
| Service Investments/Cost Pressures | | | |
| GP Led Health Centre | 150 | | |
| Premises rental increase | 80 | | |
| Premises non recurrent costs | 35 | | |
| SMI LES | 159 | | |
| VAT increase from 17.5% to 20% - GP Rent Reimbursement | 45 | | |
| Total Investments/Cost Pressures | 469 | | 469 |
| Procurement and market management implications | | | |
| A number of procurements are planned as part of this workplan: <ul style="list-style-type: none"> ▪ Tender of specialist endodontic contract ▪ Improving access to NHS Dentistry in East Brighton | | | |
| Other services will be developed in primary care e.g. enhanced services through an Any Willing Provider type framework. | | | |
| Equalities Impact | | | |
| Plans have been assessed as part of the Primary and Community Care Strategy. | | | |

1.5 Mental Health

Summary

Four areas have been identified as priorities for transformation:

- Promoting Mental Health and Wellbeing
- Developing Community Pathways to support recovery
- Developing Care Pathways to treatment services
- Improving access to psychological services

Programme Plans

- Tender and implement new service models for primary care mental health, brief psychological therapies/counselling
- Re-design and implement new service model for the Allen Centre day service.
- Roll out RTF Dementia programme and develop sustainability plan.
- Implement re-designed secondary care/community mental health services to support acute in-patient bed reductions.
- Design and implement community eating disorder service for moderate need.
- Implement Urgent Response Service (BURS) and review impact upon A&E attendance and MH admissions.
- Implementation of other key Mental Health QIPP projects, including PBR(payment by results) for SPFT
- Implement key areas of action from revised Mental Health Promotion Strategy and action plan (Suicide prevention; alcohol awareness/harm reduction; mental health promotion/awareness and tackling stigma.
- Review processes for specialist placements – implement formalised process for LD Secure Placements.

Key Milestones

- Adult Secondary Care Community Mental Health Services (Organic): SHA Mental Health QIPP F: Develop dementia services as specified in RTF Programme:
 - Memory Assessment 1/7/11
 - Dementia In-Reach 1/5/11
 - Dementia Crisis 1/7/11
 - MH Liaison Services (Acute) 1/6/11
 - Sustainability Plan – review services between Jul and January to ensure savings are realised.
- Adult Secondary Care Community Mental Health Services (Functional):
 - Community Eating Disorders services established through repatriation of resources taken from community ED services into SEDS. Align with PBC investment. SHA QIPP C and D. Operational by 1/7/11.
- Intensive Adult Clinical Case Management Service: providing extended hours services 7 days a week for those with substantial MH needs SHA QIPP D. 1/7/11.
- An integrated Community Case Management Service: to be re-designed from existing Recovery services/OPMH CMHTs in partnership with the voluntary sector. SHA QIPP D. 1/7/11.
- Re-design and re-commission Allen centre through SPFT with reduced financial envelope SHA QIPP D and H. 1/10/11.
- Develop a day services vision and strategy with the LA: Re-design remaining day service provision (in collaboration with the LA) in line with reablement principles SHA QIPP D and H. 1/1/12

- CAMHS Secondary Care Community Mental Health Services (Functional): Redesign care pathway for Looked after children improving quality and timeliness of assessment SHA QIPP C. 1/1/12
- Provide outreach to young people 14-19 attending youth hubs SHA QIPP C. 1/1/12
- Acute In-patient (Organic and Functional):
WAMHS, OPMH and CAMHS:
 - Implement decommissioning/reduced in-patient bed numbers as specified in Commissioning Intentions framework SHA QIPP D. (WAMHS/OPMH – 1/7/11; CAMHS – 1/4/11).
- Adult Primary Care Mental Health Services (Functional) – tendering of primary care MH services and IAPT services 1/1/12
- Implement Urgent Response Service (BURS) and review impact upon A&E attendance and MH admissions 1/4/11
- Adult Specialist Placements:
LD/ABI etc Specialist Placements –
 - Formalise process and funding for specialist placements SHA QIPP B. 1/7/11
 - Secure and forensic
 - Oversee financial recovery plan and transition to specialised 1/4/12
- Revise and deliver mental health promotion action plan.

Related QIPP Programmes

Mental Health

- A. The implementation of PbR to take forward the development of a mental health tariff across South East Coast.
- B. Reduction in out of area treatment (OATS) for people with complex/specialist mental health needs to improve access to local services, improve quality of care and reduce spend.
- C. Implementation of early intervention services for young people to improve the quality of care and reduce admissions.
- D. System re-design to improve the quality, efficiency and effectiveness of mental health services, with a particular focus on acute and community mental health care. This work included shifting resource from in-patient beds to interventions which are preventative and promote recovery and wellbeing. It will also aim to improve the assessment and management of people with urgent mental health needs to improve patient experience, reduce bed days and reduce risk.
- E. Work across primary, secondary and acute sectors of care to improve the management of people with medically unexplained symptoms and long term conditions to improve clinical outcomes, improve wellbeing and reduce cost.
- F. Improve secondary prevention, clinical outcomes and patient/carer experience for people with dementia. This project will also aim to reduce the diagnosis gap, reduce admissions and length of stay for people with dementia and co-morbid acute medical conditions and implement National Dementia Strategy recommendations.
- G. Continued roll out of Improving Access to Psychological Therapies Programme (IAPT) with a focus on sustainable and continued improvement and access to a range of evidence based interventions for people with mild, moderate and severe depression and anxiety disorders.
- H. Increasing the numbers of people within South East Coast with severe mental health conditions and learning disabilities in settled accommodation and employment through working with public employers and improving access to evidence based interventions to support employment outcomes.

| Outcome measures | |
|--|--|
| Measure | Target |
| Increased diagnosis of Dementia (increased number of people on the QOF dementia register) | TBA following agreement of pathway (July) |
| Reduced AVLOS in acute mental health in-patient services | <65 yrs: 28 days >65 yrs: 50 days |
| Reduced emergency re-admissions to acute mental health in-patient services | <5% re-admissions in <28 days |
| Improved access to psychological therapies: reduced waiting times for treatment | 90% treated < 8 weeks |
| Improved access to primary care mental health services for mild/moderate mental health needs – reduced waiting times for routine assessment | 95% assessed < 4 weeks |
| Early Intervention – The number of new cases of psychosis served by early intervention teams year to date. | 11 per quarter |
| CR/HT (Crisis Resolution/Home Treatment) – number of episodes | 600 per annum/50 per month |
| CPA (Care Programme Approach) – proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the quarter | 100% |
| IAPT – proportion of people with depression referred for psychological therapy and proportion referred for therapy receiving it | 6.5% and 70% |
| Delayed transfers of care (MH) | 7.5% |
| Quality metrics | |
| Measure | Target |
| Development of MH PBR and financial framework. | Shadow framework – October 2011 |
| Improved patient experience and PROMs | 80% of patients responding positively to provider survey |
| Reduced admissions and AVLOS in acute sector for patients with Dementia | TBA |
| Principal changes in activity | |
| n/a | |
| Implications for workforce | |
| Implications will depend on the outcome of the procurement exercises. | |

Commentary on financial requirements

| | 11/12 Cost | 11/12 Savings | 11/12 Net |
|---|---------------|------------------|--------------|
| Savings Plans | | | |
| Decommission Access/Commission PCMHS PYE Q4 | | (125) | |
| Decommission Adult I/P Beds PYE Q4 | | (100) | |
| Decommission CAMHS I/P Bed Q1 | | (50) | |
| Recommission Allen Centre PYE Q3 | | (50) | |
| OPMH – Dementia | 1,159 | | |
| Total Savings | 1,159 | (325) | 834 |
| Service Investments/Cost Pressures | | | |
| Good mental health (IAPTS) | 1,170 | (100) | |
| Total Investments/Cost Pressures | 1,170 | (100) | 1,070 |

Procurement and market management implications

| | |
|------------------------------------|------------------|
| Mental Health Counselling and CBT | Contract Awarded |
| Primary Care Mental Health service | 1st Nov 2011 |
| | 1st Nov 2011 |

Equalities Impact

Service changes will be subject to Equalities Impact Assessments.

1.6 Maternity

Summary

Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies.

Projects within the initiative

- Early access to maternity services provides better outcomes for mother and baby. Increase the number of women seen within 12 weeks of referral to 90%. Explore the use of pharmacy services to maintain and increase this percentage
- Commissioning of Birth Centre to support choice of place of birth, the normalisation of birth and reduction in interventions.
- Introduction of Fibronectin testing. This test is an accurate test to ascertain whether a woman is likely to give birth. A negative result means there is very little possibility of labour within the next 7-10 days therefore a woman can go home. This test will reduce admissions without delivery.
- Establishment of a triage service in labour ward to help reduce admissions by providing women with consistent, reliable advice and comfort.
- All women will be individually supported by a midwife throughout their labour and birth following confirmation of established labour. This will require adequate skill mix and midwifery staffing levels
- External cephalic version (turning baby so that it is in the correct position for delivery). 3% of deliveries are breeched which requires a caesarean section. A successful ECV can avoid this procedure and a woman can have a normal vaginal delivery.
- Improve the provision of community support to newborn infants and promote earlier discharge from neonatal units. Development of neonatal outreach and transitional care teams to enable babies to be discharged home earlier
- Consultant present for at least 40/60 hours of every week on the labour ward in every obstetric-led unit.
- Perinatal mental health – development of perinatal mental health pathways to improve access for women.

Key Milestones

- Introduce Fibronectin testing from 1/4/11
- Birth centre to be opened Sept/Oct 2011
- Establish a tariff for Neonatal outreach service (SCBU at home). The service will be piloted for start date September 2011

Linked QIPP Programmes

Maternity and newborn care

Outcome measures

| Measure | Target |
|--------------------------------------|--------|
| Reduce c-section rate | 23% |
| Number of women seen within 12 weeks | 90% |

| | | | |
|--|--|----------------------|------------------|
| Workforce planning Midwifery ratio 1:28 | March 2012 | | |
| Prevalence of breast-feeding at 6-8 weeks after birth | 69.2% | | |
| Quality metrics | | | |
| Measure | Target | | |
| Supporting stop smoking in pregnancy. All women will have a carbon monoxide test and if positive will be referred to a stop smoking service.(Cquin) | 100% referred BSUHT agreement pending | | |
| Tackling maternal obesity. All pregnant women with a BMI of over 30 will be referred to a Dietitian within BSUH. All women who have had a baby recently and have a BMI of over 30 will be referred to a community structured weight programme or a dietitian.(Cquin) | 100% referred BSUHT agreement pending | | |
| Earlier discharge from neonatal care | TBC (part of specialised service) | | |
| BSUH to achieve BFI (baby friendly initiative) accreditation | | | |
| Principal changes in activity | | | |
| Fibronectin | -36 | | |
| Implications for workforce | | | |
| <p>Recruitment of midwives to improve ratio. There needs to be a recognition that skill mix is important in delivering best practice and releasing midwives to support women in labour.</p> <p>Intrapartum care is provided either in hospital or at home by midwives allocated by the hospital team and unknown to the woman and her family. This is not an ideal model and the trust needs to explore options for different way of working. Possibility of homebirth team</p> <p>Transfers to other units had been increasing but have started to reverse. For transfers to PRH, BSUHT insists that it is ONE service across two sites – however women interpret this differently.</p> <p>Currently the ratio is 1:34. The trust has recruited more midwives to come into post by March 11 to take it to 1:32. This is still behind the expected ratio for 10/11 of 1:30. By March 2012 the ratio is expected to be 1:28. BSUHT need to demonstrate that they working towards this and recognise at the same time there is an increase in activity so far year on year and therefore this needs to be factored in their calculations</p> | | | |
| Commentary on financial requirements | | | |
| | 11/12 Cost | 11/12 Savings | 11/12 Net |
| Savings Plans | | | |
| Reduction in the Number C Section Births | | (267) | |
| Fibronetic Test | 36 | (90) | |
| Total Savings | 36 | (445) | (409) |
| Procurement and market management implications | | | |
| Equalities Impact | | | |
| Assessments will be carried out as plans are implemented. | | | |

1.7 Childrens Services

Summary

We aim to improve the lives and health of children and young people through delivering integrated, effective, evidence based and needs led services, as close to home as possible.

Projects within the initiative

- Improving the urgent care pathway for children and young people by focusing on the high volume conditions such as minor head injury, gastroenteritis, febrile child, respiratory conditions and reducing A&E attendances.
Phase 1 –data collection, pathway management and developing whole system strategies for management of minor head injury. This has included training for community professionals on management of common conditions and producing patient information for carers schools and communities.
Phase 2 – this will focus on the other high volume conditions, fever, diarrhoea and vomiting. Improving care pathways, increasing management in primary care and reducing admissions for paediatric long term conditions. Brighton and Hove PCT is an outlier when it comes to average length of stay and bed days per 100.000 population. The most common long term conditions are asthma and diabetes, with asthma accounting for the highest number of emergency admissions. We will focus on supporting children and young people with diabetes, asthma, epilepsy and chronic fatigues syndrome reducing admission rates in line with the English average for 2011/12. The work will include clinical pathway development and improving care in the community and school settings to reduce unplanned hospital admissions and improve management of LTC
- Introducing Insulin pump therapy for diabetic children
- To ensure that consideration is given locally to the implications of an increase in health visitors without PCT ring fenced money. To also consider the Family Nurse Partnership programme within the city.
- To improve early intervention and prevention in community based health care services for children and young people and their families through public health initiatives such as immunisation, breastfeeding, weight management.
- Reviewing and improving the pathway for children and young people with disability or complex health needs. The disability review commenced last year will be completed by March 2011. The transformation plan has been proposed (see appendix- for details)
- Strengthening partnerships by ensuring that working arrangements between the NHS and City council are strengthened through the section 75 arrangements, that safeguarding processes and protocols are in place and the review of the community child health contract
- Delivering on the city wide Youth Strategy including teenage pregnancy (See appendix for details)
- Continuing to improve support to children and young people with emotional or mental health and their families through a comprehensive CAMHS strategy (see appendix for details)

Key Milestones

- Improve Urgent Care pathway for children
 - Phase 1 – minor head injury Apr 11
 - Phase 2 – other high volume conditions Sept 11
- Developing clinical care pathways for asthma, diabetes, epilepsy and CFS/ME
 - Employ therapist for children with CFMS/ME Jul 11
 - Reduce admissions to national average Sept 11
 - Reduce admissions to top quartile performance Apr 12
- Introduce insulin pumps for diabetic children Apr 11

- Milestones are identified within each area of LA work

Related QIPP Programmes

Children and Young People

Outcome measures

| Measure | Target |
|---|--------------------------|
| Reduction in paediatric emergency attendances | 3.3% reduction |
| Reduce admissions of asthma in line with England average | Reduce by 152 admissions |
| Reduce admissions for diabetes in line with England average | Reduce by 40 admissions |
| Reduce admissions for epilepsy in line with England average | Reduce by 42 admissions |

Quality metrics

| Measure | Target |
|--|--------|
| Developing care pathways for LTC in accordance with best practice and NICE guidance. | |

Principal changes in activity

| | |
|----------------------------------|------|
| A&E Paediatrics | -615 |
| Paediatrics Long Term conditions | -37 |

Implications for workforce

Training of community workforce including GPs, health visitors, school nurses etc to support families including specific training for certain long term conditions e.g. CFS to ensure early identification and referral on.

Therapist to be employed for children with CFMS/ME.

Numbers of Health Visitors will be reviewed in order to meet the Operating Framework pledge on increase numbers by 2015.

Commentary on financial requirements

| | 11/12 Cost | 11/12 Savings | 11/12 Net |
|---|------------|---------------|--------------|
| Reduction in Paediatric A&E | | (59) | |
| Reduction in Paediatric LTCS | | (29) | |
| Total Savings | 36 | (445) | (409) |
| Service Investments/Cost Pressures | | | |
| Insulin Pumps (Children) | 100 | | |
| Chronic Fatigue Syndrome | 15 | | |
| Continuing Health Care - Children | 50 | | |
| Total Investments/Cost Pressures | 165 | | 165 |

Equalities Impact

Services will be assessed as implemented.

1.8 Medicines Management

Summary

We aim to

- improve the clinical and cost effectiveness of medicines management within primary care
- ensure that medicines quality issues are addressed in the commissioning process
- align the medicines management strategy with the strategy for the management of long term conditions

Through this we will maximise patient safety and improve health outcomes.

Projects within the initiative

- Prescribing efficiencies in primary care
 - Stopping prescribing where this should not be at NHS expense
 - Increase generic prescribing where appropriate
 - Reduce use of and expenditure on 'specials'
 - Reduce inappropriate prescribing of drugs of misuse (benzodiazepines, opiates, anabolics)
 - Targeted reviews in therapeutic areas
- Improved control of the management of PbR excluded drugs in secondary care (approval and payment)
- Embed medicines commissioning decision making within service redesign and integrated care pathway development
- Develop joint formulary and shared care guidelines with local providers
- Interface working with local providers to improve outcomes on transfer of care
- Improved inhaler technique

Key Milestones

- Prescribing effectiveness in primary care
 - April 2011 agreement of Prescribing Incentive scheme targets with PBC
 - Monthly monitoring of prescribing costs
 - Quarterly milestone monitoring for generic prescribing targets
 - Quarterly milestone monitoring for use of specials
 - Quarterly milestone monitoring for drugs of misuse
 - Quarterly monitoring of Better Care better Value indicators
- Management of PbR excluded drugs
 - April 2011 Blueteq database for management of PbR excluded drugs active for rheumatology
 - October 2011 Blueteq database for management of PbR excluded drugs active for dermatology and GI
 - March 2012 Blueteq database for management of PbR excluded drugs active for remaining specialties
- Joint formulary and shared care guidelines
 - April 2011 – staged workplan agreed for completion of formulary sections
 - May 2011 - SCG template agreed with providers and workplan for SCG development agreed
 - May 2011 - GI section of formulary complete and incorporated into Map of Medicine
 - Further milestones to be incorporated once workplans for formulary sections and SCG development have been agreed
- Improved inhaler technique (milestones tbc)

| | | | |
|---|-------------------|--|------------------|
| Related QIPP Programmes | | | |
| Medicines management: | | | |
| <ul style="list-style-type: none"> Improving prescribing efficiency Improving medication safety Reducing waste | | | |
| Outcome measures | | | |
| Measure | | Target | |
| Expenditure of glucosamine products | | 50% reduction (£50k) | |
| Expenditure on nutritional supplements and gluten free foods | | 25% reduction (£150k) | |
| Expenditure on inhaled corticosteroids | | 10% reduction (£100k) | |
| Expenditure on benzodiazepines | | 5% reduction (£10k) | |
| Expenditure on 'specials' | | 25% reduction (£100k) | |
| Potential savings from generic prescribing (excluding drugs which should be prescribed by brand) | | Stay below 0.5% of total prescribing spend | |
| Quality metrics | | | |
| Measure | | Target | |
| BCBV indicators | | Improve position each quarter | |
| Principal changes in activity | | | |
| Greater input into the management of PbR excluded drugs – development of templates. | | | |
| Implications for workforce | | | |
| Greater need for analytical support | | | |
| Commentary on financial requirements | | | |
| | 11/12 Cost | 11/12 Savings | 11/12 Net |
| Prescribing Efficiencies | | (1,000) | |
| Total | | (1,000) | (1,000) |
| Procurement and market management implications | | | |
| N/A | | | |
| Related Vital Signs Measures/ Existing Commitments | N/A | | |
| Equalities Impact | | | |
| N/A | | | |

2 Delivery Plans – Others

| 2.1 Cancer | |
|--|--|
| Summary | |
| We aim to: | |
| <ul style="list-style-type: none"> • Minimise people’s risk of developing cancer; • Encourage early presentation, detection and diagnosis; • Provide the very best cancer treatment including faster access; • Improve people’s experience of cancer care throughout the pathway. | |
| Programme Plans | |
| <ul style="list-style-type: none"> • Breast cancer screening age extension • Bowel cancer screening age extension • Increase/improve radiotherapy and chemotherapy, including acute oncology (refer to Planned Care schemes) | |
| Key Milestones | |
| <ul style="list-style-type: none"> • Increase availability for LINACS for radiotherapy Sept 12 • Chemotherapy at home service Sept 12 • Breast cancer screening age extension starts Apr 11 • Bowel Cancer Screening age extension starts Apr11 • Open POSCU level 3 at BSUH Oct 11 • Develop ‘survivorship’ clinics Apr 11 • Acute oncology starts Sept 11 • Implementation of IO guidance on investigation of unknown primary Oct 11 • Increase PET scans Apr 11 • Sarcoma service Jun 11 • Cervical screening Apr 11 | |
| Related QIPP Programmes | |
| None | |
| Outcome measures | |
| Measure | Target |
| Cancer waiting times targets: <ul style="list-style-type: none"> - 2 week standard - 2 week breast symptomatic - 31 day standard, first definitive treatments - 31 day standard, subsequent treatments (surgery, drugs) - 31 day standard, subsequent treatments (drugs) - 31 day standard, subsequent treatments (radiotherapy) - 62 day standard, urgent GP referral to 1st definitive treatment - 62 day standard, screening referral to 1st definitive treatment - 62 day standard, consultant upgrade to 1st definitive treatment | <ul style="list-style-type: none"> - 93% - 93% - 96% - 94% - 98% - 94% - 85% - 90% - No target set nationally |
| Screening: <ul style="list-style-type: none"> - Women to receive cervical test results within 14 days | <ul style="list-style-type: none"> - 98% |

| | |
|--|--|
| <ul style="list-style-type: none"> - Breast screening coverage - Age extension for breast screening - Age extension for bowel screening - Colposcopy referral to appointment offered within 56 days - Colposcopy referral for moderate / severe dyskaryosis to appointment offered within 28 days - Cytology turnaround time within 28 days - Cytology turnaround time within 42 days | <ul style="list-style-type: none"> - 70% - No target set nationally - No target set nationally - 90% - 90% - 90% - 100% |
|--|--|

| | |
|--|---------------|
| Other: - % of cancer treatments via the 2 week rule | - SCN average |
|--|---------------|

Quality metrics

| Measure | Target |
|---------|--------|
| | |
| | |

Principal changes in activity

Implications for workforce

Radiotherapy workforce increases (4wte)

Commentary on financial requirements

| | 11/12 Cost | 11/12 Savings | 11/12 Net |
|---|-----------------------|--------------------------|----------------------|
| Service Investments/Cost Pressures | | | |
| Bowel Cancer Screening | 80 | | |
| Breast Cancer Screening Services | 240 | | |
| Horizon Scanning - Drugs | 300 | | |
| IOG Compliant Services | | (95) | |
| Chemotherapy – Drugs/Reprovision | 1,356 | | |
| Total Investments/Cost Pressures | 1,976 | (95) | 1,881 |

Procurement and market management implications

None

Related Performance Measures

Equalities Impact

2.1 Specialised Commissioning

Summary

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

Programme Plans

Cross-cutting

Identify; clarify; and separate commissioning and contracting arrangements for those 'specialised services' that will be subject to the Secretary of State's Mandate for the operation of the NHS Commissioning Board from those services that will be the responsibility of GP Commissioning Consortia to ensure a robust platform for commissioning of these services in 'the future state'. (services likely to feature in the Secretary of State's Mandate are the 34 services outlined in Version 3 of the Specialised Services National Definition Set; HIV Treatment & Care*; Major Trauma#; and Vascular Surgery)

* - as outlined in the Public Health White Paper supporting document on Commissioning

- defined as 'the multiply injured patient' within the Specialised Orthopaedics Definition

Service Specific Plans

Rare Cancers

- Development of Paediatric Oncology Shared Care Unit (POSCU) Level 3 services at BSUH and repatriation of appropriate activity from London.
- Brain/CNS - To be determined if national tariff will cover funding of gaps in the 4 MDTs to be hosted by BSUH – neuroscience/Network Brain/Pituitary/skull based ; Host Trust BSUH to ensure 0.5PA for a clinical lead for metastatic cord compression identified
- Children and Young People - POSCU developments (level 1 ESHT and Worthing); Level 3 BSUH notice of repatriation to the Royal Marsden when agreed; Young Peoples shared care designation
- Haematology - FYE (2012/13) 10 patient Level 2 from Worthing (WSHT) to RSCH; One Level 3 and 4 provider for SCN MDTs – Kings; Shared care BMT tariff agreement needed with Kings
- PET - 1020 scans should have been contracted rate for 2010/11 (equivalent to 850 scans/million); Price per scan to rise 2.5% per annum; SECSCG recommending 925/million in 2011/12; 1000/million in 2012/13; SCN to clarify referral criteria
- Skin - MoHs costs still pending and BSUH leading on business case development. Activity makes current planning financially unviable unless a joint service development taken forward with QVH; Designated primary care skin cancer clinicians attending LSMDT x4 a year; New LES/DES GPs for low risk BBC

Neurosciences

- Introduce tertiary service for MS patients (repatriation)
- Development of South Thames network approach for the management of Neuromuscular Disorders

Major Trauma

- National tariff to be introduced
- Commence development of BSUH as Trauma centre

- Commence tertiary Hip reconstruction service (repatriation)
- Develop complex lower limb reconstruction service
- On site advanced plastics service
- Review of provision arrangements for Acetabular Repair / Pelvic Reconstruction with a view to ensuring that these are 'safe and sustainable'

Critical Care

- Introduction of new national currencies for Adult and Neonatal Critical Care in 2011/12 in advance of national tariffs
- Introduction of more granular pricing structure for Paediatric Critical Care moving from 4 to 7 levels of intensity.

Renal

- Managed movement from local prices in 2010/11 to National Tariff in 2012/13 through 50% step change in 2011/12.
- Repatriation of post transplant care from primary care to secondary, improving monitoring and management, improving purchasing, introducing home delivery and enabling shift to generic products as appropriate
- Increasing the proportion of patients on home dialysis, by improving choice. Improving quality of care and reducing pressure on unit/satellite capacity.
- Development of additional satellite dialysis capacity through the development of service at Eastbourne. Growth in activity of 7% in line with demand. Present activity is limited by lack of capacity.

Specialised Paediatrics

- Working jointly with the Sussex Paediatric Clinical Directors group develop a Sussex Specialised Paediatrics Strategy which identifies which sub-specialties can be delivered safely and sustainably within Sussex to minimise reliance on providers out-of-area.

Specialised Rehabilitation

- Develop service specifications for appropriate Specialised Rehabilitation services that effectively meet the complex needs of patients such as those requiring discharge from acute hospital stays after Major Trauma; Neuro-rehabilitation (including but not limited to Acquired Brain Injury); Complex Physical Disability (and the provision of specialised equipment); Spinal Cord Injury; Respiratory Conditions; and Cognitive/Behavioural Disorders.

Specialised Mental Health

- Work collaboratively with local stakeholders to ensure that those services described within Specialised Services National Definition Set 22 are identified; interdependencies unpicked; and plans developed to ensure that they can transfer to the NHS Commissioning Board without destabilising local arrangements for the remainder of Mental Health activity.

Cardiac

- Refer to Sussex Heart Network Annual Operating Plan (available on request).

Bariatric Surgery

- Growth tbc

Key Milestones

- n/a

| | |
|--|--|
| Related QIPP Programmes | |
| <ul style="list-style-type: none"> ◆ Rare Cancers - POSCU3 at BSUH will reduce price due to lower MFF and improve patient experience due to reduced travel times for many aspects of care. ◆ Neurosciences — Reduction in unplanned admissions of patients with Neuromuscular Disorders through better co-ordinated and more responsive planned care ◆ Renal - Increasing numbers of patients on home dialysis will significantly reduce PTS costs and improve patient experience. ◆ Renal - Home delivery and improved purchasing of immunosuppressants for renal patients will reduce expenditure ◆ Renal - Introduction of national tariff for dialysis, will result in reduction of expenditure as a result of tariff being lower than local price. ◆ Specialised Rehabilitation – development of these services will reduce acute Length of Stay, | |
| Outcome measures | |
| Measure | Target |
| Reperfusion waiting times: <ul style="list-style-type: none"> - % of people suffering from a heart attack who receive thrombolysis <60 minutes - % of people suffering from a heart attack who receive a primary PCI <150 minutes from call for help <p>Note: There are few developed national outcome measures for Specialised Services. These are, however being developed during 2011/12 as part of the preparatory work for consistent national arrangements for the commissioning of services that will feature in the Secretary of State's Mandate for the NHS Commissioning Board from 1 April 2012.</p> | <ul style="list-style-type: none"> - 68% - 68% |
| Quality metrics | |
| Measure | Target |
| National Quality Metrics for Specialised Services are being developed as part of the national workplan for the development of Commissioning arrangements for the NHS Commissioning Board | |
| Principal changes in activity | |
| tbc | |
| Implications for workforce | |
| tbc | |
| Commentary on financial requirements | |
| tbc | |
| Procurement and market management implications | |
| none | |
| Related Vital Signs Measures/ Existing Commitments | |
| Equalities Impact | |
| | |

2.2 Public Health

Summary

These programmes contribute to the prevention and early detection of the major causes of morbidity and mortality and aim to reduce the gap in life expectancy between the least and most disadvantaged populations while improving the overall life expectancy of the local population.

Programme Plans

Cardiovascular diseases

- NHS Health Checks
- Introduction of AAA screening (dependent on national approval)

Adult obesity

- Pre and post bariatric surgery behaviour change and weight management support

Alcohol and smoking

- Increase the number of people helped to stop smoking
- Reduce the number of people drinking alcohol at harmful levels

Key Milestones

- NHS Health checks support worker appointed (June 2011)
- AAA screening bid agreed by national steering group
- AAA screening programme planning begins (October 2011)
- Support programme for patients undergoing bariatric surgery in place (Jun 2011)
- Transfer those Practices running the Alcohol DES in 2010/2011 over to the re-specified Alcohol LES May 2011
- Training for practices to run the Alcohol LES June 2011
- Further 10 Practices to run the Alcohol LES March 2012

Related QIPP Programmes

Staying Healthy

- Increasing the number of people who stop smoking
- Reducing harmful drinking of Alcohol

Outcome measures

| Measure | Target |
|---|--------|
| Number of patients undergoing an NHS Health Check | 5,200 |
| Number of patients undergoing bariatric surgery given pre and post operative behaviour change and weight management support | 100 |
| Number of successful four week smoking quitters | 2,350 |
| Number of people screened for excessive alcohol consumption * <i>this overlaps with primary care</i> | 12,000 |
| Alcohol related hospital admissions | |
| All-age all-cause mortality and cardiovascular mortality rates | |

| Quality metrics | | | |
|---|-------------------|----------------------|------------------|
| Measure | Target | | |
| Specialist stop smoking services quit rate | 70% | | |
| Intermediate stop smoking services quit rate | 50% | | |
| There are national quality indicators for the AAA screening programme | | | |
| For NHS Health Checks the quality indicators are still under development nationally | | | |
| Principal changes in activity | | | |
| <p>If the local AAA screening programme is approved during 2011/12 it is expected that the first cohort of men will be screened during 2012/13 Increase in the target for smoking quitters will require additional referrals.</p> | | | |
| Implications for workforce | | | |
| <p>Post to support practices with roll-out of NHS Health Checks</p> <p>Introduction of AAA screening programme will require some additional staff though the intention is to extend the current West Sussex programme.</p> | | | |
| Commentary on financial requirements | | | |
| | 11/12 Cost | 11/12 Savings | 11/12 Net |
| Service Investments/Cost Pressures | | | |
| NHS Health Checks | 25 | | |
| AAA Screening | 20 | | |
| | | | |
| Total Investments/Cost Pressures | 45 | | 45 |
| Procurement and market management implications | | | |
| <p>The AAA screening programme requires a community based ultrasound screening programme to identify cases for surveillance or surgery under the care of accredited hospitals. The programme is already well established in West Sussex and the community screening programme is provided by the Sussex Community Trust, which is also the local community provider for Brighton. The national steering group are recommending a Sussex-wide programme and hence it would be expected that SCT would be the local provider.</p> | | | |
| Equalities Impact | | | |
| <p>Commissioning of the programmes aims to address the unequal burden of disease across different population groups. Where the data is available the uptake of services will be monitored by socio-demographic variables. Equalities Impact Assessments to be conducted where appropriate. For national screening programmes these are done at national level.</p> | | | |

2.3 Sexual Health

Summary

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

Projects within the initiative

- Increase the number of patients seen by level two sexual health services
- Maintain /Increase Chlamydia screening
- Consider extending HIV testing within primary and secondary care services.

Key Milestones

GUM service

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

Chlamydia screening programme

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

HIV testing in primary and secondary care settings

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

Related QIPP Programmes

Staying Healthy

Outcome measures

Measure

Target

GUM Service

- Proportion of first attendances at GUM seen as 'level2' appts
- Numbers of diagnoses by infection

~30% (tbc)
tbc

Chlamydia Screening Programme

- Proportion of population aged 15 – 24 yrs accepting screening for chlamydia
- Chlamydia diagnosis rates per 100,000 adults aged 15 – 24

35%

2,400 – 3,000 per 100,000

| <p>HIV testing in primary and secondary care</p> <ul style="list-style-type: none"> • Number of PoC tests undertaken in primary care • Diagnosis rates in primary care • % of BSUH acute medical admissions offered HIV testing <ul style="list-style-type: none"> • % of BSUH acute medical admissions accepting HIV testing <ul style="list-style-type: none"> • Proportion of patients presenting with a late stage of infection | <p>Tbc</p> <p>Tbc</p> <p>Weighted milestone:BSUH Offered Screening</p> <table border="1" data-bbox="1070 389 1474 580"> <tr> <td>% Offered</td> <td>50</td> <td>65</td> <td>80</td> <td>95</td> </tr> <tr> <td>% Reward</td> <td>12.5</td> <td>25</td> <td>37.5</td> <td>50</td> </tr> </table> <p>Weighted Milestone: BSUH Screening uptake.</p> <table border="1" data-bbox="1070 672 1474 862"> <tr> <td>% Uptake</td> <td>60%</td> <td>Pro rata up to</td> <td>90%</td> </tr> <tr> <td>% Reward</td> <td>25%</td> <td></td> <td>50%</td> </tr> </table> <p>Tbc</p> | % Offered | 50 | 65 | 80 | 95 | % Reward | 12.5 | 25 | 37.5 | 50 | % Uptake | 60% | Pro rata up to | 90% | % Reward | 25% | | 50% |
|--|--|----------------|--------------|---------------|-----------|----------------------|----------|------|----|---|----|----------|-----|----------------------|-----|--------------|--------------|--|-----|
| % Offered | 50 | 65 | 80 | 95 | | | | | | | | | | | | | | | |
| % Reward | 12.5 | 25 | 37.5 | 50 | | | | | | | | | | | | | | | |
| % Uptake | 60% | Pro rata up to | 90% | | | | | | | | | | | | | | | | |
| % Reward | 25% | | 50% | | | | | | | | | | | | | | | | |
| <p>Quality metrics</p> | | | | | | | | | | | | | | | | | | | |
| <p>Measure</p> | <p>Target</p> | | | | | | | | | | | | | | | | | | |
| <p>HIV testing at acute general medical admissions at BSUH is included in CQIN framework</p> | <p>Tbc</p> | | | | | | | | | | | | | | | | | | |
| <p>Principal changes in activity</p> | | | | | | | | | | | | | | | | | | | |
| <p>GUM Service Planning to reduce demand plan for level 3 GUM service first appts by approximately 30% and re-provide as level 2 appts within BSUH.</p> | | | | | | | | | | | | | | | | | | | |
| <p>Implications for workforce</p> | | | | | | | | | | | | | | | | | | | |
| <p>Commentary on financial requirements</p> | | | | | | | | | | | | | | | | | | | |
| <table border="1" data-bbox="172 1447 1345 1624"> <thead> <tr> <th></th> <th>11/12 Cost</th> <th>11/12 Savings</th> <th>11/12 Net</th> </tr> </thead> <tbody> <tr> <td>Savings Plans</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Reprovide Level II Sexual Health Services</td> <td></td> <td>(150)</td> <td></td> </tr> <tr> <td>Total Savings</td> <td></td> <td>(150)</td> <td>(150)</td> </tr> </tbody> </table> | | | 11/12 Cost | 11/12 Savings | 11/12 Net | Savings Plans | | | | Reprovide Level II Sexual Health Services | | (150) | | Total Savings | | (150) | (150) | | |
| | 11/12 Cost | 11/12 Savings | 11/12 Net | | | | | | | | | | | | | | | | |
| Savings Plans | | | | | | | | | | | | | | | | | | | |
| Reprovide Level II Sexual Health Services | | (150) | | | | | | | | | | | | | | | | | |
| Total Savings | | (150) | (150) | | | | | | | | | | | | | | | | |
| <p>Procurement and market management implications</p> | | | | | | | | | | | | | | | | | | | |
| <p>None</p> | | | | | | | | | | | | | | | | | | | |
| <p>Related Vital Signs Measures/ Existing Commitments</p> | | | | | | | | | | | | | | | | | | | |
| <p>Equalities Impact</p> | | | | | | | | | | | | | | | | | | | |
| <p>No further assessments required.</p> | | | | | | | | | | | | | | | | | | | |