

**QUARTERLY REPORT:**  
**STRATEGY AND REDESIGN**  
October 2008 to January 2009

**1.0 Purpose**

To update Board Members on the work programme of the Directorate of Strategy and Redesign for the Quarter 1st October 2008 to 1<sup>st</sup> January 2008.

**2.0 Introduction**

This is the twelfth directorate report from the Director of Strategy and Redesign to the PCT Board.

This report includes updates and progress on all major activity of the directorate for the quarter including;

- Pan Birmingham Adult Mental Health Services
- Unscheduled Care
- Pan Birmingham Sexual Health and HIV Services
- End of Life
- Chronic Disease Systems: Birmingham OwnHealth<sup>®</sup> Health and Work/Cardiac Network
- Children, Young People and Family Services
- Localities
- Complex Care
- Substance Misuse
- Learning Disabilities
- Services for Older People
- Cancer Services
- Planned Care and 18 Weeks Referral to Treatment
- Stroke

### **3.0 Pan Birmingham Mental Health Services**

#### **3.1 Citywide Joint Commissioning Team**

One Further appointment has been made to the city wide joint commissioning team, Samina Arshad, who is the project manager for the Model of Care for the Heart of Birmingham Teaching PCT

The joint commissioning team is involved in the current work streams around the section 75 pooled budget arrangement between all three Birmingham PCT's and Birmingham City Council.

NHS West Midlands is leading on the implementation of the Yorkshire Cluster model and Payment by Results (PBR) in Mental Health for which the joint commissioning team is an active participant, the completion of this work will lead to full implementation of payment by results by April 2010.

#### **3.2 Citywide Service Developments 2008 - 2009**

##### **3.2.1 Place of Safety**

Commissioners are awaiting an interim short term solution from Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) and a business case detailing the options available for the long term.

##### **3.2.2 Community Personality Disorder service**

The Service will be fully operational by March 2009 in all areas of Birmingham.

##### **3.2.3 Day/Vocational Services**

Commissioning intentions for Mental Health day/ vocational services are being developed in partnership with Birmingham City Council.

##### **3.2.4 Enhancing Primary Care Provision and Improving Access to Psychological Therapies.**

All three PCTs have invested in primary Care provision in the last two to three years. Phase three of this development will close the gap against identified national targets for Increased Access to Psychological Therapies.

This will deliver the final part of the city wide Primary Care Strategy and has been specifically mapped in each PCT area as the gaps in the Stepped Care Model are different in each locality. The national funding for stage three has been agreed with the Strategic Health Authority (SHA) and Care Services Improvement Partnership (CSIP) after the submission of a bid and was awarded £2.5 million over the next three years.

The next step is to employ a project team to lead on the implementation, tender and contracting process over the next twelve months.

### **3.3 Mental Health Services for Older People (MHSOP)**

#### **3.3.1 Community Enablement and Recovery Team (CERTs)**

The Specification for the citywide service has been agreed and recruitment for the team has commenced.

#### **3.3.2 Memory Assessment Service**

The specification for the citywide service has been agreed and the commissioning team is waiting for financial approval from the Directors of Finance.

#### **3.3.3 Future Local Delivery Plan (LDP) Priorities for 2009/10 include:**

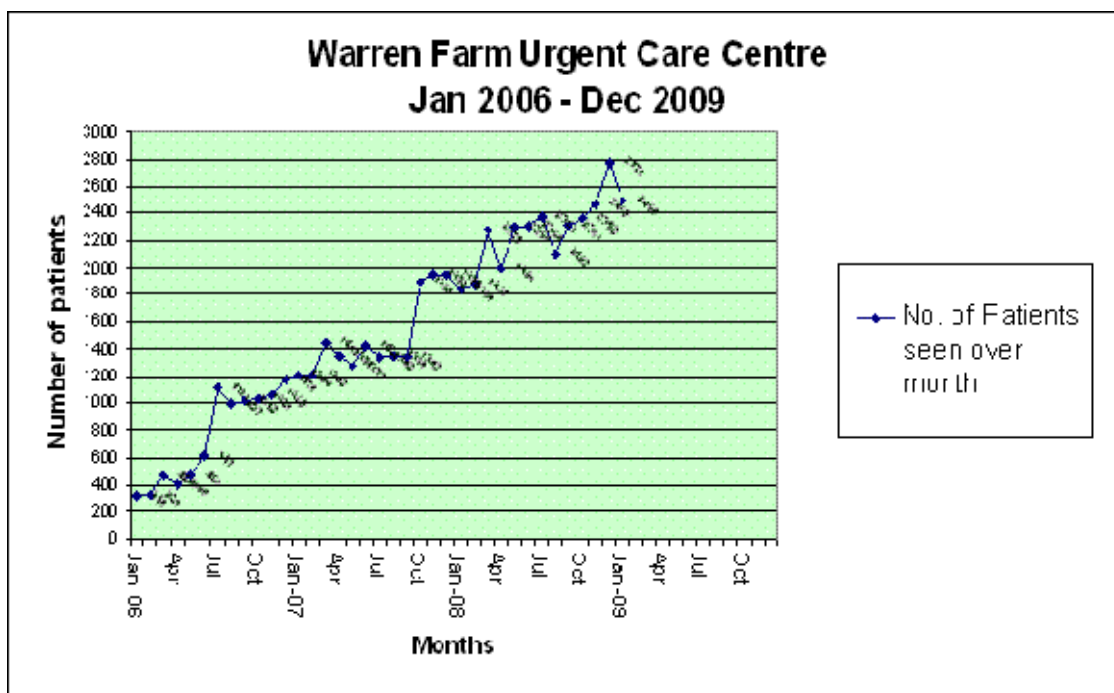
- Independent Mental Health Advocacy
- Older People Mental Health (OPMH) - Memory Assessment Service
- Older People (OPMH) – Nursing Home Liaison/Continuing Health Care Assessors/Challenging Behaviour Service
- Community Offender Management service
- Service User Expert panel
- Improving Access for the Chinese Community
- Respite Service aligned to the Home Treatment Teams
- Enhance Primary Care Mental Health tier two/three
- GP Local Enhanced Services (LES) payments for Heart of Birmingham Teaching Primary Care Trust (HoBtPCT) model of care
- Primary Care Mental Health Service for the Deaf
- BENPCT Support Time Recovery workers
- Continuation of the Barbershop project magazine
- IRISH Welfare and Information Centre
- Computer Aided Cognitive Behavioural Therapy (CCBT)
- Irish Older Adults Day service

**4.0 Unscheduled Care**

4.1 During December 2008 and January 2009 the whole urgent care system has been experiencing high levels of demand, felt most acutely by A&E departments with 18% higher conversion to admissions from A&E at Heartlands Site and 21% higher at Good Hope Hospital than expected at this time of year. West Midlands Ambulance responded to 5158 incidents across the Birmingham East and North area during December this was 4.9% higher than planned.

4.2 The PCT has been supporting the trusts to relieve pressure where possible through alternative pathways, increased use of the Urgent Care Centre (UCC), better use of the alternative pathways available in primary care and increasing the capacity of community beds. NHS Direct have also been commissioned by the Department of Health (DoH) to provide a diversion scheme for appropriate category C calls made to ambulance services.

During the winter pressures, the PCT supported the funding of an extended team at the Urgent Care Centre in Kingstanding to increase capacity and therefore utilisation by both patients but also ambulance crews diverting patients from A&E to the UCC. The graph below details the steady rise in activity experienced at the Urgent Care Centre, including a high peak in activity during December 2008.



**4.3 The Urgent Care Project**

Birmingham East and North Primary Care Trust (BEN PCT) and Solihull NHS Care Trust are working in partnership as a demonstrator site for a Department of Health, Payment by Results (PbR) project called the Urgent Care Project. The project is now at a stage where two options have been agreed in principal, by the Programme Board for testing. Both services will start in April 2009 and will be initially tested for

12 months. the two options were developed following extensive scoping through GP practice and urgent care provider visits, interviews, eleven patient focus groups, financial and activity modelling, and a visioning event that brought all providers together to create the vision for urgent care across Birmingham East and North and Solihull.

#### **4.4 Primary Care Discharge Unit at Good Hope Hospital**

BEN PCT will develop and lead the implementation of a Primary Care Discharge Unit (PCDU) admission avoidance scheme at Good Hope Hospital to test a model which will focus on reducing medical short stay admissions. The PCDU will be led by a senior GP and will be supported by a multi disciplinary primary care team including intermediate care, drug and alcohol workers, social workers, therapists, assertive case managers and admission avoidance nurse. The unit will afford the opportunity to ensure enough time is available to plan comprehensive and co-ordinated discharge.

The team, which includes support from South Staffordshire PCT, will work with A&E staff to ensure swift and co-ordinated advice, diagnosis and treatment for primary care patients including assessments by community teams where necessary and appropriate onward referrals for a full discharge package of care if required.

#### **4.5 Solihull NHS Care Trust –Care Homes**

Solihull NHS Care Trust will lead the development and implementation of the second option, which will provide a Primary Care Nursing Service to support care homes in managing their patients. This option will be tested in Solihull and two care homes have been identified to take part.

The service will endeavour to provide increased management and treatment of conditions presented by the residents, provide early intervention in an appropriate setting, avoid unnecessary hospital admissions and provide education, advice and support to care home staff. Clear links with GP practices and full integration with Solihull's Single Point of Access will be created and maintained as a fundamental part of this service.

#### **4.6 Ambulance Service and Out of Hours Providers Diversion Scheme**

The pilot continues to test pathways that divert appropriate patients calling ambulance services with primary care problems to OOH GP service providers to provide primary care interventions at: treatment centres, urgent care centres, in patient's homes (if they are housebound) or by telephone to support self care. The initial pilot phase was extended in November 2008 to cover the winter period although low referral numbers continued.

In response to winter pressures and the increase in activity during December 2008, the out of hours providers were temporarily commissioned by the PCT to provide the Category C diversion scheme during the "in hours period" in addition to out of hours. This resulted in an increased utilisation of the scheme with a total of 168

calls handled for BEN PCT alone, with 142 of calls dealt with in the period 12<sup>th</sup> December 2008 to 21<sup>st</sup> December 2008. However, on 21<sup>st</sup> December 2008, the Department of Health commissioned NHS Direct to deal with the national increase in activity for Category C calls which has resulted in a dramatic decrease to twenty-six calls handled by the out of hours providers during period 22<sup>nd</sup> December 2008 to 25<sup>th</sup> January 2009.

The project team, which include Solihull Care Trust, South and HOB PCT's, are currently analysing the activity, outcomes and call volumes from both NHS Direct and the out of hours providers and will make a decision on the preferred scheme to be commissioned from April 09 based on the most appropriate outcomes for patients.

#### **4.7 Insight for A&E**

The project to extend Insight (the referral management tool currently in use in GP practices) to include A&E attendances and emergency admissions data has been completed. Further functionality to the tool including easy tracking of emergency admissions including those for ambulatory care sensitive conditions have been made. ACMs have also received training on the tool to support their joint work with practices in admission prevention.

#### **4.8 Ambulance Turnaround**

There is a requirement to improve ambulance turnaround following the Strategic Health Authority's Turnaround Review. Commissioners have developed an action plan for improvement with Heart of England Foundation Trust and West Midlands Ambulance Service following a service improvement event led by the PCT commissioners with good engagement from both providers.

At Heart of England Foundation Trust sites progress was steadily improving prior to the sudden unexpected increase in demand.

### **5.0 Pan Birmingham Sexual Health & HIV Services**

5.1 The city wide Sexual Health Strategy consultation closed on the 22<sup>nd</sup> of December 2009. A wide reaching communication approach to the consultation was used through face to face forums and a text messaging service. A total of 2,300 responses were also received from an outreach session that took place on Saturday 6<sup>th</sup> December 2009, Bull Ring Shopping Centre, Birmingham. The total number of responses to the consultation was 4,635. The analysis of the findings is underway. The final version of the Commissioning Strategy will be submitted to the PEC and Board in April 2009.

5.2 Citywide Reproductive Sexual Health Services have been chosen as one of six national pilot sites for the development of the payment by result (PbR) tariff for contraceptive services they will lead on the development of the data set.

5.3 Robust service specifications have been developed for Genito-urinary Medicine (GUM) clinics, Chlamydia Screening and Contraceptive Services to support the

redesign of specialist Sexual Health services as outlined in the commissioning intentions of the Pan Birmingham strategy.

- 5.4 BENPCT has two dedicated youth workers specific to this area of work and is contracted to Birmingham and Solihull Connexions Young People who target pregnant women and young parents. Further work is being undertaken with young people who are deemed to be at danger of 'risky behaviour' targeted around prevention in line with the Teenage Pregnancy (TP) strategy.

## **6.0 End of Life Care Strategy**

### **6.1 End of Life Care**

The Implementation of the investment plan for End of Life Care has continued; 92% of Care homes in BEN have now signed up to the service improvement programme, with 85% of GP practices signed up to Gold Standard Framework.

This month, the Assertive Case Manager's, District Nursing team leaders and community Continuing Healthcare Co-coordinator's are attending a joint event setting out the roles and expected outcomes within the new pathway, and their role in the pathway development. The Director of Nursing, Val Jones and Head of Psychological services for the PCT, Patrick Hill are working with the commissioning team to agree a workforce development plan for the next three years. The project plan for implementation of the managed care pathway is on target.

In February 2009, the BEN PCT service improvement lead for End of Life Care, Marion Gouveia and a care home in BEN are presenting at a major National council of Palliative Care conference in London on the innovative work to improve the quality of End of Life Care for people with dementia started within the PCT.

Kingstanding locality have been accepted as one of three National pilot sites for the development of End of Life Locality registers by the National End of Life Care team, the pilot begins with an event in London on 9 February 2009.

- 6.2 The Commissioning Manager is in the process of developing the specification for commissioning a whole EOLC pathway, which will be put out to tender towards the end of 2009. In 2009 the District Nurses (DN) and Assertive Case Managers (ACM) will be supported to develop their role as central to the new pathway.

Specific developments for 2009 include:

- The establishment of a multidisciplinary EOLC team, including Clinical Health Psychology: An Action Learning Set for the DNs and ACMs is being planned in partnership with HSMC in order to develop the staff skills and confidence in EOLC and also to provide the opportunity for them to feed their experience into the development of the service.

## **7.0 Chronic Disease Systems: Birmingham OwnHealth<sup>®</sup> Health and Work/Cardiac Network**

### **7.1 Long Term Neurological Conditions**

The NSF Long Term Conditions Implementation Group has continued to meet on a monthly basis in order to make significant impact in the implementation of the NSF, which was published in 2005.

The group continues to focus on three main areas:

- Parkinson's Disease
- Epilepsy
- Multiple Sclerosis

The implementation group has representatives from health and social care from within the PCT and from Heart of England Foundation Trust (HoEFT).

### **7.2 Epilepsy**

Commissioners are currently reviewing the service provided for BEN PCT and working with the "provider arm", in order to resubmit the business case for a Clinical Nurse Specialist (CNS) in epilepsy management.

The PCT also commission services from HoEFT and City Hospital, the specifications will need to be reviewed as part of our work programme. In terms of medical clinical leadership, Dr E. Saulle (Neurologist at HoEFT) is a specialist in epilepsy and has some innovative ideas of how to move the service forward. The PCT will be working with him and his team to develop these ideas as part of pathway development.

### **7.3 Multiple Sclerosis**

Since the MS stakeholder's day in September 2008, the implementation team have been working on the 'quick wins' identified by the stakeholders, namely:

- Information leaflet to be given to the patient on diagnosis
- Improving GP awareness, with a proposed "awareness workshop and lunch/supper" in-conjunction with the MS society

Contact will be made with the professional development unit to discuss the proposal and thereby meet the training needs of the GPs within the region.

A questionnaire was distributed to all patients who attended the day to evaluate its usefulness. In response to this we have been able to identify patients willing to form

a focus group, who will review the work carried out by the implementation group to ensure that the NSF is being developed in response to the needs of the patients.

Design work will be carried out regarding commissioning pathways of care, using models from the MS Trust, Pathway for Health and Map of Medicine

Links will be made with the Adults and Communities Directorate of Birmingham City Council (BCC) regarding their physical disability pathways and how the PCT can co-ordinate both pathways to provide a more efficient and seamless service.

This will require joint working with Heart of England Foundation Trust to clarify the diagnostic phase of the pathway and subsequent branches of pathway.

## 7.4 **Parkinson's disease**

Maggie Johnson, Parkinson's disease (PD) specialist nurse has joined the NSF implementation group. An evaluation of the PD services currently offered to patients within the PCT will be undertaken.

A database of a small number of Parkinson's disease patients under the care of Dr Wallis is held by PD team at Heart of England Foundation Trust.

Unfortunately, the database does not cover the whole of the health economy as this would provide valuable data as to the population of patients currently with a diagnosis of PD.

There is work underway:-

- To contact GP practice managers to ascertain number of PD patients within each practice.
- To work alongside the provider arm to commission and deliver the appropriate level of service for this patient group

## 7.5 **Clinical Health Psychology in Birmingham East and North PCT**

The Clinical Health Psychology service (1.0 wte) is currently split:

PCT Provider arm Multidisciplinary Pain Clinic (MDPC): six sessions for the MDPC

PCT Commissioning team; Chronic Disease Systems: four sessions providing Clinical Health Psychology consultancy to commissioning managers, particularly End Of Life, Stroke, Complex Care, Improving Health Increasing Employment Partnership programme, and Birmingham Own Health and Health Incentives projects.

## 7.6 **Commissioning**

### 7.6.1 **Long Term Conditions Strategy Group ( Darzi)**

Clinical Health Psychology is contributing to the design and implementation of the stakeholder involvement in the development of the LTC strategy.

A model for the LTC strategy that can serve as a basis for behaviour change at a population level will be developed.

### 7.6.2 **Complex Care**

Clinical health psychology will provide a consultation service to support the management of Complex cases. The training needs of the Complex case team will be scoped and a programme of CPD to increase psychological knowledge and skills will be developed.

### **7.6.3 Improving Health – Increasing Employment Partnership Programme**

Clinical health Psychology has input to the review of the pilot Pathways to Work programme (07.01.09) and is contributing to the working group setting out proposals for future partnership work in this area.

### **7.6.4 Birmingham Own health and Health Incentives projects**

Consultation support will be made available to both these projects as required.

## **7.7 Birmingham OwnHealth**

Under the direction of the Care Programme Management Board the service continues to develop in terms of expansion across the PCT and extension of the type of conditions that can be supported. For example – at relatively short notice after being asked by the PEC we introduced a protocol to deal with Winter Warmth issues. In the longer term we will be offering ‘modules for chronic kidney disease, stroke/ Transient Ischemic Attack (TIA) and the ‘at risk elderly’. The PCT are also in an early design phase for a pilot of personal health budgets with a group of both members.

The PCT have undertaken a major initiative to increase recruitment into the service from the Sutton Locality and all the Practices are now either actively enrolling, about to enrol or booked for sign-up. A local meeting between the localities’ Practice Managers, the Locality Team and Birmingham OwnHealth staff to discuss recruitment issues had taken place. Sutton Locality will also benefit from two “BOH” Health Trainers and a PCT “BOH” Staff Nurse that will be working with members enrolled in the service. This is an exciting addition to the service that will enable face to face support to complement telephone-based care.

The PCT Chronic Disease Management Team now consists of a Programme Manager and two vacancies into which we are recruiting, namely an Engagement and Communications Manager and a Business Support Manager. These posts are vital to ensure BOH enrolment process is increased to membership levels of 27,000 members by 2012.

The CPMB has received the initial Year two evaluation findings. These are being finalised and prepared for publication and will be the subject of a full report to the Board in March/April 2009.

Assistive Technology-telehealthcare is now being tested. Processes for full deployment and installation of all equipment to support the Asserative Case Management service are underway.

The PCT continue to raise the profile of this service locally, regionally, nationally and internationally. The PCT has recently received visits from both NHS Barnsley a delegation from Sweden – Stockholm Council, and Spain.

## 7.8 **Chronic Obstructive Pulmonary Disease (COPD)**

Commissioners are currently in the process of preparing a specification for the market testing of a managed care pathway for COPD. This process will ensure that the service commissioned is contracted through a single supply chain (a number of providers) that has the capacity to deliver all aspects of the care pathway for patients with this condition, from screening and case-finding to palliative care.

Commissioners are working with the procurement team to undertake the process of competitive dialogue which will ensure that this specialist service is commissioned in a way that addresses all aspects (this diagnosis) and meets both current clinical standards and those on the horizon.

Whilst there is a community service in place and a pilot through localities it is recognised that in order to address the real needs of patients and their relatives we must commission a service that delivers or links into all aspects of the pathway.

A pre-tender meeting is planned for the end of March to begin the procurement process, this meeting is an opportunity to stimulate the provider market and share the PCT vision for this service

## **8.0 Children , Young People and Family Services**

### 8.1 **Children's and Adolescents Mental Health Services**

The final draft of the five year pan-Birmingham Children and Adolescents Mental Health Services CAHMS strategy is completed.

### 8.2 **Family Nurse Partnership**

BEN PCT has submitted a bid to be part of the Family Nurse Partnership pilot. The PCT has been successful and will receive funding and support to deliver the program. The focus of the BEN proposal is to work with young mothers under the age of 18 in targeted wards with a particular emphasis on young women who have little or adverse social/ family support evidenced through the maternity social risk assessment tool developed in the PCT. The two priority wards for the project would be Shard End and Kingstanding where the work would develop our existing innovative work with children's centres particularly the extension of the Neighbourhood Regeneration Fund (NRF) project for an enhanced midwifery service in deprived areas with unacceptably high perinatal mortality. The PCT will also be seeking to test out the organisational fit of the FNP intensive intervention model with the PCT's redesigned health visiting service based on progressive universalism centred on a quality and outcomes framework.

### 8.3 **BEN PCT Strategy**

A strategy group for Children, Young People and Families Services has been set up and a draft strategic commissioning plan is now developed. A stakeholder event is

due to take place on 5<sup>th</sup> March 2009 where we will consult on the intentions within the strategic plan before a final draft can be submitted to PEC/Board for approval.

## **9.0 Locality Reports**

### **9.1 Shard End, Stechford & Yardley North and Sheldon Locality**

#### **9.1.1 Local Commissioning Development Plan Refresh**

Locality Management Team to discuss with Locality Board LCDP refresh in the context of PBC re-invigoration.

#### **9.1.2 Practice Based Commissioning Re-invigoration**

Kings fund report circulated to practices, Dr Pattni to engage clinicians to participate in planning meetings scheduled for March 2009.

#### **9.1.3 Anti coagulation redesign**

Clinicians attended national anti-coagulation conference in December 2008. Hub practices are continuing to transfer patients into the primary care service. Update from all practices to be presented at February 2009 Locality Board meeting.

#### **9.1.4 Prescribing**

The Locality continues to support work around prescribing and has added support to the antibiotic reduction scheme. Practices have responded well to the prescribing incentive scheme and are committed to continuing with the prescribing work and focus, progress will be reviewed at the locality prescribing sub group in February 2009.

#### **9.1.5 Obesity**

Orders for weighing equipment, funded from PBC efficiencies created in 2007/08, will be placed in February 2009. Obesity sub group, with support from Health Improvement will meet in February to discuss work plan moving forward.

#### **9.1.6 Leg ulcer telemedicine**

Wound Care Logistics (WCL) continues to work with BENPCT provider services and specialist tissue viability teams to implement telemedicine across the patch. District nursing team update of software is in line with trajectories. WCL to support practice nurses with increased in house support. Gateway three scheduled for April 2009.

### **9.1.7 Support to Vulnerable Elderly**

The locality is working in partnership with Birmingham City Council to jointly fund a good neighbour scheme that will support vulnerable elderly patients through a volunteer and advocacy network. The scheme has now rolled out across BEN and Freshwinds, who run the scheme, have had an excellent response to advertisements for volunteers, and are accepting referrals from elderly patients requesting support.

### **9.1.8 Teenage Pregnancy**

The Locality is working with the PCT Sexual Health Commissioners and Teenage Pregnancy Lead to work on proposal to reduce teenage pregnancy rates in Shard End. Proposals including commissioning youth development worker who will link to local schools and community groups to sign post teenagers to contraception services and sexual health clinics and a nurse led sexual health clinic based at the Harlequin Surgery in Shard End, have been successful at gateway two. Both schemes of work will go live in April 2009.

### **9.1.9 PBC Data Analyst**

Data analyst is now in post and supporting practices in understanding PBC information and use of CBSA system.

## **9.2 Sutton Locality**

### **9.2.1 LCDP Refresh**

Locality Management Team to discuss with Locality Board LCDP refresh in the context of PBC re-invigoration.

### **9.2.2 PBC Re-invigoration**

Kings Fund circulated to practices, Dr Pattni to engage clinicians to participate in planning meetings scheduled for March 2009.

### **9.2.3 Anticoagulant Service**

Eight practices have now gone live with the service. The remaining four practices are being pressed for go live dates before the end of March 2009. Key clinicians attended national anti coagulation conference in December 2008.

### **9.2.4 Birmingham Own Health**

All practices are now actively engaged in Birmingham Own Health and will all be actively recruiting patients by March 2009. A practice manager BOH commissioning forum has been established.

### **9.2.5 Support to Vulnerable Elderly**

The locality is working in partnership with Birmingham City Council to jointly fund a good neighbour scheme that will support vulnerable elderly patients through a volunteer and advocacy network. The scheme has now rolled out across BEN and Freshwinds, who run the scheme, have had an excellent response to advertisements for volunteers, and are accepting referrals from elderly patients requesting support.

### **9.2.6 Obesity**

Dr Adam Ismail has come forward to lead the localities work on tackling the rising trend of obesity. A sub group will be formed with the support of Health Improvement.

### **9.2.7 Educational Sessions**

The locality management team has linked to the clinical education group, who have agreed to support a PCT wide learning event on the management of Chronic Kidney Disease.

### **9.2.8 PBC Data Analyst**

Data analyst is now in post and supporting practices in understanding PBC information and use of CBSA system.

## **9.3 Kingstanding and Oscott**

### **9.3.1 Long Term Conditions**

The Locality is currently exploring the utilisation of the King's Fund Patient at Risk of Re-Hospitalisation (PARR) tool to identify patients at the possible risk of being admitted to hospital and work with the Case Managers in managing these patients. A demonstration of the tool has been arranged for February 2009.

### **9.3.2 Reducing Deaths from CHD and Stroke**

The locality is looking to run a pilot for a period of one year to identify individuals' Cardiovascular Disease (CVD) risk and then facilitate an appropriate risk reduction management plan. Currently this piece of work is in the scoping stage and future delivery model will be informed by social marketing outcomes (PRIME).

### **9.3.3 COPD (chronic obstructive pulmonary disease) Service**

The Chronic Obstructive Pulmonary Disease (COPD) specialist nurse continues to work with practices in the locality to manage the care of patients with COPD and identify new patients with COPD. The screening for patients

with COPD pilot has been delayed as the healthcare assistant has withdrawn from the pilot and therefore the team is currently looking at alternative providers to deliver this pilot.

The six week community based pulmonary rehabilitation programme is now in its fourth cohort of patients at Kingstanding Leisure Centre and is now a rolling programme in to order to ensure maximum utilisation of the service.

#### **9.3.4 Community Anticoagulation Service**

The locality has received approval through Gateway two to proceed with the pilot. The pilot involves Sandwell and West Birmingham Hospitals Trust delivering three community outreach anticoagulation clinics in Kingstanding and Oscott wards as part of the first phase. The pilot is due to commence in February 2009 and will run for a period of one year.

#### **9.3.5 Minor Surgery**

The locality is currently reviewing the activity for a number of procedures which can be carried out in primary care. This will inform whether it is financially viable to move certain procedures out of secondary care into primary care.

#### **9.3.6 Reducing Life-Style Risk**

The pilot with Slimming World continues in the locality and patients are actively being targeted by practices to enrol with this service.

#### **9.3.7 A&E Insight**

The new enhancements to the A&E module within the Insight tool went live on 26<sup>th</sup> January 2009. Training for the new enhancements is currently being rolled out to the locality.

### **9.4 Erdington, Tyburn and Stockland Green Locality**

#### **9.4.1 Chlamydia Screening**

The locality is exploring a three prong approach to increasing uptake of Chlamydia. The approach will encapsulate utilisation of incentive scheme for opportunistic screening through general practice, commissioning a youth organisation to opportunistically screen young people between the age ranges of 15-17 years and outreach screening through an external marketing company.

#### **9.4.2 Falls Prevention**

The pilot to identify patients at the risk of sustaining a fall is now almost coming to an end and the evaluation process has begun. This evaluation will

include patient satisfaction through a number of focus groups with the individual risk groups identified in the pilot. The findings from the evaluation will be shared with the Locality Board and recommendations put forward for the next phase of this project.

#### **9.4.3 Reducing Deaths from CHD and Stroke**

The locality is waiting to hear the outcomes of the cardiovascular disease pilots in BSA and Kingstanding locality.

#### **9.4.4 COPD**

The six week community based pulmonary rehabilitation programme is now in its fourth cohort of patients at Pype Hayes Community Centre and is now a rolling programme in to order to ensure maximum utilisation of the service.

#### **9.4.5 Anticoagulation**

The subgroup is exploring the current service provision and enlisting the views of general practices with their views around current and future service provision. In addition to this, views of patients are being gathered. Together these will inform a future delivery models for the locality.

#### **9.4.6 Reducing Life-Style Risk**

As part of the PBC Incentive Scheme, a number of practices have agreed to focus their efforts on increasing the recording of BMI as well as developing individual care management plans for weight management, through the use of the Health Trainer service. One practice in the locality has agreed to review and identify patients who have osteoporosis or may be at the risk of developing osteoporosis and promote lifestyle interventions aimed at improving bone health. Furthermore one practice has agreed to focus on pre-conceptual identification and counselling obese women contemplating pregnancy. All three proposals have received approval through the PCT Gateway Panel and work has commenced.

#### **9.4.7 A&E Insight**

The new enhancements to the A&E module within the Insight tool went live on 26<sup>th</sup> January 2009. Training for the new enhancements is currently being rolled out to the locality.

### **9.5 Bordesley Green, South Yardley & Acocks Green (BSA) Locality**

#### **9.5.1 Sexual Health Services**

The Locality is working with local practices to ensure they have the capacity to deliver Sexual Health in Practice (SHIP) services and will build upon that to enable the provision of enhanced Sexual Health services within the

locality in line with the Sexual Health Strategy. Most practices have sent staff to the 'Getting it Right' training session.

#### **9.5.2 Cardiovascular Disease (CVD) Risk Assessment, Screening and Management Programme**

The Locality has formed a steering group which is planning the implementation of this programme. The programme will involve all 15 practices in the Locality in identifying, risk stratifying and managing all patients, aged 40 – 74 years with a CVD risk. This programme fits with the Department of Health's policy for providing vascular checks. It is anticipated that the programme will 'go-live' in February/March 2009.

#### **9.5.3 Lifestyle Project**

The BSA and Washwood Heath Localities have agreed to jointly commission a weight management and physical activity programme as a pilot to encourage people within the locality to live healthier lifestyles. The programme was formally launched in December 2008 and referrals are beginning to be made into the service; this programme is supported by the Health Trainers.

#### **9.5.4 Insight A&E Scheme**

Fourteen of the fifteen practices in the Locality have signed up to this scheme. The scheme uses real time A&E data to focus practices on patients who attend A&E routinely or/and frequently. The second part of the scheme asks the practice to identify patients who have had an emergency admission through A&E that they suspect could have been avoided.

#### **9.5.5 Good Neighbour Scheme**

The Locality has part-funded this scheme which is working in partnership with Birmingham City Council; the scheme supports vulnerable elderly adults through a volunteer and advocacy network.

### **9.6 Washwood Heath/Hodge Hill Localities**

#### **9.6.1 Mental Health and Well Being Worker**

The Locality has agreed with the Primary Care Mental Health Team to recruit on a fixed one-year contract, a Primary Care Mental Health Well Being Worker to work with people who have long term conditions, and initially, the work will be with diabetic patients; this is work in progress.

#### **9.6.2 Lifestyle Project**

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programme was formally launched in December 2008 and referrals are beginning to be made into the service; this programme is supported by the Health Trainers.

### **9.6.3 Insight A&E Scheme**

Nine of the fifteen practices in the Locality have signed up to this scheme. The scheme uses real time A&E data to focus practices on patients who attend A&E routinely or/and frequently. The second part of the scheme asks the practice to identify patient(s) who have had an emergency admission through A&E that they suspect could have been avoided.

#### 9.6.4 **Good Neighbour Scheme**

The Locality has part-funded this scheme which is working in partnership with Birmingham City Council; the scheme supports vulnerable elderly adults through a volunteer and advocacy network.

### **10.0 Complex Care**

#### 10.1 **Care Packages in the Community under £40K per annum**

Care packages in the community with an annual cost of under £40K per annum are currently managed by South Birmingham PCT. Following agreement of the Directors of Resources and Commissioning across the City, it has been agreed that these cases will transfer to BENPCT under the portfolio of the Complex Care Team.

Whilst it was originally agreed that the transfer would take place on 1 January 2009, this will now slip to 1 April 2009. Currently BENPCT are in discussion with SBPCT in order to establish an agreed process and pathway for these applications. This will be shared with all stakeholders during February in readiness for implementation from 1 April 2009.

#### 10.2 **Service Specifications and Contracts**

Meetings are taking place during January 2009/early February 2009 with independent providers, and the complex care nursing service provided by SBPCT to discuss the service specifications recently developed for these services.

Work is ongoing with the development of the introduction of the national contract for community services. Staff is attending regional training sessions for this during February 2009.

#### 10.3 **Funded Nursing Care and Supporting Team of Lead Nurses**

The transition of the continuing care assessment team and funded nursing care assessors has now fully taken place from the Provider Arm of the PCT into the Complex Care Commissioning Team. This is proving beneficial to the PCT as there is a clear interface with commissioners and has improved the pathway for BENPCT residents who have complex care needs.

#### 10.4 **Partnership Working**

The PCT are continuing to work with our partners in the local authority developing a joint resolution policy and an agreed joint action plan for continuing NHS health care. This will address the issues relating to the assessment and appeal process, and also how we can improve the joint issue of public and patient involvement. It has been proposed that a joint City wide steering group is established to take forward these actions.

## 10.5 **Activity and Projection of Complex Care Cases**

There has been a significant increase in the number of continuing NHS health care cases agreed during the period 2008/9. Over this time period, the increase has averaged out at 48% as predicted following the launch of the National Framework for Continuing NHS Health Care and Funded Nursing Care in October 2007, particularly with the move to one banding of funded nursing care as opposed to previously three. Prior to 2008/9 we had completed a financial modelling exercise which forecasted the increase in both activity and allocated budget. It should be recognised that the number of continuing NHS health care cases has increased at a national level.

## 10.6 **Appeals**

During the last quarter there has been an increase in the number of appeals for continuing NHS health care, particularly for case in the Acute Sector. The increase can partly be attributed to the ongoing media attention on the general public having to pay for nursing home care.

## 10.7 **Managing the Market**

Complex/Continuing NHS Health Care is recognised at a national level as being a challenging area to manage. The Complex Care Team priority is to have in place service specifications in order to facilitate the introduction of the national contract. Existing services will be reviewed over this period with the intention of simulating the market for further providers during 2009/10.

## **11.0 Substance Misuse**

### 11.1 **Drugs**

The lead commissioner for the Birmingham Drug and Alcohol Action Team (BDAAT) is now in post and has now drafted a strategic summary for the adult treatment plan 2009/10.

The finance strategy has been presented, and follow up meetings with all Primary Care Trusts have now been completed.

Numbers in Treatment - quarter three shows amber - but BDAAT analysis indicates only eleven people under target at this stage and have commissioned further targeted action and initiated specific internal BDAAT activity to focus attention on maximising effort on achieving the national target.

### 11.2 **Alcohol**

Procurement of Tier two alcohol services is now complete and awaiting Joint Commissioning Group agreement. A report is to be submitted to the Heart of Birmingham PCT's Executive Board for approval on 12<sup>th</sup> February 2009.

## **12.0 Learning Disabilities**

### **12.1 Second Phase Notice to Quit**

Work is well advanced to appoint new care providers for a selection of care homes and care homes with nursing following the notice served by the current care provider South Birmingham Primary Care Trust.

### **12.2 Partnership Working**

Following the decision by The Executive Group of The Birmingham Health and Wellbeing Partnership that Learning Disabilities will be commissioned via a pooled budget arrangement under Section 75 of the National Health Services Act 2006 with Birmingham City Council acting as lead commissioner the independent project lead is currently developing an action plan. In line with DOH guidance the transfer of social care funding from the PCT to the Local Authority will be complete by 1<sup>st</sup> April 2009. Work is on-going to support the local authority in managing its Learning Disability cost pressure.

### **12.3 NHS Campus Project**

Work to resettle the remaining twenty-one individuals currently living in provision that has been designated as an NHS Campus is well advanced. Nine individuals have placements identified and transitional work has commenced. Work continues to identify appropriate placements for the remaining twelve.

### **12.4 Service Specifications and Contracts**

Service specifications are in the final stages of development for NHS contracts.

### **12.5 Healthcare for All**

Discussions with the Local Medical Committee (LMC) are continuing with regard to the implementation of a new Direct Local Enhanced Service.

## **13.0 Services for Older People**

### **13.1 Redesign of Intermediate Care**

The BENPCT day and bedded Intermediate Care services moved into the two newly opened Care Centres in Perry Common and Sheldon in quarter three. The move had been delayed by the need to upgrade the emergency call system in the Care Centres. In the interim period, temporary facilities were set up with the City Council at the Florence Hammond Care Home.

Consultant geriatricians continue to be actively involved in the Intermediate Care Services including working with the PCT on the market testing process to appoint General Practitioners (GPs) under a Locally Enhanced Service (LES) agreement to each of the Intermediate Care units.

### **13.2 Delayed Transfers of Care**

The usual pattern of Interim Care services, providing convalescence for people in nursing homes and care homes, continue to be commissioned for people awaiting their next move to become available. In addition a thirty-one bedded Enhanced Assessment Unit was set up at Berwood Court Nursing Home and an eight bedded Unit at the City Council Florence Hammond Care Home for the period January to March 2009 to enable people with complex needs to be discharged from Heart of England Foundation Trust (HoEFT) quickly and undergo multi disciplinary assessment in an unhurried way in a community setting. Both Units receive input from a Consultant Geriatrician, Community Nursing and Therapy, Social Workers and a GP under a locally enhanced service agreement. Early indications show that a number of people have been enabled to return home with a revised care package and admission to long term institutional living was avoided.

### **13.3 Health Care in Nursing Homes**

Joint work, in quarter three, with the City Council to revise the Tripartite Contract for the commissioning of Nursing Home services was successful in creating a robust and transparent set of schedules defining the standards and expectations of health care. The revised Contract is currently subject to a period of consultation with providers that will end in February 2009 and is expected to be in place from April 2009.

BENPCT has worked closely with the City Council to address safeguarding issues that have arisen in Nursing Homes and to agree a more streamlined approach to the de-commissioning of unacceptable services. Importantly, a comprehensive balanced scorecard system for rating the standard of Homes is being developed jointly that will include the findings of Health Care Commission monitoring and CSCI ratings (Care Quality Commission from 1<sup>st</sup> April 2009). This will form the basis for a City Council incentive scheme to improve standards.

The PCT Steering Group for Nursing Home care continues to monitor health care issues in Homes. It is developing an action plan to raise the standards of health care in the majority of Homes that are currently rated as Adequate to Good or Excellent. The action plan will be part of the key objectives for the Directorate in 2009/10.

### **13.4 Equipment and Wheelchairs**

Both services show a consistent annual shortfall in resources to meet demand and are in the process of review. An external citywide review of the Wheelchair Service was completed in quarter three and the findings are awaited. A parallel review of the Equipment Service is planned for quarter four.

### **13.5 Well-being Strategy for Older People**

BENPCT was an active participant in developing the joint citywide Well-Being strategy that is currently out for consultation. One of the top priorities identified by

older people is for an accessible toe nail clipping personal care service for people too frail or disabled to manage this aspect of their own care. Although the identified need is cosmetic rather than health or community care in nature it does affect the ability of vulnerable people to be independent. The development of a pilot scheme has been led by South Birmingham PCT and the involvement of BENPCT will be sought in quarter four.

### 13.6 Carers

Joint work with the City Council began in quarter three on the best use of the forthcoming PCT Carers Grant. Plans will be ready for consultation with carers and other stakeholders in quarter four.

The BENPCT Carers Support Services will be reviewed and specified in quarter four as part of the Development Plan for the provider arm services.

## 14.0 Cancer Services

14.1 The Local Health Economy Cancer Group has now approved plans to develop workstreams on early detection and prevention in line with the Cancer Reform Strategy. In addition work is being undertaken on screening services, Survivorship and patient satisfaction for cancer services.

14.2 The PCT's service provider for breast screening is in the process of developing plans to move from analogue to digital mammography along with an increase in age range from 50-70 years to 47-73 years. This is being closely monitored by the Cancer Network and the West Midlands Cancer Intelligence Unit.

The target for cervical screening for results to be received within fourteen days from sample being taken is also being progressed as a key piece of work.

14.3 The PCT has been accepted as a test site for the first phase of the National Cancer Survivorship Programme working with NHS Improvement. The aim of the project is to redesign follow up services which are based within secondary care. Current follow up does not meet user need, is expensive and shows no evidence of increasing survival or rates of detection of further tumours.

A stakeholder session has been held and a working group established to deliver the project. The focus is the redesign of breast cancer follows up with the aim of also developing a colorectal follow up pathway. A proposed model has been designed which involves developing a tele-care support service, a key worker based within the community, self-management education programmes and support from the Breast Care Nurses based within secondary care. The aim is to offer a choice of follow up services for patients to empower them to manage their own condition.

## **15.0 Planned Care and 18 Weeks Referral to Treatment**

### **15.1 18 Weeks National Target Requirements**

By December 2008, all trusts will have achieved a maximum waiting time of 18 weeks from referral to start of treatment for 90% of admitted patients and 95% of non-admitted patients. Trusts will be assessed on having maintained this performance during the final quarter of the financial year (January to March 2009).

Trusts will also be assessed against an 18 week maximum wait for direct access audiology patients. These are patients referred into audiology services without a consultant and are outside the scope of the 18 week target but are included as a supporting measure in the Vital Signs published in January 2008.

A data quality test using the Department of Health data completeness methodology will be applied prior to use of the data and assessed over the whole quarter. Failure of the data quality test for admitted, non-admitted or audiology patients will lead to overall failure of the indicator.

### **15.2 Latest performance**

The BENPCT achieved delivery of 18 week referral to treatment times (RTT) for December with 91.32% of admitted patients and 95.06% of non-admitted patients treated within 18 weeks.

There has been an improvement in RTTs across all specialties including trauma and orthopaedics which has been the most challenged specialty with 89.21% of admitted patients treated in 18 weeks in December (November's RTT for admitted patients was 83.83%).

For direct access audiology patients, 99.52% of patients were treated within 18 weeks in December.

Data completeness as reported in November showed that overall this was within the required parameters.

### **15.3 Ensuring the 18 week RTTs are delivered and sustained**

Since November, the PCT has been holding weekly telephone conference calls with the 18 week leads at Heart of England Foundation Trust (HoEFT). A number of key issues have been the focus of discussions and actions have been implemented to ensure that delivery of 18 weeks is achieved through the measurement period of January to March and thereafter sustained. These are:

### **15.4 Capacity**

HoEFT has ensured that capacity is available across all specialties to achieve and maintain the 18 week RTT through the provision of additional clinics, a mobile theatre on Solihull Hospital site and modular wards at Good Hope Hospital for

medical patients so that surgical wards can continue to admit patients during the busy winter period. The Trust has also focused on improving systems and processes across patient pathways, for example, reducing waiting and reporting times for diagnostic tests.

The PCT is leading a number of projects that will improve capacity and sustain 18 week RTTs in the longer term including the redesign of musculoskeletal services.

#### **15.5 Data completeness**

Further work has been required by Heart of England Foundation Trust (HoEFT) to ensure that data completeness falls within the required tolerances for admitted, non-admitted and audiology patients. The changes to the underlying assumptions in relation to activity have been submitted to and accepted by the Department of Health so that data completeness is within the required parameters.

The assumptions for the data completeness for the provider arm have also been revised for approval by the Department of Health and once approved will meet requirements.

#### **15.6 Backlog**

Backlog (the number of patients who have breached 18 weeks owing to patient choice, compliance or complexity) has reduced at HoEFT and current numbers fall within an acceptable limit which equates to less than half a week's work. A regular audit is being carried out by the trust to continually validate the backlog.

Heart of England Foundation Trust (HoEFT) has assured the PCT that it will achieve the RTT for admitted, non-admitted and audiology patients for January 2009 and that this will be sustained. With this assurance and the performance of the PCT's other main providers, there is confidence that the PCT will meet and maintain the 18 week target.

#### **15.7 18 Weeks Patient Experience Survey**

The results of the survey have just been published with 315 Birmingham East and North PCT patients responding completing a questionnaire that was sent out in November last year. The PCT is required to produce an action plan in response to the survey's findings by mid-March and a project group which will include service users is being established to undertake this work.

The survey results and planned actions will be reported at next month's board.

#### **15.8 Planned care commissioning strategy**

Birmingham East and North's strategy for the commissioning of planned care services was approved by the PEC Board in January 2009. A Planned Care Executive Group, chaired by Dr Peter Thebridge has been established to oversee the implementation of the strategy and develop a delivery plan.

Progress with ongoing developments is summarised below:

- **Musculoskeletal redesign project**

The Consultant Led Integrated Knee Service (CLIKS) six month pilot commenced at the beginning of January. This has involved the integration of the consultant outpatients' service, orthopaedic triage service and community physiotherapy service into a single service with one point of access.

Following telephone assessment patients are given an appointment with a consultant, a colocated extended scope practitioner (ESP) and consultant clinic, an ESP clinic or community physiotherapy clinic. It is hoped that the new service will enable patients to be seen quicker and with fewer appointments ensuring that patients receive appropriate treatment without delay. It is anticipated that fewer patients will need to see a consultant thus freeing up capacity and resources for investment in community services.

The next pathways for redesign are the back and shoulder and work is starting with all stakeholders to map and agree the processes for the provision of an integrated service for each pathway.

- **Community urology service**

A consultant led community urology clinic is to be piloted for six months in the Kingstanding locality commencing February. The clinic will have links to the community continence service and as well as providing a local service for patients will provide education and training for GPs on the management of patients with urological problems

- **Dermatology**

The community dermatology service pilot in the East of the PCT is continuing and will be formally reviewed in April 2009.

- **Multidisciplinary Pain Clinic (MDPC)**

Developments in the MDPC prior to October 2008 mean that the MDPC is able to offer Primary Care based medical and physiotherapy assessment and treatment services for people with chronic back pain, referred from the Orthopaedic Triage Service.

The service is currently operating two clinics per week seeing a maximum of twenty one patients per clinic both new and follow-up; these are undertaken in two locations; at The Dove Primary Care Centre (Kingstanding) and Partners in Health Centre (Bordesley Green). This is expected to increase in the coming months as a result of the Sutton Cottage re-opening and other facilities becoming available.

A Clinical Health Psychologist is now in post (0.6wte) which facilitates the service in delivering a full bio-psychosocial assessment of patients within a

single appointment; part of this role includes providing training for physiotherapy staff in Cognitive Behavioural Therapy. Upon securing Pain Consultant sessions from Heart of England NHS Foundation Trust a programme of education and clinical awareness commence linking directly to General Practitioners.

In addition to individual medical and physiotherapy treatments, the service has been running a range of six week functional restoration programmes; Active for Life. There are now eight groups up and running supporting patients who have been assessed and require supportive measures to manage their condition. Each of the groups have been targeted to specific needs i.e. mixed sex, interpreted groups and single sex groups which are provided from a range of locations.

Pain Management Programmes (PMP's) have also been commenced in clinic locations, this model is soon to be extended with the recent publication of The Pain Toolkit, a written booklet for patients who have undertaken a pain management programme and require support in revisiting the tools and coping strategies taught within the programme, this toolkit will be developed into a DVD in a range of languages to improve accessibility.

A major advertising campaign is currently underway within the PCT area using the orange man to convey key messages regarding how to manage back pain and advertise the service; these are currently displayed on bus stops large billboards and taxis. This campaign will be extended with a leaflet to households in the North of the PCT area which will be issued with the next version of Your Guide .The Pain service is also the focus for the next phase for service redesign within the Musculoskeletal specialty this will begin in March 2009.

### 15.9 **Choose and Book**

Choose and Book performance has improved since Christmas with 62% of patient's appointments being booked using the system. The Choose and Book team continue to support practices and any choose and book issues are also being discussed at the practice annual reviews.

The implementation of the direct booking system (DBS) at Heart of England Foundation Trust has been delayed owing to technical reasons. A new timetable for the implementation of DBS is to be communicated and agreed.

## **16.0 Stroke**

### 16.1 **Stroke**

Two pieces of work are currently underway:

- To create a system of identification and urgent care which is auditable, and then follows an easy pathway into emergency care for Transient Ischemic Attack (TIA) and Stroke;

- The tracking of stroke patients through A&E to develop a pathway with prompts that will ensure patients get to the appropriate destination as quickly as possible. This will include end of life care.

16.2 Clinical health psychology will contribute to the development of a local Stroke Care Pathway to develop rehabilitation in the community. A review of current Psychology input to the existing stroke services will be undertaken in February 2009.

### **17.0 Recommendation**

- The Primary Care Trust Board is asked to receive and note the report.