

PCT Business Plan 2007/8

Approved by Birmingham East & North PCT Trust Board, April 2007

***Working in partnership to tackle
inequalities and improve the health and
well-being of local people***

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Executive Summary

Birmingham East and North PCT was created in October 2006 following the merger of Eastern Birmingham PCT and North Birmingham PCT and provides primary care, intermediate care and community services on behalf of 437,500 people. Employing over 1,700 staff and covering nearly 90 practices, the PCT has a budget in excess of £500 million and hosts a specialized commissioning budget of nearly £400 million for the whole of West Midlands.

One of the most striking aspects is the huge variation of health and levels of deprivation across the population we serve, with some of the richest and poorest wards in the country. Mortality rates vary from being 34% higher than England as a whole in one ward to 11% in another ward. Our priorities are to reduce health inequalities with the highest death rates – circulatory disease and cancer and tackling the factors affecting them – particularly smoking and obesity, and other factors associated with deprivation such as infant mortality and teenage conception.

This Business Plan describes how the PCT will deliver the final year of our current Local Delivery Plan and what steps we will take to move towards our Strategic Goals this year. It is produced against a backdrop of significant financial pressure, which means that in delivering this plan the majority of future investment will come through:

- Radical service redesign
- Delivery of demand management initiatives
- Effective Care and Resource Utilisation
- Significant reductions in Acute trusts costs

The emphasis of the 2007/08 LDP and this Business Plan is achieving effective service redesign to ensure efficient and effective health care services are available throughout the BEN PCT area, rather than simply looking to invest additional services. This includes focusing on areas of good practice that may be operating at a local level, with the aim to make them mainstream and in place across the organisation. It also aims to further develop the innovative service redesign work taking place as part of the 'Making the Shift' project, Locality Based Commissioning, system reform and health inequalities.

There are also a number of national priority areas that the PCT is required to meet and are outlined in the LDP. These include:

- Patients should only have to wait a maximum of 18 weeks from the time of their GP referral to the start of treatment;
- Reducing rates of MRSA and other healthcare associated infections;
- Reducing health inequalities and promoting health and well-being (including sexual health);
- Achieving financial health.

In addition to the national priorities, the key areas where the PCT will concentrate its efforts over 2007/08 include:

- Extension of Community and Intermediate care services
- Stroke services including primary prevention
- End of Life Strategy and links to cancer drugs
- Development of the Making the Shift projects particularly Continence and pain management services
- Birmingham Own Health and links to male life expectancy
- Redesigning of Mental Health services with a particular focus on Alcohol services
- Review and redesign of Sexual Health Services
- Dermatology services as a model of market testing

- Review of Midwifery services and links to infant mortality
- Learning translated into service redesign with initial focus on CHD, COPD and Diabetes
- Disinvestment strategies

In continuing to develop the way in which we deliver our services, we will also:

- Look to provide patients more choice of provider.
- Continue to build the engagement we have with our communities, particularly in explaining what we do and in listening to how our communities want and need their care.
- Strengthen the way we commission and contract for services, using the new system reforms to challenge what we pay for and improved information to judge the performance of our providers.

1. Introduction

1.1. Introduction and Purpose of Document

This document is the Business Plan for Birmingham East and North PCT for 2007-2008, which outlines how we will deliver the final year of the current 3-year Local Delivery Plan and our priorities as an organisation for 2007/8 in order to progress our Core Purpose and Goals and Commissioning Strategy. It provides high-level work programmes that the PCT will pursue to achieve its objectives this year and progress towards our strategic objectives. It is supplemented by detailed Directorate / Functional Business Plans and Locality Plans and should be read alongside our Local Delivery Plan, Commissioning Strategy, and Financial Plans available via our website www.benpct.nhs.uk.

1.2. Profile of the PCT

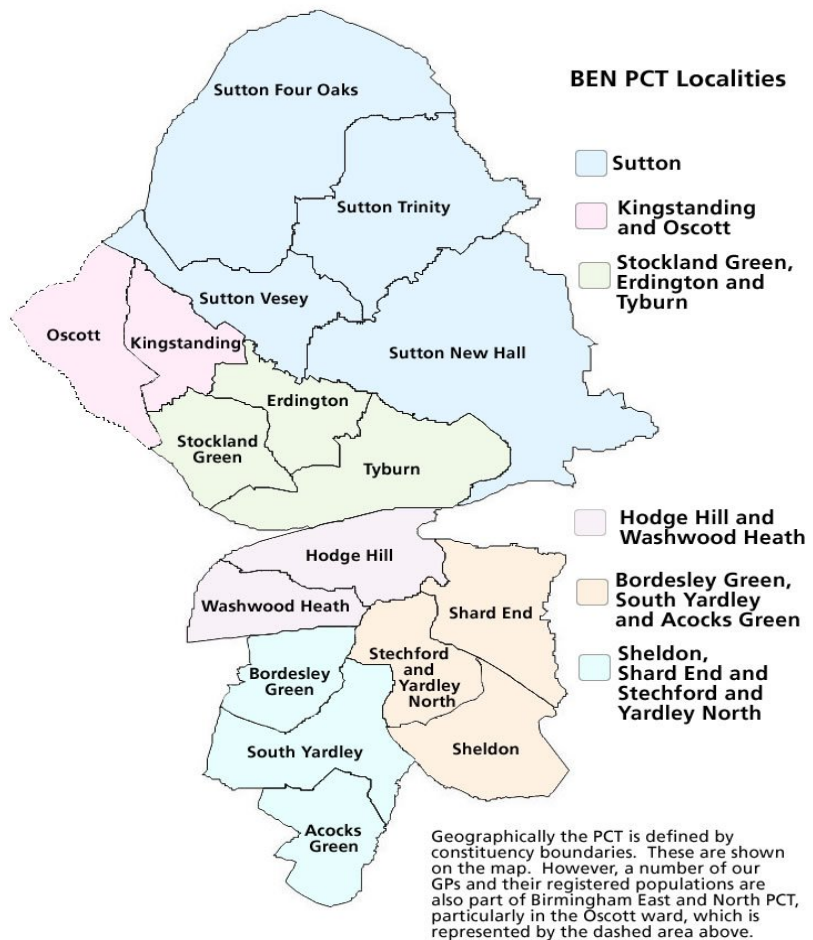
Birmingham East and North PCT was created in October 2006 following the merger of Eastern Birmingham PCT and North Birmingham PCT and provides primary care, intermediate care and community services on behalf of 437,500 people. We employ over 1,700 staff and are responsible for circa 240 GPs over nearly 90 practices, as well as John Taylor Hospice and Sutton Cottage Hospital. The PCT has a budget in excess of £500 million to provide services for its local population and hosts a budget of nearly £400 million to spend on commissioning specialized services for people across the whole of West Midlands.

One of the most striking aspects of our profile is the huge variation of health and levels of deprivation across the population we serve.

Several of our wards fall within the 20% most deprived wards in England, with Washwood Heath, Kingstanding, Shard End and Bordesley Green in the top 5% of most deprived communities.

All wards in these areas are classified as urban, are within the 25% least healthy with relatively high rates of chronic disease e.g. coronary heart disease and diabetes, and are the most deprived in terms of income and employment.

The Sutton wards, however suffer much less deprivation and ill-health being in the top 25% of affluent (unemployment is low at 2% - 3%.) and healthy communities. However, even within these prosperous areas lie areas of great need, for example Falcon Lodge.



The proportion of minority ethnic groups varies greatly between wards in the PCT from 71% in Bordesley Green to 6% in Sheldon. The average age in Bordesley Green is 30, with Washwood Heath having a relatively young population with more under-16s than in most parts of Birmingham. In contrast, however in the Sutton wards there is a higher proportion of people aged 50 plus compared with the national average and a below national average proportion of 15 to 35 year olds.

1.3. Health Needs Assessment:

Every year, over 4,000 people in the PCT area die. The single largest group of deaths are from diseases of the circulatory system, which account for over 38% of the deaths. They include deaths from heart disease and stroke, where the vessels that circulate blood around the body cannot function normally because of fatty deposits and/or inflammation associated with lifestyle factors, mainly smoking, unhealthy diet and lack of exercise. The second largest group of deaths are from cancer, which cause 26% of deaths. Respiratory disease causes 14% of all deaths.

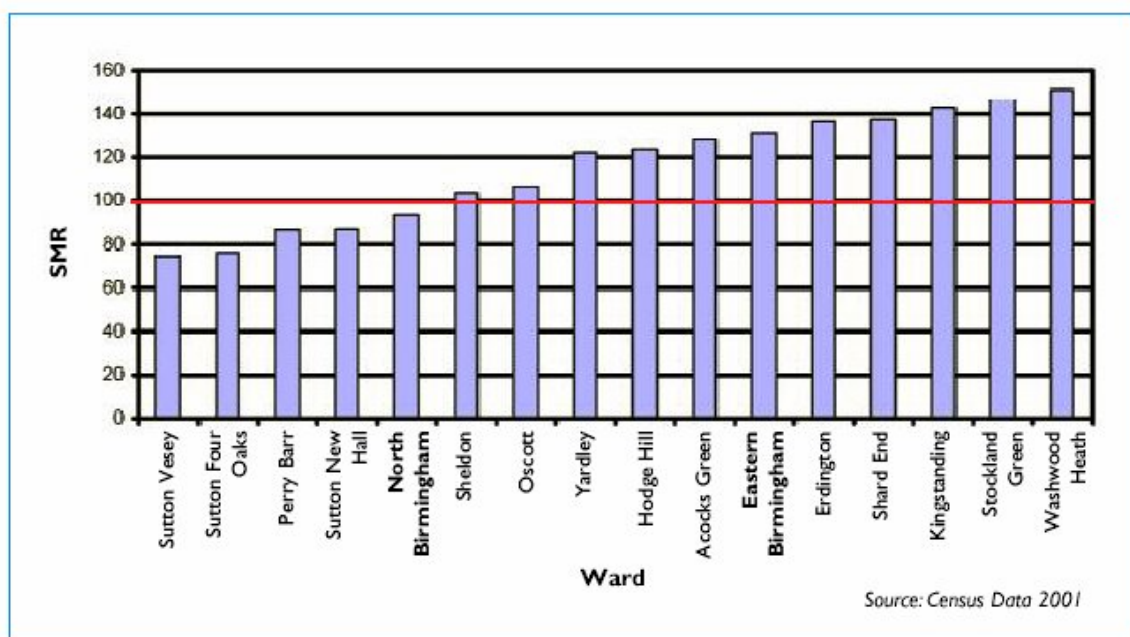
As reflected above, the rates of mortality vary greatly across the different wards in our area. For example, the standardised mortality rate (which allows us to compare our death rate with those of the country as a whole, taking in account the differences in age and sex) is 50% higher in Washwood Heath (compared to England as a whole) whilst it's 11% lower in Sutton Vesey.

Most of the differences in mortality and life expectancy are associated with deprivation. Our figures tell us that the most deprived communities have mortality rates around twice as high as those in the most affluent communities. You can see from the table and graph below how mortality and deprivation not only varies greatly across our area, but how the worst occurs in the same wards.

2004 Ward name	IMD*	Income	Employment	Health	Education	Housing	Crime	Living
Washwood Heath	58.4	0.5	0.2	1.3	62.9	27.1	0.9	34.9
Kingstanding	49.8	0.3	0.2	1.0	57.3	27.8	0.9	42.4
Shard End	49.1	0.3	0.2	1.0	60.7	24.8	1.0	45.8
Bordesley Green	45.3	0.4	0.2	1.0	49.7	28.6	0.5	27.2
Tyburn	42.0	0.3	0.2	0.9	49.0	27.0	1.0	26.5
Stechford And Yardley North	40.1	0.2	0.2	0.8	44.2	25.0	1.1	34.6
Hodge Hill	38.3	0.2	0.2	0.7	42.0	25.1	0.7	33.1
South Yardley	37.9	0.3	0.2	0.7	41.1	26.5	0.8	33.3
Stockland Green	36.4	0.2	0.2	1.0	31.0	27.1	0.7	26.5
Erdington	33.9	0.2	0.2	0.7	31.0	27.3	0.8	25.7
Sheldon	31.0	0.2	0.1	0.4	34.1	25.5	0.7	35.4
Oscott	27.6	0.2	0.1	0.4	33.0	24.9	0.4	38.4
Sutton Trinity	19.3	0.1	0.1	0.1	11.4	25.4	0.4	26.2
Sutton New Hall	14.0	0.1	0.1	-0.2	7.6	25.2	0.3	30.7
Sutton Vesey	13.4	0.1	0.1	-0.1	6.7	24.1	0.3	20.8
Sutton Four Oaks	11.0	0.1	0.1	-0.2	5.0	26.0	-0.1	14.6

- IMD = Index of Multiple Deprivation. IMD scores are based on the idea that deprivation is made up of 7 separate dimensions or 'domains'. These are income deprivation; employment deprivation; health deprivation and disability; education, training and skills deprivation; barriers to housing and services; living environment deprivation; and crime.

Figure 3: Standardised mortality ratios (all causes) for individual wards within Birmingham East and North PCTs



In order to reduce health inequalities and reduce avoidable deaths, it is clear that our 3 highest public health priorities are:

- Circulatory disease
- Cancer
- Smoking

Tackling these areas involves recognising the inter-relationship between disease and lifestyle/environmental factors. For example:

- *Perinatal and Infant Mortality:* There is considerable evidence of strong links between deprivation, smoking and perinatal mortality. In addition, poor infant health contributes to inequalities between different social groups. Initiatives such as tackling teenage conceptions, breastfeeding, protecting infants and children from second-hand tobacco smoke, and immunisation rates all contribute to improving perinatal and infant mortality.
- *Teenage Conception and Sexual health:* In both these areas, there are high rates in those wards with high deprivation. The national findings from the Teenage Pregnancy Unit show that teenage mothers are more likely to not finish their education, more likely to bring up their child alone and in poverty, have a 60% high rate of infant mortality, be more likely to smoke during pregnancy, are less likely to breastfeed, and have three times the rate of post-natal depression. Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life. These factors make both teenage mothers and their children more likely to suffer from disease and die early.
- *Obesity:* Obesity is increasing in the UK and appears to be linked to deprivation. Obesity is defined as having a body mass index of more than 30. More people in our deprived wards are obese than those in our least deprived wards and there are clear links between obesity and circulatory disease and cancers. The growing problem of childhood obesity is of particular concern and new national targets are coming out to measure this. Regular consumption of 5 fruit and vegetable a day, regular exercise, and a healthy diet have been

shown to substantially reduce the risk of many diseases, including heart disease and cancers.

- *Older People:* Elderly men are at a much greater risk than women of the same age of dying early, particularly during the winter months. Many of these deaths are preventable if appropriate care is provided early and if they have the right living conditions. Older people are also more likely to suffer from long-term conditions and multiple diseases, which if not managed correctly and tackled early can contribute to a poor quality of life and early death.
- *Long-Term Conditions:* As healthcare improves and early deaths from preventable conditions decreases, there is also a growing number of people who live with long-term conditions. Whilst many older people suffer from long-term conditions, there are significant numbers of people of other ages that also suffer from these conditions. Supporting people to manage their long-term conditions pro-actively can help people to manage their symptoms, feelings and other factors associated with their condition.

Our work, therefore, is targeted at actions that will improve lifestyles and reduce disease in these areas. As people's health is affected by factors wider than simply the healthcare they receive, this work involves working with communities and other agencies to positively influence the environment in which people live in order to tackle these inequalities. For further information on the health of our population, the Public Health Annual Report 2006 is available on the PCT website www.benpct.nhs.uk

2. Strategic Direction

2.1. Purpose & Values

In June 2005, recognising the health issues facing our population, and in preparation for merger, both predecessor PCTs agreed on a shared set of values and goals and common purpose:

Working in partnership to tackle inequalities and improve the health and well-being of local people

We know that people (whether our communities or our staff) are key to ensuring that we can achieve our purpose, and so we also agreed on a common set of values:

- A.** Active approach, competent, progressive and innovative;
- C.** Caring about our patients, staff, and communities, in all their diversity;
- E.** Empowering people and partners to work together.

2.2. Strategic Goals

As well as agreeing our core values and goals, we agreed our strategic goals:

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

To help achieve this, the PCT has 5 key strategies:

- *R 4 – Redesign, relevance, responsiveness, resources*; this is the core commissioning approach across all three tiers for which the new PCT is responsible;
- *Quality Patient Service*: this is concerned with a systematic approach to clinical governance and evidence based practice;
- *Promoting Health/Saving Lives*: the focus here is on improving health status and tackling inequalities within the PCT and between the PCT and others in the city and region;
- *Involving People*: a commitment to continue to operate in a way which maximizes opportunities for people to participate, whether as patients, members of the public, colleagues in the City Council or other NHS Trusts, or staff;
- *Consistently fit for purpose*: a focus on ensuring that the infrastructure (Estate, Information Technology and Workforce) is right to meet the demands that will be placed upon it over time.

3. Commissioning Plan:

Significant work has been undertaken over the last twelve months to develop the commissioning function of the PCT and 07/08 is our first Commissioning Plan, reflecting an integrated approach to our populations needs and building on the success of our predecessor organisations. The plan is underpinned by a Commissioning Strategy 2007/08 to 2009/10, which sets out the public health needs of the population.

The plan is also produced against a backdrop of significant financial pressure which means that in delivering this plan the majority of future investment will come through:

- Radical service redesign
- Delivery of demand management initiatives
- Effective Care and Resource Utilisation
- Significant reductions in Acute trusts costs

The aim of the commissioning plan in 07/08 is to build on the work undertaken in the PCT during 06/07, which was aimed at commissioning services which:

- Prevent illness and unplanned admissions to hospital
- Increase self-care
- Shift activity and services into Primary Care where appropriate
- Are based on the development of new pathways for patients
- Increase joint commissioning with partner organisations and increase the range of pooled budgets
- Demonstrate increased productivity and efficiency
- Deliver the targets outlined in the 07/08 operating framework
- Increase accessibility and choice
- Achieve 18 weeks

The commissioning plan in 2007/08 signals changes in the following areas:

- Acute activity contracting challenges
- Extension of Community and Intermediate care services
- Stroke services including primary prevention
- End of Life Strategy and links to cancer drugs
- Development of the Making the Shift projects particularly Continence and pain management services
- Birmingham Own Health and links to male life expectancy
- Redesigning of Mental Health services with a particular focus on Alcohol services

- Review and redesign of Sexual Health Services
- Dermatology services as a model of market testing
- Review of Midwifery services and links to infant mortality
- Learning translated into service redesign with initial focus on CHD, COPD and Diabetes
- Disinvestment strategies

As far as implementation planning is concerned much of this work has been underway for some time and has involved providers at all stages. This is intrinsically linked to the “Working Together for Health” approach adopted across the health economy and the strategies adopted through “Working Together for Health” and “Lets Do” principals as well as ensuring all commissioning planning is built on the introduction of new patient pathways. A large majority of the commissioning planning changes are agreed with providers.

The PCT has an agreed approach to the measurement of new service developments to ensure the envisaged outcomes are achieved. The PCT undertakes outcome measurement under five key headings:

- Financial
- Activities
- Clinical
- Satisfaction (patient and clinician)
- Organisational

3.1. Developing Practice Based Commissioning

BEN PCT has been developing Practice Based Commissioning (PbC) since its introduction in 2004. The PCT has a well-established strategy for PbC, which has been reviewed by both the Audit Commission and the Prime Ministers Delivery Unit. Eighty-one out of eighty four practices are engaged with PbC at differing levels. There are clear governance structures through the six localities and Localities have a management team, which is led by a Clinical Director and supported by Locality Director and support staff. Budgets are devolved to PbC and are aggregated at Locality level. All the requirements of the PbC guidance have been implemented.

During 06/07 Practice Based Commissioners were asked (due to the financial challenges) to concentrate on four key objectives:

- Focus on managing referrals
- Increased use of Community Based Services
- Focus on managing prescribing costs
- Planning for 07/08

PbC responded by reducing referrals between 10 and 15 per cent, maintaining prescribing costs way below the national increase and increasing the use of case managers and intermediate care services as well as supporting the introduction of prior approval and utilisation management techniques as outlined in the July 2006 Commissioning framework.

All the above was on the basis that PbC and the PCT were preparing for 2007/08 and a real step change in commissioning planning from PCT to PbC level. This change is supported by the production of Locality Commissioning Delivery Plans, which set out PbC aspirations for 2007/08. The PCT has already committed to supporting PbC with real management costs and pump-priming resource to support service change and this is included within the PCTs financial plan for 07/08.

The key objective for 07/08 is to give freedom to PbC to make local commissioning decisions within BEN PCT’s identified key priorities areas, which not only meet local peoples needs but

address issues in the commissioning strategy and support the delivery of national targets. This will also require PbC to find innovative ways of ensuring that local people support their commissioning decisions. Work has been underway during 2006/07 to ensure that PbC have the necessary support and capabilities to undertake these tasks particularly related to public health and information requirements.

4. National and Local Targets

4.1. National Targets

We are committed to achieving a series of national targets, which are outlined in Appendix 1. In addition to these targets, we are working on:

4.1.1. Achieving a maximum wait of 18 weeks from GP referral to start of treatment

Traditionally, waiting times have been measured from the time a GP refers a patient to them first seeing a hospital consultant. However, for many patients this is only part of the process, as some then wait to start their treatment. There has been considerable progress in improving waiting times over the past few years for our population and at the end of March 2007 the relevant milestones will have been met.

We recognise however that achieving the 18 week target is extremely challenging and requires a focus on the whole patient pathway to ensure that the invisible delays in the system are recognised and addressed. As a basic principle across all of the PCT's commissioning intentions, redesign and reinvestment will be the main focus and in particular within diagnostics. Challenges and key action include:

- Capacity and demand modelling – identifying and action planning for the gaps
- Service redesign in key areas which will alleviate 18 week breaches and ensuring clinical leadership in these areas of redesign
- Ensuring new pathways and protocols are reflected in new contractual arrangements
- Ensuring direct access to diagnostics for relevant Primary Health Care Professionals especially those not provided by the Independent Sector Contracts
- Setting up systems for performance management

However we recognise that additional investment is also required in order to ensure the milestones are met and our investment in this area is outlined in the section on finance.

4.1.2. Tackling MRSA

BEN PCT and our major providers have commitments to year on year reductions in MRSA infections and other hospital acquired infections including C. Diff. We have set out our requirements for reducing MRSA and C. Diff. rates in 2007/08 in our contracts with all our providers and this includes requirements to demonstrate that they are applying best practice in infection control in their strategies for reducing hospital acquired infections.

We are also a provider of community services and are implementing a comprehensive action plan and audit programme. In addition, we are investing £42,000 in an additional wte Infection Control Specialist to improve infection control management as both a provider and commissioner.

4.2. *Preparing for Forthcoming National targets in 2008/9:*

To prepare for new targets in providing choice for pregnant women; care for those people facing the end of their lives; and weighing and measuring children we are.

4.2.1. *Maternity Choice*

Work is underway to reduce peri-natal mortality levels across Birmingham. A key part of this work will be to review midwifery services in 2007/08 in preparation for offering choice of maternity care in 2008/09.

4.2.2. *End of Life Care*

We have agreed a strategy for end of life care, which aligns with the End of life care networks approach. In 2007/08 we will continue the work to implement a model of supportive care for people with Long Term Conditions in the last year of life. We will through the end of life strategy implementation group continue to deliver the agreed approach on home care through the hospice at home scheme as well as preparing for 2008/09 to implement the work that emerges from the end of life care national strategy.

4.2.3. *Weighing and Measuring Children*

A system has been agreed for uploading data for reception year children into the PCT database to enable us to track changes and best provide services. With support from our School Nursing teams, this will be rolled out to all primary schools in our area as part of a curriculum based methodology. For further details, check http://www.southbirminghampct.nhs.uk/services/public_health/YoungPeople/BMI.htm

4.3. *Core & Developmental Standards*

The Standards for Better Health (SFBH) (published in July 2004, comprising of 24 Core Standards and 13 Developmental Standards) set out the level of quality that the Department of Health expects all organisations providing NHS care in England to meet (or in the case of the Developmental Standards, aspire to meet). The areas covered and the responsible Directors are outlined in Appendix 2.

4.4. *Tackling Health Inequalities*

Earlier we outlined our highest public health priorities and workstreams. Here we describe in more detail, the work we will be doing this year to work towards those priorities.

A lot of the work in 2007/8 is the continuation of existing workstreams that either involve redesigning the amount of resource currently invested (e.g redesign of Midwifery Service) or are funded from external sources (e.g Male Life Expectancy Programme). Our share of the increased funding identified for "Choosing Health" in 2007/8 is £601k and we are committed to investing at least this amount.

Tackling inequalities and improving health involves looking at areas wider than just healthcare. Local Area Agreements are "deals" between local partners and central government designed to improve key outcomes by making integrated use of funding and innovative delivery of services. The Birmingham Strategic Partnership Board has overall responsibility for delivering the LAA.

In Birmingham the LAA covers over 100 current funding streams and over £100m of funding for the city (including neighbourhood renewal funding). These have been merged into just four blocks, potentially making cross-cutting partnership working more effective:

- [Safer and Stronger Communities](#) – Birmingham Community Safety Partnership
- [Children and Young People](#) – Birmingham Children and Young Peoples Board
- [Healthier Communities and Older People](#) – Birmingham Health Action Partnership
- [Enterprise and Economic Development](#) – Birmingham Economic Development Partnership Management Board.

We are actively working with our partners through the Birmingham Strategic Partnership, the Birmingham Health and Wellbeing Partnership and these four blocks (particularly Children and Young People, and Healthier Communities and Older People) to tackle health inequalities.

Within the LAA, there are two particular targets the PCT is focussed on (Male Life Expectancy and Infant Mortality). Funding for this is currently via the Neighbourhood Renewal fund, but from 2008 this will become core NHS activity through the PCT Investment Plans.

4.4.1. *Male Life Expectancy (funded through LAA and delivered across Birmingham)*

The LAA has a male life expectancy target of reducing the gap between Birmingham and the national average by 10% from our 2004 starting position, and closing the gap between the 20% most deprived wards in Birmingham and the city average.

The Male Life Expectancy (MLE) project, delivered on a city-wide basis, has an ambitious programme of work for 2007/08 targeted at improving MLE; this is supported by £2.6m of NRF funding. An analysis of the cause of death in men considered along side current initiatives identified the following two key areas for immediate action

- The identification and systematic management of circulatory diseases in primary care, paying particular attention to men aged 40-65 and the most deprived areas of the city; the Birmingham Own Health Project which delivers a targeted care management programme is being extended across Birmingham in 2007/8
- Improvements in the targeting and delivery of smoking cessation and tobacco control services; a city-wide call centre has recently been commissioned with significant investment in publicity and advertising to encourage smokers to access stop smoking services.

Other areas of focus for 2007/08 include:

- Re-commission Cardiac Rehabilitation Services
- Deliver Social Marketing Campaign
- Roll out Pharmacy Screening Pilot
- Commission mobile health screening unit
- Appoint a Cardiovascular Nurse Consultant
- Embed Neighbourhood Healthy Heart Workers in local processes
- Commission evaluation

4.4.2. *Infant Mortality*

With our partners, the LAA has a target of reducing the gap in infant mortality between Birmingham and the national average by 10% from our current position (2004) and closing the gap by reducing the number of wards with rates above 10 per 1000 live births.

We are working through the LAA in a number of areas across Birmingham including establishing a Pan Birmingham approach to commissioning maternity services in order

to ensure city-wide standards to an agreed city-wide specification of service and a joint response to the city-wide CESDI findings. As well as this we are launching a number of local initiatives including improved access in our most disadvantaged wards to local clinics for prenatal services such as booking and scans.

As reflected in an earlier section on Health Needs Assessment, we are also taking a number of actions on tackling teenage conceptions, breastfeeding, protecting infants and children from second-hand tobacco smoke, and immunisation rates.

4.4.3. *Teenage Pregnancy & Sexual Health*

Teenage pregnancy is a complex issue, affected by young people's knowledge about sex, relationships, access to advice, support and influenced by aspirations, educational attainment, parental and cultural environment. A number of wards in BEN PCT are seeing significant rises in teenage conception rates and sexual infections. Whilst sexual infections are not an exclusively young person's problem, we are participating in a national approach to reducing teenage pregnancy by improving access to information and sexual health services, working with schools and providing support to families. In addition to this, we are continuing to roll out our Locally Enhanced Services for Sexual Health which provides incentives for GP practices to test for sexually transmitted infections (all age ranges).

Our Teenage Pregnancy Action Plans which involve increasing access to contraceptive services, as well as providing accurate advice and information to help young people make the right choices and develop increased confidence and self-esteem. Some of the specific areas we are focussing on are:

- Mainstream and Expand Here4You clinics
- Mainstream the Young Parents Support Groups
- Collaborate with City-wide approach on the Youth Development Programmes, Teenage Pregnancy and SRE policy development.
- Agree a new sexual health service specification for Birmingham.

4.4.4. *Early Years*

A key goal for the PCT is to improve the health and well being of the local population. The PCT recognises that in order to achieve this aim in the long term we have to focus our services on the younger population and provide information that allows informed decision making for long term healthier lifestyles. The initial focus of this approach is to concentrate on the following areas:

- Infant Feeding (including peer counselling training and staff training)
- Healthy Schools
- Immunisations and Vaccinations
- Childhood Obesity

4.4.5. *Lifestyle Change*

Your health to a large degree is affected by lifestyle choices; we are developing a range of services that are targeted at those life style choices that have the worst impact on your health:

- Smoking Cessation Services
- EOP
- Community Awareness
- Obesity (Childhood and Adult)
- Sexual Health clinics.

4.4.6. *Cardiac Vascular Disease (CVD) Programme*

One of the key areas identified within our commissioning plan is to develop stroke services including primary prevention. To reduce mortality and morbidity from heart disease and stroke there is a need to identify and treat patients earlier who are at risk of Coronary Heart Disease. The CVD risk reduction programme will be the initial focus on achieving this. Key elements of which are:

- Establish primary prevention programme
- Redesign Hypertension Services
- Support 'Accelerating the Pace of Change CVD Projects'
- Expand CPR programme

4.4.7. *Self-Care*

The Expert Patient Programme (EPP) is based on research that shows that people living with chronic illnesses are often in the best position to know what they need in managing their own condition. Provided with the necessary 'self-management' skills, they can make a real impact on their disease and quality of life, we are expanding our programme in the following areas:

- Expand EPP partnership working with Mental Health/Waterloo Housing
- Establish PiH EPP programme for those on incapacity benefit
- Our greatest asset is our staff; we are encouraging staff with LTC to undertake the course during work hours and possible going on to become a volunteer tutor.
- To Achieve BENPCT share of LAA target in 07/08 (1902 by 07/08)

5. Finance

5.1. *Financial Context*

BEN PCT was required to identify savings of £25.8m in order to set a balanced budget as a result of the changes to the funding regime for PCTs signalled in the Operating Framework published in January 2006. Despite delivering 80% of these savings the PCT will not manage to achieve a balanced position for 2006/7 largely as a result of three factors

- The average hit across the West Midlands as a result of the changes to the funding regime was 4.2%; if this had been applied to BEN PCT then our contributions to the SHA Bank would have been £4.6m less than they are.
- The full level of historic debt in North Birmingham PCT which including the impact of arbitration case in 2005/6 is £7m (towards which the SHA provided £1m support from the SHA Bank). This in effect has required the PCT to identify additional savings of £6m (1.2%) in 2006/07 on top of the £25.8m
- The PCT has contained activity at lower levels than 2005/06 in most areas of its portfolio, despite this costs have continued to rise as a result of "better" coding by providers – a position that is currently being challenged by the PCT.

Looking forward to 2007/8 the key issues for the PCT in achieving financial health are:

- Setting out commissioning plans to take account of the required capacity to deliver the 18 week target (using NHS and non NHS providers).
- Outlining in advance the PCTs commissioning intentions to providers based on the positive actions taken in 2006/07 to contain demand.
- Use the Commissioning Framework to ensure best value, such as the tendering of the Dermatology service
- Set up a Prior Approval system to ensure appropriate conditions are treated in the appropriate places.

- Sharing commissioning plans with providers to avoid any disagreements regarding the intentions and expectations for 2007/08 and ensure that contracts are agreed before the beginning of the financial year that clearly state both the levels of activity to be delivered and how the PCT will be charged for that activity.
- Ensuring that cost improvement programmes are robust and in place before the beginning of the financial year.
- Focussing attention on the amount of resource already invested and using redesign to increase productivity and reduce costs rather than rely on additional investment.
- Rigorous monitoring and review of activity to ensure that where necessary action is taken to ensure that financial balance is not put at risk by activity over-performing against plan.

Most of the above areas formed part of the PCT's Fitness for Purpose exercise, which was positively received. The feedback highlighted the robustness of the PCT's financial planning and reporting. It should be noted though that the exercise was based on delivering a 1% surplus and not a 2% top slice which has impacted on our ability to achieve financial balance.

5.2. Budgets & Investments

5.2.1. Revenue Budgets:

The financial year 2007/08 is the final year of above inflation growth that the NHS is due to experience. However, despite record levels of investment, achieving financial balance is a large challenge across the health economy.

As in 2006/07, the PCT is required to make a contribution to the SHA in order to achieve balance across the economy; this has been set at 1% of the opening resource allocation for 2007/08 (£5,926k).

In addition to this contribution the PCT must hold a 1% contingency, and generate a share of the planned West Midlands surplus of £22.3m, which are accounted for in the application of funds.

Below is a broad summary of the sources and application of funds:

Summary of Revenue Resource Limit 2007/08	£'000
2006/07 recurrent allocation	551,721
Recurrent increase on allocation	55,194
Repayment of 2006/07 forecast overspend	-902
Contribution to SHA Reserve	-5,926
Other Allocation adjustment (mainly practice transfers)	-7,117
Initial Revenue Resource Limit	592,970
Summary Expenditure Plans 2007/08	
Commissioning	432,388
Prescribing	67,680
GMS/PMS	53,111
Management	20,518
1% Contingency	5,926
Non recurrent solutions 2006/07	2,400
Earmarked reserves	8,568
Identified Risks	600
Total Expenditure	591,191
Required surplus	1,778

The above figures are subject to confirmation and are based on initial SHA guidance.

Appendix 3 provides a breakdown of the application of growth funding for 2007/08 based on current information.

5.2.2. Investing to Reduce 18 Week Waiting Times:

The required investment to deliver 18 weeks has been discussed with and agreed with our providers. Achieving the target is one of the largest challenges facing the PCT in 2007/08, and this is reflected by the level of investment, 9.3% of available resources.

Summary of 18 Weeks Investment 2007/08

Area	Amount £'000s
Elective and Day Cases	2,579
Outpatients	445
Diagnostics	400
Total	3,424

It should be noted that BEN PCT has generally a lower set of waiting times compared to the National average and therefore the level of investment will be lower when compared to some PCTs. In addition the successful application of the Prior Approval scheme will enable greater capacity within secondary care to address the target.

5.2.3. Capital Programme 2007/08

The PCT receives streams of funding for capital and Revenue and is required to manage within these Capital and Revenue resource limits separately. One of the challenges facing the PCT in terms of financial management is that the source of funds does not always match the type of expenditure incurred e.g. funding for IT hardware received as Revenue where the expenditure is capital and funding for LIFT project costs received as Capital where the expenditure is Revenue. Below are details of the capital funds we receive and how we plan to invest them:

Sources of Capital Funds for 2007/08

Source of Capital Funds	£000
Block Capital	613
CAMHS LD b/fwd from 2006/07	118
Dental services capital b/fwd from 2006/07	350
Total sources of capital	1,081

Proposed Application of Capital Funds for 2007/08

Site	Works	£000
Church Lane	Replacement roof	20
Hodge Hill	Landscaping	10
James Preston	Window replacement	15
Oscott	Outside lighting	10
Receipt & Distribution centre	Storage and sorting systems	30
Waterloo Road	Heating and air conditioning	35
Various	Statutory maintenance, Fire safety, security works and energy management	228
Various	Items charged to revenue providing flexibility for capital spend from other revenue allocations	265
CAMHS LD	B/fwd from 2006/07	118
Dental services	B/fwd from 2006/07	350
Total application of Funds		1,081

It should be noted that this forms part of the PCT's investment in its Estate; the PCT also makes revenue grants to General Practices to improve their premises and manages investment on the maintenance of its premises.

5.3. *Cost Improvement Programme*

Cost improvement targets for our providers are passed on directly through the national tariff. For our provider arm and corporate services plans have been drawn to deliver a savings target of £831k. This will be delivered in summary through the redesign of services, staff skill mixing, value for money procurement and an establishment control system. It should be noted that in 2006/07 the PCT exceeded its CIP target and maintained a high quality level of services, therefore there is an expectation that the £831k will be achieved.

6. **Delivering the PCTs Plans:**

How well we succeed in our plans is dependent on our capabilities, recognising the risks to our plans and recognising that there are factors beyond healthcare that effect an individual's health such as lifestyle and the environment they live in. Involving, informing and empowering our communities is one of our strategic goals. We also want to be the first choice organisation that people want to work with and for. Below are the key strategic areas that we will be focussing on to ensure that we can deliver on our plans.

6.1. **Tackling Ill-Health With Everyone's Help**

We have a mission to tackle ill health and look at new ways of offering services to best achieve results, using learning from multiple organisations to know more about the communities we serve and offer the best possible services. It is a key goal to involve and empower patients and enable self-care, giving responsibility for the development of local services back to the population. We also directly employ over 1,700 staff, working for and living amongst the communities we serve. To achieve our goals we need the commitment of our staff to embrace and promote new models of care so that our communities understand what we provide and that we understand what they need.

This approach underpins everything we do and is behind our thrust of "**Taking the Story to the People**" (*Tackling Ill-health through innovative improvements, only with your help*). However, we know that we need to do more and we will particularly be focussing on:

- Building on the work of our Neighbourhood Health Development Officers and patient/public involvement groups, we will find new ways to **engage with our communities** so that we better provide the services they need in the way they need them.
- Extend **joint working** with our partners (including the Health and Wellbeing Partnership).
- Build on initiatives such as the **Expert Patient** Programme to help people manage their symptoms, feelings and other factors associated with their conditions.
- **Equal but Different:** Examine the way we provide all our services to ensure that we meet their needs regardless of who they are, but particularly looking at equality regardless of **race, gender, age, or disability**. Within 2007/8, we will particularly focus on progressing work on these equality schemes.

6.2. **Organisational Capacity & Capability**

6.2.1. *Clinical Leadership*

Recognising that commitment of clinical staff is key, clinical leaders from the PCT continue to engage directly with clinical staff at Heart of England NHS Foundation

Trust and Good Hope Hospital NHS Trust and other providers to plan and implement service changes. Our organisational structure not only recognises the importance of the PEC Chair and Medical Director role, and Clinical Directors for each Locality (leading Practice-Based Commissioning), but has also developed Clinical Directors in Organisational Development & Strategy; Clinical Effectiveness; Involving People; and Organisational Capacity.

During 2007/8, we will continue work in:

- Supporting clinical staff to redesign service provision and pathways of care in our priority areas, utilising the:
 - Clinical forum for Clinical Directors from both the PCT and Heart of England Foundation Trust focussing on designing the pathway of care & service provision.
 - Working Together for Health change management approach to accelerate the pace change.
- The development of Practice-Based Commissioning and the implementation of Locality Development Plans.
- Developing performance tools supporting General Practice.
- Investing in Clinical Development days.

6.2.2. Organisational Development (OD)

Our approach to organisational development is grounded in a belief that those working within, working with and using services in an organisation, at all levels, are those best placed to drive effective change. One of the outstanding achievements in OD over the past 18 months has been the successful integration of the two PCTs. Alongside this, additional activity has been undertaken in a number of areas including:

- developing an acute services strategy alongside Acute Trust partners for the North of the economy;
- internal core development including Board development days;
- “Managing Performance” dialogues for key managers;
- 2-two training programme to develop 21 members of staff as OD facilitators.

The PCT faces a number of OD challenges over the next 18 months to 2 years with three key focus areas being a priority:

- Maintaining a focus of ensuring total integration of two organisations into one.
- Ensuring a workforce and an approach that is fit for purpose within the new responsibilities set for PCTs.
- Developing a culture that is responsive and innovative and continually seeking to drive efficiency and quality.

6.2.3. Fitness for Purpose

During 2006/7, the PCT underwent the Fitness for Purpose assessment process. This confirmed a number of positive areas but also helpfully re-enforced the need for the PCT to address areas that, if left unaddressed will threaten the achievement of our long-term objectives. Specifically, our priorities are:

- To develop a robust contracting framework complete with finance, activity, clinical outcome and patient experience clauses based on the needs of the population to ensure good prioritisation, a good relationship with the acute trust and to enable better control over commissioned activity, costs, clinical outcomes and patient experience.

- The development of a contestability strategy to increase the range of providers and access points, which also successfully engages the public, local authority and other stakeholders so that they not only understand but own the changes in care. Work will begin early in 2007/8 on the next stage of the Fitness for Purpose process, which is the Development Plan that will help work through these priorities.

6.2.4. Physical Infrastructure

The main priorities, which we will be focusing on, include:

- Opening of the new Primary Care Centre in Perry Common.
- A new Primary Care Centre in Stockland Green is under construction and will be completed in May 2008.
- The development of new Primary Care Centres in Stechford and Sattley, and progress to Full Business Case and financial close of both projects by 31 March 2008.
- Extensions to Yardley Green Medical Centre and Great Wood Road Surgery completed during the year to provide additional capacity in Primary Care.
- The development of a permanent solution for the Partners in Health Centre and progression to Full Business Case by 31 March 2008.
- Improvements to John Taylor Hospice funded by the League of Friends.
- Progress development of new Primary Care Centres in Hodge Hill and Kitts Green.

6.2.5. Connecting for Health

“Connecting for Health” is the overarching project to ensure that information is provided where and when it’s needed in order to improve the service that is provided to patients. During 2007/8, the Connecting for Health team within the PCT will focus on:

- Community Patient Administration System (PAS) – major upgrades scheduled throughout the year.
- GP Systems of Choice (GpsOC) – a major project to upgrade all GP systems to meet new national standards.
- Electronic Prescription Service – a major upgrade so that all GPs and Pharmacists process prescriptions electronically.
- Child Health System – introduction of a new child health system.
- Information Governance and Data Quality – working towards developing and integrating Integrated Governance and Data Quality against emergency national Connecting for Health Standards.
- Network Infrastructure enhancements and the development of a mobile technical solution to meet the changing needs of services.

Connecting for Health shouldn’t be viewed simply as computer systems, and all these projects will involve significant service re-design of services, with a particular impact on the provider arm.

6.2.6. Sustainability

With the growing attention to climate change and global warming, the PCT has taken a positive step to produce a Sustainability strategy, which reflects local and national government targets to reduce Co2 emission.

Following extensive work to procure energy from renewable sources and reduce fossil fuel consumption, the PCT has been awarded accreditation from the Carbon Trust, for progress achieved to date.

Accreditation has led to selection to participate in the NHS Carbon Management Programme, which will see further development of a range of strategies to reduce Co2 emissions in the various areas of Construction, Energy, Transport, Waste, Procurement and IT.

The aim of the PCT is to be viewed as a good corporate citizen, and at the forefront in the health sector in reducing Co2 emissions to the ultimate benefit of the local and global populations.

6.3. Providers

6.3.1. Independent Contractors

The Quality Outcome Framework (QOF) was introduced in 2005 as part of helping to improve the information available on services in primary care. This tool proves valuable in determining the quality of care provided by GP practices, but also provides a systematic way of collecting data that is used to estimate the prevalence (the percentage of people who are living with a particular disease) of some conditions. This allows us to target those patients who are most likely to benefit from a change in lifestyle and specific healthcare interventions. This means that not only are we targeting wards with the highest public health needs, but also individual patient level.

Key areas of work also include early detection of diseases such as diabetes and high blood pressure, as well as secondary prevention of harm from established circulatory and respiratory disease. Specific actions being taken in 2007/08 are:

- Development of GP / Pharmacy / Dental balanced scorecard
- Use of QOF data to improve care for patients with chronic diseases
- Use of QOF and contract data to improve chronic disease mortality rates
- Use O2 assessment commissioned services to improve quality of life and mortality rates for patients with COPD
- Ensure there is adequate orthodontic services for patients with severe IOTN ratings
- Ensure there are suitable premises for NHS dentistry in line with the Dental Capital Funding Policy
- Improve pharmacy performance against contract in order to provide a more integrated service in primary care
- Ensure there are PCT integrated early warning systems in place to identify and improve the performance of independent contractors
- Provide through the tendering process the right amount of GP/ Dental care in the BEN PCT area

6.3.2. Acute Services

During 2007/8, we will continue to build on our tripartite working with our main acute service provider to ensure that we work as a health economy. In addition, recognising that the changes that Payment by Results bring, we will use the following Systems Reform principles to modernise systems:

- Unbundling Diagnostics
- Prior Approval Schemes:
- Coding & Counting:

6.3.3. Operational Services

Continuing the gradual separation of the PCT's provider services (Operational Services Directorate), the PCT will during 2007/8 apply the Foundation Trust model to the Operational Services Directorate.

6.3.4. Third Sector

Following on from the Fitness for Purpose assessment, during 2007/8 the PCT will actively develop contestability and specifically develop a strategy to increase the range of providers and access points. This strategy will include potential development of and use of the Third Sector.

6.4. Risk Strategies

The PCT has an Assurance Framework that details the risks to us that may prevent us achieving our objectives. Underpinning this is the Corporate Risk Register that quantifies the impact of these risks and lists improvement plans. Both will be updated for 2007/8 and each Directorate will develop/complete their own Risk Register specifically linked through to the Corporate Risk Register.

The strategies and approaches outlined in the PCT Business Plan are designed to mitigate the risks that could prevent us from achieving our objectives, those risks are:

Ref	Principal Objective
AF 1	Within the Operating Framework for 2007/08 to achieve financial balance and mandatory financial targets set by the Department of Health whilst meeting the Government's agenda to press forward with the modernisation agenda.
AF 2	To develop robust financial and governance business processes to demonstrate best practice as outlined in the ALE.
AF 3	To ensure compliance with core standards and demonstrate progress towards developmental standards as outlined in <i>Standards for Better Health</i> .
AF 4	To meet set targets and demonstrate progress towards existing and national targets as outlined by the Healthcare Commission in the Annual Health Check.
AF 5	To continue to develop models of care which continue the process of moving services from secondary to primary care, through the transformation and redesign of services by: <ul style="list-style-type: none"> ▪ Working in partnership with acute and specialist providers to continue to roll-out the programme of developing a systematic approach to long-term care. ▪ Building capacity in primary care and community services, enabling patients to be seen and treated either in their homes or in the local communities. ▪ Supporting and managing the operation of practice-led commissioning.
AF 6	To identify and tackle waiting times in order to make progress towards the long-term goal of being so responsive to the population in East and North Birmingham that no one waits for the health care they need. (Ref to AF 8)
AF 7	To improve the health and well being of the population and to reduce inequalities which contribute to the goal of people enjoying ten more years of quality life – wherever they live in the PCT; and maintain a focus on infant mortality and male life expectancy as agreed in LAA.
AF 8	To manage any outstanding issues following the establishment of BEN PCT in October 2006 whilst maintaining the focus on improving patient services and business continuity.
AF 9	To encourage and support self-care and healthier lifestyles and to further develop patient and public involvement in health care – establishing communities in East and North Birmingham as the most involved, informed and empowered in the country.

AF 10	To continue to develop models of partnership working that enable the new PCT to be regarded as the first choice organisation to work with, and for.
AF 11	<ul style="list-style-type: none"> ▪ To review the information provided to the public and patients and to support patient choice as a further step towards the long-term goal of having the most informed, empowered community in the country. ▪ To obtain patient and public feed-back to increase the understanding of the needs of local communities. ▪ Focus on information to be available to public and taking the story to the people.

Outlined throughout this Business Plan are a number of strategies that we are using that will help us to mitigate the effects those risks have on us. In summary, we recognise that many of these risks can be addressed through:

- Pro-active clinical leadership and engagement and whole economy service redesign.
- Pro-active engagement with communities, partner agencies and other stakeholders in order to understand what our communities need and provide innovative and effective ways of meeting those needs.
- Strong business processes, including strong performance management, use of performance tools to support this, increased choice for patients, and integrated feed-back.

7. Next Steps

This Business Plan outlines what the PCT will do, as a corporate body, to deliver our Local Delivery Plan for 2007/8 and work towards achieving our strategic goals. Underpinning this is a high-level work programme against which the Trust Board and its Sub-Committees will performance manage our progress.

Supporting this are our Directorate and Departmental Business Plans which describe in more detail how each of our Directorates will deliver against our PCT Business Plan.

National Targets

Strategic Objective	Target	BEN Plan	Responsible Director
Efficient Use of Resources	Financial Balance		
	PBR New Outpatients: GP Referrals	32,939	JT
	PBR New Outpatients: C2C Referrals	18,087	JT
	PBR New Outpatients: Other Referrals	5,468	JT
	A&E Attendances: HoEFT	86,035	JT
	A&E Attendance: GHH	54,895	JT
	Non-Elective Admissions (PBR non-maternity)	19,438	JT
To be so responsive to the population we serve that no-one waits for the health care they need	Access to a GP* (not including walk-in centres)	100%	JT
	Access to a PCP* (not including walk-in centres)	100%	JT
	Cancer waiting times – 2 week, 1 month, 2 months	0	AD
	Ambulance: Category A calls meeting 8 minute target	75%	AD
	Ambulance: Category A calls meeting 19 minute target	95%	AD
	Ambulance: Category B calls meeting 19 minute target	95%	AD
	Delayed transfers of care	2.166%	LP
	Number of inpatients waiting longer than the standard	0	JT
	Number of outpatients waiting longer than the standard	0	JT
	Thrombolysis – 60 minutes call to needle time	68%	RM
	Total time in A&E: 4 hours or less	98%	JT
	Patients waiting longer than three months for revascularisation*	0	RM
	Access to genito-urinary medicine (GUM) clinics	76.80%	AD
	Access to reproductive health services	63%	AD
Waiting times for all diagnostic tests	0	AD	
That the health and well being of our population will have improved so much that people will enjoy 10 more years of quality life, wherever they live	Diabetic Retinopathy screening	80%	RM
	Four week smoking quitters	3,386	RM
	Practice Based Registers – Patients called for review	61%/81%	RM
	Blood Pressure	80%	RM
	Cholesterol Levels	68%	RM
	Infant mortality: breastfeeding initiation rates	58%	RM
	Infant mortality: smoking during pregnancy	14%	RM
	Drug misusers sustained in treatment	55%	AD
	Number of drug misusers in treatment	5500	AD
	Number of very high intensity users	850	LP
	Practice-based registers	30	RM
	Smoking status aged 15-75 years	80%	RM
	Emergency Bed Days	265,125	AD
GP recording of BMI status	50%	RM	

Our communities will be the most involved, informed and empowered in the country	Number of MRSA infections (acute trusts)	104	DW
	Convenience and choice: PCT booking	90%	AD
	Convenience and choice: facilities to support choice	80/80/80%	
	Community Equipment	100%	LP
	Community Matrons	23	LP
	Percentage of population served by practices achieving 80% or more QOF points (LAA)	95%	
	Number of pts recruited to Expert Patient Programme (LAA)	117	RM
	% Complaints resolved w/in 25 days (w/out exclusions)	100%	
That people regard us as the first choice organisation to work with and for	Achievement against HCC Core and Developmental Standards	100%	All
	Commissioning of crisis resolution/home treatment services*	945	AD
	Commissioning of Early Intervention Services	113	AD
	CPA 7-day follow-up	88%	AD
	Full-time equivalent staff in post (FIMS workforce return)	1466.10	TT
	Older People's MH: assessment of needs and services	compliant	AD

KEY:

JT = Jonathan Tringham, Director of Resources

AD = Andy Donald, Director of Redesign & Commissioning

LP = Louise Pritchard, Director of Operations

RM = Dr Richard Mendelsohn, Director of Health Improvement

DW = Dr Doug Wulff, Medical Director

All = All Directors

Core and Developmental Standards

SBH Ref	Core Standard	Responsible Director
1st Domain	Safety	
C1	a Incident reporting, analysis & learning	Director of Professional Services
	b Patient safety notices	Director of Professional Services
C2	Child protection including inter-agency working & CRB checks	Executive Nurse
C3	NICE Interventional Procedures	Director of Professional Services
C4	a Health care acquired infections including MRSA reduction	Director of Professional Services
	b Medical devices management	Director of Professional Services
	c Decontamination	Director of Professional Services
	d Medicines management	Director of Professional Services
	e Waste management	Director of Operations
2nd Domain	Clinical and Cost Effectiveness	
C5	a NICE technology appraisals & national best practice including NSFs & NICE CGs	Director of Professional Services
	b Care provided under supervision and leadership	Director of Professional Services
	c Clinical skills training	Director of Professional Services
	d Clinical audit and reviews	Director of Professional Services
C6	Inter-agency co-operation over individual patients	Director of Operations
3rd Domain	Governance	
C7	a Good clinical and corporate governance	Director of Performance and OD
	b Openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	Director of Resources
	c Systematic risk assessment and risk management	Director of Professional Services
	d Good financial management	Director of Resources
	e Discrimination, equality, human rights	Director of Performance and OD
	f Existing performance requirements	Director of Performance and OD
C8	a Whistleblowing	Director of Performance and OD
	b Organisational and personal development programmes including BME groups staff	Director of Performance and OD
C9	Records management	? Director of ICT
C10	a Employment checks and professional registration	Director of Performance and OD
	b Codes of professional practice & mechanisms to address issues	Director of Performance and OD
C11	a Recruitment, workforce planning & training	Director of Performance and OD
	b Mandatory training programmes & induction	Director of Performance and OD
	c Further professional and occupational development	Director of Performance and OD
C12	Research governance	Director of Health Improvement
4th Domain	Patient Focus	
C13	a Dignity and respect including DDA & acting on issues	Executive Nurse
	b Consent for treatment and use of patient confidential information	Director of Operations
	c Confidentiality	Director of Operations
C14	a Complaints and feedback	Director of Professional Services
	b Non-discrimination of complainants	Director of Professional Services
	c Response to and improvements after complaints	Director of Professional Services

C15	a	Choice of food, providing a balanced diet, which is prepared safely	Director of Operations
	b	24 hour access to food & patients' individual nutritional, personal and clinical dietary requirements	Director of Operations
C16		Information on services and care and treatment	Director of Performance and OD
5th Domain	Accessible and Responsive Care		
C17		Views of patients in designing, planning, delivering and improving health care services	Director of Performance and OD
C18		Equality of access to and choice in services and treatment	Director of Operations/ Director of Redesign and Commissioning
C19		Timely access to emergency care & services	Director of Performance and OD
6th Domain	Care Environment and Amenities		
C20	a	Safe and secure environments including protection of physical assets	Director of Operations
	b	Environments support patient privacy and confidentiality	Director of Operations
C21		Environments are well designed and well maintained with good cleanliness levels	Director of Operations/ Director of Professional Services
7th Domain	Public Health		
C22	a	Inter-agency co-operation to improve the health of the community served including sharing information on health and needs	Director of Health Improvement
	b	Local Director of Public Health's Annual Report informs policies, practices and commissioning	Director of Health Improvement
	c	Local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships	Director of Health Improvement
C23		Analysis of needs, planning priorities, provision & monitoring of programmes in line with NSF's and reducing obesity, smoking, substance misuse and sexually transmitted infections, supporting healthy lifestyles & public health lead	Director of Health Improvement
C24		Response to incidents and emergency situations including inter-agency working for annual testing	Director of Performance and OD

SBH Ref	Developmental Standard	Responsible Director	
1st Domain	Safety		
D1	Best Practice in Patient Safety and Risk Management	Director of Professional Services	
2nd Domain	Clinical and Cost Effectiveness		
D2	a	Best Practice defined by NSF's, NICE, and national guidelines	Director of Professional Services
	b	physical, cultural, spiritual and psychological needs and preferences	Director of Professional Services
	c	Seamless service across organisations, especially social care organisations	Director of Operations
	d	evidence-based practice	Director of Professional Services
3rd Domain	Governance		
D3	Best practice in Integrated Governance across organisations, health communities and networks	Director of Performance and OD	
D4	a	ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service	Director of Professional Services

	b	implement a cycle of continuous quality improvement	Director of Professional Services
	c	ensure effective clinical and managerial leadership and accountability	PEC chair/Director of Professional Services
D5	a	appropriately constituted workforce with appropriate skill mix across health and social care organisations.	Director of Performance and OD
	b	ensuring the continuous improvement of services through better ways of working across health and social care organisations	Director of Operations
D6		effective and integrated information technology and information systems	Director of ICT
D7		best practice in human resources management and continuously improving staff satisfaction.	Director of Performance and OD
4th Domain		Patient Focus	
D8		continuously improve the patient experience, based on the feedback of patients, carers and relatives	Director of Professional Services/Director of Performance and OD
D9	a	Patients, service users and carers receive timely and suitable information, are encouraged to express their preferences.	Director of Performance and OD
	b	and are supported to make choices and shared decisions about their own health care.	Director of Redesign and Commissioning
D10		Patients and service users, particularly LTCs, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.	Director of Operations
5th Domain		Accessible and Responsive Care	
D11	a	plan and deliver health care which reflects the views and health needs of the population served based on evidence or best practice	Director of Redesign and Commissioning
	b	which maximises patient choice	Director of Redesign and Commissioning
	c	which ensures access (including equality of access) to services through a range of providers and routes of access	Director of Redesign and Commissioning
	d	which uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.	Director of Redesign and Commissioning
6th Domain		Care Environment and Amenities	
D12	a	Health care is provided in well-designed environments that promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns	Director of Operations
	b	and are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections	Director of Operations/Director of Professional Services
7th Domain		Public Health	
D13	a	identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role	Director of Health Improvement
	b	implement effective programmes to improve health and reduce health inequalities	Director of Health Improvement
	c	protect their populations from identified current and new hazards to health	Director of Health Improvement
	d	take fully into account current and emerging policies and knowledge on public health issues	Director of Health Improvement

Resources and Applications Submission

The table below analyses the financial plan for 2007/08 growth funding for BEN PCT as per the submission to the SHA for March 2007.

Resources Available	£'000s
Growth Funding	55,194
Income Adjustments	(7,307)
Sub Total	47,887
1% SHA top slice	(5,926)
Forecast deficit in 2006/07	(4,990)
Forecast Resources Available	36,971
Applications	
Pay Inflation	7,079
Non-pay Inflation	9,254
Drugs (Primary and Secondary Care)	5,022
Efficiency	(9,816)
Specialist Commissioning	5,452
18 Weeks Target Investment	3,424
Non-18 weeks activity investment	3,389
Demand Management	(2,750)
Quality / Public Health	976
Mental Health	1,156
Learning Disabilities	614
Primary Care	1,823
Dentistry	2,201
Community Services	1,918
Ambulance Services	356
1% Contingency to be held by the PCT	5,926
Planned CIP	(831)
Forecast Applications	35,193
Planned Surplus – share of SHA £22.3m surplus target	1,778