

Buckinghamshire



Primary Care Trust

**Final Operational Plan
March 2008
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Final Operational Plan

PART 1: WHAT WE ARE DOING AND WHY?

1 Introduction - key achievements and challenges in 2007/08

This is our second annual operational plan since being formed as a PCT in October 2006. This plan sets out our aspirations for the people we serve and our expectations for the next three years of the providers from whom we commission services. There is a particular emphasis on what we wish to achieve in 2008/09.

The PCT is responsible for providing leadership to the NHS in Buckinghamshire. We are developing our skills and expertise as a commissioner and, embracing the challenges set out by the Department of Health, to become a 'World Class Commissioner'.

Buckinghamshire PCT inherited a challenging financial position and ended 2006/07 with an accumulated deficit of £22.5m on a total budget of £550m. During 2007/08 we have put in place an ambitious cost improvement programme while at the same time still striving to meet our key targets. This has enabled us to end the year with significantly reduced deficit of £11 million.

1.1 Achievements

During 2007/08 we have achieved the following:

- A saving of £18m in our expenditure. This has been achieved through greater efficiency in the services we commission, efficiencies in our provider services, reduced management and accommodation costs, and improved prescribing practices.
- We have made significant progress in meeting our key targets. For example we have:
 - Made significant progress in reaching the 18 weeks from referral to treatment time
 - Improved access to our Genito Urinary Medicine (GUM) services
 - Reduced the level of Health Care Acquired infections (HCAIs)
 - Met the 4 hour A&E access standards, and maintained effective emergency services during the winter
 - Improved Speech and Language Therapy waiting times
- We have improved the relationship with our key health providers and our local authorities. We have further developed the key joint structures between us, which has resulted in better engagement in key future decisions affecting local health services.

- We have had regular discussions with the Patient and Public Involvement (PPI) forum and other patient organisations. This has increased openness and dialogue, and laid the foundations for our future engagement. We have a constructive ongoing dialogue with the Buckinghamshire Overview and Scrutiny Committee (OSC), and consult them regularly on key issues
- We have ensured that the PCT provides an effective leadership role and has worked to develop our reputation to enable us to become leaders of the local health economy.
- We have undertaken a range of activities to develop our Board, and have established an effective Executive Team. We have effectively reorganised and developed the provider and commissioning arms of the PCT to enable them to respond to future challenges.
- Our Primary Care Mental Health Service, working with our partners, has been recognised as a national demonstration site for psychological therapies. The Healthcare Commission and the Commission for Social Care Inspection have rated Buckinghamshire as “excellent” for adult specialist community mental health services.

1.2 Health challenges in Buckinghamshire

To understand the current and future health needs and requirements of our population, we have undertaken a needs assessment for Buckinghamshire which outlines the health needs of our population. Buckinghamshire is very affluent compared to the national average and therefore considerably healthier. The population has better self-reported health, lower death rates for all age groups and longer life expectancy than the national average. Overall death rates have been falling over the last decade. However there are still significant challenges to the health of the population including:

- The huge burden of preventable chronic diseases such as heart disease, diabetes, cancer, and infectious diseases such as sexually transmitted infections, HIV, and tuberculosis. Chronic diseases account for more than 60% of all deaths in Buckinghamshire and very significant resource use.
- Stark, preventable inequalities in health are seen in vulnerable groups including socio-economically deprived groups
- Adverse trends in risk factors for disease such as the rising prevalence of obesity, alcohol misuse, numbers of problematic heroin and crack cocaine users who are not engaged in effective treatment, physical inactivity which unchecked will lead to a marked increase in the burden of ill-health

1.3 Financial Challenges

Based on our latest month forecast (January 2008 data) we expect to end the financial year at the end of March 2008 with an outturn of £11 million deficit, against a target of £10 million.

For 2008/09 we have produced a plan which returns the PCT to financial sustainability. To achieve this we have identified a level of cost improvements for 2008/09 of £22million, which represents 3.5% of our total expenditure. This has involved starting a major redesign of our services coupled with continuing robust financial control.

We feel this is an ambitious but achievable level of cost improvements. We are clear that while we believe the cost improvements to be deliverable the plans are complex, and have significant scale. There is a significant level of risk in them, and they rely on close working between the PCT, our Practice based commissioners, our Providers, and other stakeholders such as Buckinghamshire County Council.

The cost improvements will be achieved primarily through robust redesign and demand management with our partners, in the areas of non-urgent acute care, urgent acute care, prescribing and non-acute services. This document sets out these plans, while at the same time being realistic about the level of change.

This plan does require a step-change reduction in the amount of money we spend on secondary care. Without that, an appropriate amount of spend on public health initiatives will not be affordable and this will adversely impact the health of our population over time.

We need to hold an appropriate level of contingency reserve. As a result of the very high levels of risk inherent in the demand management plans we feel that contingency provision should be set at £6.9 million (1.1%) 2008/09 and at 1% in subsequent years

It is important to stress that we need to plan for the repayment of past debt resulting from past overspending. A number of options have been considered including full repayment and total debt write-off. Normal carry forward arrangements under the Resource Accounting and Budgeting (RAB) rules would mean an unaffordable level of new cost improvements in 2008/09. For this reason deferment of these rules has been sought, and a request made for repayment suspended until 2009/10 when surpluses will be available from the full-year effect of redesign and demand management schemes. Until our debt is cleared, our ability to invest fully in the prevention and public health agenda will be affected.

The SHA response to this request is to require £2.8 million to be repaid in 2008/09 will the remainder cleared over the following three years. It has also been agreed that half of the 0.5% strategic levy can be used to offset this cost rather than accelerate local investment. The agreement of the proposed debt repayment profile reduces the contingency to £5.6 million (0.94%) and the Strategic levy to £1.5 million (0.25%). Additional measures to increase the contingency back to the original level are being developed

1.4 Demand management plans

The £22m cost improvement programme is underpinned by detailed delivery plans that will be monitored throughout the year by the Executive Team and the oversight Group. The majority of the savings (£16m) come from reductions in the amount that

we invest in hospital based care - this is made up of the service redesign programmes for scheduled and unscheduled care and more accurate contract coding and costing. As our main provider of acute care, a large proportion of our expected cost saving comes from Buckinghamshire Hospitals Trust (BHT). The PCT and the Trust will be working closely together to oversee the delivery of the work programme.

The nationally mandated contract for acute services includes utilisation management agreements that require both parties to identify where the lead sits for achievement of agreed service redesign so that it is clear which party is responsible to ensuring achievement of the planned levels of activity. This exercise has been completed with BHT: the nature of the service developments means that the majority of the risk does sit with the PCT and rests on our ability to engineer whole system change in clinical behaviour in primary as well as secondary care. Our Practice based Commissioning (PbC) partners will be instrumental in helping us achieve this aim.

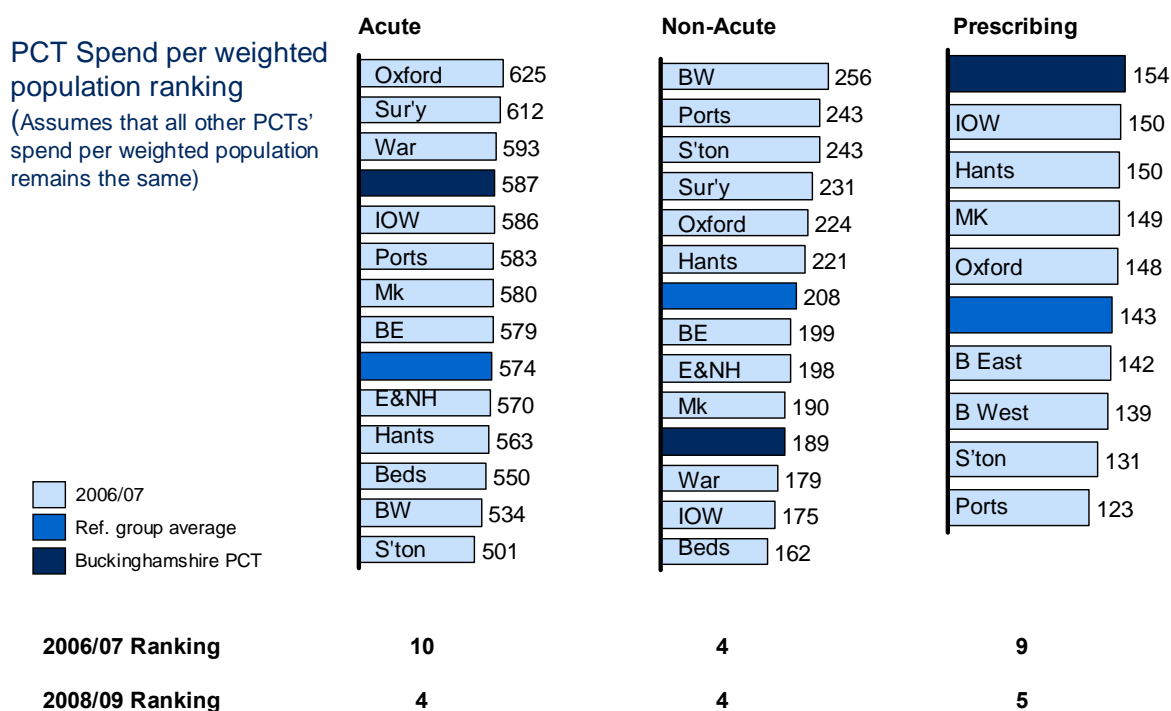
2 How do we compare? - Benchmarking

To ensure we are making best use of our resources, it is important that we measure how we compare to other PCTs in South Central and similar PCTs in other parts of England. Benchmarks for Buckinghamshire PCT and other South Central PCTs were established as part of the national 'Fitness for Purpose'¹ programme.

As shown in the table below the benchmarks indicated that for 2006/07:

- Our acute secondary care spend (which currently accounts for over 43% of total spend) was significantly above the SHA average and was 10th out of 14 PCTs.
- Our spend in other major areas such as Provider Services and Mental Health was below the SHA average and was 4th out of 13 PCTs.
- Our Prescribing spend, on a weighted population basis, was top out of the nine PCTs reviewed. However on the more appropriate measure which takes into account each practices mix of Age, Sex and Temporary residents, we were among the better performers in the SHA but still with opportunities for savings.

It is therefore essential for the health system that we move our performance well into the upper quartile in all areas.



The initiatives we have already put in place for 2006/07, and those set out in this plan for 2008/9, will reduce the level of acute activity and increase the efficiency of our commissioned services. This will improve our performance in 2008/09 and bring us closer to our target, as follows:

¹ Department of Health - PCT Fitness for Purpose Programme, May 2006

- The relative performance of the PCT in acute spend will improve from 10th to 4th out of 13.
- Prescribing has changed in position from bottom in South Central to 5th on a weighted average basis.
- Non-acute has maintained 4th position.

In 2009/10 the full-year effect of the changes and the implementation of our strategic changes will see a further improvement in our ranking.

3 What we are planning to do: 'Getting Healthcare right for the future'- Buckinghamshire PCT Priorities for 2008/09 - 2010/11

Meeting the health and social challenges in Buckinghamshire requires us to respond on several fronts:

- Promoting a robust prevention agenda as outlined in the Wanless Report² is the best way to secure an affordable health and social care system. This will involve addressing the broader determinants of health such as poverty, educational attainment, employment, environment and the "lifestyle choices" that are often made as a result of a person's wider social and economic environment.
- Empowering patients and their carers to self-care improves satisfaction and outcomes for patients and reduces health care resource use.
- Improving efficiency and cost effectiveness.

In September 2007 we produced and circulated our interim strategic plan³. This summarised our medium-term plan to deliver healthcare which meets the future needs of the population of Buckinghamshire and addresses the health needs outlined above.

Our vision for the future is to improve the health and well being of our population by purchasing services and leading partnerships to:

- Ensure that people get effective, timely and appropriate healthcare when they are sick
- Reduce health inequalities
- Prevent avoidable ill-health
- Help people take care of themselves
- Promote healthy communities
- Ensure the best use of every pound invested in us by the taxpayer and manage within the total financial resources available to us

We need to change our services in the future to meet this vision. An important part of this is to be clear about the different options for community services including the possibility of developing primary care hubs to act as bases to serve our different communities.

In this plan we demonstrate how we intend to work with our providers to make progress in meeting these priorities. This includes the PCT-provided community services and our primary care contractors.

The strategy is underpinned by a joint public health approach with our Local Authorities.

² *Securing Our Future Health: Taking a Long-Term View HM Treasury 2002*

³ *Buckinghamshire PCT – Getting Healthcare right for the future 2007*

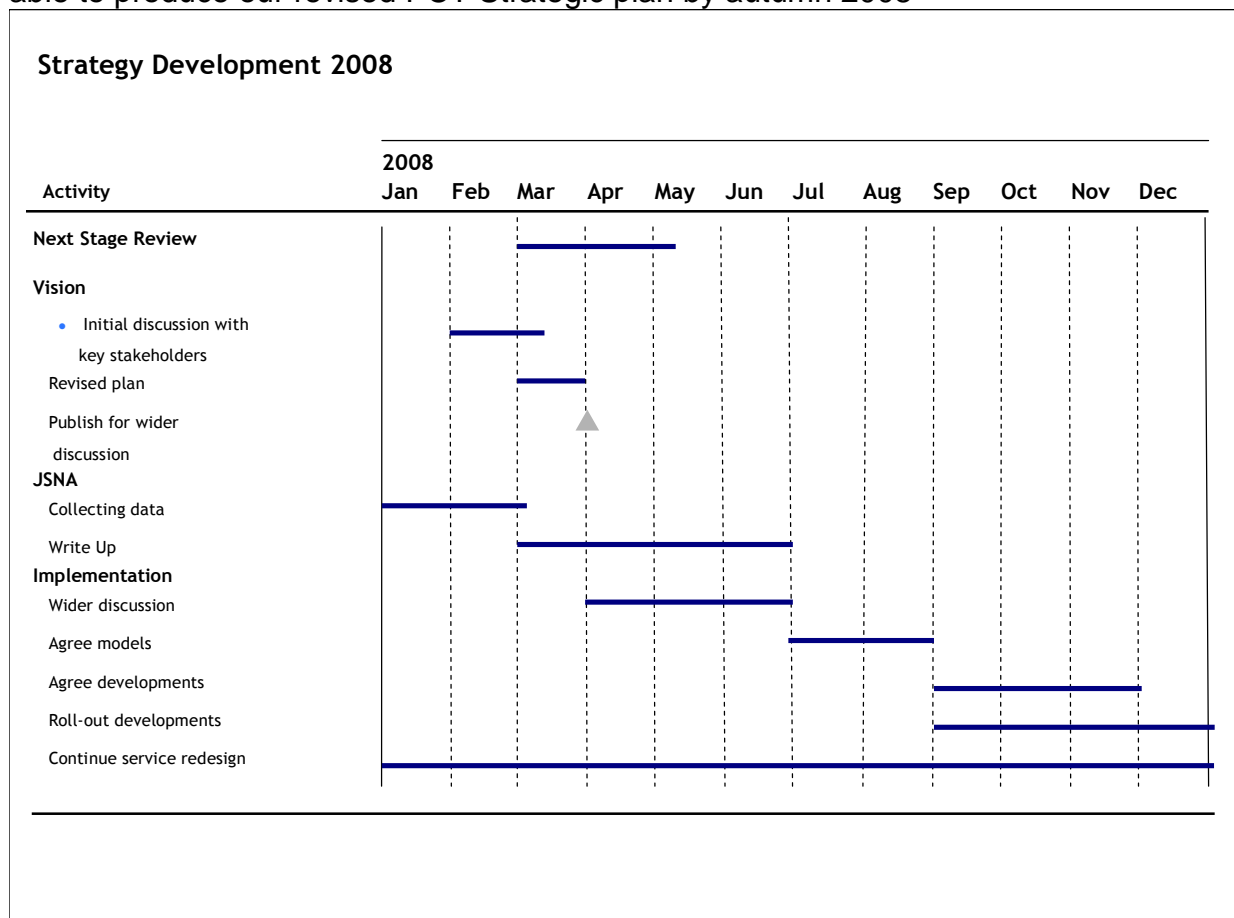
3.1 Strategy Development

2008/09 will see the first significant steps to implementing this strategy. There will be important discussions taking place in Buckinghamshire over a further Joint Strategic Needs Assessment (JSNA) and the county-wide public health strategy.

The ‘Our NHS, our future - Next Stage review’ is currently being co-ordinated across South Central SHA, and is focusing on improving care in three general areas: Improving the quality and safety of services; improving access to these services; and reducing the inequalities in health described. The following eight different patient pathways or journeys are being reviewed by clinical groups: Maternity and Newborn, Children, Staying Healthy, Long Term Conditions, Acute Care, Planned Care, Mental Health, and End of Life Care. The output of these clinical groups will be used to shape a vision for the NHS in South Central in early 2008 with any recommendations being consulted upon shortly thereafter.

We wish to discuss each of these with our stakeholders before making any final decisions, and we will therefore carry out an integrated series of discussions, using the existing and new groups. We will then agree the developments, roll out agreed changes and continue the redesign of services.

This will allow us to conform to the new World Class Commissioning (WCC) assurance timetable which the DH and SHA launched in spring 2008. We will be able to produce our revised PCT Strategic plan by autumn 2008



4 How we are going to do it – Our overall priorities, approach and challenges for 2008-09

Building on 'Getting Healthcare right for the future' this plan identifies the key priorities which will help to achieve these aims and make progress in meeting the needs of the population – these priorities are our ambitions.

We have also taken account of the *NHS Operating Framework for 2008/09*⁴ which sets out the national priorities which PCTs need to meet, and also requires PCTs to set some local priorities.

The Department of Health (DH) has developed a series of indicators – called 'vital signs'⁵ which will ensure we measure and monitor our progress in meeting our goals. We have also taken account of these in setting our priorities.

Our approach for 2008/09 is to:

- Ensure robust demand management by building on 2007/08 service redesign and delivery work. We have identified and started schemes in non-urgent care to redesign both in and out patient pathways for patients.
- Improve our local urgent care system to ensure it can respond quickly and appropriately to the needs of patient. This will involve developing urgent care centres, reviewing our 'out of hours' primary care services, and developing our community services to meet patients needs.
- As a developing 'World class commissioner' we will continue our organisational development, particularly to strengthen our commissioning capability and capacity. We will strengthen our commissioning team further, and develop a Strategic Decision support service to provide better analysis and support to our commissioning function, and to work with other PCTs to maximise working with them on more specialist information needs.
- We will clarify the roles, responsibilities and accountabilities of our key groups including our board, Executive team, and Professional Executive Committee (PEC) to ensure they meet their full potential.
- Formalise the Practice Based Commissioning (PBC) relationship and responsibility to ensure we maximise the potential for using their skills and experience. We will agree appropriate business plans with them which support this plan.
- Implement the Commissioner / Provider split, and enable our provider services to develop to ensure that the optimum service profile is offered and can be delivered with maximum value for money. During 2008/9 options for models for delivery will be considered.

⁴ NHS Operating Framework for 2008/09 – 2010/11, DH December 2007

⁵ *NHS Operating Framework for 2008/09 – 2010/11, - 'Vital signs' - DH December 2007*

- Maintain effective financial forecasting to ensure we have a sustainable and predictable pattern of spend.
- Continue to work with our local authorities and other stakeholders in partnerships through arrangements such as the Local Area Agreement (LAA) and Local Strategic Partnership (LSP) to improve the health of the population.

We face a number of challenges in 2008/09:

- To deliver a minimum of £22 million Cost Improvement Programmes (CIPs) – in the areas of Prescribing, Urgent, Non-urgent, Provider services which will require strong project and programme management to achieve, together with support from our partners and providers
- Because of our financial challenges, only limited investment will be available in 2008/9. This will be focused on the key ‘vital signs’, and supporting the shift to primary and community care
- The important self-care and Public Health agenda is constrained by our financial obligations
- We have particular challenges to make continued improvement in areas of performance where we do not fully meet existing commitments. These include:
 - Stop smoking – Increasing the number of 4 week quitters
 - Choose and Book – Increasing the number of practices offering choice and the ability to book an appointment on line
 - Improve Ambulance standards including the new ‘call connect’ standard – the percentage of A category calls responded to in 8 minutes (75%) and 19 minutes (95%); the percentage of B category calls responded to in 19 minutes (95%). From April 2008, the targets will remain the same but will start from the time of connection (approx 90 seconds earlier)

Part 3 of this plan sets out the detailed plans to improve performance in these areas.

We have linked our key priorities with delivery and appropriate outcome measures, for example:

Priority	How delivered	Outcome measures
Ensure that people get effective, timely and appropriate healthcare when they are sick	<ul style="list-style-type: none"> • Improving cleanliness and reducing rates of HCl • Improving access to range of services 	Health Care Commission standards / National targets

<p>Reduce health inequalities and prevent avoidable ill health, Promote self care and healthy communities</p>	<ul style="list-style-type: none">• Focusing on big killers such as cancer and CHD by increasing emphasis on smoking cessation and obesity• Developing targeted initiatives to focus on the most disadvantaged populations• Producing a Healthy Communities strategy in 2008/9 which will include tackling the wider determinants of health	<p>Vital signs</p>
<p>Ensure the best use of every pound invested in us by the tax payer and manage within the total financial resources available to us</p>	<ul style="list-style-type: none">• Implement programmes to move Buckinghamshire towards first quartile benchmarks for external spend and incorporate efficiency opportunities identified in the Operating Framework	<p>Auditors Local Evaluation (ALE) scores</p>

5 Where we are investing in 2008/09

Investment in 2008/9 will be focused on improving performance in key areas and supporting the redesign of services. These investments have been assessed using the following criteria:

- Benefit to patients
- Contribution to local and national targets
- Clinical safety, quality and governance
- Finance – Robustness, Affordability and Value for money
- Shifts in services from secondary care

In 2008/09 we will increase significantly our level of spend on the following services we commission:

- Specialist services
- Primary care services
- our 'pooled' and 'continuing care' budgets with Buckinghamshire County Council
- Prescribing budgets to meet the demands for new drugs
- investments to support redesign and allow shift to primary and community care including:
 - urgent care - long term conditions, clinical assessment unit, GP in A&E
 - non-urgent care - service redesign and reduction in non-urgent referrals
 - our capacity to undertake clinical challenges
- Primary care developments in Aylesbury to serve Berryfields
- Free nursing care
- Investment in our commissioning and decision support capability, our referral facilitation
- Ambulance services including 'Call Connect' and investment to meet national targets
- A limited number of unavoidable cost pressures

6 Looking ahead: Our overall approach, assumptions and challenges - 2009/10 and 2010/11

For 2009/10 and 2010/11 our approach is to:-

- Continue to build on our strong partnership with Buckinghamshire County Council, and the District Councils. We will play our full part in the Local Strategic Partnership (LSPs) and Local Area Agreement (LAA) arrangements, and use this to maximise the benefits for the health system.
- Accelerate the programmes for developing health promotion and prevention services, and encouraging people to develop appropriate self-care, and environmentally sustainable approaches.
- Deliver sustainability for the health system, by continuing to develop efficient and effective services, including progressing further care pathways and demand management initiatives with our PBC commissioners and our providers.
- Continue implementation of primary and community reconfiguration agreed in 2008/09 as part of our strategy development.
- Fully implement a revised urgent care system, building on the actions taken in 2008/09.
- Continue to develop the PCT as a 'World Class Commissioner' particularly developing the role in market development.
- Develop social marketing, (which uses a range of marketing techniques and approaches to help people change their behaviour to achieve a specific goal, e.g. stopping smoking), to focus on reaching specific groups of the population more appropriately, while at the same time further increasing public involvement and engagement⁶
- Begin the management of the longer-term impact of debt repayment
- Maximising opportunities with local government partners over efficiencies, building on the opportunities created by the 'pathfinder' initiative between District and County Council.

⁶ See <http://www.nsms.org.uk> – National Social Marketing Centre

PART 2 : HOW WE ARE GOING TO ACHIEVE OUR PLANS

1 Developing the PCT as a World Class commissioner

We have ambitions to be World Class commissioners. We will do this through:

- Working collaboratively with community partners to commission services which optimise health gains and reduce health inequalities
- Proactively seeking and building continuous and meaningful engagement with the public and patients, to shape services and improve health
- Leading continuous and meaningful engagement with clinicians so that their views inform strategy, drive quality and service design, and influence the way we use our resources
- Undertaking robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements and synthesise data from a range of services so that we remain responsive to local need and best practice, continually improving services
- Prioritising investment according to local health needs, service requirements and the values of the NHS
- Effectively stimulating the market to meet demand and secure required clinical, and health and well-being outcomes
- Promoting and specifying continuous improvements in quality and outcomes through clinical and provider innovation and configuration
- Securing procurement skills which ensure robust and viable contracts
- Effectively managing systems and working in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
- Making sound financial investments to ensure sustainable development and value for money

2 Developing our Organisation – Our Organisational Development Plan

As the environment within which we work is rapidly changing and developing, to meet these aspirations effective organisational development is vital. We need to develop and change our organisation and how we relate to the local health community. It requires our staff and the organisation to become more public and population focused. We aim to develop an open and outward-looking culture which reflects this, which values our staff, and respects the needs of our population. We expect appropriate and empowered behaviour both in our commissioning and provision.

To guide us in this we have developed an Organisational Development (OD) plan, and have agreed our Organisation Development goal as being:

- To significantly improve internal and external working relationships and to develop our key commissioning capabilities consistent with being a world-class

commissioner of health care, so that we inspire the trust and confidence of our population.

During 2007/08 to understand what we needed to do to meet this goal this we undertook a number of tasks:

- Used a wide variety of data sources to understand our OD needs
- Engaged with our own staff to be clear about what they are telling us both in terms of leadership and employee engagement
- Undertook an assessment of our commissioning capabilities. As part of the Recovery and Support Programme (RISP) we reorganised our commissioning capability around key workstreams, which helped us to achieve our cost improvement targets.
- Undertook an assessment of the status of our external partnerships. We increased our engagement with our external providers, and PBCs.
- Developed a regular series of communications and newsletters
- Initiated a 'delivery academy' to increase staff capability. This covered areas such as problem solving, coaching, negotiation skills, and also helped us to reflect on our development.
- Introduced new business redesign methodology into the PCT and our partners. This included working with a joint team from the PCT, Acute Trust and Atos Consulting/Unipart Alliance to apply the principles of 'Lean Thinking' which put the patient at the heart of the redesign methodology.

Based on this work, in the OD plan we identified and agreed four key goals:

- To improve senior leadership practice in the PCT
- To improve engagement between staff and Executive/Board and staff groups
- Identify the gaps in our commissioning capabilities and seek to resource them
- To develop our external partnerships with key stakeholders

In 2008/09 we intend to meet these goals as follows:

To improve senior leadership practice in the PCT

We are investing time and energy in developing our senior management tier and ensuring clear organisational vision and common values to drive performance improvement, and development of a learning organisation. We will:

- Continue the 'delivery academy'
- Continue the development of the Executive Team – this has included the acceptance of two of our executives onto the 'high potential leaders programme'.

- Continue our work programme with our senior management team. This will include running more externally supported workshops focusing on the commissioning strategy and matrix working
- Strive to be a learning organisation. We will continue the investment in training and development of our staff and will take every opportunity to innovate, particularly in using new commissioning tools
- Optimise use of the various NHS Institute web-based tools to implement and deliver change in a systematic and embedded way.
- Progress the development of our Board processes, including aligning Board meetings to the 'Intelligent Commissioning Board' agenda. This defines the information our Board needs to fulfil its strategic and governance role, and links to our aspirations to improve our decision support capability.
- Use the Board Effectiveness Survey from the NHS Institute to assess board performance and develop an action plan to improve

To improve engagement between staff and Executive/ Board and staff groups

In 2008/09 we will:

- Continue and further develop our internal communications, including a new PCT intranet
- We will develop further feedback loops within the organisation including from staff to executive and board
- Clarify role and remit of Professional Executive Committee (PEC) and its relationship to Practice Based Commissioners

Identify the gaps in our Commissioning capabilities and seek to resource them

In 2008/09 we will:

- Strengthen capacity to support delivery of new initiatives i.e. decision support, service redesign and project management,
- Strengthen capacity to support delivery of appropriate levels of care for example appointing additional assessors for continuing care eligibility, and developing our referral facilitation service
- Work with other South Central PCTs and the SHA to maximise benefit of shared working through the joint 'Build /Share /Procure' initiative. This involves working with the other PCTs in NHS South Central to explore opportunities about what commissioning functions to either 'build' within each PCT, to 'share' across several or all nine PCTs and/or to 'procure' from outside the PCT network.
- Increase our understanding of local market development and management
- Continue to develop our 'Lean' redesign capability. 'Lean' thinking is a way of streamlining the patient journey and making it safer, by helping staff to eliminate all kinds of waste and to treat more patients with existing resources. Originally developed by Toyota, it is now being successfully applied in healthcare across the world. We will be expanding our use from the implementation and embedding of the initial three pathways to ensure lean training becomes one of the key models for delivering change

- Implementing Map of Medicine (MoM) with our PBC. The MoM is a web-based visual representation of evidence-based patient care journeys covering 28 medical specialties and 387 pathways. We will ensure that the training and education programmes as part of MoM supplement the roll out of new pathways.

Investing in our commissioning capability and capacity and focusing on our delivery of service improvement will deliver significant improvement in patient services.

To develop our external partnerships with key stakeholders

In 2008/09 we will

- Develop more extensive and real-time feedback from patients and a higher profile with local people so that their views have direct impact on the way services are developed and delivered
- Develop the skills of our staff in listening and responding to patient feedback through our local programme: 'Trust me I'm a patient' - a patient and public involvement role play game to improve engagement with patients
- Continuing development of the PCT website

The remaining sections of this part of the Plan show how we aim to develop the organisation by enhancing and improving our organisational effectiveness in the following areas:

- Improving Education, Learning and Development, undertaking effective workforce planning and developing our Staff engagement and satisfaction
- Enhancing Public engagement, and Improving Patient Experience
- Developing Practice Based Commissioning, and undertaking Market Development and Management
- Maximising the value of Information Management & Technology, and improving our Information capability
- Developing our provider services
- Monitoring clinical governance and performance

3 Improving Staff engagement and satisfaction

In 2007/08 we have carried out significant engagement with staff to identify our OD priorities. As well as the earlier outcomes from the 'Fitness for Purpose' reviews and informal data, we used a wide range of information including our Workforce Barometer Survey, the McKinsey/Alvarez assessment of commissioning capabilities and external partnerships, various Email surveys and focus groups

During 2008/09 we will:

- Encourage staff to participate in the NHS Staff Survey and act on the findings helping staff understand their role in delivering a better NHS
- Continue the Workforce Barometer Survey
- Continue to develop cross-directorate working

- Communicate with staff as part of our strategy development
- Continue the development of this strategy.

3.1 Education, Learning and Development

We aim to match personal development with the needs of the organisation. The PCT is committed to ensuring that all staff have the ability to participate in ongoing professional and occupational development commensurate with their work throughout their working lives, and that access to that development is supported and enabled through the flexible use of resources and commissioned services to meet individual needs.

Individual, team and organisation learning and development are critical to the ongoing success of the PCT, particularly as the NHS continues a programme of significant change.

During 2007/08 we have undertaken a complete review of our Training and Development processes and procedures, starting with a complete revision of our training structures.

In 2008/09 we will

- Maximise the use of the newly-created Department of Education, Learning and Development to meet the emerging needs of the new organisation.
- Strengthen systems to ensure that all staff, clinical and non-clinical, receive an annual appraisal and personal development review and that each person has a personal development plan which will identify and remedy skills gaps. This will inform the planning of programmes with the contracted universities, and the provision of in-house training. In addition, it will enable a rapid response when new clinical guidance is received.

The Development of an Education and Learning Strategy will underpin the Human Resources (HR) and Workforce Strategy, ensuring that staff continue to be viewed as our most valuable asset. A key element in support of this aim is that the ongoing learning and development of our workforce is supported in an open, flexible and equitable manner.

4 Workforce Plans

Growth and Change

The workforce plan for PCT HQ and Provider Services staff supports the delivery of a competent, healthy, motivated and engaged workforce. We aim to use it to integrate activity, finance and workforce data to provide evidence of value for money for services being commissioned.

The PCT investments to allow the shift of services from secondary care to a community setting mean that our emphasis will be on redeploying staff to avoid

redundancies and to provide appropriate training to re-skill or refresh skills to meet this change in service delivery.

There will be changes in activity as demand for services increases as the local population grows and this is particularly true for the Aylesbury area.

An action plan will be put in place to ensure workforce developments are aligned with the business planning processes across organisational boundaries.

The PCT recognises the importance and value of staff engagement and will continue to work in partnership with staff-side representatives on workforce issues.

The makeup of the workforce broadly reflects the diversity of the population it serves. The PCT is recognised as a 'Positively Diverse' site and has published a comprehensive Single Equality Scheme.

To meet the European Working Time Directive work will continue to monitor compliance and the job planning process will provide evidence of planned work activities for our medical staff.

Staff Turnover

Currently 24% of our workforce is over 55 years old and a high level of retirements can be expected. The turnover rate for December 2007 is 18% which is above the benchmark and plan for 2007/08 of 15%.

During 2008/09 we will:

- analyse exit interviews to identify reasons for leaving, the length of service of leavers, and develop an action plan to address any concerns
- review our recruitment and selection process to ensure that we have the 'right staff with the right skills in the right place' delivering the 'right care'. We will ensure this is aligned to PCT strategic direction.
- To improve retention we will provide all staff with development opportunities, based on the 'Key Skills Framework', 'Leadership Qualities Framework' and World Class Commissioning competencies, and embracing the principles of the 'Investors in People' standard.

Sickness absence rates

Our current sickness rate of 4.3% is above the benchmark and plan for 2007/08. Episodes of short term sickness absence will be closely monitored and the Management of Sickness Absence policy will be strictly enforced by operational managers. This will involve return to work interviews following each absence. In addition HR case managers work closely with Occupational Health to ensure support for staff and to consider innovative ways of enabling staff to return to work following any long-term sickness absence. It is anticipated that these steps will bring about a reduction in the current sickness absence rates which can be sustained at the South Central benchmark of 4%.

Reducing agency costs

Robust management of vacancy control is required during the year to facilitate service realignment between healthcare sectors. This needs to be balanced against the potential use of agency staff to cover vacant posts.

Our approach will be to undertake role redesign, where appropriate, and appoint to substantive posts at the earliest opportunity to reduce the cost of agency staff. Recruitment to substantive posts within PCT HQ will be our initial focus. Plans for making more effective use of internal bank staff in Provider Services will be developed.

Realignment of services

The workforce will grow as services are moved from secondary to primary and community services. Standardising working practices across the PCT and using skill mix where possible will result in productivity savings.

During 2008/09

- The initial focus will be on further development of integrated community teams, which will also supporting the cost improvement plans
- Provider Services will be supporting Long Term Conditions with an admissions avoidance initiative. More detailed plans will be agreed as further commissioning intentions are made clear.

5 Enhancing Public engagement

The PCT has a systematic and rigorous approach to seeking, collecting and acting on the views of individuals and partners in the local community. We are working to create greater opportunities for our communities to make their voices heard, raising awareness of those opportunities and empowering patients and the public to use them and Local Involvement Networks (LINKs). This will include the major discussion planned for summer 2008 on the development of our strategy. An Engagement Plan for this programme is being developed which will ensure that the views of all sections of the population will be gathered, recorded and acted upon.

The public engagement activities described below will also contribute towards increased public confidence in the NHS. This will be measured by the market research which the South Central Strategic Health Authority (SCHA) is undertaking, the results of which will be made available to the PCT.

- Following a concerted marketing campaign in January 2008, the **PCT Patients' Panel** has a growing membership (currently 49) from all geographic areas of the PCT. The members are contacted whenever views are sought on draft policies or service developments, draft patient leaflets or other material. They are also invited to act as patient representatives on PCT working groups and committees. All members of the PPI Forum have been invited to join the Panel so that they can continue to be involved with the PCT after 31st March 2008.

In 2008/9 the PCT is setting up quarterly meetings of Patients' Panel members with representatives from local voluntary and community organisations, where a two-way exchange of information can take place, enabling the PCT to capture systematically the views of a wide cross-section of the community.

- **PCT website.** This has been recently redesigned and reinvigorated. In 2008/9 it will be used for providing considerably more information to the public on the PCT's policy and strategy development, new services, etc, and will enable the public to have much more direct input and influence. It will also be used to share DH and SCHA news and initiatives and stimulate greater response from the Buckinghamshire population into these. For example, items such as the Public Questionnaire on 'Our NHS Our Future' have been featured on our website.
- **Mental health, learning disability, physical and sensory disability and Older People Partnership Boards and Children and Young People's Trust.** These Boards have user or care involvement and provide good mechanisms for reaching and involving vulnerable groups in commissioning.
- All **service re-design work streams** have patient/carer involvement. Models for patient involvement are being piloted with the primary care commissioners (diabetes, patient participation groups).
- **Partnership working.** The PCT engages in a great deal of joint working with statutory, voluntary and community organisations across Buckinghamshire, all of which contribute to the PCT's engagement with the wider community. One such example is a joint project, the Pathfinder Community Engagement project, which is currently being piloted in Wycombe District. This will greatly increase the PCT's public engagement activity in a large part of its area. The aim is subsequently to roll it out across the whole of Buckinghamshire. As a PCT we constantly seek opportunities to work with partners internal and external to the PCT in identifying new ways to engage with the public.
- **County Council Overview and Scrutiny Committee for Health.** The PCT will continue to engage regularly with the OSC, providing information on the development of our strategy, asking views on this and other issues as they arise and ensuring that its feedback informs the PCT's decision making.
- **Buckinghamshire LINK** The PCT is already closely involved in the process for creating the LINK for Buckinghamshire and will continue to provide input to the process. We will actively engage with the new network as it emerges and do whatever we can to encourage its development and effectiveness.
- **Developing staff competencies.** The PCT aims to ensure its staff have the competencies effectively to involve patients and the public in its activities. A structured training programme focused on commissioners, Board members and local authority commissioner partners will support this. A number of means have been identified to support this programme, including interactive/facilitated workshops, development of consistent toolkit material for commissioners, expert patient programme, and non-executive director training programmes

- **Lay involvement in quality assessments.** The PCT will continue to include trained lay members in Quality Outcomes Framework (QOF) assessment visits and in Patient Environment Action Teams (PEAT) assessments.
- Systems to **involve patients in training programmes and in educational policy.** This initiative is new and is being developed by the PCT and the Deanery.

These activities are already included in PCT management costs but will need to be kept under review.

6 Improving Patient Experience

The PCT will measure patient experience through national and local surveys, develop robust strategies to ensure year-on-year improvements in reported patient experience, and use both national and local data of patient experience to inform commissioning decisions.

The “Patient Experience and Public and Patient Involvement Performance Assessment Framework” used by Thames Valley Strategic Health Authority in 2006 will form the baseline from which the PCT will subsequently measure itself against to assess year-on-year improvement.

In 2008/09 this will be achieved through the PCT Patient and Public Involvement Strategy and action plan and specifically through:

- The Patient Advice and Liaison Service (PALS) which will continue to record and analyse issues and trends arising from contacts made to the service by patients and carers. This will ensure regular feedback to PCT managers and the Board of areas in local health services where improvements are required or where ideas are working well.
- The PCT’s complaints service. Formal complaints and compliments to the PCT will continue to be analysed and reported to management and the Board, so that the appropriate lessons are learned and acted upon. Complaints to providers of services will also be monitored.
- Patient surveys (national and local) will inform commissioning by identifying how providers have responded to patient experiences and where there are gaps in commissioning.
- Appropriate use of Patient Reported Outcome Measures (PROMs) in commissioning decisions
- The PCT plans to work with all the PCTs in SCSHA on a social marketing initiative to inform and understand the needs of its different groups within the population. The plan is to pilot an A&E social marketing and awareness campaign to promote key messages on access to and appropriate use of health care services.
- Through close working with the new LINKs, the Buckinghamshire OSC, and the PCT’s Patients’ Panel.

7 Developing Practice Based commissioning

World Class Commissioning is an aspiration for both PCT and Practice Based commissioners, and we know that there is a need for development of competence and capacity across the PCT and PBC commissioning team. We are engaged in discussions with the PBC groups to ensure a common vision for the future and to develop an implementation plan that will see the vision come to fruition over the next few years. Developing strong and effective practice based commissioners is central to the delivery of the PCT operational plan and to redesign of the healthcare system in Buckinghamshire. In 2008/09 the PCT and commissioning groups will form an agreement to deliver against key PCT objectives as identified through the operational plan.

Practice based Commissioners are partners in the delivery of the Operating Plan. The PbC DES provides baseline infrastructure funding for the Collaboratives and the Operating Plan also includes a small amount for the development of both PCT and PbC commissioners. PbC Groups will receive indicative budgets net of the £22m cost improvement programmes and are currently developing their own Operating Plans that will demonstrate the programmes on which they are best placed to lead or support the PCT to ensure we achieve the target.

Both parties PCT and commissioning groups will be set key performance indicators (KPIs) which will be robust and measurable. KPIs for the commissioning groups may focus on demand management (e.g. referrals, prescribing), delivery of the 'vital signs' or expansion of PPI.

As part of the agreement commissioning groups will be expected to think outside the old business plan approach and to formulate clear structured operational plans specifying how they will deliver against each KPI. Incentive, schemes can be developed by collaboratives but will not form part of the PCTs strategy for PBC engagement. PCT KPIs for 08/09 will centre on improving data availability and quality to enable informed commissioning and service redesign.

We are developing a programme with the PbC groups to design together the joint development of commissioning over the next few years, with a gradual and planned transfer of commissioning functionality to the Collaboratives and a growing focus within the PCT on holding them to account for impact of their commissioning activity on health and health services.

The PCT will work with commissioning groups through the weekly PBC operational group and PBC steering group. It is expected that these groups will provide a forum through which commissioning groups can be informed, involved and supported thereby facilitating the delivery of the individual operating plans and related KPIs. As a consequence of this more structured approach it is a secondary aim that relationships between the collaboratives and PBCs will thrive.

8 Market Development and Management

The DH competition principles document⁷ identifies how the widening range of provision, increasing autonomy of NHS organisations, devolution of decision-making (including PBC and procurement) and greater patient choice mean that system management will be conducted in a more open context with increased scrutiny.

For Buckinghamshire PCT the Market Development and Management will become an increasingly important role, as the number of providers grows and the services provided develop.

During 2007/8 we have concentrated on working with the PEC and PBCs on service tendering, particularly developing specifications and letting tenders for intermediate care. We held workshops on market management, and supported tender development where appropriate

As we develop our strategy during 2008/9 this will involve developing appropriate intermediate and primary care provision, together with changes to the urgent care system. We will consider the market management implications of this including:

- What we want to achieve from market development – key themes, benefits to patients, areas that are not desirable, etc
- Developing our capability to take a short, medium and long-term view of market changes
- Move forward on tariff unbundling to allow new entrants to market
- We will develop entry and accreditation, as well as exit processes
- We will develop performance management processes for new providers sharing responsibilities appropriately with PBCs

Independent Sector Commitments

The PCT has an allocation of the nationally procured independent sector capacity at Horton for the provision of orthopaedic surgery. It has been difficult to persuade patients to use this service due to the inconvenience of being treated at a unit that is some distance out of county. However during 2008/9 every effort will be made to encourage patients and GPs to use the capacity available in order to reduce pressure on local services.

The PCT also access to the nationally procured diagnostic independent sector capacity. Progress has been made in year to amend the contract to better reflect demand for MRI rather than plain film; this is improving the cost effectiveness of this service for the commissioners.

The unscheduled care work programme includes the procurement of new style services including GP led Health Centre, Urgent Care Centre, Single point of access and Out of Hours service. The services will be in place from April 2009, and although at an early stage it is likely that there will be some element of independent sector provision in this development.

⁷ *Principles and rules for Cooperation and Competition*

The scheduled care work programme includes the development of intermediate services to help reduce pressure on acute care. While it is our initial intention to develop these with our local providers of secondary care, it is likely that some services will also include input from independent sector partners.

9 Estates

We are reviewing and developing our estate to deliver our strategic plans and, with our local providers, have identified some cross-cutting themes.

Steps have been taken to improve the condition of the estate in Buckinghamshire, with significant Private Finance Initiative (PFI) developments in Buckinghamshire Hospitals Trust (BHT), and major plans for redevelopment in Oxford and Buckinghamshire Mental Health Trust (OBMHT). OBMHT has an agreed estate strategy, which includes the redevelopment of Manor House in Aylesbury. BHT has ongoing plans for redevelopment at Stoke Mandeville and Wycombe.

An overview of the strategic estate was undertaken for the Buckinghamshire partnership produced in October 2007 by Hunter and Partners. This identified cross-cutting issues which are now being considered jointly by the Trusts. They included:

- Potential for maximising the use of major assets between the organisations
- Opportunities created by the location of 'intermediate facilities' and development of Local Community and Primary Care facilities
- Limited availability of capital
- Minimising our 'carbon footprint'

The PCT has also reviewed the estate issue in all its community hospitals and has identified the following priorities for 2008/09 in community hospitals and other facilities:

- Thame Community Hospital – we have submitted proposals to the DH on the partial redevelopment of the hospital to maximise the opportunities that exist on the site
- The Chalfonts and Gerrards Cross Hospital – the poor physical layout and condition of some of the site will need urgent resolution
- The Manor House developments will require our provider services to identify alternative accommodation elsewhere in Buckinghamshire
- At Marlow and Buckingham Community Hospitals we will continue to review the estate opportunities and work with local practices
- Chesham Healthzone will begin and is scheduled for completion in 2009/10

10 Information Management & Technology

We are developing our IM&T for the benefit of staff and patients.

Robust governance in place across Buckinghamshire Local Health Community (LHC) will ensure that this plan is reviewed, adopted and appropriately adapted by all stakeholder organisations at executive level. The PCT Chief Executive will chair the IM&T board.

The publication of the '*The NHS in England: the Operating Framework for 2008/9*' together with its supporting document '*Guidance on Preparation of Local IM&T Plans for 2008/9*' explicitly require the IM&T investment portfolio to be part of mainstream NHS planning, in order to deliver better and safer care.

This document is the second such produced since the new PCT was formed, and serves to build on the first, demonstrating continued effort and commitment from the LHC as a whole, and its history of collaborative working within IM&T.

Although the responsibility for ensuring that IM&T underpins healthcare and its transformation agenda for a Health Community rests with the CEO of the Commissioning PCT, the preparation of such a plan requires the cooperation and agreement of all stakeholders within the LHC. Therefore governance structures formed around IM&T must be robust and show clear linkages to business processes.

In 2007, Connecting for Health, (CfH), published its plans for a local ownership programme, (NLOP), whereby responsibility for delivering the National Programme for IT, (NPfIT), passed from the original Clusters to SHAs. Buckinghamshire is now part of the Southern Programme for IT, (SPfIT). The overarching principle of NLOP is that IM&T has to be embedded in the mainstream business of each Trust, with Commissioning PCTs having overall accountability for the planning and implementation within each LHC.

Robust governance in place across Buckinghamshire LHC will ensure that this plan is reviewed, adopted and appropriately adapted by all stakeholder organisations at Executive level.

Each organisation must have its own IM&T plan, but this is compatible with, and supportive of, the LHC overall plan. The Senior Reporting Officer (SRO) of the Programme must therefore agree these plans with each organisation in the LHC. In Buckinghamshire, this will be achieved by open and iterative dialogue between all parties, managed by the Programme Support Office (PSO). This plan has been signed off by the PCT Chief Executive.

The emphasis of the plan is to deliver benefits to patients and staff but it also reflects the investment, capacity and capability and therefore the commitment required to deliver it.

The plan includes those elements of the national IT agenda that are appropriate to this LHC, and/or that have been nationally mandated. Given that Buckinghamshire has already implemented some of the core NPfIT products in its provider organisations⁸, the plan will only cover in detail those that remain to be deployed.

⁸ E.g. Millennium CRS R0 in Bucks Hospitals NHS Trust and Bucks PCT inpatient areas

Working with stakeholders within the LHC this document sets out the Buckinghamshire programme framework for 2008/9, taking into account the following aims:

- To align the implementation of SPfIT with the LHC's strategic modernisation and service delivery change programmes. (As part of the Integrated Service Improvement Plans.)
- To improve the focus on change management and benefits realisation for each LHC as a whole.
- To develop a more co-ordinating programme management approach, based on greater collaboration between projects across each LHC area.
- To improve the collaborative development of plans and funding arrangements.
- To provide appropriate levels of control and delegated authority to ensure efficient and effective implementation of the NPfIT products.
- To ensure there is a single point of contact for the SPfIT Local Service Provider to work with (this is a contractual requirement).
- To simplify the arrangements for LHC level working.
- To maximise cost-effectiveness and value
- To avoid duplication of effort

11 Information capability

We are developing our 'radar capability' to identify and respond early to key risks to the quality of patient care, achievement of performance targets or emergence of unplanned spend.

We will develop a coherent technical and performance architecture and a model of connected performance that drives the entire organisation at strategic, tactical and operational level by:

- Developing a Strategic Decision Support Service (SDSS) to ensure that we can analyse, forecast and monitor local service provision and the needs of our population effectively, and being clear about what functions we provide 'in house'
- Shaping and sharing the 'Build/Share/Procure' proposals for SDSS with other PCTs
- Work on a joint project with East Berkshire PCT to fast track appropriate implementation of SDSS
- Continued investment in the 'Dr Foster' data analysis system used by the PBCs, PCT and BHT to ensure we have comparable data

12 Provider Services Development

The PCT has a dual function as a Commissioner and a Provider. The goal of our Provider Services is to offer to our patients a range of quality services by improving productivity and meeting the needs of revised care pathways. Services will be delivered consistently across Buckinghamshire PCT.

In 2007/08 our provider services have concentrated on

- Redesign of community-based services to ensure greater focus and efficiency
- Restructuring of management functions
- Quality improvement
- Maximising the utilisation of infrastructure
- Improving the procurement capability

In 2008/9 they aim to

- *Business Strategy* - Develop a business strategy in order to ensure that the optimum service profile is offered and can be delivered with maximum value for money. This will redesign and develop a range of services to respond to the intermediate care agenda, and respond to the opportunities created by the Urgent care system redesign
- *Increased Productivity* - This includes the continuing redesign of clinical and non-clinical services using 'Lean' principles to release resources. Precise number of staff released will only become clear as the redesign work progresses, but the aim is for these staff can be redeployed in additional services being funded by PCT, and new income generating services.
- *Increased Efficiency* - Savings from better procurement, renegotiation of contracts and rates for property, marketing core services to new customers.
- *Income Generation* - A number of opportunities have been identified for deriving income from providing services to new customers or new services to existing customers.
- *Rationalising Services* - Alterations to the provision of services which mean that recurrent savings can be made on estate costs without affecting the quality of patient care.

During 2008/9 options for models for delivery will be considered.

A sub-committee of the Board, the Provider Services Forum has specific responsibility for the Provider Services and this is chaired by a non-executive director. Work is underway to separate further the Provider Services from the commissioning arm of the PCT during 2008/9 and a detailed action plan is currently being constructed.

Cost Improvement Plans 2008/9

The cost improvement target 2008/09 are set out in Appendix 3

13 Clinical governance

We have in place robust systems to ensure that patient safety and clinical risk are actively managed at all levels of the organisation. The Corporate Risk Register supported by the directorate registers ensures that the Board is informed not only of the key risks but of the actions being taken to manage those risks and the impact of those actions.

We have developed a learning culture throughout the organisation demonstrated by our incident reporting system and by the changes which have been made as a result of these. All incidents are risk assessed and an appropriate level of investigation carried out. We have a good track record of working with our partners in providing care to investigate Serious Untoward Incidents jointly and make appropriate changes across the care pathway. For example by working with the Acute Trust the pathway for referring children with headache as a primary diagnosis has been reviewed as a result of a late diagnosis of a brain tumour.

We actively learn from other organisations too. through being a member of the Federation for Patient Safety, through implementing the actions outlined in Safety Alert Broadcast System (SABS) alerts, National Patient Safety Agency (NPSA) alerts etc.

We have developed our commissioning processes continuously to improve the care of our patients. Our demand management work is evidence based, taking into account best practice, as are the quality indicators which we have used in commissioning our services. From April 2008 all commissioned services will have quality indicators in place which will be regularly monitored and action plans developed, where appropriate, to improve care.

The quality improvement and clinical governance agendas are co-ordinated by the Clinical Governance and Risk Committee which provides assurance to the Board that patients are treated safely and to high standards of care. They also provide assurance to the Board that all Serious Untoward Incidents have Root Cause Analysis carried out and that the resulting action plan is implemented.

14 Emergency preparedness

The aim of the PCT is to ensure that plans are in place across the health economy which will ensure an adequate health response to any emergency and meet our statutory responsibilities as a Category 1 responder.

The PCT is working closely with the Local Authority and other partners to develop an emergency planning risk register which links to the Thames Valley Community Risk Register.

The PCT has in place a series of business continuity plans, covering all activities, which meet the requirements of BS25999 and link to the PCT risk management processes. These plans are tested annually taking into account current guidance and any recommendations are built into the current commissioning plans.

The PCT has a Major Incident Plan in place which supports our response to any emergency, in collaboration with partner organisations. The PCT is reviewing a series of more specific plans to support incidents which may occur, e.g. Pandemic Flu plan and Chemical Biological, Radiological and Nuclear plan, to ensure they meet current guidance.

Emergency Planning is co-ordinate through the Buckinghamshire Health Emergency Planning Group which has representation from all health partners, Local Authority, Police, Ambulance Services etc. Oxfordshire PCT, as lead PCT for Emergency Planning, represents the PCT at the Thames Valley Local Resilience Forum.

The health economy has submitted its pandemic flu audits to the DH and has an action plan in place to ensure robust plans are in place by December 2008.

The action plan will be reviewed in the light of feedback from this audit. The PCT Clinical Governance and Risk Committee receives regular reports on Emergency preparedness and provides the Board with assurance that action plans are being implemented.

In 2008/9 we will ensure that:

- Staff are trained for the role they may have to undertake in an emergency
- Work closely with the lead PCT and SHA to develop test exercises that meet the needs of the PCT
- Work with other Category 1 responders to test the plans to ensure they meet the needs of the local population and local circumstances. Each test will be followed by a gap analysis and action planning cycle.
- The health economy works together to deliver the actions identified in the Pandemic Flu audits
- We review and maintain our Business Continuity Plan and Chemical, Biological, Radiological, nuclear (CBRN) plan.

15 Performance

The PCT has in place a high-profile and robust regime which monitors and manages performance against local and national targets, to ensure that the highest possible standard of care is provided to patients, and that the demands on the NHS are met. The main elements of this performance management regime are:

- A comprehensive performance report, detailing performance against national targets and key performance indicators, which is presented to every meeting of the PCT Board.
- Performance is reviewed on a regular basis by the PCT's Audit Committee.

- Exception reports are presented to the Audit Committee to detail action being taken to address poor or below-trajectory performance.
- Each performance indicator has a lead manager who is responsible for that particular area of activity, and a Corporate Performance Manager co-ordinates the performance management process in the PCT.
- Regular performance meetings take place between the PCT's performance leads and provider trusts
- The PCT has regular performance meetings with the Strategic Health Authority

In 2008/09 we will

- Review our performance framework to build in targets and performance indicators contained in 'vital signs'
- Move towards augmenting existing performance reporting and monitoring processes with a system of performance improvement
- Make better use of information technology in collating performance management information within the PCT
- Maintain and improve levels of performance against key national and local performance targets such as healthcare-acquired infections, Choose and Book, 18 weeks referral to treatment times, smoking quitters, and Chlamydia screening.

PART 3 : OUR DETAILED PLANS FOR DELIVERY

1 Vital signs progress - responding to specific priorities

The DH Operating Framework sets out the national priorities which all PCTs need to meet. It also requires PCTs to set local priorities. Collectively these are known as 'vital signs'. The complete list of vital signs is set out in Appendix 2.

The priorities fall into four groups:

1. Priorities determined and set locally with partners
2. National priority for local delivery, where we need to set local improvement plans
3. National Priorities for 2008/09, grouped into five key areas
4. Existing commitments which should have been achieved by April 2008, and are in our baseline

Plans responding to these groups of priorities are included in this plan.

1.1 Local targets

The Operational Framework requires PCTs to describe local targets and how they have been agreed; define success; detail milestones; and detail proposed LAA content on health outcomes.

We have selected local priorities based on what our local communities tell us is important, using evidence from the 'vital signs', strategic needs assessment and best practice to support local decisions. We have identified those that best match our key criteria of providing benefits to patients, contributing to local and national targets, supporting clinical safety, quality and governance, and encouraging shifts in services from secondary care.

We are working closely with our local partners to conduct the joint strategic needs assessment and LAAs

Following local discussion in PEC, PPI and Partnership, the Board has selected the following local targets (vital signs) that are appropriate for the Buckinghamshire PCT health economy:

- Delayed transfers of care (VSC06) – this supports our aim to get people out of hospital as soon as clinically appropriate
- Number of emergency bed days (VSC20) - this supports our aim to develop community based services to keep people out of hospital
- Ambulatory care sensitive conditions - rates of hospital admissions (VSC21) - this supports our aim to develop community based services to keep people out of hospital

- Alcohol related harm - rate of hospital admissions (VSC26) - this supports our aim to prevent self harm

The following targets currently in development are ones we support and may wish to introduce in due course:

- People with depression and/or anxiety disorders offered psychological therapies (VSC02) - this supports our aim to develop psychological therapies
- People with a long-term condition feeling independent and in control of their condition (VSC11) - this supports our aim to develop community based services to keep people out of hospital
- Proportion of carers receiving a 'carer's break' (VSC18) - this supports the provision of services to this important group

We will continue to take soundings from other stakeholders, including take account of LAA targets as agreed in June 2008.

2 Quality in commissioning

The PCT is developing a quality framework based on the World Class Commissioning model. The PCT seeks continuously to improve the quality of care provided by comparing the performance of local services with best practice guidance from a range of sources.

All the major providers of services are members of the Buckinghamshire Quality Group which actively strives to make the patient experience better across the health economy by encouraging partner organisations to work more closely together.

All contracts contain quality schedules which contain both process indicators and outcome indicators. Progress against these indicators is regularly monitored to ensure continuous quality improvement. Areas of care currently being monitored include stroke, maternity and coronary heart disease.

In addition all providers not regulated by the Healthcare Commission are required to submit an annual declaration of compliance with the Core Standards. (DH – Standards for Better Health).

The PCT meets regularly with all providers of services to monitor the quality of care and to develop action plans for improvement where appropriate.

The following highlight areas of particular focus:

2.1 Improving cleanliness and reducing Healthcare Acquired Infections (HCIs)

During 2007/08 we have continued to work with our providers to make progress with the minimum target of halving the annual number of MRSA bloodstream infections compared with 2003/04.

Up to the end of December 2007 we had 21 cases and are currently two cases over the trajectory of 19. This is a 50% reduction in cases reported in 2004/05.

Work to reduce and monitor the levels of MRSA is ongoing, with a further campaign on hand washing taking place in Spring 2008. Infection data is monitored regularly by the Infection Control Team, reporting to the Director of Infection Prevention and Control.

We expect providers to introduce MRSA screening for all non-urgent admissions from 2008/09, and for all emergency admissions as soon as practicable within the next three years; and to implement the forthcoming HCAI and Cleanliness Strategy. We consider that these costs will be covered within the tariff costs for our Acute providers.

We also expect providers to deliver a 30% reduction by 2011 in Clostridium difficile, (C Diff) compared to the 2007/08 baseline figure.

C Diff levels are monitored alongside those for MRSA and show a general downward trend in infections. During December 2007 13 cases were reported against a target of 15. Strict guidelines and monitoring of antibiotic usage are in place.

There is a Clinical Lead in all community hospitals; in addition there is a responsibility on the part of each ward sister to deal with and respond to hygiene issues on the ward.

In partnership with Buckinghamshire Hospitals NHS Trust and the Health Protection Agency we have secured joint national funding of £350,000 for 2007/08. This is being used to support additional infection control measures which will continue during 2008/9. These include:

- Production of e-learning package for healthcare staff
- Nurses providing education on infection control within nursing and residential homes
- An epidemiological study of C difficile strains

2.2 Mixed – sex accommodation

Our aim is to ensure that no patients are accommodated in mixed sex wards.

Currently the PCT's own inpatient units comply with the requirements of single sex accommodation in that all units either have individual rooms or where rooms are multi-occupancy then these are always kept to single sex occupancy.

At present because of the configuration and location of toilet facilities we are not able to designate individual toilets for male or female use only. This will require major investment or redevelopment of sites in order to be able to address this issue as part of the capital estates strategy.

3 Prevention, self care and promoting healthy communities

As set out in the needs assessment, promoting a robust prevention agenda is the best way to secure an affordable health and social care system for the future. The promotion of health, especially for those most vulnerable to developing ill-health, requires action across the whole life cycle and action to improve the environments in which people live, work and socialise. In recognition of this the PCT has prioritised with partner agencies the need to improve the health of children and tackle childhood poverty, improving health where it is needed most, tackling key lifestyle issues and focusing on vulnerable groups such as Black and Minority Ethnic Groups, Older People and Prisoners.

For those with long-term conditions, empowering patients and their carers to self-care improves satisfaction and outcomes for patients and reduces health care resource use.

The PCT has a comprehensive work programme for 2008/09 to improve health and tackle health inequalities

3.1 Partnership Working

The PCT works through a range of multi-agency partnerships in order to harness the contribution that other sectors can make to promoting the health of the population. A key vehicle for this is the Healthy Communities Partnership which, led by the PCT and County Council, will be developing a multi-agency Healthy Communities strategy which will build on the outcomes of the recent IDEA Healthy Communities Peer Review and Audit Commission Review on Health Inequalities. The strategy will also incorporate the outcomes of the joint Strategic Needs Assessment

3.2 Tackling Health Inequalities

Tackling local health inequalities underpins the public health work programme of the PCT, and there are a key focus of the County Community Strategy, the Local Area Agreement and the emerging Healthy Communities Strategy. All public health work programmes are based on an understanding of where inequalities exist and focus on addressing these.

In 2008/09 the PCT is specifically targeting tackling inequalities in cardiovascular health and will be:

- Implementing a pilot project to improve the health of people from BME groups in a primary care setting. This will include improving the monitoring of ethnicity, identifying the health behaviours and health needs of ethnic minority populations and enabling practices to develop plans to meet the self-reported needs of this population group. The project will also aim to assess the health outcomes of this population in comparison to the general population and develop programmes to reduce the risk factors for diabetes, heart disease and stroke in these populations and support better care of these conditions where they exist.

- Improving the detection and treatment of risk factors for cardiovascular disease initially in our most deprived populations.
- As part of a package of primary prevention targeted at the most disadvantaged populations, investing to increase access to evidence-based services to support changes in behaviours e.g. weight reduction, increased physical activity, smoking cessation which will bring about reductions in heart disease, stroke and cancer.
- Supporting the implementation of relevant national guidance from NICE on statin prescribing, the stroke strategy, the cancer strategy, proposals for targeted cardiovascular screening.

3.3 Improving Healthy Lifestyles

3.3.1 Reducing Smoking

- Smoking is the single largest preventable risk factor for cancer. Differences in smoking rates between the least and the most deprived groups account for half the inequalities gap in mortality between these two groups. We will continue to work to ensure that the smoking targets are achieved and that smoking cessation services target the more deprived areas of the PCT.
- A comprehensive action plan has been established within the PCT to deliver a whole organisation solution to delivering smoking quitters. The action plan incorporates promoting the stop smoking message and specialist service, increasing referrals from NHS practitioners and maximising capacity in primary care settings to deliver smoking quitters.
- An evaluation will be undertaken of the impact of the local and SHA promotional and marketing campaigns and benefits incorporated into the annual review of the action plan
- Work is being undertaken with the Acute Trust to improve referrals, initiation and discharge out to community services, and action on smoking quitters is being considered in the contract negotiations with the Trust
- A Tobacco Control Alliance is in place with a full work programme including action to target pregnant women, young people and manual workers
- The Buckinghamshire Smoking Cessation and Tobacco Control Strategy will be reviewed

Detailed actions are outlined in the Buckinghamshire Alliance for Action on Smoking Action Plan, Buckinghamshire Stop Smoking Service Delivery Plan

3.3.2 Obesity (incorporating Healthy Eating and Physical Activity)

There is an increasing recognition of the impact of obesity on health. Obesity is linked with a range of conditions including Type 2 diabetes, coronary heart disease and a number of cancers. After quitting smoking maintaining a healthy body weight is one of the best ways to reduce the risk of cancer. In light of this, obesity has been identified as a priority for the Healthy Communities Partnership and Strategy.

Detailed plans outlining local action on obesity are available in the Buckinghamshire Obesity Strategy, and LAA Delivery Plan and include:

- Appointment of an obesity dietician to provide additional weight management capacity and to support training and expansion of support in primary care
- Mapping and review of the adult obesity pathway in Buckinghamshire expanding number of practices providing evidence-based weight management support currently eight practices delivering counterweight
- Improving the recording of overweight and obesity to enable effective trend monitoring
- Maintaining 'Cook and eat' programmes for families, and the Health Walks Scheme
- Working with the Physical Activity Alliance and County Sports Partnership to expand physical activity schemes in areas of deprivation including additional sport and leisure activities

3.3.4 Alcohol

Alcohol has a broad ranging impact on health services and local communities. In addition to links to cancer and other health conditions, alcohol is also related to injuries as a result of accidents and assaults, and to community safety. The PCT is tackling alcohol through:

- Active membership and support to the DAAT.
- The implementation of a pilot project for Alcohol Brief intervention in the Aylesbury A+E and five GP practices. Implementation due April 2008 to March 2009. Roll out of the project dependent on evaluation.
- Working with the Alcohol Commissioning Co-ordinator at DAAT on developing the Alcohol Play (theatre production) in schools
- Supporting the DAAT awareness-raising work to promote the dangers of harmful and hazardous drinking

3.3.5 Sexual Health

The trends in sexually transmitted infections in Buckinghamshire mirror those seen nationally. To address this:

- A Sexual Health Strategy is in place to give direction to sexual health promotion activity
- Sexual health needs assessment underway and additional funding secured from DH to undertake a profiling exercise of our risk / target groups to inform the further development of the prevention programme
- Work continues to improve access to GUM services. We will maintain and sustain the percentage of patients attending GUM services being offered an appointment with 48 hours and close the gap between numbers offered and numbers seen. Expanded clinic space in Wycombe should enable rapid progress towards the 100%. Work includes further reception staff training, the recruitment of extra administrative staff, development of nurse-led clinics, improved communications with GPs, improving the telephone and IT system, and the introduction of new clinic times

- We will review Tier 2 commissioned services, and review long action reversible contraceptives (LARC) in line with NICE guidance
- Brookside GUM has been included in a Department of Health publication as an example of good practice

3.4 Cancer services

The PCT will make progress towards delivering the Cancer Reform Strategy by implementing the agreed NHS South Central strategy.

3.4.1 Cancer Screening

The PCT will continue to work to ensure that national standards are met for breast and cervical screening including coverage. It will also work towards ensuring that vulnerable groups within the population, e.g. those from deprived areas, those with learning disabilities have access to screening. There is evidence that the uptake of breast screening is significantly lower in women with learning disability compared to women overall.

For cervical screening services the Cancer Reform Strategy states that for cervical screening all women will receive the results of their screening tests within two weeks by 2010 - no further timescales available as yet.

For breast screening the age range for breast screening will be extended to cover the age range 47 to 73.

Breast screening

In 2008/09 we will work with local providers of the various components of the Breast Screening Programme to:

- maintain the very high quality programme currently provided for Buckinghamshire women – in 2006/7 the Buckinghamshire Programme achieved 83.7% coverage (highest in SC) – national standard is 70% minimum with a target of 80% - the programme is performing over and above the national standard – also the programme consistently achieves very high standards re the 36 month screening round length – 99.8% - where the minimum standard is 90% and the target is 100%
- plan the phasing in of the age extension; initial work will involve modelling of increased activity - modelling will take into account data definitions for Vital Signs (VSA 09) when available

Colorectal screening

From 2010 digital mammography colorectal screening will be extended to include those aged 70 – 75. In 2008/09 we will work to plan the transition, and from April 2008 all Buckinghamshire residents aged 60 – 69 will be screened via Milton Keynes General Hospital.

3.4.2 Access to cancer services

The PCT currently meets the following standards:

- Cancer Out patient referrals to be seen in two weeks
- Maximum wait from diagnosis - 31 days
- Maximum wait from referral to treatment - 62 days

In 2008/09 the PCT expects that providers will maintain these standards within existing resources.

3.5 Stroke Services

The PCT will drive up standards of care to reduce mortality and morbidity through implementation of the Stroke Strategy

In terms of preventing strokes, action to reduce smoking, levels of overweight and obesity, and alcohol misuse and increase physical activity, will reduce the incidence of stroke in the population. Effective treatment of high blood pressure and effective primary and secondary prevention will also help reduce incidence of stroke.

Care for patients who suffer stroke involves a range of clinicians in a wide range of settings. The ageing population means this condition is likely to increase. Analysis of use of resources in Buckinghamshire suggests that there are different patterns of service across the PCT which need to be consolidated.

For 2008/09 the PCT will:

- Support the development of stroke care networks and the redesign of services across networks to ensure appropriate urgent care for stroke and Transient Ischaemic Attack and to meet needs for the long term.

3.6 Coronary Heart Disease (CHD) prevention and care

During 2007/08 the PCT undertook significant analysis of its coronary heart disease service. This work was summarised in the August 2007 strategic commissioning plan and its stakeholders identified the following high priority interventions to be made to be the CHD pathway:

- Increase the smoking quit rate via smoking cessation services.
- Increase coverage of community nursing services to cover multiple CHD - related admissions
- Successfully implement and monitor current CHD guidelines

The rationale for these and the measures of success are set out in the table below:

PCT priority areas for CHD commissioning

Priority	Measures of success
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Increase the smoking quit rate via smoking cessation services	<ul style="list-style-type: none">• Lower QOF smoking prevalence versus norms• Lower QOF CHD and Hypertension prevalence versus norms
Increase coverage of community nursing services to cover multiple CHD - related admissions	<ul style="list-style-type: none">• Lower rates of admission and numbers of bed days per CHD registered patient• Lower rates of re-admission following CHD - related acute episode

During 2008/09 our aim will be to make progress against these areas.

4 Improving Access to Primary, Community and Intermediate Care

As we outlined in 'Getting healthcare right for the future' we will expand and develop the range of services and choices available to our population. Our aim is that patients will receive appropriate, safe and high quality services increasingly delivered within primary care in a more local setting improving access and convenience.

We are achieving the existing target of 'access to a primary care professional in 24 hours and GP in 48 hours'. As highlighted in our needs assessment we will give particular priority to schemes which improve accessibility for disadvantaged, vulnerable groups, and for people who currently struggle to access services⁹. And will consider their needs in our strategic planning this summer.

This will include the needs of armed forces personnel and dependents based in Buckinghamshire, and will take account of their needs to access NHS dentistry, immunisation programmes and health promotion activities, and the particular needs of veterans. We have two military bases within Buckinghamshire: RAF Halton & RAF Naphill. Health visitors provide clinics on both bases and all families have access to the full range of services regardless of whether or not they are registered with a local GP, protecting them from any disadvantage associated with frequent moves between military establishments.

The December 2007 guidance on priority for veterans for conditions that relate to their service career will be reiterated with local GPs; at this stage we are not planning to undertake a needs assessment or to commission services separately for this population, but believe that the additional capacity in place to achieve improved access times for all will assist clinicians who identify individuals who are entitled to priority treatment. We will ensure that our patient and public involvement team seek views from the relevant support groups for military personnel as part of our planned programmes of engagement and feedback, and draw on best practice from other PCTs.

In 2008/09 we will:

- Improve access (including evenings and weekends) to GP services, by working with GPs to ensure that, by the end of the year, at least 50 per cent of practices offer extended opening to their patients, with the additional opening hours based on patients' expressed views and preferences on access.
- Undertake procurement of new primary care led walk in facilities in Wycombe and Aylesbury, a coordinated service to provide a single point of access to urgent care services, an out-of-hours GP advice, treatment and visiting service and a GP-led health centre. This procurement follows a national timescale which includes the requirement for consultation and which is expected to result in new style services being in place by the end of March 2009.
- Discuss with wider stakeholders, the next stage of the implementation of our strategy, including their views on the development of primary care hubs, and the most appropriate use of our community hospitals

⁹, Darzi review of the NHS announced 4 July 2007

- Finalise plans with local stakeholders for the new Chesham Healthzone

In 2009/10 and 2010/11 we will:

- Complete the Chesham Healthzone development
- Continue the development of primary care hubs as agreed during 2008/09

4.1 Dentistry

Access to dental care is a key priority. We will monitor how easy it is to access local dentistry services and manage the development of services. We will manage the new contract, and communicate information to the public about the services.

For 2008/09 the PCT is planning to use the additional investment in dental services made possible by the increase of 11% in funding for 2008/09.

The PCT is currently developing its Commissioning Strategy and action plan, which is informed by the Buckinghamshire Oral Health Needs Assessment (2007), PALS data and recent patient surveys. We are making a commitment to:

- Expand NHS dental services and improve general access to all, focusing in particular on the north Buckinghamshire locality where access is the worst. The PCT will be looking to develop access to all and will not be actively promoting 'child only' or 'exempt adult' contracts. In line with 'vital sign B' on dentistry the PCT will be aiming to increase access by at least 10% over the next two years.
- Facilitate the smooth departure of the transitional dental contracting arrangements which are due to come to an end in April 09. Ensure that the PCT is geared up in terms of resources and contracting data to review all existing contracts using a rolling cycle of reviews starting with 'children only' and 'exempt adult' contracts, salaried services contracts and then all general contracts.
- Strengthen the performance management framework for dental contractors in terms of activity delivery.
- Maintain the quality of existing services.
- A long-term aim to review the provider arm salaried dental services specifically looking separately at the access and special needs elements of the service.
- Strengthening the PCT patient communication strategy and promoting relations with the public
- Improve the oral health of the Buckinghamshire population in line with the document '*Delivering better oral health*' working collaboratively with public health teams.

Continuing controls on spend will be maintained, including stringent contract monitoring.

4.2 Primary Care

Work will begin on developing the Primary Care Strategy during 2008/9, in conjunction with revisions to the Strategic Services Development Plan

(SSDP). Instrumental to this work will be the involvement of the Commissioning Collaboratives.

This work is planned to build on and complement the strategy discussions on the development of primary care hubs, and to develop national models of primary care around the needs of Buckinghamshire.

The main challenges for primary care in 2008/9 continue to be the ongoing development of positive and constructive relationships with primary care contractors (GP Practices, Community Pharmacists, Dentists, Optometrists) and representative committees, i.e LMC, LPC, etc and working in partnership to deliver national initiatives to local benefit.

In particular, the primary care team will:

- Continue to deliver key national initiatives and targets, including delivery of choice and Choose & Book by GP Practices
- implement extended access and procurement of the new GP led Health Centre
- maintain and continue to develop the quality of existing services, i.e through mechanisms such as QOF
- continue to use enhanced services as a vehicle to commission locally sensitive services within primary care settings, through General Practices, Community Pharmacists
- Strengthen the performance management arrangements through the development of a balanced scorecard for dentistry and general practice
- Implement the new national optometry contract, expected June/July 2008.

4.3 Drug and Alcohol Services

In partnership with DAAT colleagues we will continue to commission and performance manage providers (both voluntary and statutory sector providers) to ensure accessible and effective treatment. We will continue to provide access to a full range of tiered intervention. Emphasis will remain on delivering care, planned interventions and effecting positive discharge.

In partnership with the DAAT we will evaluate the impact of the pilot 'Stimulant Service' (which aims to effectively engage crack cocaine users in appropriate treatment). We will commission accordingly; and where appropriate will re-tender elements of the service including psychosocial interventions for alcohol and substance misuse.

4.4 Prescribing (Medicines Management)

The successful prescribing incentive scheme in 2007/08 has achieved more effective prescribing. The PCT will benefit from the full-year effect of work already undertaken in 2008/9, and will aim to achieve further savings of £1.6m in 2008/09 in a number of areas. Examples include:

- Discussion with respiratory clinicians and specialists to ensure the best use of inhalers in asthma, reducing inappropriate exposure to long-acting agents in accordance with national guidelines
- Production of clinical protocols to stop inappropriate and excessive use of blood glucose testing strips
- Develop guidelines for enteral nutrition (sip feeds)
- Review of antidepressants
- Review of dermatology formulary
- Continuation of the existing dressing scheme with close monitoring of compliance
- Review of diabetic protocols

The full delivery of the CIP depends on:

- the appropriate use of QOF Medicines Standards 6 & 10
- an audit-based incentive scheme
- good interface working with specialists to produce evidence-based clinical protocols
- a “whole practice” approach – engaging with practice nurses

4.5 Maternity Care

The PCT will work with its providers to improve access as part of the wider *Maternity Matters* Strategy to deliver safe, high-quality care for all women, their partners and their babies. This requires the NHS to increase the percentage of women seeing a midwife by week 12 of the pregnancy, and to ensure there are sufficient maternity staff and neonatal teams.

There is a Maternity Action Plan based on the commissioning toolkit review. This includes plans to enable all mothers to see a midwife by 12 weeks and have had an assessment of their needs completed.

100% of women currently receive written information about maternity services and options for their place of delivery, all women also have documented individual post natal care plans and compliance against this target is audited annually. The PCT is committed to improving access for maternity services: our contracts with BHT include within the Quality Specification the requirement to increase the percentage of women who have seen a midwife or maternity healthcare professional by 12 weeks of pregnancy.

During 2008/09 the PCT will

- Support BHT in completing the implementation of the ‘Shaping health services strategy’¹⁰
- Be reviewing how best to develop an intermediate service to provide care for women who would otherwise attend hospital for reasons other than delivery. This would be both an improvement in the range and convenience of local services as

¹⁰ Shaping health services, Buckinghamshire Hospital trust 2004.
See www.buckshospitals.nhs.uk/shaping/shapingnew.asp

well as a more cost effective way of delivering local services but needs to be developed carefully in order to avoid unplanned consequences for the existing range of secondary care services.

- Support the funding of the following pre and post natal screening:
 - The antenatal haemoglobinopathy screening service and the switch from triple test to combined Downs screening test.
 - The testing for newborn sickle cell, and cystic fibrosis
 - The testing of newborn hearing

4.5.1 Breastfeeding

A national target to increase breastfeeding initiation rates has been in place since 2003. PCTs are tasked to deliver an increase of two percentage points per year in breastfeeding initiation rates, focusing especially on women from disadvantaged groups. We aim to increase the number of babies still being breastfed at the 6-to-8 week breastfeeding target. An action plan has been produced as part of the Children and Young People's Plan. Key deliverables include:

- Establishing data collection system
- Training midwives and health visitors and extension of training to children's centres (see below)
- Maintaining breastfeeding cafes and support groups
- Student midwife support to assess the facilities for and the perceptions of breastfeeding in public places and provision in statutory services
- Maintain peer led breastfeeding support in acute hospitals and assess feasibility of extending to home / community sites
- BHT to pursue breastfeeding friendly status
- Action to support initiation of breastfeeding has been included in the BHT contract.

4.6 Children's services:

The PCT aim is to improve children's and young people's physical and mental health and wellbeing.

4.6.1 Childhood immunisation

The DH has announced the introduction of a human papillomavirus (HPV) immunisation programme to routinely vaccinate girls age 12 – 13 years of age against cervical cancer, starting in September 2008, as well as a catch up programme for girls up to 18 years which will run into 2010. 3 doses of vaccine will be administered to over a 6 month period.

In line with the DH recommendation the intention is that this programme is run through the school nurse service with a catch up programme being run by GP practices. The work programme also includes a communication plan to raise awareness amongst parents, girls and local schools.

4.6.2 "Every Child Matters" and the Children's Plan

The PCT is working with BCC and other partners, in the context of Every Child Matters and the Children's Plan¹¹, to ensure that children's and young people's health and wellbeing needs are assessed and that action to address these is included in PCT plans, Local Area Agreements (LAAs) and our contracts, as appropriate.

BCC is planning to increase the number of children's centres across Buckinghamshire

In 2008/09 we will, through the joint agency planning and commissioning of services, develop the following services and initiatives:

4.6.3 Childhood Obesity

- Pay special attention to obesity as one of the most serious, and growing, health challenges for children. We will aim to reduce the proportion of overweight and obese children in Buckinghamshire to 2000 levels by 2020.
- Expand the number of practices providing evidence based weight management support
- Childhood obesity has been retained as a target for the new LAA Development of family based obesity management programme for children scheduled to be implemented 08/09
- Appoint an early years food and activity facilitator from April 2008, and provide 'early years' training on food and activity for health professionals and children's centre staff
- 'Cook and eat' programmes for families
- Working through Healthy Schools and Physical Activity networks to deliver a stretched target in the percentage of schools which offer two hours a week of physical education
- Deliver the national child measurement programme

Detailed plans are available in Buckinghamshire Obesity Strategy, LAA Delivery Plans and Children and Young People's Plan

4.6.4 Children with Disability

- This is a priority of the Joint Commissioning Group as directed by the Children's Trust Board. There is a review of all jointly-commissioned respite and short break care in Buckinghamshire. All stakeholders will be consulted to identify the most appropriate service to meet the needs of Buckinghamshire children. There is also a joint review of 'special schools' within the County to develop the provision of support in county for children and young people with LD.
- Identify actions and set local targets to improve experience and range of services for disabled children, including short breaks, palliative care, access to therapies and transition to adult services

4.6.5 Child Death Review Overview Panels

¹¹ Buckinghamshire Children and Young People's Plan Refresh 2007 - BCC

It has been agreed to establish in Buckinghamshire a Child Death Overview Panel. This will review all child deaths including those in hospital, on the road and due to child abuse. The panel will commence in 2008/09.

4.6.6 Teenage Pregnancy

Buckinghamshire is fourth best performing authority in England for reducing teenage pregnancy with a conception rate of 22.7 per 1000 15 -17yr olds (218 conceptions in 2006). This compares with an England average rate of 42.1.

The PCT works in partnership to:

- Work collaboratively with all agencies to identify young people at risk of early parenthood, and jointly with the local authorities as part of the Healthy Schools programme, to ensure the provision of high quality education on sex and relationships with special emphasis on those who are most at risk.
- Commission the provision of flexible and accessible contraceptive and sexual health services for young people.
- Deliver the Buckinghamshire joint teenage pregnancy action plan for 2008/09 including work on:
 - Increase the uptake of the early hormonal contraception scheme (EHC)
 - Continue the joint work with local authority colleagues on the Healthy Schools programme with particular focus on sex and relationships education
 - Implement the reviewed condom strategy and distribution scheme
 - Media campaign
 - 'Sex Matters' training for Tier 1 workers (available to a range of agencies)

4.7 Child and Adolescent Mental Health Services (CAMHS)

All children and young people who need them have access to a comprehensive CAMHS service. The LAA target is to increase the access to Tiers 2 and 3 and we have exceeded our target, by working with the providers to develop new referral pathways and agreed thresholds of care.

We will however be jointly recommissioning the service as joint commissioners with BCC within a pooled budget arrangement, to ensure the stability of a comprehensive CAMHS and a single point of access.

All children with a learning difficulty have access to a CAMHS service as required. All young people aged 16-18 are offered a CAMHS service, and plans are in place to ensure that admissions will not be to an adult ward.

Emergency cover is provided from the CAMHS team, and a joint protocol has been agreed between OBMHT and BHT for children and young people in A&E who require mental health services/assessment.

Early intervention for mental health issues at 'Tier1' has been jointly commissioned with BCC and a training programme has been developed and thresholds for access to the service have been agreed.

5 Non Urgent Care

We aim to work closely with our providers to improve access to non-urgent care, including achieving the 18-week waiting time target from referral to treatment. The analysis of benchmarks undertaken by the PCT in 2007/08 (included in our strategic commissioning plan)¹² clearly demonstrated that we over consumed acute services. Our aim is therefore to ensure that there is a sustainable health economy by reducing this over reliance on hospitals. We expect that:

- Planned referrals to secondary care will take place where patients require more specialised opinion and treatment
- Patients will be provided with appropriate and timely information at all stages of their referral, including the offering of choice and use of the Choose and Book system.
- Patients will wait a maximum of 18 weeks from referral to treatment
- GPs will take on a greater level of patient management following the discharge of patients from the acute setting ensuring that follow up appointments and visits to hospital are minimised.

5.1 18 weeks

In 2007/08 we expect to be achieving the 18-week referral to treatment pledge early. We have agreed brokerage with the SHA for the procurement of additional activity to ensure the achievement of the 18 week target of 90% - 95% target by end of March 2008.

In 2008/09 we will work closely with our providers to maintain the 18 week wait by ensuring that the programme of service redesign planned for 2008/09 is driven forward on a Health System basis. We aim to continue to work closely with our providers to increase their productivity while improving quality and access. We will continue to implement and roll out business improvement methods, including the use of 'Lean' techniques to improve pathways

5.2 Specialty Updates

A crucial part of our plans is, with our providers, to redesign pathways of care for patients to maximise efficiency and outcomes for patients. We have been working in the following specialties during 2007/08 with practice-based commissioners and local providers to agree targeted changes, including where appropriate the implementation of intermediate services (as recommended in *Our Health, Our Care, Our Say*)¹³.

In 2008/09 we will implement these proposals for redesigning non-urgent care and establishing or expanding intermediate services in the specialties of Dermatology, Gynaecology, Musculoskeletal, Ophthalmology, Diabetes and Urology as set out below. We will also begin work on service redesign in ENT and General Surgery.

¹²

¹³ *Our health, our care, our say: a new direction for community services, Dept of Health, January 2006*

These specialties, together with Cardiology, are those which have been identified as having the greatest opportunity for delivery care in a different way, closer to home.

For specialties where redesign work is either on-going or planned for next year we have assumed a greater reduction in activity as set out below. These assumptions are based on work undertaken previously in the workstreams and the 100 referrals project¹⁴.

5.3 Cardiology

During 2007/08 the PCT undertook significant analysis of its coronary heart disease service with the aim of ensuring that patients receive the most efficient and effective services, delivered in the most appropriate setting. This work was summarised in the August 2007 Strategic Commissioning Plan¹⁵ and is covered in appendix 3.

In 2008/09 we complete the establishment of the heart failure service, and will achieve our targets for ensuring that the Rapid Access Chest Pain Service (RACP) sees patients within two weeks, and that revascularisation takes place within three months.

5.4 Dermatology and Plastics

The aim is to develop an integrated service across primary and secondary care to ensure a sustainable balance of service while maintaining high quality and accessibility. Analysis undertaken by the PCT in 2007/08 has suggested that up to 40% of referrals and minor surgery could be undertaken in primary care or in an intermediate service

During 2008/09 we will continue to working with local clinicians to review patient pathways and referral processes with a view to implementing changes during the latter part of 2008/09.

5.5 Diabetes

In Buckinghamshire more patients with diabetes are managed in secondary care compared to the national average. A workstream has been reviewing the patient pathway for diabetes in order to allow more care to be delivered closer to people's homes in primary care and community settings. As a result of this work we expect to implement service redesign during 2008/9 reducing reliance on hospital care and achieving a financial benefit.

5.6 Urology

Our aim is to develop an integrated urology service across primary and community care which will allow rapid access and high quality treatment.

¹⁴ *Wycombe and CSB PCTs 2006*

¹⁵ *Buckinghamshire PCT Strategic Commissioning Plan August 2007*

The local provider is currently finalising a business plan for a redesigned service which will be considered by the PCT in March 2008. This service will then be implemented from April 2008. In developing the specification and the business case our estimates are that about 15% of outpatients and 10% of the minor procedures could be managed differently or seen in intermediate care.

5.7 Gynaecology

The aim is to develop an intermediate care gynaecology assessment and treatment service which will better integrate services across primary and secondary care, ensuring patients are seen in the most appropriate setting.

We have issued service specifications and are awaiting responses from willing providers. During 2008/09 we will work with local clinicians to establish the new service. This will allow GP-initiated outpatient attendances to be reduced by 18%, and 20% of the minor procedures to be managed differently or seen in an intermediate service.

5.8 Musculoskeletal (MSK) services

The aim is to develop an intermediate MSK assessment and treatment service covering relevant Orthopaedic, Rheumatology and Pain Management referrals. The new service will allow the triage of all referrals to these specialties by a multi-disciplinary team and treatment in a specialist community MSK service. A consortium of local providers is currently finalising a business plan for this service and implementation will be from April 2008.

There is widespread evidence from other schemes across the country that such a service can reduce referrals into acute care by 30%. However, elements of the service are already in place in Buckinghamshire and the impact here is therefore expected to be less – a reduction of 18% in referrals to acute care.

5.9 Ophthalmology

There is already an intermediate eye care service operating in Buckinghamshire. Our aim is to expand the service to cover a broader range of ophthalmic conditions. Work in this area is scheduled to start at the beginning of 2008/09, with implementation later in 2008/9. This will allow referrals to be reduced by around 600 a year.

5.10 ENT and General Surgery

The aim is to develop appropriate intermediate care services in ENT and General Surgery. During 2008/9 we will work with the practice based commissioners and local providers to redesign patient pathways. However, implementation of new pathways in these areas is not likely to be until the end of 2008/9. The specific activity and financial assumptions will be included in the 2009/10 operational plan.

5.11 Non Urgent Acute Activity

Our activity assumptions are set out below and have been reflected in all our contracts with our providers.

GP-generated outpatient activity

As a general rule we have assumed a reduction of GP-generated outpatient activity in secondary care of 4%. From April 2008 as RFC and other processes are in place. This will be achieved through greater use of agreed patient pathways through the following actions:

- Further progress of agreed action by the collaboratives to manage referrals. Implementation of management of referrals began in the latter part of 07/08 and detailed action plans are being agreed in the business plans of the collaboratives for next year.
- Systematic triage of low priorities cases through the RFC. The RFC was newly commissioned in January 2008 and regular reports from their Attend system will identify low priority procedures being requested and those requesting them.
- Monthly monitoring meetings are in place to review progress and develop the service of the RFC.
- Implementation of Map of Medicine (MoM) – a project manager is in post to oversee implementation. Project and Implementation plan being developed to ensure as systematic and widespread an implementation as possible.

Consultant to Consultant referrals

Comparative analysis of consultant to consultant referrals at BHT found that these were considerably higher than at other acute Trusts serving similar populations. The aim of this work is to reduce Consultant to Consultant referrals ensuring patients are seen by the right person first time, and on-going referrals are appropriate. BHT has introduced a 'prior approvals' process which is designed to ensure that all these referrals are appropriate. Our contracts include a 15% reduction in consultant to consultant referrals. This is phased over the year. Full year effect will be delivered but delivery is phased from May 2008 onwards.

Follow-up Outpatient Appointments

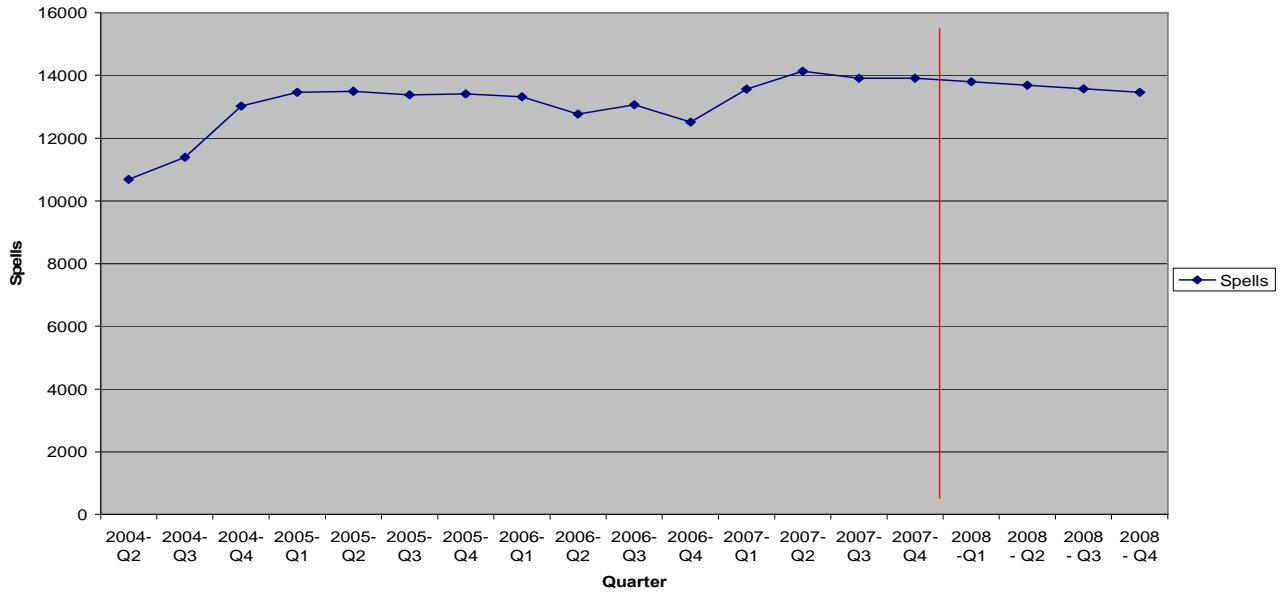
Comparative analysis shows that historically at BHT 'new to follow-up' ratios are higher than other Trusts with comparable populations. We have agreed with BHT to set targets for new to follow up ratios by specialty. Implementation will be through a group of specialties at a time. We have agreed a phased implementation to reach an overall 20% reduction by the last quarter. The full year effect of the impact in 2008/09 is expected to be 2-5% across all specialties. This issue has also be included in the contract negotiations with other Trusts.

Non-urgent Admissions

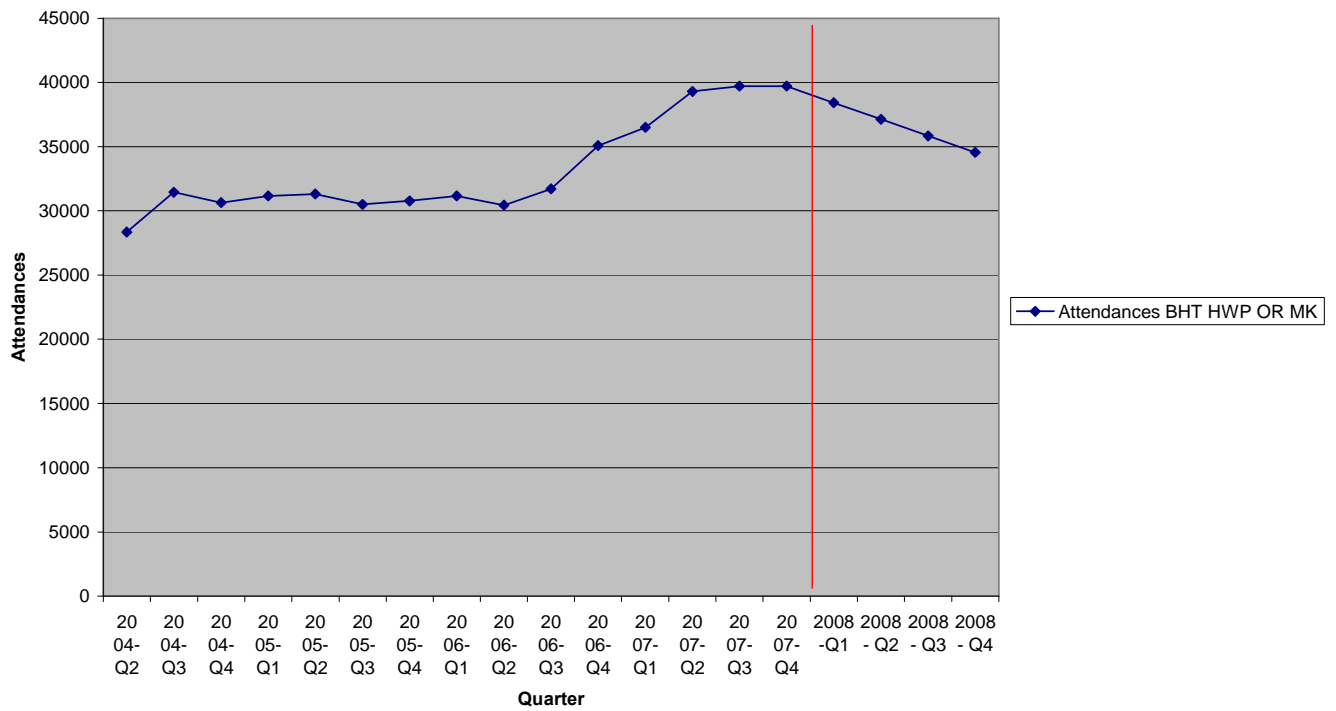
Some reduction in non urgent admissions is expected as a result of the service redesign measures and as a result of reductions in first outpatient appointments described above. These will be focused on the more minor procedures.

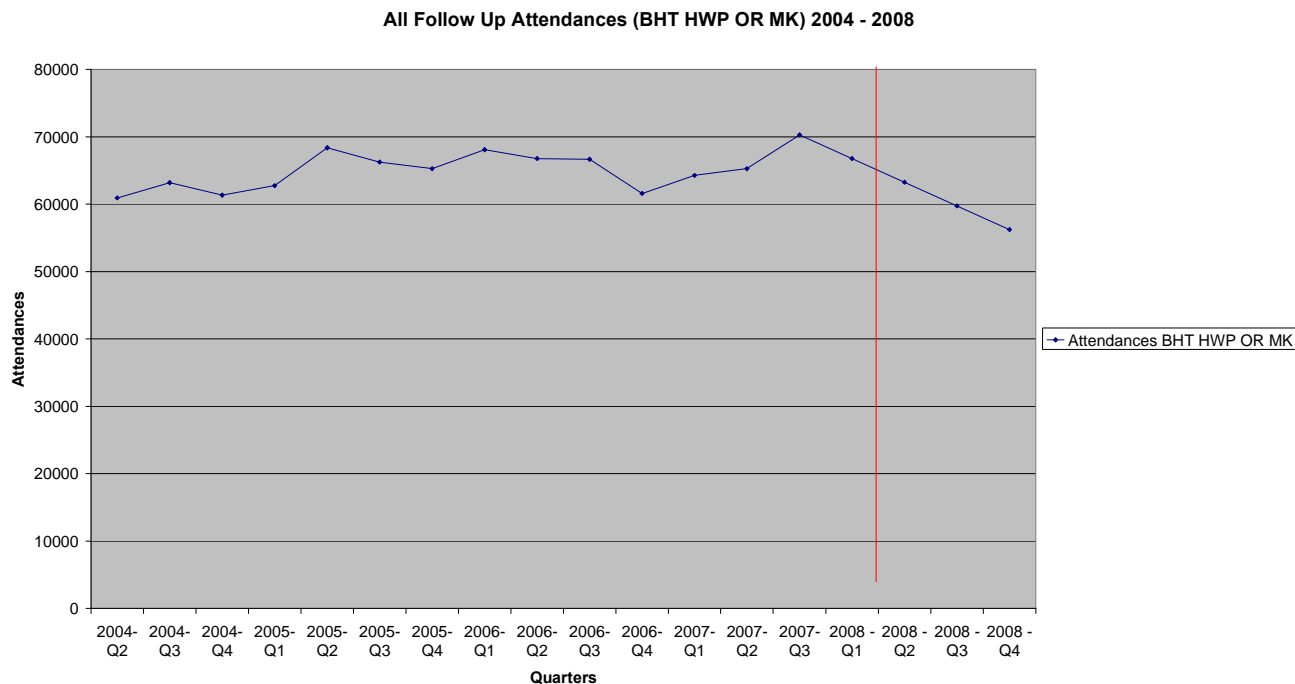
The effect of these projections for 2008/09, compared with previous years is shown in the tables below.

All Elective activity (BHT, HWP, OR and MK) 2004 - 2008



All 1st OP Attendances (BHT, HWP, OR, MK) - 2004 - 2008





The detailed activity assumptions which support these levels and which we will use in our contract discussions are set out in appendix 3.

5.12 Choose and Book

- We will work with and support GPs, Buckinghamshire Hospitals NHS Trust and our new Referral Facilitation Centre (RFC) to ensure that the Choose & Book (CaB) system is effectively implemented. Through the use of RFC staff entering referrals onto CaB we aim to achieve the national target of 90% of eligible referrals are made using CaB achieving this in April 2008.
- Buckinghamshire PCT is committed to the implementation of Choice, Free Choice, Choice in Diagnostics and the use of the Choose & Book (CaB) software within GP practices of the PCT for the benefit of patients.
- Working with all stakeholders, the PCT is currently preparing a CaB Strategy Plan for executive sign off and agreement with collaboratives and NHS South Central. This includes the resources required for successful implementation, supporting the 18 week wait targets and referral demand reduction.

Cost improvements 2008/09

Based on the phasing in of schemes as outlined above we expect these schemes to deliver cost improvements in 2008/09 as set out in Appendix 2.

6 Urgent Care

People who need urgent care, whether in the day or night, require easy-to-access services that give prompt reassurance, assessment and intervention. Those with known conditions will increasingly have a personalised care plan that supports self care and helps avoid unplanned emergency admission to hospital. In order to care for people in the most appropriate setting, those providing the initial assessment and treatment need access to a coordinated and flexible range of community and hospital-based services. Partners across the health and social care community are working together to re-shape urgent care services to achieve these aims.

Currently the PCT is achieving the target that 98% of people attending A&E wait less than 4 hours from arrival to admission, transfer or discharge. Since December 2007 there has been a GP at Wycombe and Stoke Mandeville Hospitals, providing support to the A&E clinicians to identify alternatives to admission and making use of the Single Point of Access (SPA) service which coordinates packages of community-based care. These services are helping to identify further opportunities to enhance our community and intermediate care services in order to help reduce the stay of those who do need to be admitted and to avoid admissions where clinically appropriate.

During 2008/09 with our partners we will undertake the following initiatives:

6.1 A&E Waiting Times Target

We will continue the achievement of the A&E waiting times target

6.2 Urgent Care Centres (UCC)

The aim is to develop urgent care services to support the existing A&E services in Stoke and High Wycombe, learning from the 'GP in A&E' schemes that are currently in place.

The 'GP in A&E' scheme began in mid December. This is assumed to deliver a saving straight away based on avoiding 2 Urgent admissions a day / 14 per week. The alternative services required for the majority of these patients include community hospital beds, better primary care assessment and management, intermediate care, and IV therapies.

The business case for the UCC is now being validated and refined and is being considered in conjunction with the requirement for the new GP-led health centre by April 2009. While the UCC is unlikely to have a financial impact in 2008/09 because of the procurement timetable, the project plan which will also incorporate the re-provision of OOH contract and SPA is underway.

6.3 Development of Integrated Teams

The aim is to develop and shape both our community hospital and our peripatetic community services in order to minimise admission to acute hospital for frail older people. Evidence from benchmarking analysis and 'Dr Foster' data shows that there are approximately 1000 admissions that could be avoided. (This is in addition to the 780 admissions avoided within the GP in A&E scheme above).

We aim to reduce the length of stay for those who are admitted to hospital by improved coordination of acute and community services and by redesigning community based support and rehabilitation services.

6.4 Care of People with Long Term Conditions

The aim is to streamline the care of people with long term conditions and promote independence and improved quality of life, for example through the pulmonary rehabilitation programme, the expansion in the heart failure nursing service and the diabetes education programme.

There are a number of relatively low cost actions involving training, systematic identification and management of patients, and education and treatment programmes which will reduce admissions to hospital for long term conditions by an estimated 20%. These reductions will be in the areas of asthma, COPD, heart failure and diabetic lower limb complications.

The National Service Framework for Long-term Conditions focuses on services for people of working age with long-term neurological conditions. It aims to promote quality of life and independence and sets out 11 quality requirements (QRs), each supported by an aim, rationale and evidence based markers of good practice, drawing upon NICE and other nationally agreed guidelines.

The PCT and BCC have now appointed a joint commissioning post to Physical and Sensory Disability and will be developing a Joint Commissioning Strategy in year 08/09. There is a newly formed reference group now in place to provide expert advice from clinicians, service users and carers to the formation of that strategy.

6.5 Community Assessment

The aim is to develop seven community assessment beds from September 2008. At the same time we will review the current utilisation, patient profile and future healthcare need for community beds, before the start of the community assessment function. We will also consider what proportion of beds should be allocated to admission avoidance rather than discharge facilitation from acute services.

6.6 Out of Hours Primary Care Service

We will review the out of hours primary care service and ensure that it coordinates well with the new urgent care services being developed.

6.7 South Central Ambulance Service (SCAT)

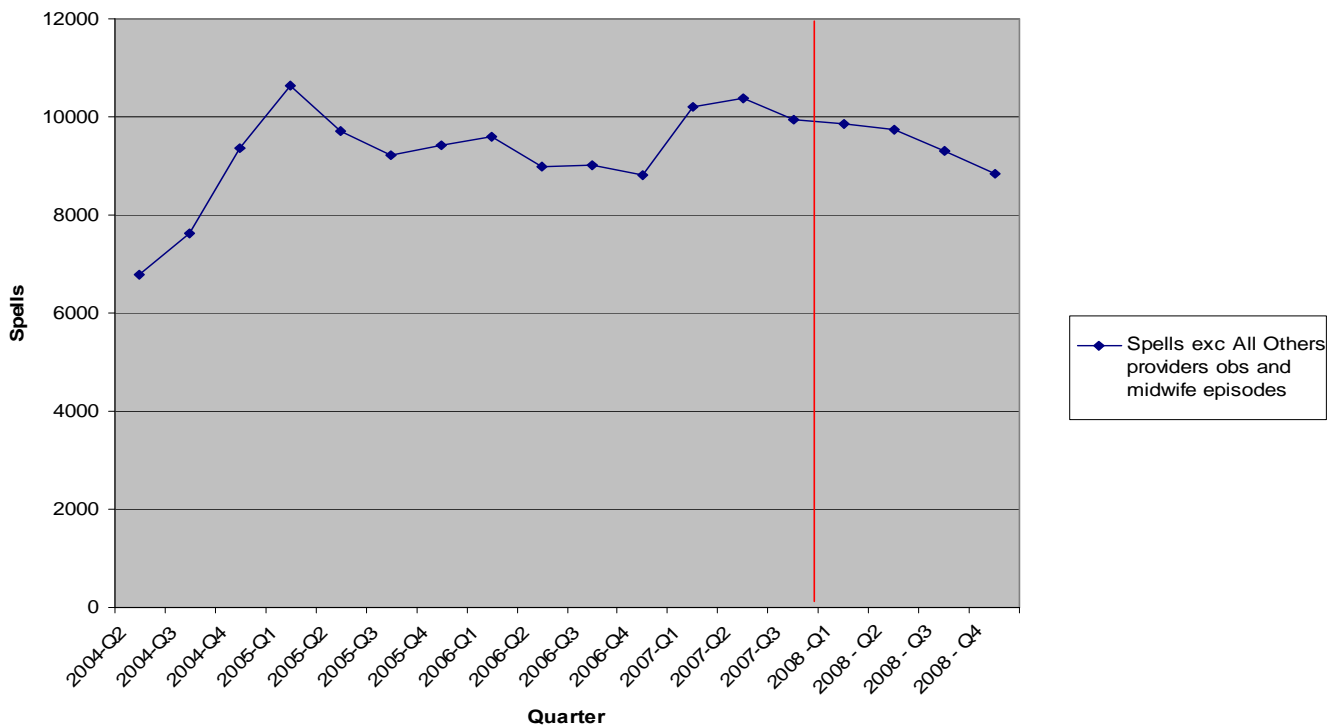
We will commission the South Central Ambulance Service to ensure implementation of the 'call connect' initiative which will deliver quicker ambulance response times.

South Central Ambulance Trust has made significant improvement in its response times to emergency calls. However there is still more progress to be made for our rural population. SCAT is developing a range of new and more flexible services that will ensure achievement of the current national targets of 75% of Category A calls responded to within 8 minutes, and 95% of all Category A and B calls be responded to within 19 minutes.

6.8 Urgent Acute Activity

Based on the schemes outlined above we have planned for a reduction of 4.4% in unscheduled admissions, the effect of this in 2008/09, compared with previous years is shown in the table below

All Urgent care (Non Elective) Activity 2004 - 2008



6.9 Benefits

In summary, the schemes above will deliver real benefit to patients – they will be supported at home wherever possible, which is what people say they prefer; their care will be well coordinated and promptly available day and night and they will have much greater control over their health and healthcare. These schemes also deliver efficiencies to the local health economy.

A number of other system wide solutions require further exploration and integration throughout 08/09:

- Rapid response GP
- Improved access to rehabilitation services
- Community Intravenous (IV) therapy service
- Leg ulcer management
- Further integration of health and social care services

Cost improvements 2008/09

Based on the phasing in of schemes as outlined above we expect these schemes to deliver cost improvements in 2008/09 as set out in Appendix 2.

7 Contracting

The New National NHS Contracts nationally-mandated contract for acute services provides a solid foundation on which to base our relationship with NHS Trusts and Foundation Trusts. The contract introduces new levers to ensure consistent and high quality services for our population, and places emphasis on building long-term productive relationships which encourage both parties to be proactive in managing variance from plans.

During 2007/08 the PCT introduced a programme of work to ensure coding accuracy and minimise invoicing anomalies. This style of working is incorporated in the new contract along with other increasingly commercial approaches which place the NHS on a more even footing with the increasing number of independent providers in the market place.

During the later part of the year we developed stronger and more mature working relationships with our main acute and mental health providers. We see the new acute contract as a tool to cement these relationships further and to lever the benefit for patients and a health system which works together to solve problems in a context of mutual accountability.

During 2008/09 a nationally mandated contract will be developed for Mental Health Trusts, Ambulance Trusts and community service providers. Buckinghamshire PCT has put itself forward as a potential pilot for the development of these new contracts so that we take early benefit of streamlining the business process that comes from having a mandatory contract terms. Being a pilot site for community services will also offer the chance to work for our PBC commissioners to prepare provider services on both the PCT and Primary care for greater levels of independence.

As set out in the Quality section, all our contracts contain quality schedules which contain both process indicators and outcome indicators. Progress against these indicators is regularly monitored to ensure continuous quality improvement. Areas of care currently being monitored include stroke, maternity and coronary heart disease.

We will continue our contract challenges, including the technical and clinical challenges. Technical challenges include areas such as patients who are not the responsibility of the PCT, multiple first outpatient appointments on the same day for the same patient, and multiple inpatient admissions on the same day. An example of a clinical challenge could include looking at the classification of surgically significant debridement of skin - (the removal of damaged tissue to improve the healing potential of the remaining healthy tissue) or re-admission rates. Detailed work has been ongoing with BHT to agree the contracting principles for 2008/09 based on 2007/08 challenges.

We expect the technical challenges to recover £1.9m in 2008/09 based on the assumption that 07/08 challenges will have been agreed and rectified in year. We have agreed with BHT and the other main Trusts that quarterly meetings will be set up with them to review, discuss and agree the challenges that have been set to providers.

We expect the Clinical Challenges in 2008/09 target to recover £0.9m based on the assumption that a contract to carry out the work will be renewed or sourced. The project with BUPA around clinical challenges has identified a number of areas which need further investigation and these will continue until May 2008. Clinical challenges will be undertaken either reviewing patient notes or by sending a questionnaire to Consultants in relation to identified patients.

We expect the Clinical Challenges in 2008/09 target to recover £1m based on the assumption that a contract to carry out the work will be renewed or sourced. The project with BUPA around clinical challenges has identified a number of areas which need further investigation and these will continue until May 2008.

8 Specialised Services Commissioning

At the start of 2007/08 a new Specialised Commissioning Group (SCG) was created for the commissioning of specialised services across South Central. Following a review of the arrangements during early 2007 a number of recommendations were made, and work began on implementing these recommendations. The Business Case for the expansion of the management budget to approximately 0.6% was agreed by PCTs in October 2007.

In 2008/09 the aim is that there will be a substantial change of emphasis with less time spent on retrospective financial reporting and reconciliation and more on prospective financial planning and promoting change. The new contractual relationship with the Public Health Resource Unit (PHRU) will be extended to the Priorities Fora and arrangements made for obtaining pharmaceutical advice and input to the team. The following actions will be undertaken:

- Complete the introduction of Carter – review compliant arrangements for the South Central Strategic Commissioning Group (SCG)
- Ensure competent in-year monitoring takes place of finance and activity in order that budgeted sums are not breached and that PCTs are able to plan in an assured manner.
- Harmonise practices across the SCG area with a view to achieving consistency and equity by 2009/10
- Expand the size and scope of the pooled budget for specialised services across South Central for 2009/10

A range of service specific reviews by the SCG will be undertaken during 2008/09 in the following areas:

- Tier 4 Child and Adolescent Mental Health Services
- Cystic Fibrosis Services
- Burns
- Rare Cancers
- Genetics
- Tertiary Paediatrics
- Broadmoor Redevelopment programme

- High / Medium secure Forensic Services
- Personality Disorder Services
- Perinatal Mental Health Services

Buckinghamshire PCT supports this development programme and will ensure that this work is integrated with its own commissioning. We are keen to ensure the system reform and specialised services commissioning agendas are aligned and used to optimum advantage. We will be looking to investigate further opportunities for cost savings in 2008/09

9 Non Acute Services

With our 'Pooled budgets' and continuing care commissioning our aim is to maintain and extend the progress we have made in 2007/08. In 2008/09 we aim to have improved procurement and reduced inappropriate out of area placements by:

- Formal risk sharing agreement with The Ridgeway Trust regarding the Out of Area Treatments (OATS) spend for people with Learning Disability.
- Consolidation of present range of 28a agreements, campus changes and OATs into one partnership agreement between the PCT, BCC and the Ridgeway Trust for LD services.
- Trialling of domiciliary care for people with continuing healthcare needs through BCC brokerage.
- Appointing eight additional continuing care assessment staff to ensure that assessments and reassessments are conducted in a timely manner. The strengthened team will be focussing on ensuring that the way we commission continuing care services is cost effective and well coordinated, and in line with the national framework for adults and for children when this is published. There are a small number of retrospective reviews that are unlikely to be completed before the end of March 2008 due to late notification of their existence; these will be resolved as quickly as possible.
- Working with specialist providers to obtain best value service for Bucks residents.
- Benchmarking brain injury continuing care spend in south east.
- CAMHS Tier 2 and 3 to be market tested (joint PCT and BCC) to realise performance and cost improvements.

We expect these schemes to deliver cost improvements in 2008/09 as set out in Appendix 2.

9.1 Adult Mental Health Services

In Buckinghamshire both the PCT and Buckinghamshire County Council aim to commission services that:-

- Prioritise better prevention services with early intervention. We will bring in more support to maintain good mental health and emotional well being in the wider community.
- Give people more choice and a louder voice to take greater control over decisions about the way they want to live their lives and the services they need to support them to do this.
- Do more to tackle inequalities and social exclusion that lead to poor mental health and improve access to the services people may require.
- Provide more support in the community for people with long-term mental health conditions, supporting people to manage their condition themselves with the right help from integrated health and social care services.
- Ensure that all providers promote recovery-based mental health services, helping people to realise their full potential and become active citizens within their local communities

Our strategy for this is set out in the 2008/2011 Buckinghamshire Joint Commissioning Strategy for Adult Mental Health¹⁶. To achieve this vision we and our partner are changing our pattern of services to:

- Broaden out the mental health agenda towards inclusion and well-being
- Promote mental well-being through the health and social care system, co-ordinating services to tackle health and social inequalities
- Focus on outcomes being achieved for people and not solely on inputs and outputs
- Reduce reliance on inpatient care
- Develop services which promote recovery, social inclusion and self-determination and reduce social isolation

During 2008/09 the PCT will:

- Work with OBMHT on the implications of the redevelopment of the Manor House site
- Meet the 2008/09 targets for seeing new psychosis cases via early intervention teams, providing crisis support with new Crisis Resolution and Home Treatment Teams (CRHT) episodes, and improving crisis resolution by the continued build up of CRHT teams.
- Define for 2008/09 the implications of improving access to psychological therapies, planning how to implement a stepped-care psychological therapies service, supported by best-practice guidelines. We will carry out a needs assessment of the local population, to understand what level of services will need to be provided; and will take forward the development of an integrated psychological therapy service over a six-year timescale.

9.1.2 Suicide prevention

A mental health and wellbeing strategy is being developed which will integrate the broad mental health promotion aspects of suicide prevention and provide the basis for planned activity on this area.

A suicide action plan has been produced as a response to the last suicide audit in 2006. A Suicide Action Group (SAG) is being set up, meeting in March in preparation for agreeing audit and feedback for the 2007 related data. The suicide audit did not identify any specific common issues in relation to suicide and only a very small number of those who had committed suicide had been in contact with mental health services or identified as self harmers. The main strands of the suicide action plan will be:

- Incorporating suicide prevention in the mental health and wellbeing strategy
- Providing training for GPs on suicide prevention
- Including actions on suicide prevention in the SLA for the Mental Health Trust, including their involvement in the SAG

¹⁶ 2008 – 2011 Buckinghamshire Joint Commissioning Strategy for Adult Mental Health, Buckinghamshire PCT and Buckinghamshire County Council February 2008

- Completing an annual suicide audit
- Explore the feasibility of establishing a real time notification system

9.2 Older people

The Buckinghamshire health economy has a very active Local Partnership Board (which has developed out of the Local implementation Team) to deliver on the objectives and targets of the National Service Framework for Older People. Following on from those initial targets the Partnership Board has identified an ambitious plan for Older People, and key to that planning is the very active involvement of Older People's Champions.

To support that very comprehensive plan the PCT and BCC have a joint commissioning post for older people and expect to have in place during 2008 a joint commissioning plan. This plan will recognise that as a county we expect to have an ageing population with longer life expectancy than the national average. Telecare/ Telemedicine is just one example of modernising services which will provide opportunities for empowering people to be in greater control of their own care.

9.3 Older People with Dementia:

With an ageing population the incidence of dementia is increasing - it spans primary, secondary and mental health care services. Within Buckinghamshire, there are adverse trends in risk factors for disease such as the rising prevalence of obesity, alcohol misuse, physical inactivity which unchecked will lead to a marked increase in the burden of ill-health.

In 2008/09 we will, in partnership with other agencies, update the strategy for meeting the mental health needs of older people and will identify the range and level of services required in future years to meet the growing numbers of people with dementia.

9.4 Learning Disabilities

The PCT has a joint commissioning arrangement with Buckinghamshire County Council for the commissioning of learning disability services, and we will prepare for the transfer of learning disability funding to local authorities, as set out in *Valuing People Now*.

For 2008/09 we will:

- through the Joint Management Group agree local action plans setting out our plans to address the shortcomings identified in the Healthcare Commission's audit.
- Finalise with OBMHT and Ridgeway the plans for closing the Manor House campus and developing and implementing plans with individuals of their care and health needs.
- For CAMHS, consider the implications of providing 24-hour cover for 16 and 17 year olds and for children with learning disability

9.5 Prison Health

Buckinghamshire PCT is responsible for the commissioning of healthcare for three prison establishments within Buckinghamshire, (Aylesbury Young Offenders Institute, Grendon and Springhill). The provision of healthcare at these establishments, and therefore the PCTs commissioning responsibilities, will be an operationally challenging area for the PCT over the year 08/09. Actions include:

- Prison healthcare needs assessment by the public health team, required to inform commissioning.
- PCT commissioning of a new healthcare service to begin in April 2009 at the latest as the prison governors have served notice on prison provided healthcare services. The new service will be opened out to the national market using a standard tender process. It is expected that the service specification will incorporate:
 - primary care medical services including the subcontracting of additional services such as physiotherapy, sexual health, podiatry, etc.
 - new prison working arrangements (4.5 day working week)
 - reducing escort costs through relevant care pathways
 - the challenging issue of TUPE staff.
- Improving the quality of current prison health services and reducing risk using the Prison Health Performance Indicators¹⁷. The first assessment is currently being validated by the PCT with an accompanying action plan to be reviewed by the prison partnership board.
- A new mental health in-reach service has been commissioned for the three prisons in Buckinghamshire which is scheduled to begin on 1st April 2008 and will therefore require appropriate and robust performance review.
- The addition of hardware and clinical systems to support clinical working and data capture following the introduction of an IT infrastructure for the prisons during 2007/08.

¹⁷ National Offender Management Service, & DH October 2007 Prison Health Performance Indicators

9.6 End of Life Care

The National Strategy for 'end of life' care is set out in the NHS End of Life Care Programme which aims to improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice. The proposed outcomes of the programme are:

- Greater choice for all patients in their place of care and place of death;
- Decreased numbers of emergency admissions for patients whose preference is a home death;
- Decreased numbers of patients transferred from a care home to district general hospital in last week of life;
- Generalists skilled in the use of care models to improve end of life care.

Central to the delivery of this change will be the development of rapid-response services and coordination centres;

The PCT aims to commission and provide services which deliver these aims. Currently the PCT commissions services from:

- Florence Nightingale Hospice at Stoke Mandeville
- Sue Ryder
- Ian Rennie
- Macmillan

In 2008/09 the PCT will:

- Build on our baseline reviews of end of life care services,
- Consider the implications of the DH *End of Life Strategy* to be published in summer 2008
- Consider the development of rapid-response services and coordination centres

10 Conclusion

We believe this plan shows how in 2008/09 the PCT will make significant progress to deliver our stated vision to improve the health and well being of our population by purchasing services and leading partnerships to:

- Ensure that people get effective, timely and appropriate healthcare when they are sick
- Reduce health inequalities
- Prevent avoidable ill health
- Help people take care of themselves
- Promote healthy communities
- Ensure the best use of every pound invested in us by the tax payer and manage within the total financial resources available to us