

# **Birmingham East and North Primary Care Trust**

## **Operating Plan 2008 / 09**

**“Working in Partnership to Tackle  
Inequalities and Improve the Health  
and Well Being of Local People”**

## CONTENTS

<b>Executive Summary.....</b>	<b>3</b>
<b>1. Introduction.....</b>	<b>4</b>
<b>2. Context.....</b>	<b>6</b>
<b>3. Public Covenant.....</b>	<b>7</b>
<b>4. Investment Plan.....</b>	<b>10</b>
<b>5. World Class Commissioning.....</b>	<b>12</b>
<b>6. Operational Plan.....</b>	<b>13</b>
<b>7. Governance of Operational Plan.....</b>	<b>47</b>
<b>8. Review and Evaluation.....</b>	<b>47</b>
<b>Appendix A</b>	
<b>Appendix B</b>	

## **Executive Summary**

The following sets out Birmingham East and North (BENPCT) Primary Care Trusts' Operating plan for the year 1<sup>st</sup> April 2008 to 1<sup>st</sup> April 2009.

This Operating Plan describes how BENPCT is going to invest its significant commissioning resources to ensure the development and delivery of services in line with our core purpose and goals that meets the needs of our population. The plan also sets out how the PCT is proposing to deliver improvements against a number of key local and national indicators. These indicators include:-

- National Indicators for Health and Well-Being
- Department of Health Vital Signs

The Operating plan also demonstrates how BENPCT will ensure that the improvements achieved over the last few years are sustainable as well as addressing shortfalls in performance from previous years.

PCTs are increasingly expected to show how they will deliver the “ordinary extraordinarily well” whilst simultaneously developing their organisation, to enable the transformation of health services through the eleven World Class Commissioning competencies; this operating plan describes BEN PCTs approach to delivery of world class commissioning.

The PCTs operating plan also focuses on the joint commissioning of services and the increasingly integrated approach to health and social care through the Local Area Agreement. The plan describes how partners have identified the key indicators for joint work locally and how they propose to ensure operational delivery.

The Primary Care Trust, with its local partners has developed through its Local Health Economy Overarching Vision and Plan, its proposed investments for the next twelve months. This Operating Plan will reference the investments and the future approach to the procurement of services to invest this resource wisely.

This operating plan is for the year 2008/09 however the Primary Care Trust is in the process of developing longer terms plan through the production of a new three year Local Delivery Plan which sets out proposed actions and investments for the years 2009 / 2010 and 2010 / 2011. This is in addition to the Local Health Economy overarching vision and plan recently produced for the period 2008 to 2013.

During the autumn BENPCT will draft its Strategic Plan, which will demonstrate commitment to changing the nature of the relationship we have

with our local population, in order to build confidence and assurance of delivery against our core purpose and goals.

## **1.0 Introduction**

Birmingham East and North PCT (BENPCT) is one of 153 Primary Care Trusts within the English National Health Service. As a PCT it is responsible for the wise investment of public money to secure health improvement, access to health services and where appropriate the provision of health services to a local population of some 438,000 people. Geographically, the PCT covers seventeen wards along the eastern half of Birmingham City Council, Britain's second city and the single largest metropolitan authority in Europe. The registered population is diverse, with significant differences in profile at ward level; Washwood Heath is 70% black and ethnic minority (mainly of Pakistani or Bangladeshi Muslim origin) with less than 15% over 60s and some 30% under 16 year olds; in contrast, Sutton Four Oaks has only 5% ethnic minority (mainly Indian) and 25% over 60s, with only some 15% under 16s. The diversity of demography is reproduced in significant disparities in socio-economic status with no super output area in Sutton in the most deprived percentage for England but 100% of the population in Washwood Heath living in an area falling within the highest 10% deprivation for the country as a whole. Not surprisingly, this disparity is again reflected in significant inequalities in health status and mortality with an over 6 year difference in average life expectancy between the two wards. Whilst these two areas illustrate the most extreme differences, each local area has distinct characteristics, within a majority deprived area.

The PCT is a complex organisation. Its core role of commissioning involves some 150 managers, from both clinical and general management backgrounds responsible for some £630m of investment each year. The PCT also host the specialised services commissioning function for all seventeen West Midlands PCTs and this team of some forty people are responsible for £680m expenditure for which the PCT is budget holder and accountable body. The PCT is the lead commissioner across the city for Mental Health, Learning Disabilities, Sexual Health and Addiction Services. We employ two hundred and sixty staff in Estates, ICT, Finance and Contractor and Financial Services, who work across the city supporting the three Birmingham PCTs and in some cases also Solihull Care Trust. As a provider of Community Health Services, we deliver a range of core Community Nursing Services, Demand Management Services, Rehabilitation, End of Life Care and nurse led urgent care, employing over nine hundred clinical staff from a variety of professions and including a number of medical and non-medical consultants. Many of our staff live or have families locally.

The PCT has a well-established and close working relationship with Birmingham City Council. The CEO has developed and led the Birmingham Health and Wellbeing Executive for the last three years and is a core member of both the Be Birmingham Summit and Executive. The PCT participates actively in employer and economic forums and are a Board member of Digital Birmingham. The PCT manages a range of integrated Intermediate Care

services on behalf of the Directorate of Adults and Communities (Birmingham City Council) and have a joint estate development programme for the future delivery of this rehabilitation focused programme. The PCT has also invested significantly in our relationship with our main acute provider, the Heart of England NHS Foundation Trust, now a single organisation operating through three local hospitals. Our collaborative programme of clinical re-design and improvement (Working Together for Health) has been the subject of academic commentary as a Kaiser Beacon site since 2003 (by Universities of Birmingham, Warwick and Toronto) and has been identified by the University of Toronto as an exemplar of system improvement alongside Jonkopping in Sweden, Veteran's Administration in the USA, Henry Ford Health System and Inter Mountain Healthcare, USA. More recently we have brought our partnership commitment to commercial relationships and are currently exploring appropriate legal forms to recognise our shared investment of knowledge, expertise and time with UK Pfizer Health Solutions and NHS Direct.

The PCT is the local commissioner of primary care services, most of which are provided by small independent contractors. The PCT works with some eighty-two general medical practices of which thirty-three are single partner practices. These practices have been encouraged to collaborate at a local level in six locality groups to deliver practice-based commissioning each covering between 55,000 to 100,000 people. We are in the process of developing our relationships with other key contractors (dentists, pharmacists and opticians), building on our learning with family practice. A number of local independent medical and other practitioners are employed on a sessional basis by the PCT as Clinical Directors or Clinical Leads.

BENPCT has a clearly stated core purpose of 'Working in partnership to tackle inequalities and improve the health and well being of local people' and the PCT has four audacious goals which provide the core framework for investment and development:

- To be so responsive to the population we serve that no one waits for the high quality care they need;
- That the health and well being of the population will have improved so much that people will enjoy 10 more years of healthy life
- That people regard us as the first choice organisation to work with and for;
- Our communities will have the most involved, informed and empowered partnerships in the country

These strategic goals are underpinned by a set of principles which guide how the PCT works. These are that the PCT is collectively and personally committed to:-

- the best interests of the whole and caring about the (perspective of the) individual,
- investing wisely to do the right thing,
- purposeful partnerships,

- Innovation for transformation, committed to maintaining and improving core activities.

To deliver the operating plan BENPCT has recently revised its key strategies which drive delivery of its objectives and sustained improvement. In effect these strategies have been designed for sustained high performance, the strategies are:-

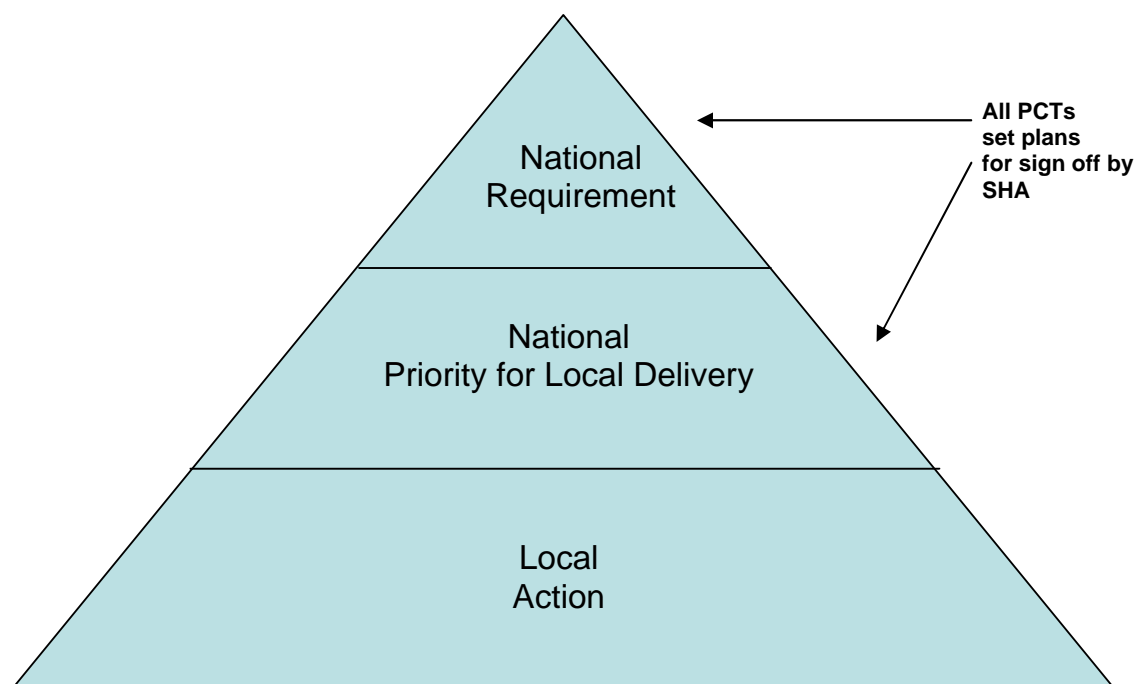
- Quality Safe Services
- Promoting health and empowering people
- Extending Working Together for Health
- (B)RISK Processes (Bold, Redesign, Investment, Sustainability, Knowledge)
- Consistently fit for purpose

All action plans are framed under one of the five key strategies.

## 2.0 Context

One of the key elements of this Operating Plan is to describe how the PCT is going to deliver a number of key targets and improvements to services in 2008 / 09 and not only to demonstrate that there are plans in place but show that those plans have substance. This Operating Plan therefore details plans for delivery of key targets and achievement of service improvements. There are three levels set out in the Department of Health Vital signs document which outline the three levels of target / improvements, these are:-

### Operational Plan-Vital Signs 2008/09



The PCT identifies in section 6 its key actions and risks against all targets/ improvements identified as Vital Signs but in particular the PCT will demonstrate:-

- How target/ improvements which have a national requirement will be delivered
- How national priorities which require local delivery will be achieved and the level of importance attached to each
- How Local targets have been identified and chosen as priorities, whilst demonstrating how these choices link with the Local Area Agreement.

Alongside the PCT purpose, goals and strategies there are a number of other important developments which underpin the production of this Operational Plan. These are:-

- The Joint Strategic Needs Assessment
- The Birmingham Local Area Agreement
- The outputs from the Darzi clinical pathway groups
- The Strategic Health Authority Investing for Health strategy
- The PCTs Commissioning and Financial Investment Strategy
- The PCTs desire to achieve “World Class status” in commissioning
- Organisational Developments including the Provider Services Development Programme

All of the above have been considered in setting out how the PCT plans to achieve the delivery of its operational plan in 2008/09.

### **3.0 Public Covenant**

In setting out the PCTs Public Covenant for 2008/09 it is worth reiterating that the Primary Care Trusts Purpose and Goals underpin this covenant. The covenant is a set of promises and actions that the PCT will make to the public through one of the PCTs core publication (Health News). The key promises / actions for 2008/09 are:-

#### **To be so responsive to the population we serve that no one waits for the health care they need**

- The Primary Care Trusts will commission services to fully implement its strategies for End of Life Care and Rehabilitation Services
- The Primary Care Trust will commission an extension of telephone based care (Birmingham Own Health) to increase access for adults and in particular for the frail elderly during 2008/09 for preventative services to support them. This will be in conjunction with Birmingham City Councils Adult and Communities Directorate

- The Primary Care Trust will achieve the 18 week target from referral to treatment for all its residents by December 2008
- The Primary Care Trust will implement fully in 2008/09 its Pain Management service in Primary Care
- The Primary Care Trust will increase access to Psychological Therapies for people with mild to moderate Mental Health problems
- The Primary Care Trust will increase access to Sexual Health Services through the implementation of its Sexual Health Strategy
- The Primary Care Trust will implement the agreed strategy for Older People with Mental Health problems
- The Primary Care Trust will develop a joint commissioning strategy for the delivery of effective services for the treatment of stroke during 2008/09 with Birmingham City Council and Providers of Stroke services
- The PCT alongside other PCTs and the Children's Trust will develop plans for the commissioning of increased health and social care services for children
- The PCT through its Practice based Commissioners will introduce a number of services in Primary Care during 2008/09 which will increase access and move services closer to an individuals homes for example the implementation of locally based anti-coagulation services and tele-medicine services
- The PCT in conjunction with Heart of England Foundation NHS Trust will build and test out a number of new service models which are integrated to ensure the individual receives a seamless service, for example the development of an integrated musculo-skeletal service with a single point of access

**That the health and well being of their population will have improved so much that people will enjoy ten more years of healthy life**

- The PCT will ensure with patients a reduction in Health Acquired Infections across the economy
- The PCT will support the development and production of the Strategic Joint Needs Assessment
- The PCT will look to commission services with partners that "add life to years and years to life"

- The PCT will work alongside a range of partners and play an active part in ensuring that the improvements set out in the Local Area Agreement are delivered particularly related to reducing unnecessary deaths, reducing smoking prevalence, increasing choice for people with palliative care and end of life care needs, increasing direct payments and individual budgets, reducing the length of time people spend unnecessarily in hospital and increasing support for carers
- The PCT commits to introducing technology in the home both telehealth and telecare in 2008/09 as part of its strategy to support people to look after their own health
- The PCT will continue its increased commitment to identify those individuals at increase risk of developing cardio vascular disease, and then through the implementation combination of lifestyle interventions and treatment reduce the burden of mortality
- The PCT will continue to work to reduce infant/peri-natal mortality and increase male life expectancy

**Our communities will be the most involved, informed and empowered partnerships in the country**

- The PCT will develop and implement a systematic approach to understanding and engaging with its population through the development of strategic partnerships with organisations who have the necessary tools, skills and capabilities to engage and empower populations in a non traditional way
- The PCT will develop an approach to partnering with every member of its population
- The PCT will develop a range of access points provide education and training to enable individuals to self care and manage more effectively there long term condition

**That people regard us as the first choice organisation to work with and for**

- The PCT will implement a wellness programme for all staff which will assist staff in looking after their own Health. This will include the development and testing of a health incentives scheme which subject to its evaluation will be further developed for its use with the general population
- The PCT will develop a workforce strategy with staff which responds to both the staff opinion survey and Ipsos Mori Patient Survey Information

- The PCT will through its workforce development approach look to ensure that the workforce is appropriately developed to meet the future needs of world class commissioning and world class provision
- The PCT will take part in the strategic Health Authorities middle management talent managing programme, to ensure that PCTs has an appropriate number of staff, skilled to deliver the core purpose and goals of the PCT

## **4.0 Investment Plans**

### **Strategic Context**

The Comprehensive Spending Review (CSR) for 2008/09 to 2010/11 announced an increase in the Department of Health (DH) budget of 4% in real terms for the next three years.

This increase will be reflected in the funding passed to PCTs. However, unlike the previous CSR, the DH is yet to confirm the level of growth to be applied to individual PCTs in each of the three years. Therefore the DH has opted to give a one-year, flat rate increase of 5.5% to all PCTs and announce the increases for year two and three at a later date.

### **Sources of growth funding**

The PCTs financial allocation for 2008/09 is an increase of 5.5% and equates to a financial increase of £33.2 million on the PCTs baseline budget, which is then adjusted downwards by national non-recurrent adjustments.

In addition to this increase in the allocation there is a significant level of recurrent funding that was applied non-recurrently in 2007/08, this gives a further £11 million to be used for developments in 2008/09.

Once all the above factors have been taken into account the total level of uncommitted allocation in 2008/09, which can be invested wisely for service developments improvements, is £46.3 million. However it is important to emphasise that the PCT will consider wisely the total resource it can apply to secure improvement.

### **Proposed Applications**

There are three levels to the application of the £46.3 million growth funds in 2008/09 these are under the headings of assumptions, planned applications and specific investments for development of services.

The assumptions are that inflation has been assessed at 5.3% with a requirement for 3% efficiency. The PCT is also planning for £1.9 million surplus in 2008/09.

Planned applications are as follows:-

	<b>2008/09 £000</b>
Inflation	29,092
Efficiency	(16,467)
Secondary Care	8,260
Community Services	6,638
Public Health and Reducing Inequalities	5,449
Primary Care	2,800
Other Investments	8,650
Surplus Target	1,897
<b>Total Funding Available for Investment</b>	<b>46,319</b>

The proposed additional investments for 2008/09 are as follows:-

<b>Area</b>	<b>Intention</b>	<b>Investment £000</b>
Birmingham OwnHealth	Expansion of existing scheme form 2,000 members to 11,000 members in 08/09 and 27,000 members by 2012	4,000
End of Life Care	Commissioning for extended community services and beds outlined in the End of Life Care Strategy	2,500
Intermediate Care	Commissioning for extended community services outlined in the Intermediate Care Strategy	1,500
Pain Management in Primary Care	Full implementation of new services	500
Mental Health	Increase in Primary Care provision	1,100
Sexual Health	Implementation of strategy	600
Older peoples Mental Health	Implementation of strategy	500
Older people	Additional Investment	750
Urgent Care Centre	New Development	350
Children	New investment Joint Commissioning	350
Practice based Commissioners	New developments as outlined in Locality Commissioning Delivery Plans	600

The PCT is presently developing a procurement strategy which will be complete by the 31<sup>st</sup> July 2008.

## **5.0 World Class Commissioning**

BENPCT recognises that to deliver its aspirations the organisation needs to become world class particularly in relation to its commissioning function. The development and introduction of the programme to support PCTs to become world class commissioners has created a major opportunity for the PCT to reflect on its progress to date and to review its strengths and weaknesses in relation to the eleven competencies which have been identified as key areas which PCTs must address to become truly world class. This is a major undertaking for any PCT as there is no where in the world which can truly demonstrate world class commissioning. However the PCT sees the opportunities that this programme gives the organisation to move to the next level of performance and alongside its strategies creates a powerful vehicle for change and improvement.

The PCT introduced a World Class Commissioning Programme Board in January 2008 chaired by a Non- Executive Director. The Board has developed a project initiation document and plan setting out the initial tasks to be undertaken to March 2008. This plan has now been extended to March 2009.

Initial self assessments of the PCTs position in relation to the eleven competencies have been undertaken by Directors and this has identified a number key actions relating to:-

- Knowledge Management
- Patient, Public and Stakeholder engagement
- Systematic use of processes across the organisation
- Organisational design

A significant number of actions are in place to address the above including the procurement of two external organisations one to support organisational development and the other to support the development of a new relationship with patients, public and other partners. These procurements will be completed by the end of June 2008. Furthermore there are a significant number of pieces of work underway to address many of the challenges in relation to doing the “ordinary extraordinarily well”. This includes consortium agreements with all partners where we provide commissioning support, a new short form legal contract for all providers with contract values under a certain value. The PCT will be using the PCT OSCAR (Appendix B) outcomes framework across all providers and contracts. We will also be testing the use of incentives as well as providing systematic performance management and reporting across all providers and contracts.

A copy of the project initiation document with the current project plan is for World Class Commissioning attached at Appendix C.

## **6.0 Operational Plan 2008/09**

Birmingham East and North Primary Care Trust is proposing investments in service developments in 2008 /09 of up to £12.6 million (see section 4.0) across a range of areas some of these investments relate to PCT specific developments others are investments to support delivery of the Local Area Agreement. These new investments support recurring investments from previous years, Neighbourhood Renewal Funding pickup and service redesign plans. These investments also support a number of proposed decommissioning decisions, thereby ensuring that where a new service is implemented, the present service does not continue to operate if not required.

It is also worth noting that the present set of performance indicators (existing commitments) of which there are 20 and which were used for measuring performance in 2007/08 remain in place in 2008/09. The trajectories for these indicators were set previously and any investment has already been agreed prior to the 2008/09 year. These indicators have been consistently monitored through the Primary Care Trusts Integrated Governance and Performance Committee and reported on a monthly basis to the PCT Board. The plans in place to either maintain or move towards the target as set are within the PCTs plans for 2008/09 and targets which are deemed as high risk have already been flagged and appropriate action plans are already in place to address the risk. As far as the Primary Care Trust is concerned there are areas of performance from 2007/08 that continue to need further actions, work and close monitoring these are:-

- Reduction of Healthcare Acquired Infections
- Smoking Cessation
- Chlamydia Screening
- Access to Gum
- Diabetic Retinopathy Screening
- Delivery of 18 weeks

For Chlamydia screening and access to Gum, these are being addressed through the commissioning of additional services and the introduction of a Sexual Health Strategy which sets out a new specification for Sexual Health Services both in the BEN PCT area and across Birmingham. These actions will address the shortfall in the performance which occurred during 2007/08 although it is noted that the Chlamydia Screening target in 2008/09 has increased to 17.5% from the present level of 15%. This will continue to be a challenging target as the expected performance at the end of 2007/08 was 8.13% even though this achievement was substantially above the English average but below the target of 17% in 2008/09. The PCT notes the new DOH Guidance for this target which will enable us to track screening data.

For Diabetic Retinopathy Screening BEN PCT is part of the Birmingham & Black Country wide Diabetic Retinopathy Screening Programme which is the largest in the country.

To date the PCT has invited 100% of people on the register for DR screening by 31st December 2007 but currently stands at only 54% who have been screened in the last 12 months

We have accredited optometrists at 22 locations throughout our area to ensure ease of access for patients and therefore capacity is available.

However this has been a major technical installation and as a consequence we have encountered some significant software and logistical problems in rolling out the call and recall programme. As a result steps have been taken to learn the lessons from the first year and we are strengthening the central management of the programme and expect to be able to maintain a regular and smooth flow of both recall and DNA letters throughout the year which will also enable us to identify low response rates much earlier in the year and so be able to intervene with patients and GPs should the need arise

We have also raised at a national level the concerns we have with the nationally specified software. We understand that some steps are being taken to improve the quality of the software and the interconnections between the DR database and GP clinical systems which should lead to significant improvements

The Department of Health Operating Framework for 2008/09 set the direction of travel in relation to targets, improvement and performance monitoring. The document Operational Plans 2008/09 -2010/11 set out the implementation requirements on PCTs and others. Those implementation requirements have manifested themselves as a set of "Vital Signs" at three levels National "must dos", National Priority for local delivery and Local Action. The PCT has set out below how it proposes to ensure delivery of key targets and improvements as follows:-

### **How will the PCT deliver the National Targets?**

#### **Hospital Acquired Infections**

The reduction in hospital acquired infections is a serious issue and continues to be a challenging one. The PCT has identified this area as its number one priority in 2008/09. A range of actions and plans are in place to ensure that significant attention is paid to both MRSA and C Difficile outbreaks and this information will be reviewed and discussed at a number of levels within the PCT including at Board level.

There are a number of significant actions that the PCT has put in place to assure itself that the work ongoing to reduce the number of cases of MRSA and C Difficile is reducing in line with the trajectories as set. However the

PCTs view is that one case is one too many and is striving to achieve a position where there are zero cases.

The actions planned that are already in place or being developed fall into four areas:-

### **Information**

- The PCT will ensure weekly and daily reporting systems are tracked through the PCT information team with Executives receiving alerts of special causes. The MESS system will be our core reference point.
- Clearly there are limits to focusing on absolute data. Given the Heart of England NHS Foundation Trust (HoEFT) has one of the highest rates of activity in the country – we are keen to ascertain the rates of HCAI. The PCT will review these rates with the intention of ensuring HoEFT are within the top decile performing hospital Foundation Trust in the country.
- The PCT will also be reviewing the current levels of infection in relation to mortality data.
- The PCT will be focusing the Economy Wide Commissioning of Infection Prevention Group on a regular review of a meaningful data set and an economy wide plan

### **Planning**

- The PCT are keen to ensure all providers have robust plans which are located within our economy wide framework, regularly reviewed by the Commissioning of Infection Prevention Group as a core focus. This plan will be drawn up and signed off by the Economy Clinical Group meeting on 13th June 2008. The matter is a significant agenda item at the Tripartite Performance meeting between HoEFT, BENPCT and Solihull Care Trust.
- The PCT will have an economy wide plan which addresses HCAs as a whole. The PCT anticipates the need to focus this plan as much on community services including social care.

### **Execution**

- The PCT will ensure a relevant data set is drawn up which allows us to identify numbers, rate, location, causes and to monitor themes and actions from root cause analyses.
- The PCT will ensure requirements of HoEFT are set out within the new contract due to be signed off at the end of June 2008. This will include compliance with the new data set and its review, evidence and assurance of HoEFT's internal plan to eliminate HCAs. The PCT will also ensure compliance with reporting against other HCAs which may emerge. The data set will be appended as part of the contract and linked to penalties/incentives.
- The PCT will provide energy, capacity, capability and focus to the issue -therefore the PCT will be reviewing levels of participation in

the different Prevention of Infection Committees and anticipate the need for greater expert advice in certain areas.

- Meetings with Regional HCAI lead and participation in the regional Directors of Operations and Performance meeting in June where attention is focused on this matter

### **Governance**

- HCAIs will be monitored through the Local Economy Prevention of Infection Committee. We will ensure that the prime focus of this group will be to analyse and act on the new data set and to monitor progress against the new economy wide plan.
- An economy clinical reference group will feed into the above meeting.
- HCAIs have been raised at our tripartite meeting between HoEFT, BENPCT and Solihull Care Trust. As lead commissioners we will retain this issue on the agenda.
- Within BENPCT we have changed the reporting arrangements for HCAIs to ensure this issue is brought firmly within the Performance Management Framework (Performance and Business Planning Group) which reports on all performance issues.
- The PCT will be reinforcing all of the above requirements through the contractual processes.

The plans and actions will be formally signed off by the PCTs Integrated Governance Committee which is a sub committee of the Trust Board. Regular reports will be provided on this matter to the Trust Board.

### **Delivery of 18 week target**

The PCT recognises the challenge of achieving the 18 week target by December 2008 and has in place a number of actions to ensure that providers continue to focus their efforts on achieving the target by September 2008.

The PCT has in place a number of systems of assurance which include a Local Health Economy Group which meets monthly to monitor progress on 18 weeks and diagnostic waits and in particular supports all the service redesign and pathway development activity with the main provider Heart of England Foundation Trust. The Trust has developed its own plan which is signed off and monitored by the PCT through this health economy group as well as the tripartite performance management group. PCT staff are involved in the Trusts pathway redesign groups also which includes a PCT Clinical Director. Weekly monitoring of progress to achievement of 18 weeks has been undertaken for a number of months and will continue throughout 2008. Any changes in performance are flagged by direct contact with the Foundation Trusts Chief Executive to ensure he is aware of issues and can assure the PCT that remedial action is in place. The PCT and the Trust continue to work together to monitor specialities where the 18 week target will be challenging. This particularly relates to Orthopaedics. To address this, the system is developing a single point of access for all referrals through an integrated musculo-skeletal service.

Through the Finance and Commissioning function activity has been commissioned to achieve 18 weeks and the PCT will use the contract mechanism should the need arise.

Over the last two years the PCT has undertaken significant pieces of work to reduce unnecessary patient journeys to secondary care. This has included a 14% reduction in GP referrals in 2006/07 and a further 7% reduction in 2007/08. The competitive tendering of Dermatology service in 2007/08 will see all referrals seen within two weeks and all follow ups are under review to either redirect those patients back to Primary Care or self-care. Continued work through the use of Prior approval has seen a significant drop in follow ups after surgery and their will continue to be a focus on reducing unnecessary referrals to secondary which will support the achievement of 18 weeks.

#### **4 hour A&E target (Urgent and Emergency Care)**

There have been significant challenges in 2007/08 in ensuring that the urgent and emergency care system was working at its optimum and this has resulted in a difficult winter period. This has been recognised by both commissioners and providers and there are agreements and plans now in place to avoid some of the problems that have occurred during 2007/08.

In looking forward into 2008/09 and putting in place the actions that have already been agreed it is worth pointing out a review of winter and Easter planning has been undertaken across the economy. A significant amount of demand and capacity work has been undertaken in 2007/08 to understand the route cause of the problems related particularly to A&E attendance and flow through of patients at Heartlands and Good Hope Hospitals. From the data the PCT has now clearly demonstrated that demand for urgent and emergency care did not increase during 2007/ 08, however length of stay did increase across the two hospitals by one and half days and this created significant pressures on bed capacity and did mean that the flow of patients was blocked at some points which would also mean that patients would be backing up and it would cause problems to the Ambulance Service in relation to turn round times. The other piece of work that has been undertaken has demonstrated that an increasing number of patients presenting at A&E out of hours are immediately transferred to the Badger out of hours service thereby continuing to support the Trust in reducing pressure on it's A&E service. Clearly the PCTs intention in 2008/09 is to ensure patients who do not need to go to A&E have different options and work through the Emergency Care Network that is now in place and being actioned will assist with this. The PCT continues to review the type of Patients requiring urgent / emergency care treatment and has identified that there are patients who have End of Life Care needs and also patients with Complex Care packages who can through the implementation of new strategies be identified and targeted to ensure that effective care coordination is in place to avoid an emergency which results in an admission through A&E.

A work plan is in place, this will be further enhanced during 2008/09 and will include:-

- A second Urgent Care Centre will be commissioned in the Saltley area and will be in place by October 2008.
- A pilot scheme is presently running with the West Midlands Ambulance Service that creates an alternative pathway to A&E by linking WMAS with the GP out of hours service and having available GP advice to ambulance personnel either on receipt of the patients call or when the ambulance arrives at the patients home this will divert a number of patients to different services, subject to the discussion the patient main be treated at home. Early evidence of the effect of the pilot will be available in July 2008
- The Local Health Economy is signed up to the Department of Health pilot project which is setting out to redesign the urgent care system and move from a system which is chaotic and unplanned to a more planned approach. This will involve testing the hypothesis that the Local Health Economy can create a pathway for urgent care which streams patients more appropriately and works with the population to help them make the right decision when they need treatment. This pilot is in the initial stages of development but the plan is to be able to test parts of the pathway on a desktop basis during autumn 2008 and test for real in the early part of 2009 with a roll-out of the pathway subject to evaluation in April 2009 onwards. It is envisaged that there will be significant changes in activity flows and this work will also model a system of payment which looks to incentivise providers for doing the right thing, this involves the review of the Payment by Results system as part of the pilot
- The PCT has had significant success in the use of Practice based information for referral management where General Practitioners are routinely reviewing referrals. This has led to a significant reduction in referrals to secondary care. The PCT through a sponsored piece of work via the Department of Health is enhancing the InSight referral management tool to include real time A&E and Emergency Admissions data which will then be reported against an indicative target to highlight to the practice how much cost / activity is occurring in this area and how this affects their Practice based Commissioning performance. Practices will then be expected to review this data and put in place plans to discuss with patients their use of urgent and emergency services where the Practice believes a more appropriate service should have been accessed. Where a patient has had multiple admissions to hospital this again will be provided to the practice through the InSight tool to enable the practice to review the case and look at ways through the Practice or Community teams to coordinate care for this patient more effectively. This could involve referral in to for example the care management programme or the introduction of a key coordinator of care for that individual to avoid an unnecessary admission to hospital. Evidence has shown that practice

peer review reduced referral levels by 14% 2006/07 and 7% on emergencies 2007/08. Although it is not envisaged that these levels will be achieved the targets set for each practice will see a reduction of potentially up to 5%.

- Work has begun on an active campaign to change patient behaviour and promote right treatment, right place and right time
- The Scenario Generator tool (NHS Institute) will be used to support the redesign of the Urgent and Emergency Care Services

Further work is commissioned through the Health Economy Emergency Care Network this includes revised arrangements for the Bed Bureau (1<sup>st</sup> July 2008) through Heart of England Foundation Trust which will aid the management of capacity and smooth the flow of patients. This approach will also give the PCT outcome data about the appropriateness of GP referrals, accuracy of differential diagnosis and referral hotspots. Work is under way to review workforce issues and communication across the system. A campaign called “message in a bottle” is underway for the over 65s. A review of winter planning has been undertaken to ensure that the plan for 2008/09 reflects the lessons from the previous winter.

The work to address urgent and emergency care is governed in a number of ways, operationally through the Emergency Care Network and from a PCT commissioning perspective through ongoing performance review via the PCTs performance and planning group, Integrated Governance Committee and the Health Economy tripartite performance group.

### **Patient Experience of access to Primary Care**

The development of increased access to Primary Care is a key undertaking for the PCT as it is one of the areas identified as under doctored consequently there is significant focus on the development and procurement of new practices alongside the capital developments.

The PCT has established a programme board chaired by Jonathan Tringham who is the senior responsible officer of the project and has appointed a project manager to lead the various work streams to deliver the new practices and health centre.

The Board meets monthly and has overseen the determination of the locations of the new practices and health centre (exact premises locations are still under discussion). It should be noted that given the timescales interim premises solutions will be required for those practices where a permanent solution has been identified. The PCT board has approved the proposals and supported the recommendation of the programme board to reinvest any monies into primary care released as a result of patient transfers from practices to the new facilities.

The PCT submitted an engagement strategy to the SHA, this has been approved and the PCT will be following a comprehensive programme of engagement activities, these will inform the service specification. Further

engagement with the overview and scrutiny committee who have suggested consultation plans from Birmingham PCTs should be submitted to them.

The PCT has a detailed plan in place for delivery of the new GP Practices and Health Centres and is building its management capacity to ensure delivery of the Practices and developments in the timescales as set. The PCT is also working with Practices to ensure that all Practices offer extended opening and although there is commitment to extended opening from 70% of GP practices there is need to secure that as a reality. The PCT is committed to achieving the 50% target and would hope that this figure will be substantially higher. However at this stage the PCT has taken a view that to suggest an increase substantial above the target level without full assurance that it will be achieved would not be helpful.

Given the issues highlighted with regard to potential non cooperation by some practices and a mounting campaign by patients asking that their practice should not offer extended hours and therefore we would not commit at this stage to go beyond 51%.

The PCT will of course have a new GP led health centre offering appointments to both registered and non-registered patients from 2009 open 7 days a week 8am – 8pm, so patients registered with a practice not offering extended hours will be able to access GP services during these times.

### **Implementation of the Stroke Strategy**

The PCT has recently agreed a staged approach to the development of a full Stroke Care Pathway, which includes significant investment in the current financial year (£150,000), to address known shortfalls. Currently a process is underway to agree with partners, users and carers the principle components and models which need to be adopted to ensure that the Care Pathway is robust, this will be completed in September of this year. This activity will lean heavily on the recently published National Stroke Strategy, guidance from the Royal College of Physicians, other professional bodies and recognised best practice; it will also reflect the experience of users and carers who will be involved in every aspect of the Care Pathway development process, including the development of outcome measures and monitoring of the Pathway.

The PCT intends to follow the *Managed Care Pathway* route for the development of the service which will culminate in January 2010 with the tendering of the entire pathway. Details of investment, outline pathway and programme are given below.

### **Stroke Care Pathway**

The Pathway currently being developed by the PCT with Partners is made up of 6 core elements, these include:

1. Health Promotion and Primary Prevention
2. Pre-hospital and Emergency Care

3. Acute Care / Treatment
4. Stroke Rehabilitation
5. Secondary Stroke Prevention
6. Community Re-engagement / Re-integration

None of these elements are mutually exclusive, each affecting the other and as with most care pathways elements of each may affect any of the others. It is for this overriding reason that consistency across the whole pathway is essential to ensure that both users and carers experience a coherent service. The PCT has therefore decided to follow a *Managed Care Pathway* model. The model has been developed further for the End of Life Care Pathway which will be tendered first, and will be followed using the same model by the development of a pathway for Frail Older People.

*Managed Care Pathways* allow for a single contract to be let by the PCT for any care pathway. They require the PCT to identify the various aspects of service which are currently contracted for, bundle them up and assign them to a single provider in a contract which requires the contractor to manage the entire care Pathway.

#### Timetable

The Pathway development will follow the following timetable:

##### July 2008 – January 2009

- Review outline Strategy for the Stroke Pathway confirm procurement process and timescale.
- Confirm Timetable for Stroke Pathway with local providers and agree early commissioning of key aspects of Business case either by competitive tender or with current providers through increased investment. The PCT intends to invest £150,000 during this financial year (full year effect of £300,000)
- Agree process and timescale for bringing together all elements of the Stroke Pathway under single management of the Project Manager
- Confirm the overall project Management structure for Stroke Pathway implementation.

##### February – September 2009

- Complete Service Specification for the Stroke Pathway tender including 5 year financial projections. (March 2009)
- Begin internal shadow management of the full Stroke Pathway based on the Service Specification.
- Complete draft Contract Stroke Pathway (September 2009)
- Formal Procurement Stroke Pathway (January 2010)

#### **How will the PCT deliver National Priorities for local delivery?**

The PCT has detailed within the table outline plans for local delivery of key national priorities. Many of these priorities are part of joint plans with Birmingham City Councils Adults and Communities Directorate and the

Children's Trust and are reflected in the Local Area Agreement for Birmingham. The plans and performance against these priorities will be managed and monitored through the joint governance arrangements which are in place through the Health and Well-being partnership and the Children and Young Peoples Board. Other priorities related to Suicide, CAMHS, Chlamydia screening, Drug users are being managed across the three PCTs with each PCT having a requirement to deliver a contribution to these priorities. These plans are managed and monitored through the Pan Birmingham PCT commissioning arrangements. Local priorities which are PCT specific relate to Immunisation uptake, Patient / User experience, Staff surveys and access to NHS Dentistry. There are actions in place in all of these areas as identified within the matrix. In addition to this the following is also in place:-

- Procurement of external provider to support a new relationships with the patients, public and partners **Linked to IFH projects 1,2, and 4**
- Directorate and Corporate action plans to improve staff survey results

### **What are the Joint PCT / Local Authority Indicators**

The three Birmingham PCTs with Birmingham City Councils Adults and Communities Directorate through the Health and Well-Being Partnership have agreed six key priorities which feature in the Local Area Agreement and it has been agreed that these need to be a focus of all partners and are reflected in this Operating Plan the joint targets are:-

- NI120 All-age all cause mortality rate PSA 18
- NI 123 16 plus current smoking rate prevalence PSA 18
- NI129 End of life access to palliative care enabling people to choose and die at home DH DSO
- NI130 Social care clients receiving Self Directed Support (Direct payments and individual budgets) DH DSO
- NI131 Delayed transfers of care from hospitals DH DSO
- NI135 Carers receiving needs assessment or review and a specific carer's service, or advice and information

Each one of these targets has a plan attached to it which will be formally signed at the Health and Well-being Partnership in June 2008. These plans will be used to monitor progress and put in place remedial action where a target is not being met.

Over and above this PCTs have a responsibility as Local Leaders in their area to also focus on supporting the agreed 35 targets identified in the next three year Local Area Agreement.

The table outlines the key indicators within the Operating Framework-Vital Signs and sets out to do the following:-

- Identify a commitment for all areas

- Identify the commissioning level for this target
- Identify the proposed outline / actions
- Any proposed investment in 2008/09 over and above present commitments (see section 4)
- A view on the risks to delivery and any mitigation of those risks
- An identified Director lead

This format will enable an effective monitoring system to be developed to ensure progress is being made in all areas throughout 2008/09. The specific objectives in this plan will form part of Directorate business plans and will be part of Directors and their staff's personal objectives.

### **Local PCT Indicators**

The PCTs has defined a number of local indicators which it sees as important to the organisations ability to deliver its core purpose and goals. The organisation has developed a set of criteria by which decisions on which indicators are going to be the focus of the PCTs attention. The criteria is set out below:-

- Supports delivery of PCT purpose and goals
- Aligns with the PCTs Commissioning Strategy
- Links to Joint work underway through the Health and Well-Being Partnership and the LAA
- Fits with operational work planned for 2008/09
- Target that has an easily identifiable baseline
- Target that has an ability to be measured effectively
- Indications of the level of importance to Patients, Users and Carers

There are eleven areas targets / improvements have been chosen (based on the above criteria) as a focus for local delivery they are:-

- Number of delayed transfers of care per 100,000 population (Aged 18 and over) **(LAA Target) Priority 1**
- Proportion of people with long-term conditions supported to be independent and in control of their condition **(Linked to key goals and linked to IFH) Priority 6**
- Ambulance conveyance rate to A&E **(Linked to Unscheduled Care Commissioning Service Strategy) Priority 8**
- Proportion of all deaths that occur at home **(LAA Target) Priority 2 link with IFH 2A**
- Patient-reported measure of choice of hospital **(Linked to key goals) Priority 7**
- Number of emergency bed days per head of weighted population **(Previous Measure of effectiveness of Case Management) Priority 10**
- Rates of hospital admissions for ambulatory care sensitive conditions per 100,000 population **(Linked to Care Closer to Home) Priority 9**

- Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality and Outcomes Framework (QOF) **(Linked to key goals) Priority 5 linked to IFH Project 3 Year of Care**
- Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over) **(LAA Target) Priority 3 linked to IFH Project 3 Individualised Budgets**
- Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community-based services **(LAA Target) Priority 4**
- Under-18 conception rate per 1000 females aged 15-17 **(LAA Target Children's Trust) Priority 11**

Over and above this the PCT is working jointly with Partners on the delivery of targets and improvements in worklessness in three key PCT areas (Kingstanding, Shard End and Washwood Heath) in conjunction with Job Centre Plus and the Learning and Skills Council. The target / improvement itself relates to the reduction of working age adults claiming out of work benefit.

Furthermore in 2008/09 the PCT is proposing an expansion of Radiotherapy services with the commissioning of capacity supporting Acute Trusts to invest in capital developments for the treatment of an increased number of cancer patients with radiotherapy, implementation of the equitable access in Primary care project and specific action in relation to Children and Young People through the Children's Trust.

Each one of the priority areas has a commitment, actions, risk to delivery and any mitigation of that risk.

**AGENDA ITEM 2.4**

**QUALITY SAFE SERVICES**

Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
<b>National Requirement</b>								
<b>Cleanliness and healthcare associated infections</b>	MRSA number of infections	MRSA levels sustained, locally determined stretch targets taking us beyond the national target			✓	Use learning from root cause analysis of cases in both primary and secondary care to develop appropriate training programme for employed and contractor staff	Unable to ensure patient safety <b>MITIGATION</b> Work monitored through Clinical Infection Group and Monthly Contract Review Group	Doug Wulff
	Rates of <i>Clostridium difficile</i>	<i>C difficile</i> reduction of 30 per cent by 2011, differential SHA envelopes to deliver a 30 per cent reduction nationally by 2011 659 08/09			✓	To analyse data available in order to address hotspots. This will be achieved through joint clinical infection group	The rate of infections don't reduce <b>MITIGATION</b> As above	Doug Wulff
<b>Access to personalised and effective care</b>	Primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services <b>PRIORITY RATING LOW</b>	Year on year increases in the number of patients accessing NHS dentistry. SHAs to set out agreed planning assumptions at PCT level. Number of patients in receipt of NHS dental services=262,910 (60% of PCT population)			✓	Revisiting contract plans, utilising growth monies to adjust targets in line with need  Promotion of availability of NHS Dentistry within the PCT	No agreed planning assumptions Data validity issues <b>MITIGATION</b> Focus on use of growth monies monitoring through Primary Care Strategy Group	Jonathan Tringham
<b>Cleanliness and</b>	Achievement of CNST risk	Higher scores reflecting better risk management			✓	Complete the action plan arising from the NHSLA standards for PCTs	Core standards will not be achieved	Doug Wulff

AGENDA ITEM 2.4

**QUALITY SAFE SERVICES**

Area National Requirement	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
healthcare associated infections	management standards	standards and safety culture.					and cost of NHSLA subscription will increase <b>MITIGATION</b> Monitoring of action plan to ensure compliance through Professional Services Directorate	

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>Improving health and reducing health inequalities</b>	Implementation of the stroke strategy	80% of patients spend at least 90% of their time in a stroke unit. 60% of higher risk TIA cases are treated within 24 hours by 2010/11. 70% of patients will reach required standard of treatment			✓	PCT will lead the development during 2008/09 of a comprehensive strategy for the development of services for patients at risk of or who have had a stroke. This will reflect the National Strategy	Strategy work not completed <b>MITIGATION</b> Internal strategy development group in place to ensure delivery. Work across LHE to consider implementation of further quick wins	Andrew Donald
<b>Improving health and reducing health inequalities TARGET WITHDRAWN</b>	Proportion of women receiving cervical cancer screening test results within 2 weeks	All women should receive the results of their cervical screening tests within 2 weeks by 2010			✓	Progress being made to deliver against target	Capacity of providers to deliver changes in pathways to achieve next stage reductions <b>MITIGATION</b> Action planning through local implementation group to ensure capacity / demand issues addressed	Nicola Benge
<b>Improving health and reducing health inequalities</b>	All-age all-cause mortality rate per 100,000 population (AAACM) <b>PRIORITY RATING HIGH</b>	To meet national targets the 2010 figures for non spearhead groups must be: Males – 78.6 years or higher Females – 82.5 years or higher Relative gap in life expectancy for	✓* <b>Note agreed joint target</b>			Joint working through the BHWP. Maintain and extend successful projects from the previous floor target action planning. Target resources and primary care interventions at those at greatest risk of premature mortality	These are very challenging targets for Birmingham, to achieve there will be a need to maintain targeted approach and improve primary care services <b>MITIGATION</b> Managed and monitored through Health and Well-being partnership	Nicola Benge

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>		spearhead groups when compared to England should be: Males – 2.32% or lower Females – 1.59% or lower				Improve management of long term conditions		
	<75 CVD mortality rate <b>PRIORITY RATING HIGH</b>	See AAACM requirements LAA Target 89.4	✓			As above + Identify earlier those at greatest risk of premature mortality from CVD. Ensure optimum management and increase provision for target lifestyle interventions including access to physical activity schemes, smoking cessation, nutrition advice, weight reduction, alcohol and drug misuse programmes and psychological support.	As above	Nicola Benghe
	<75 cancer mortality rate <b>PRIORITY RATING HIGH</b>	See AAACM requirements LAA Target 120.5	✓			As above + Increase early diagnosis in target wards where mortality is higher. Review current clinical pathway to ensure they do not	As above	Nicola Benghe

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>						disadvantage those who may suffer poorer prognosis.		
	Suicide and injury of undetermined intent mortality rate <b>PRIORITY RATING MEDIUM</b>	PSA target requires a 20% reduction in the mortality rate from Suicide and Injury of Undetermined Intent, nationally, by 2010. Indicative trajectories have been provided.		✓		City wide Suicide Audit Group in place. Audits identifying high risk groups to inform strategic action plans on a Pan-Birmingham basis	Lack of system to identify individuals with suicidal tendencies <b>MITIGATION</b> Clarity around risk factors and targeting key groups	Andrew Donald
	Smoking prevalence among people aged 16 or over, and aged 16 or over in routine and manual groups (quit rates locally 2008) <b>PRIORITY RATING HIGH</b>	The number of 4 week smoking quitters who have attended NHS Stop Smoking services per 100,000 populations should be maintained at least the levels achieved in the baseline period (2004/5-2006/7). Target 2646	✓ <b>NOTE agreed joint</b>			Review current models of provision to maximise capacity through current services. Increase activity in the group who smoke large quantities and have co-morbidities. Including hospital attendance and admission. Develop a programme that aims to reduce smoking levels but does not comply with current 'quit' model.	We are currently seeing a drop of in numbers attending smoking cessation services, there is a possible that we continue to chase numbers without focusing at those in higher risk categories such as manual worker. <b>MITIGATION</b> Use number of service developments to ensure that smokers are targeted	Nicola Benghe
	Under-18 conception rate per 1,000 females aged 15-17 <b>PRIORITY RATING</b>	Guidance requires a decrease in conception rate over time. Target Rate 35.2	✓	✓		Target schools with highest incidence of teenage pregnancy. - teenagers who have already had a	The current trend in under 18 conceptions is increasing; to achieve the target would be impossible. This is a partnership	Nicola Benghe

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>	<b>HIGH</b>					termination Increase access to sexual health services, and long acting contraception. Work with partners on childhood mental well being, self esteem and educational achievements	agenda and can not be addressed by health alone <b>MITIGATION</b> Work monitored through Pan-Birmingham Commissioners	
	Obesity among primary school-age children <b>PRIORITY RATING HIGH</b>	Rate of increase in prevalence of childhood obesity that is lower than the current national trend. National plan is to return to 2000 levels of obesity by 2020. Obesity in reception year 17.75% Obesity in year six=17.49%	✓		✓	Development of Pan-Birmingham Obesity Strategy linked to work of Health and Well-being partnership  Local PCT commissioned services for Children with Obesity in 2007/08 and continued into 2008/09	Strategy not delivered to timescales  Commissioned services don't deliver real benefits <b>MITIGATION</b> Strategy delivery monitored by Health and Well-Being Partnership Local Commissioned services monitored through the Gateway process	Nicola Benghe
	Proportion of children who complete immunisation by recommended ages <b>PRIORITY RATING HIGH</b>	95% of children receive 3 primary doses of diphtheria, tetanus, polio and pertussis in the first year of life. 95% receive a first dose of MMR by 2 years of age. 90% receive a booster dose of			✓	Increase appropriate engagement from primary care and provider services. Develop a provider immunisation team to increase uptake Develop robust SLA for provision and reporting of immunisations.	Current performance is well below national target  <b>MITIGATION</b>  Monitor effect of new initiatives through Integrated Governance and Performance Committee and reports to Board	Nicola Benghe

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>		tetanus, diphtheria and polio between 13 to 18 years of age. As of September 08 90% of girls around 12-13 years of age should receive a complete course of human papilloma virus vaccine. 5051, 1 year olds (DTaP/IPV/Hib)=87.7% 5111, 2 year olds (PCV,MenC,MMR)=87.7% 4941 5 year olds (DTa/IPV)=87.7% 5204 5 year olds (MMR)=92.3% 2660 12-13 year olds females (HPV)=90% 5236 13-18 year olds (school leaver boosters)=82%				Introduction of HPV from Sept 2008, model currently being developed		
		Tuberculosis <ul style="list-style-type: none"> <li>all infants living in areas of UK where the annual incidence of TB is 40/100,000 or greater</li> <li>for children with a</li> </ul>			✓	As above	As above	Nicola Benghe

AGENDA ITEM 2.4

PROMOTING HEALTH & EMPOWERING PEOPLE								
Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
National Requirement		parent or grandparent born in a country where the incidence is 40/100,000 or greater <ul style="list-style-type: none"> <li>• all infants</li> <li>• previously unvaccinated children aged 1-5 years</li> <li>• previously unvaccinated TB –ve aged 6 to under 16</li> <li>• previously unvaccinated TB –ve contact cases of respiratory TB</li> <li>• previously unvaccinated TB –ve new entrants born in or lived for a prolonged period in a country where the TB incidence is 40/100,000 or greater</li> </ul>						
	Percentage of infants breastfed at 6–8 weeks	85% coverage by 2008/09 quarter 4 90% coverage by	✓		✓	Increase education re value of breastfeeding. Ensure a core activity	Currently significantly below target <b>MITIGATION</b>	Nicola Bengie

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>	<b>PRIORITY RATING MEDIUM</b>	2009/10 quarter 4 95% coverage by 2010/11 quarter 4 Numbers 08/09 146 babies exclusively breastfeed (15%) 828 babies breastfed/supplemente d (85%) 974 babies with complete feeding records (60% of total number of babies)				of midwifery and support services. Increase post natal support to maintain feeding.	Part of focus for revision of maternity services / community midwifery in terms of scope and style of service. Joint work between PCT and HofEFT. Part of city wide initiatives	
	Prevalence of Chlamydia <b>PRIORITY RATING LOW</b>	17% of eligible people screened for 2008/09.		✓		A continuation of the work in 2007/ 08 to increase the number of points where Chlamydia screening takes place whilst increasing accuracy of recording. Over and above this the PCT intends to implement its Sexual Health Strategy which increase Primary Care provision and the range of Providers to ensure this challenging target can be achieved	Trajectory and target not being achieved, new developments do not deliver increased screening <b>MITIGATION</b> Specific monitoring through Pan-Birmingham Commissioning Group and Local Integrated Governance and Performance Committee	Andrew Donald

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>								
	Number of drug users recorded as being in effective treatment <b>PRIORITY RATING MEDIUM</b>	Guidance simply specifies that good performance is typified by an increase in numbers. Target agreed 7% increase to 87% in 2008/09. 5295 patients	✓	✓		Birmingham's position in relation to effective treatment is already above the national average performance. The Joint Commissioning Group agreed the target for Drug Users in effective treatment which is line with the performance this year i.e. an increase in 7% which achieves 87%	Resources available to DAART continue to be reduced year on year <b>MITIGATION</b> Monitored through Joint Commissioning Group. Financial Plan in place to ensure services are maintained	Andrew Donald
<b>Access to personalised and effective care</b>	Proportion of adults (18 and over) supported directly through social care to live independently at home	Expectations would be for modest increases year-on-year to reflect gradual changes in practices rather than large increases in annual rates. Review outturn 07/08	✓			Waiting for clarification of PI definition working jointly with Local Authority to plan interventions for 2008/09.	PIs present unforeseen targets <b>MITIGATION</b> Joint working across agencies to identify solutions	Andrew Donald
	Proportion of people with long-term conditions supported to be independent and in control of their condition	Number of emergency bed days to serve as a proxy in year 1. No specific performance targets given. See emergency bed day's comments.			✓	The extension of Birmingham OwnHealth to cover an increased population of up to 11,000 members plus the introduction of telehealth and telecare in conjunction with	Capacity to deliver, membership take up <b>MITIGATION</b> Monitored by Programme Board and Operational Management Board	Richard Mendelsohn

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
	<b>LOCAL TARGET</b>					Birmingham City Council will ensure that increased number of people will be supported and in control of their condition		
<b>National Requirement</b>	Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over) <b>LOCAL TARGET</b>	Good performance is typified by a higher rate. 133.6 per 100,000 head of population	✓* <b>Note joint target agreed</b>	✓		Work with Adults and Communities and also Project three Investing for Health to develop individual healthcare budgets	Results of work within IFH do not show benefits. Legislative Framework for Individual budgets in healthcare <b>MITIGATION</b> Testing out through IFH projects allows for limited risk to be managed	Andrew Donald
	Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community-based services <b>LOCAL TARGET</b>	Good performance is typified by a higher rate. 22.2%	✓* <b>Note joint target agreed</b>	✓		Complete PUK Carers Support Service Review Devise Service Strategy Redesign of current Carers Service Carers unit assessments are accepted direct by BCC BCC Adults and Communities Directorate are responsible for the provision of short term breaks. BCC have reviewed and revised	PCT Commissioners decide not to support broader carers support work. BCC Adults and Communities Directorate fail to deliver on this target. <b>MITIGATION</b> Carers support commissioned through other organisations e.g. third sector	Director Provider Arm

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
						their policy to improve delivery and increase numbers of carers accessing breaks.		
<b>National Requirement</b>	Percentages of patients admitted with a heart attack who, upon discharge, are prescribed an anti-platelet, a statin, a beta-blocker	Maintained at NSF standard levels of between 80% and 90% if patients are being prescribed these drugs upon discharge.			✓	Monitor against Minnap audits		Nicola Benghe
	Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality Outcomes Framework (QOF) <b>LOCAL TARGET</b>	A year on year Increase in this measure is desirable for individuals because it is an indicator of the management of diabetes and a measure of long term health. Year on year increase is stated as desirable in the guidance. Plans will show 1% improvement each year of the planning cycle.			✓	Increase monitoring of performance at practice and patient level. Ensure treatment regimes are being utilised. Increase access to weight management services in primary care	Increasing numbers of diabetic being identified, increase in local levels of obesity, insufficient resources to fully tackle the problem and reduction of obesity. <b>MITIGATION</b> Continue to explore commissioning of further services to support increase in number of patients identified with diabetes	Nicola Benghe
	Proportion of people where health affects the amount/type of	Good performance would show a decline in numbers.	✓	✓		Increase access to talking therapies and low level mental health	High incidence of worklessness within the local community.	Nicola Benghe

**AGENDA ITEM 2.4**

<b>PROMOTING HEALTH &amp; EMPOWERING PEOPLE</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>								
	work they can do					services. particularly targeting those who experience stress related incidents. Work with primary care in relation to appropriate management of requests for sick notes and absences form work.	<b>MITIGATION</b> Increased access to Primary Care MH services to support return to work, increase in Psychology input to support this approach	
	Hospital admissions caused by unintended and deliberate injuries	The aim is to see a decreasing number of emergency admissions for children and young people.			✓	Development Plan required		Nicola Benge

**AGENDA ITEM 2.4**

<b>EXTENDING WORKING TOGETHER FOR HEALTH</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>								
	Number of delayed transfers of care per 100,000 population (aged 18 and over) <b>LOCAL TARGET</b>	Good performance in typified by a lower rate. 15.3 per 100,000 head of population aged 18+  114 delays  Please note that this is an average for the year. Target for the end of the year is 105	✓* <b>Note joint target agreed</b>	✓		Mainstream reimbursement grant posts Review commissioning of interim beds LEAN work plan at GHH and Heartlands Review Physical Disability and Mental Health long term placements/beds from a capacity perspective	Commissioning reviews not completed Capacity <b>MITIGATION</b> Agreed plan across Local Health Economy and Emergency Care Network plus PbR Demonstrator Site	Director Provider Arm
	Proportion of all deaths that occur at home <b>LOCAL TARGET</b>	Good performance represented by an increasing proportion ion deaths occurring at home. 14.88%		✓* <b>Note joint target agreed</b>	✓	The implementation of the PCTs End of Life Care Strategy will increase the choice for individuals about place of death and this will ensure an increasing percentage of deaths outside Acute Hospital. The agreed target for 2008/09 is	The strategy is predicated on procurement of a range of new services and beds that will take a minimum of 107 days to procure through tendering processes <b>MITIGATION</b> Capacity identified to complete procurement work	Andrew Donald

AGENDA ITEM 2.4

<b>(B)RISK PROCESSES (BOLD, REDESIGN, INVESTMENT, SUSTAINABILITY, KNOWLEDGE)</b>								
Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
<b>Access to personalised and effective care</b>	Percentage of patients seen within 18 weeks for admitted and non-admitted pathways  <i>Supporting measures:</i> <ul style="list-style-type: none"> <li>• Number of diagnostic waits &gt; 6 weeks</li> <li>• Percentage of patients seen within 18 weeks for direct access audiology treatment</li> <li>• Activity levels</li> <li>• Patient-reported experience of 18-week pathways</li> </ul>	To ensure that, by December 2008, no one waits more than 18 weeks from referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks)			✓	Plans in place to achieve 18 weeks ongoing monitoring through Local Health Economy 18 Weeks Programme Board. Substantial work underway through Heart of England FT to ensure delivery and sustainability of 18 weeks  Increased work on Pathways in challenged specialities to ensure outpatients and diagnostic waits continue to reduce	Audiology continues to be an identified risk which is being managed through the Local Health Economy programme Board <b>MITIGATION</b>  All work monitored through Local Health Economy plus weekly monitoring of PTL to ensure continued reductions in referral to treatment	Andrew Donald
	Patient experience of access to primary care <i>Supporting measures:</i>	<i>At least 50 per cent of GP practices in each PCT offer extended opening to their patients</i>  <i>100 new GP practices, including</i>			✓  ✓	Undertake a baseline assessment of current practices Work with Practices to agree extension to current hours Target areas identified by patient survey as having access problems	Difficult negotiations with GPs and low uptake leading to delayed implementation	Jonathan Tringham

AGENDA ITEM 2.4

<b>(B)RISK PROCESSES (BOLD, REDESIGN, INVESTMENT, SUSTAINABILITY, KNOWLEDGE)</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>								
	<i>Extended opening hours for GP practices Increased capacity in primary care Patient reported access to out-of-hours care (indicator to be developed)</i>	<i>up to 900 GPs, nurses and healthcare assistants introduced into the 25 per cent of PCTs with the poorest provision</i>  Overall levels of satisfaction when averaged over the 5 measured elements-81%					Demanding timescales and limited PCT capacity <b>MITIGATION</b> Establishment of PCT Programme Board to oversee equitable access programme linked to Primary Care Strategy Group. Capacity issues being address	
	Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices, by 12 completed weeks of pregnancy <b>PRIORITY RATING MEDIUM</b>	Guidance requires an upward trend with no specifics given. Target % =47.2% (number of births=6300)	✓		✓	Continued development of work commenced in 2007/08 through the work to reduce Peri-mortality through the introduction of risk stratification of at risk women alongside the increase in the number midwives and support workers in deprived areas. Further work will be undertaken as part review of maternity services in relation to service scope and style to ensure we are able to meet this target	No changes to Maternity Services provision following HCC review. Data provision still poor <b>MITIGATION</b> Joint group to ensure HCC action plan put in place  Through contractual mechanisms PCT will ensure compliance	Andrew Donald

**AGENDA ITEM 2.4**

<b>(B)RISK PROCESSES (BOLD, REDESIGN, INVESTMENT, SUSTAINABILITY, KNOWLEDGE)</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>								
<b>Emergency Planning</b>	Confidence in preparations for a flu pandemic	To have robust plans in place by December 2008 to respond to a flu pandemic			✓	Programme to achieve to develop robust plans in place with links to multi-agency groups (Including Birmingham Resilience Group)	Not all DH guidance is yet finalised <b>MITIGATION</b> Work being completed as far as possible	Louise Pritchard
	Timeliness of social care assessment	Good performance is typified by a higher percentage.		✓		Plans are delivered by BCC Adults and Communities Directorate	BCC unable to deliver required improvement. However current performance is good <b>MITIGATION</b> Joint monitoring	Director Provider Arm
	Timeliness of social care packages	Good performance is typified by a higher percentage.		✓		Plans are delivered by BCC Adults and Communities Directorate. Joint work with PCT Provider Arm is being undertaken to reduce the size of on going care packages via joint delivery of intermediate care services, thus freeing up more resource to ensure timeliness of care packages	BCC unable to deliver required improvement. However current performance is average to good <b>MITIGATION</b> Joint monitoring of performance	Director Provider Arm
	Ambulance conveyance rate to A&E (to be developed) <b>LOCAL TARGET</b>	Guidance states that the ambulance conveyance to A&E is to be reduced to 48% by 2010. Current performance in 07-08 is approx.74% and plan will show straight line trajectory to target by			✓	Work being undertaken through Emergency Care Network to ensure conveyance rate improves. Action plan to ensure improvement is being developed. This will be linked to work on unscheduled care through PbR	Performance doesn't improve <b>MITIGATION</b> Monitored through Emergency Care Network	Andrew Donald

**AGENDA ITEM 2.4**

<b>(B)RISK PROCESSES (BOLD, REDESIGN, INVESTMENT, SUSTAINABILITY, KNOWLEDGE)</b>								
Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
<b>National Requirement</b>		2010				demonstrator site		
	Number of emergency bed days per head of weighted population <b>LOCAL TARGET</b>	Reduction in the number of emergency bed days is desirable. Guidance specifies a simple reduction in number of bed days. PCT is currently ranked 30 <sup>th</sup> out of 35 in the cluster but this is based on 2005-06 data. 07-08 data shows a dramatic improvement on 06-07 outturn and gives an average LOS per admission of 4.4 days. The plan will show a straight line trajectory through to the end of the planning period to achieve an average LOS of 3.8 per admission.			✓	Continuation of the work through Assertive Case Managers to reduce EBDs increased integration with Birmingham Own Health project particularly in relation to Telehealth development	As Birmingham OwnHealth	Andrew Donald
	Rates of hospital admissions for ambulatory care sensitive conditions per 100,000 population <b>LOCAL TARGET</b>	Reducing admissions is the intended direction for this indicator. Plans are to show reduction of 8% by the end of the planning period on the current performance. This will be on a straight line basis i.e. 4% in year 1, 6% in year 2 and 8% in year 3.			✓	Continuation of work during 2006/07 and 2007/08 to reduce unnecessary admissions to hospital for ACSCs particularly focussed on chronic diseases which are in the top 5 of admissions as identified by NHS Institute Priority Tool	Does not deliver reduced admissions <b>MITIGATION</b> Case Manager work being integrated into next phase of BOH where benefits are measured continuously	Andrew Donald
	Rate of hospital admissions per 100,000 population	Good performance is typified by a decreasing or negative percentage change from the level	✓	✓		Commissioning of Alcohol services will be commissioned jointly between PCTs and other partners through the	Appropriate resourcing of strategy	Andrew Donald

**AGENDA ITEM 2.4**

<b>(B)RISK PROCESSES (BOLD, REDESIGN, INVESTMENT, SUSTAINABILITY, KNOWLEDGE)</b>								
<b>Area</b>	<b>Indicator</b>	<b>Commitment</b>	<b>LAA</b>	<b>Joint with other PCTs</b>	<b>PCT</b>	<b>Proposed action to deliver priorities</b>	<b>Risks</b>	<b>Director Lead</b>
<b>National Requirement</b>	for alcohol-related harm	recorded between the previous financial year and the current financial year.				Drug and Alcohol Action Team (DAART). A strategy and three year plan has been developed and agreed for Birmingham. During the next twelve months all funding will be pooled within a section 75 arrangement.	<b>MITIGATION</b> Commitment through Health and Well-being Partnership for increased Commissioning of services for people with Alcohol problems	
<b>Finance</b>	NHS estates energy/carbon efficiency	Both measures should be heading towards the levels specified in the targets.			✓	PCT has approved Sustainability Policy and Carbon Implementation Plan – this will provide all actions needed to improve on this vital sign. PCT needs to implement systematically the Policy and Plan. PCT already achieving 2010 target and majority of estate conforms to energy efficiency target.	Minimal risk of achievement of this vital sign as the PCT is already achieving the 2010 target of reducing overall level of primary energy and the PCT estate already allows buildings to conform to the energy efficiency performance targets as part of the investment plan and all new developments conform to the target.	Martin Wiltshire

**AGENDA ITEM 2.4**

**CONSISTENTLY FIT FOR PURPOSE**

Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
<b>National Requirement</b>								
<b>Finance</b>	Financial balance (PCT)				✓	Comprehensive financial strategy and plan in place. Surplus for 2008/09 £1.9 million	Minimal Risk envisaged	Jonathan Tringham
	Effectiveness of Children and Adult Mental Health Service (CAMHS) (percentage of PCTs and local authorities that are providing a comprehensive CAMHS) <b>PRIORITY RATING LOW</b>	Guidance simply specifies that the direction of travel should be upwards. Full range of CAMHS services for children with LD = level 3 16-17 year olds requiring MH services with access to services and accommodation=level 3 Arrangements for 24 hour cover =level 4 Full range of early intervention services=level 3		✓		Full range of services already in place. Further work being undertaken to strengthen protocols and working practices to achieve level four across all measures	Definition of full range of intervention services <b>MITIGATION</b> Gain agreement across Birmingham on definition	Andrew Donald
<b>Reputation, satisfaction and confidence in the NHS</b>	Self-reported experience of patients and users <b>PRIORITY RATING HIGH</b>	Success is defined as an increase in the index score for each survey as measured across the entire PSA period. Acute Adult inpatient score=74.4 Acute Adult outpatient score=75.6 Acute A&E score=74.0			✓	Radical redesign of PPI mechanisms and strategy including new partnering arrangement- implementation plan developed Specific Action plan developed on basis of Provider Arm PUK patient survey for the provider arm.	Unable to implement radical redesign due to capacity Investment Other external demands prevent radical redesign and limit capacity to achieve	Louise Pritchard

**AGENDA ITEM 2.4**

**CONSISTENTLY FIT FOR PURPOSE**

Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
National Requirement		Community MH Trust score=72.41 PCT patient experience score+76.21					<b>MITIGATION</b> External Support and internal development group	
	NHS staff survey scores-based measures of job satisfaction <b>PRIORITY RATING HIGH</b>	Success is defined by sustained higher levels of staff job satisfaction. Score= 3.56			✓	New Staff engagement and communication strategy to be produced Wellness Programme implemented PRIDE development programme implemented and evaluated	Changes in senior posts Capacity to deliver <b>MITIGATION</b> External support commissioned to ensure development of wellness programme Monitoring of PRIDE development programme	Louise Pritchard
	Patient-reported measure of choice of hospital <b>LOCAL TARGET</b>	Guidance gives no specific steer as to direction of travel. Current national survey results show approx. 40% patients reporting awareness of choice. BEN performance is generally better than that in HOB and South. Plan is to show a straight line			✓	Work already underway in 2007/08 through a number of communication campaigns to ensure patients, users and the public are aware of choice. The PCT has recently completed its own choice survey and plans to develop this approach systematically so as to ensure that increased awareness of choice is demonstrated	Percentage of Patients who recognise being given choice doesn't improve <b>MITIGATION</b> Systematic monitoring of survey results and targeting communication	Andrew Donald

**AGENDA ITEM 2.4**

**CONSISTENTLY FIT FOR PURPOSE**

Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
National Requirement		improvement in awareness of choice starting at 50% at 07-08 Q3 through to 70% by 09-10 Q3. Current performance shows 87% of patients either attended the hospital of their choice or showed no preference. Plans are to maintain performance at 90% across the entire planning cycle.						
Reputation, satisfaction and confidence in the NHS	Patient and user reported measure of respect and dignity in their treatment	Upwards is improvement.			✓	This will be measured through Healthcare Commission Patient Experience Survey – results due Autumn 2008, no further information at this stage. It is also anticipated that this will include social care data from April 2009 Need to review and implement subsequent action plans for patient and user respect and dignity as part of work being undertaken in the Provider Arm	No guidance available at present re: content of survey and target audience to be able to produce targeted action plan prior to the survey if required	Louise Pritchard
	Parents' experience of services for disabled children	Likely to be Upwards.	✓			Regular surveys of Parents experience and satisfaction with services	Poor response / comments <b>MITIGATION</b> Identification of	Andrew Donald

AGENDA ITEM 2.4

**CONSISTENTLY FIT FOR PURPOSE**

CONSISTENTLY FIT FOR PURPOSE								
Area	Indicator	Commitment	LAA	Joint with other PCTs	PCT	Proposed action to deliver priorities	Risks	Director Lead
National Requirement								
							cause of dissatisfaction through joint group PCT / Local Authority	

## **6.0 Governance arrangements Operational Plan**

Birmingham East and North Primary Care Trust have well established governance arrangements for the deliver of targets and improvement. The delivery of the Operational Plan will monitored through the Integrated Governance Committee which is a sub-committee of the Trust Board and that Committee will report monthly to the Trust Board on matters appertaining to the delivery of the Operational Plan. This will provide the necessary assurance to the Board that work is progressing as predicted in the delivery of the Operational Plan. Over and above this, reports on progress to achieving Local Area Agreement targets and improvement will be presented to the Health and Well-Being partnership on a regular basis.

## **7.0 Review, Evaluation and Outcome Measurement**

A key to delivery against the Vital Signs is to ensure that the organisation puts in place processes to ensure that there is continuous review, evaluation and measurement of progress in delivering service change and ultimate the targets that are set. The PCT already has an active system of review and evaluation of work operationally through good governances processes. However over and above this the PCT uses a gated process for review and evaluation of work plans and also uses the OSCAR (**O**rganisational, **S**atisfaction, **C**linical, **A**ctivity and **R**esource Utilisation) outcomes framework to ensure Directorates are not only measuring outputs but have real and systematic focus on outcomes which may a real difference for Patients.