

DELIVERING THE FINAL YEAR OF THE CURRENT LOCAL DELIVERY PLAN 2005-2008

1 Introduction

This paper describes the final year of Birmingham East and North PCT's current 3-year Local Delivery Plan (LDP). It must be read in conjunction with the finance paper to the Trust Board, which contains the financial detail for the LDP.

2 LDP - The Process to Date

BEN PCT' predecessor organisations, Eastern Birmingham PCT and North Birmingham PCT, developed 3-year Local Delivery Plans covering 2005-2008, which came into place for 2005/6. For 2006/7, the PCTs hold a prioritisation event (including representatives from community groups and partners organisations), which resulted in harmonised Local Delivery Plans, and an agreed list of prioritised investments that would be made as resources allowed.

For 2007/8, the plan has been updated based on this core work. It ensures that the PCT focuses on key strategies that will enable progress towards the core purpose and key goals of the organisation, and meet national priority areas within identified financial constraints.

In January, a presentation was made to the Trust Board outlining the draft Local Delivery Plan (including planning assumptions, priorities from the national Operating Framework, financial context, context for the next couple of years, the process being followed by the PCT, the submissions required by the SHA, and the priority areas for the PCT in 2007/8).

A further paper was presented to the Trust Board in February 2007 outlining the key principles underpinning the agreement for the last year of the current LDP. This included the principles agreed with Heart of England Foundation Trust.

3 Local Delivery Plan 2007/8

The PCT has now submitted its LDP templates to the SHA in line with national and local timetables. These templates include:

- Financial Templates (see summarised information in finance paper to March Board)
- National priorities (including preparing for 2008/9 targets) - Appendix 1
- Expenditure on Public Health & Health Promotion. – Appendix 2
- Commissioning Plan – Appendix 3
- System Reform Tools – Appendix 4
- Public Statement – Appendix 5
- IM&T Investment Plans – Appendix 6

Separate submissions have been made via the Department of Health UNIFY website for the trajectories that the PCT will follow in order to meet and monitor progress against a number of targets.

Workforce plans have been submitted as part of FIMS.

4 LDP – Trust Board Requirements

The Trust Board is required by national guidance to sign off the LDP at its March Board. A test of assurance has been laid out in national guidance that Trust Boards are recommended to follow when agreeing the PCT plans. The various tests of assurance are detailed below with the corresponding summary of assurances outlined.

4.1 Strategy

Test to be applied: The Board has agreed the Commissioning Plan which accompanied the Local Delivery Plan and identified further work to be done to produce a comprehensive strategy. This should identify for key stakeholders the key components of that future work, the process to be followed and timescales.

The draft Commissioning Strategy was presented to the Trust Board in January 2007 and the final document is being presented to the March Trust Board meeting. It links directly to the PCTs Strategic Objectives and health needs assessment as well as describing the key service changes and action plan for progressing the Strategy.

The Commissioning Plan summary for 2007/8 (Appendix 3) summarises these key changes, timescales, and metrics. The PCT intends to build upon the good work that it has already undertaken this year to deliver the final year of the LDP. The PCT will be applying a set of system reform levers to be discussed with the main acute providers as outlined in Appendix 4.

The PCT has also developed Locality Based Commissioning Plans for all localities in line with LDP priorities.

4.2 Practice Based Commissioning

Test to be applied: The Board should confirm the level of PBC coverage and sign up, in particular to any care and resource utilisation and cost improvement plans. Where this is less than 100%, it should sign off the action plan to extend coverage.

The take-up of Practice Based Commissioning has been excellent with only a few practices not engaging in the process. An action plan to extend coverage to 100% has been developed by the Commissioning Directorate and is available upon request.

4.3 Public Statement

Test to be applied: The Board has signed off a summary statement which sets out the benefits to patients from the plan including the rationale for key investment decisions.

The summary statement of what the LDP will be achieving in its final year is attached as Appendix 5. The plans within the LDP are based upon a comprehensive prioritisation event that included representatives from across the whole health economy, community groups, and public representatives.

4.4 Finance

Tests to be applied:

- ❖ *The Board can confirm that the plan if delivered would ensure the statutory duties of the organisation are met.*
- ❖ *The Board is able to reconcile the movement in income and expenditure between 2006/07 and 2007/08 including accounting for the allocation of all of the additional resource received for 2007/08*
- ❖ *The Board should assess the level of risk of savings plans in 2007/08. This should include consideration and sign off of risk management plans, especially those relating to care and resource utilisation, prescribing and the organisation's overall cost improvement plans. The Board should see and approve plans to deliver cost improvements. For any plans identifying savings in excess of 2.5% there should be clear mitigation plans in place from April 2007. Boards should ensure that overall plans are scheduled to deliver at least half of the projected savings in the first 6 months.*

Overall Context

The national financial framework set out in the NHS Operating Framework for 2007/08 refers to the need for "sustained financial health". This requires the PCT to be planning for recurrent financial balance and also planning flexibility into the financial strategy to allow for reinvestment.

The financial year of 2007/08 is the final year of above inflation growth that the NHS is due to experience. We therefore cannot rely on additional funding for reinvestment and need to look at where we currently invest our money and through service redesign and systems reform deliver real cost reductions and productivity gains to create the financial flexibility to deliver against our strategic objectives.

Sources of Funds

The PCT has an opening Revenue Resource Limit of £551,721k on which we will receive a 10.0% uplift. 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 plan for a £2m surplus; being the PCTs share of the NHS West Midlands' surplus of target of £25 million.

A summary of the Source of Funds is shown on the table below

Revenue Resource Limit 2007/08	£000
2006/07 recurrent allocation	551,721
Recurrent increase on allocation	55,194
Repayment of 2006/7 forecast overspend	(4,990)
Contribution to SHA Reserve	(5,926)
Other Allocation adjustment (mainly practice transfers)	(6,992)
Initial Revenue Resource Limit	589,007

Application of Funds

The Broad application of Funds is shown in the table below

Summary Expenditure Plans 2007/08	£000
Commissioning	431,119
Prescribing	67,680
GMS/PMS	53,111
Management	21,090
1% contingency	5,926
Non-recurrent solutions 2006/07	2,400
Earmarked reserves	5,081
Identified risks	600
Total Expenditure	587,007

Key Assumptions

- Inflation has been applied at 5% with a 2.5% Cash releasing efficiency saving applied to our entire portfolio (with the exception of GMS/PMS that has had a net cash uplift of 1%)
- The only areas of our Acute Portfolio that are experiencing underlying growth are Maternity and Orthopaedics and this has been provided for at 6% and 3% respectively.
- Additional investment of £3.424m to meet 18 week target
- Demand Management Schemes to reduce activity by £2.7m
- GP Prescribing to grow by 5.5%
- Management Budgets Funded in line with the structure approved by the Board which deliver the required level of savings as a consequence of "Commissioning a Patient-Led NHS".

The Finance Report for the Trust Board March 2007 meeting should also be referred to as an assurance.

4.5 Governance & Target Delivery

Tests to be applied:

- ❖ *The Board should be clear how the plan will support continuous improvement in the overall performance of the organisation, for example as measured by HCC*
- ❖ *The Board can confirm that if delivered the plan would ensure achievement of the key NHS targets for 2007/08, understand the level of risk to successful delivery and ensure adequate risk management plans are in place.*

- ❖ *The Board will certify compliance with an assurance framework by monthly sign-off of a Statement of Requirements in line with SHA policy.*

Appendix 1 summarises the PCTs priorities for achieving national targets in 2007/8 and preparing for implementing new targets from 2008/9 onwards. The PCT Business Plan specifically supports implementation of the final year of the current 3-year LDP and the PCT has strong governance arrangements in place to monitor performance against these targets and ensure rectification plans (if needed) are in place to achieve targets.

Throughout the year, the PCT has developed key strategies to addressing risks to achievement of targets and the recent Fitness for Purpose report has clarified important next steps to address risks posed by the changing environment over the next 5 years.

The current Assurance Framework was reviewed by the Integrated Governance and Performance Committee in November 2006 and accepted by the Audit Committee in January 2007. The Corporate Risk Register have been reviewed and approved by the Audit Committee that met in January 2007 and the Integrated Governance and Performance Committee, on behalf of the Trust Board.

The Assurance Framework and the Corporate Risk Register are standing items on the Agenda for the Integrated Governance and Performance Committee and various elements of the Risk Register are formally reviewed on a monthly basis. The emphasis is now on the implementation of Directorate Risk Registers that feed into the Corporate Risk Register.

4.6 Service Level Agreements

Test to be applied: The Board should ensure that Service Level Agreements are signed by 28 February or enter a formal dispute resolution process. Boards should ensure that any adverse outcome of dispute resolution is incorporated into the organisation's risk assessment.

The new model contract has been signed with our main providers, Heart of England Foundation Trust and Good Hope Hospital NHS Trust. All other contracts have been agreed and we are awaiting confirmation from the co-ordinating PCT's regarding signatures.

4.7 Workforce

Test to be applied: The Board should consider and agree the organisation's workforce plans to ensure that they are affordable and can be delivered.

Although the current Workforce Plans address the requirements for short term planning and the final year of this LDP, further work will be required in the Summer to inform discussions in preparation for the next LDP.

The Workforce Plans submitted via FIMS are within the financial envelope available and takes account of the new management structure arrangements.

The emphasis on service redesign and new service models will require robust assessments of the future workforce requirements. These will collectively feed in to the working planning processes for the next 3 – 5 years.

A new workforce strategy committee is being set up within the Integrated Governance and Performance structures to address workforce development and training/education requirements.

5 Delivering the Plan

The PCT is currently working up it's PCT Business Plan (to be presented to April Trust Board) which describes how the final year of the LDP will be delivered within the PCT.

The PCT will also start work on the next 3-year LDP (2008/9 – 2010/11) during the forthcoming months.

*Dawn Roberts
Head of Core Business Processes & Strategy
DRAFT 12th March 07*

National Priorities – LDP Statement

Priority 1

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

There has been considerable progress in the improvement of waiting times over the past few years within the North and East Birmingham health economy and at the end of March 2007 the relevant milestones will have been met. The PCT recognises however that achievement of 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 commissioning intentions redesign and reinvestment will be the main focus and in particular within diagnostics. However the PCT recognises that additional investment will be required in respect of waits in order to ensure the milestones are met. Outlined below are the high level assumptions in terms of investment and a summary of ongoing actions.

Financial Information:

Based on MF01 September 2006 and diagnostic return Aug 06. Subject to change.

Required activity and cost of achieving 18 weeks by 2008:

18 weeks targets

2007/08 Activity required to meet 18 weeks	Waiting time target	Additional Activity	Average Price £	Finance required £
Elective	11 weeks	708	2,287	1,619,196
Daycase	11 weeks	866	677	586,282
New Outpatients	5 weeks	3,067	102	312,834
Diagnostics	6 weeks	2,082	150	312,300
Totals		6,723	3,216	2,830,612

2008/09 Activity required to meet 18 weeks (In addition to activity already bought out in 2007/08)	Waiting time target	Additional Activity	Average Price £	Finance required £
Elective	10 weeks	97	2,382	231,054
Daycase	10 weeks	129	693	89,397
New Outpatients	4 weeks	723	104	75,192
Diagnostics	4 weeks	866	150	129,900
Totals		1,815	3,329	525,543

Operational progress to date on 18 weeks:

- Cardiac Network audit – outcomes to be implemented
- Primary Care Diagnostics audit in terms of which Primary Health Care professionals request diagnostics, where tests are carried out (provider details), how results are interpreted, number and frequency of referrals and if direct access can avoid the need for patient referral to Secondary Care. Recommendations from the audit to be actioned
- Building of a PAD at Castle Vale Health Centre to ensure better utilisation of the MRI service offered by Alliance
- Developing the Model Contract – part of national team

- Service redesign – seven specialities identified for initial review in terms of stripping our procedures and processes that are of no/low clinical value.
- Heart of England Foundation Trust – representation to ensure the PCT is influencing all developments with respect to diagnostics, clinical processes and measurement
- Scoping meetings with Secondary Care colleagues to scope the issues behind the waits and jointly plan appropriate remedial action
- Developing IT solutions to ‘Referral to Treatment Measurement ‘ with main Provider
- Setting up direct access for diagnostics provided by the Independent Sector DH contracts and using these contracts to clear Acute Trust backlogs

Challenges:

- 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

For further detail, please see 18 weeks program plan (available on request)

Priority 2

Reducing MRSA rates and other healthcare-acquired infections

The PCT and its major providers have commitments to year on year reductions in MRSA infections and other hospital acquired infections including C. Diff. Whilst targets are being met at HEFT there are concerns at GHH over their inability to meet their challenging trajectory. Additional focus is therefore ongoing and the PCT is part of the provider MRSA taskforce and is monitoring progress against the implementation of their action plan.

The PCT has set out its requirements for the delivery of the target level of reduction of MRSA and C. Diff. rates in 2007/08 in its contract with all providers and this will include requirements to demonstrate that they are applying best practice in infection control in their strategies for reducing hospital acquired infections.

In respect of the PCT provider arm a comprehensive action plan and audit programme is being implemented. Key actions include:

- High risk patients are isolated/cohort nursed where necessary in inpatient areas.
- Pre-operative screening and treatment completed when requested.
- Contracted cleaners have received infection control information.
- BENPCT have fully functioning Infection Control Committee.
- New uniform policy launched.
- Visiting regimes in place in inpatient areas.
- Audits of policy compliance continue as per annual audit plan
- Policy manual in continual development.
- Handwashing roadshow events have taken place specifically for patients and public.
- NICE information leaflet – ‘Prevention of healthcare associated infections in primary and community care’ (code N0219) available for patients in the community via primary events care contractors, GP practices, pharmacists, District Nurses, Health Centres, community nursing teams & local libraries and publicised for use with patients through local training.
- New antibiotic policy launched.

- Extensive antibiotic awareness programme launch including pt info leaflets and events.
- Trust web site carries health awareness information.
- BENPCT is signed up to the National Patient Safety Agency Clean your hands Campaign in the Community Setting.
- PEAT inspections have rated highly the in-patient areas in BENPCT. Expert Patients accompanied Team.
- Cleaning supervisor for the in-patient area won National award for Impact of Cleanliness.
- Presentations to pt forums explaining BENPCT and pt actions to reduce MRSA.
- Local acute Hospital Microbiologist/ICNS, GHH, HoEFT informs PCT ICNS of all pts with MRSA colonisations and infections discharged to inpt areas to action as necessary.
- A Discharge letter has been developed for use by acute Trusts to inform GPs and DNs of pt MRSA status.

In terms of additional investment the PCT will invest £42k in an additional wte Infection Control Specialist to improve infection control management as both a provider and commissioner.

Priority 3

Reducing health inequalities and promoting health and well-being (including sexual health),

The PCT's priority areas and key workstreams are summarised below. A lot of the work 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). The PCT's share of the increased funding identified for "Choosing Health" in 2007/8 is £601k; the PCT is committed to investing at least this amount although we are still identifying those priorities that can be met through service redesign and those that will require additional investment.

The Director of Public Health's Annual Report sets out the PCT's priorities for action for tackling health inequalities across the PCT. The work of the PCT is centred around a number of work programmes as summarised below:

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

The MLE project delivered on a city wide basis has an ambitious programme of work for 2007/08 targetted 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

Infant Mortality

We are working through the LAA in a number of areas across Birmingham to tackle infant mortality where a city wide approach is needed; these include establishing a Pan Birmingham approach to commissioning maternity services in order to ensure city-wide standards 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.

Teenage Pregnancy

A number of wards in BEN PCT are seeing significant rises in Teenage Conception rates; we are working to address this as part of 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
 - Youth Development Programmes
 - SRE policy development and consultation in schools
 - Staff training programme for Teenage Pregnancy

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
 - Peer counselling training for breast feeding
 - Staff training programme (Acute/Children's Centres)
- Healthy Schools
 - Increase participation in reaching HSS by 14 06/07 and further 20 07/08
 - Develop obesity interventions
- Immunisations and Vaccinations
 - External contract with EHS to increase uptake

Self-Care

The Expert Patient Programme (EPP) is based on research which 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, the PCT is expanding its 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 assets 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)

Lifestyle Change

Your health to a large degree is affected by lifestyle choices, the PCT is developing the range of services it offers that are targeted at those life style choices that have the worst impact on your health.

- Smoking Cessation Services
 - Expand provision via primary care contractors
 - Collaborate with R&D project on BME Community Smoking Cessation Advisors
 - Expand Partnership Drop-ins with LSPs
- EOP
 - Work within NICE Guidance for provision within an evaluation in collaboration with Birmingham University
- Community Awareness
 - Roll out community health awareness events
 - Roll out Face Facts II

CVD Programme

One of the key areas identified within the PCT 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 CHD. The CVD risk reduction programme will be the initial focus on achieving this. Key elements of which are outlined below.

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

Priority 4

Achieving Financial Health

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 the year 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.

Priority 5

Recovery action on current national standards not being achieved

The PCT has concerns in the following national areas:

Ambulance Targets:

The PCT continues to work with the Ambulance Service regarding improving performance through the Emergency Care Network and the Birmingham and Black Country Director of Operations Forum. The Ambulance service has reported to the Healthcare Commission on a series of actions underway to reduce turnaround delays.

Delayed Transfers of Care

Although the full Q3 figure is not yet available, based on partial Acute data received by information services the rate has dropped for Q3 from 4.76% to 4.19%. The following actions are being pursued for the Q4:

- Reimbursement Strategic Implementation Group January meeting committed in the short term an additional 18k from the planned contingency to release funding for up to 8 younger adults delayed across Acute and IC services.
- GHH are changing one aspect of their model from 2.0 WTE Allied Health Professional posts providing IC links to 1.0 WTE nurse specialist post which has been more effective at HoEFT
- New citywide targets now set for 2007 /08 - HEFT 15 (21) delays and GHH 9 (13), based on population and number of Acute Beds. Both have achieved 2006 /2007 targets.

Inpatient and Outpatient waiting times

These targets form a core part of the PCT's 18 week strategy. The Trust is working closely with both key Acute Trusts, who have given assurance that these targets will be met by March 2007.

Thrombolysis – 60 minute call to needle time

As Thrombolysis has been almost entirely replaced by primary angioplasty in HoEFT as a more effective treatment, this target is heavily affected by small numbers of patients. The target is split in two for acute trusts, with a 30 minute target for call to hospital door, and 30 minutes from door to needle. Only 35 patients have been seen in total for thrombolysis across HoEFT and GHH, and of these patients, 97% have achieved the door to needle target. Therefore, underperformance reflects the larger problem with ambulance service response times, as outlined above.

Access to Genito-Urinary Medicine (GUM) clinics

A problem was identified across the city with the citywide trajectory that had previously been set. All the relevant parties met late in 2006, and a more realistic trajectory has been drawn up for the remainder of 06/07, and the following year. Although currently showing a small underperformance, it is expected that the service will meet the target by the end of the year, as well as the more ambitious 2008 target.

Waiting times for all diagnostic tests

The diagnostic waiting times targets form a core part of the PCTs 18 week strategy. The Trust is working closely with our key Acute Trusts. HoEFT and GHH have given assurance that these targets will be met by March 2007. Concern is still high over the number of audiology waiters at SWB NHS Trust, and we are working closely with them to attempt to achieve a resolution in this matter.

Convenience and Choice: PCT Booking

The denominator for this target has now been adjusted to a more appropriate level, and the SHA and PCT are awaiting Department of Health confirmation. Should this be approved, the joint PCT for Q2 is demonstrating a more positive 35.4%. The PCT has put actions in place to ensure the best possible chance of success in this endeavour, including using the Insight referral management tool to double check that practices are inputting all referrals into Choose and Book, and implementing a traffic lighted assessment by practice of who is and who is not using Choose and Book and the actions in place to achieve 100% coverage.

Convenience and Choice: PCT Facilities in place to support choice

From the two sets of survey results that have been published, the combined PCT is currently underperforming. However, this situation is replicated nationally, and current belief is that the indicator will be redefined before the end of the year. This is supported by the following paragraph in the DH's July survey report:

Issues for PCTs: The number of valid responses received varied by PCT, from fewer than 20 in ten PCTs (where there were local problems with the survey process) to more than 700 in one PCT, as shown in Annex Table A.6. If responses were unbiased, the average confidence interval around the percentage of patients offered choice in each PCT would be $\pm 8\%$, but in some cases this is as low as $\pm 3\%$ or as high as $\pm 37\%$. The variable response, possibility of response bias and lack of weighting for age and sex bias at a local level means that PCT results should be treated with some caution.

Community Equipment

This target remains a concern as performance has been heavily affected by the implementation of a new IT system. This is the biggest fundamental change in these services that has been seen and is only partially completed. Some HR difficulties at the ELS have been and continue to be experienced and agency staff have had to be utilised to meet the increased demands on the service. Recently 4 new staff have been employed on short-term contracts in an attempt to improve the position

Actions in place:

- Full Implementation of New citywide IT system (Bchoice)
 - o Implement hand held devices for warehouse
 - o Implement hand held devices for delivery staff
 - o Roll out of system to referrers city wide
- Review of agency staff usage
 - o Employment of staff on short term contract
- Improved system admin and report writing – additional training being undertaken
 - o Recently carried out improved reporting for commissioners
- Continued requests to Commissioners to develop a service specification for

these services against which we can be measured

- Negotiations with Commissioning Managers as the performance target is linked to current financial pressures.

Early Intervention Services

This is a difficult year for the development of EIS as service changes/ redesign/ efficiency savings are being negotiated at the same time as expanding the geographical coverage and overall capacity of the service.

An agreed set of performance measures are in place and the PCT meets with the EIS service to monitor performance on a regular basis, however underperformance is an issue which is recognised by BSMHT at the highest level, as an area of concern to us.

It should be noted that the actual share of the national target given to BEN PCT is proportionately higher than comparable PCTs, therefore this is a very challenging area for improvement.

Priority 6

Preparatory plans on priorities for 2008/2009 (including maternity choice, end-of-life care, weighing and measuring children)

The PCT has agreed a Commissioning Strategy for 2007/08 to 2009/10. This document provides a local overarching framework for BEN PCT's commissioning approach and provides strategic direction for Local Commissioning Delivery Plans. A key local driver in developing the PCTs strengthened commissioning role is to take a number of its present initiatives that are focussed on commissioning for prevention and health and well being and scale up these developments to a level where larger segments of the population are able to access these services as part of mainstream commissioning and delivery.

The agreed areas for focus in 07/08 are outlined in the PCT commissioning plan.

- 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

It is intended that the work in 07/08 will provide a firm foundation on which to build in 08/09 and beyond. As part of the PCTs annual business cycle work will begin in April 07 on developing the next steps for the 2008/2011 LDP to ensure a robust direction of travel that has been widely influenced by our partners and public.

Particular plans for maternity choice, end of life care and weighing and measuring children are summarised below.

Weighing and Measuring children

Agreed system for uploading all data from reception year into PCT database

To roll out to all primary schools in PCT the curriculum based methodology

(http://www.southbirminghampct.nhs.uk/services/public_health/YoungPeople/BMI.htm)

with support from PCT School Nursing teams

End of Life Care

The PCT has an agreed strategy for end of life care, which aligns with the End of life care networks approach. In 2007/08 the PCT is intending to continue the work to implement a model of supportive care for people with Long Term Conditions in the last year of life. The PCT will through its 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. The PCT's end of life care action plan is attached for information.

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.

Appendix 2

Expenditure on Public Health & Health Promotion

Initiative	Expenditure 2005/6	Forecast Outturn 2006/7	Budget 2007/8	Services included
	£'000s	£'000s	£'000s	
Stop Smoking Services	448	602	602	
Sexual health services	1150	1435	1435	
Chlamydia screening	0	342	342	
Health trainers	145	145	145	
School nurses	473	745	745	
Action on diet, activity and obesity	98	101	101	
Alcohol Interventions	350	350	350	
Capacity Expansion (Workforce)	200	200	200	
Well-being support programmes	50	50	50	
Total	2914	3970	3970	
Other Public Health / Health Promotion			602	Work on going to identify where priorities can be delivered through service redesign and therefore where new investment needs to be targetted
Total Public Health & Health Promotion Budget	2914	3970	4572	

Commissioning Plan 07/08

1.0 Introduction- Developing a Commissioning Plan

Birmingham East and North Primary Care Trust (BEN PCT) were formed from the former Eastern and North Birmingham PCTs on the 1st October 2006. Significant work has been undertaken over the last twelve months to develop the commissioning function of the PCT and 07/08 will be the first Commissioning Plan, which reflects an integrated approach to the total populations needs and builds on the success of the predecessor organisations.

The plan is underpinned by a Commissioning Strategy, which sets out the public health needs of the population. It covers the period 2007/08 to 2009/10, which has been presented to the Board, PEC and Practice Based Commissioners through the six Localities. The strategy will be used to assist in the dialogue with patients and the public and will be subject to further change in light of that ongoing dialogue. The strategy marks a key point in the new PCTs development as it sets out clearly the four goals that the PCT wishes to achieve: -

- To be responsive to the population we serve and that no one waits for the health care they need
- That the health and well-being of our population will have improved so much people will enjoy ten years 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

These goals are underpinned by five key strategies

- R4-Redesign, Relevance, Responsiveness, Resources
- Quality Patient Services
- Promoting Health / Saving lives
- Involving People
- Consistently fit for purpose

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

Aim

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

This is supported by the Commissioning frameworks for acute services and Long-Term conditions as well as the Locality Commissioning Delivery Plans, which are under

development through Practice Based Commissioners and their Locality Governing Bodies.

The further aim of this plan is to use the model contract to ensure Commissioning Plans are delivered in line with key requirements already set out in the letter to the PCTs main Acute Provider during December 2006.

2.0 Proposed Areas of Change 2007/08

The PCT has already proposed a number of changes in 2007/08 but as noted above this needs to reflect further the commissioning plans of Localities which maybe more specific to their geographic patches than detailed below. These plans will be available in February and will be formally signed off through the PEC in February. Against this backdrop the PCT has already signalled the following will be part of its commissioning plan in 2007/08: -

- 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

Timescales

Due to the approach taken by the PCT during 2006/07 many of the developments outlined within the commissioning plan for 2007/08 have been in the planning stage for some time and will be implemented during the first quarter of the new financial year. Any developments proposed through Locality Commissioning delivery Plans will be signalled during February to ensure providers are clear about potential in-year changes. However it is expected that any changes due to Practice based Commissioning will occur in the final six months of the year to ensure that appropriate plans and discussion have been undertaken with all parties concerned. This includes patients, public and relevant scrutiny bodies. Clearly the implementation of any of the above is subject to the appropriate finance being identified through the LDP or redesign process. The important point to note is that the PCT has signalled to all its providers that the large majority of supported developments will come through disinvestments in services elsewhere and will not come through the allocation of new resources.

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. There are specifics related to disinvestments particularly outlined in the letter to our major acute provider, which are still under discussion.

Measurement and Metrics

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

Each of the commissioning intentions needs to set out as part of its proposal the outcome metrics to be measured under the five headings and how and when these will be measured. For example Birmingham Own Health agreed a number of metrics across the five areas and these are measured at the agreed points i.e. Blood Pressure, Cholesterol and Hba1c for diabetics (Clinical), service utilisation rates (Activity). These are measured in the case of clinical every six months across the cohort of participants and monthly in the case of utilisation rates both across the cohort and individually.

3.0 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 due in, February, which will set out PbC aspirations for 2007/08. The PCT has already committed to supporting PbC will real management costs and pump-priming resource to support service change and this is included within the PCT's financial plan for 07/08. The key objective for 07/08 is to give freedom to PbC to make local commissioning decisions, 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.

PbC has a well developed structure in BEN PCT, however there is now a need to turn that structure into real delivery of changes through effective local commissioning which is on a scale that the patients and public see real benefit and this has to continue to be actively supported by the PCT through on-going commissioner development.

4.0 Conclusion

The importance of a strong commissioning approach has always a key objective of BEN and its predecessor PCTs. The work undertaken during 2006/07 has given the organisation a solid basis to move forward and deliver both its 07/08 Commissioning Plan and its longer-term strategy. BEN PCT has made it very clear to all its providers that service developments have to come in most cases through disinvestments in activities with little or no clinical benefit to patients. If this achieved BEN PCT is clear that it is willing to share the risk of those disinvestments on the understanding we achieve major service change and deliver the commissioning strategy with a major shift from treatment to prevention. BEN PCTs view is simply to ensure we commission the right services, which do the right thing for the patients and the public.

Please note that this document should be read in conjunction with the PCTs Commissioning Strategy and other Local Delivery Plan pro formas.

System Reform Tools

Unbundling

2007/08 PBR National Tariff
Using Tariff to Drive Service Change

Unbundling Diagnostics

The key purpose of unbundling is to put in place the correct incentives to encourage appropriate alternatives to traditional hospital “bundles of care” such as direct access primary care diagnostics.

Given the 18 weeks target, it is increasingly important to ensure that there are incentives for PCTs to commission imaging scans via direct access prior to referral. We also need to avoid any perverse incentive to refer all patients to outpatients on financial grounds (eg. If the outpatient tariff is lower than the cost of commissioning an imaging scan via direct access).

Benefits of commissioning diagnostic tests via direct access:

- Reduces the time people have to wait for tests.
- Reduces the number of unnecessary referrals to secondary care outpatient clinics, which could potentially save the PCT money. This should also lead to freed up capacity in the trusts to enable the 18 week target in outpatients to be met.

Unbundling Diagnostics

Guidance is clear that commissioners should not pay twice for diagnostics. Current outpatient tariffs include the cost of diagnostic imaging that has been commissioned as a result of an outpatient attendance. The PCT will need to consider the following three scenarios:

Scenario 1: Diagnostics carried out during an inpatient spell or requested at an outpatient attendance, and carried out by the same provider. **Here tariff should not be split.**

Scenario 2: Diagnostics commissioned as a direct access service from the same provider carrying out the outpatient attendance.

Scenario 3: Diagnostics carried out by an alternative provider to the one in which the outpatient appointment takes place.

Prices need to be agreed for the following:

- a) Direct access diagnostics prices (should be purchased on a cost per case basis). The department of health has released indicative tariffs, which should be used as the starting point in any discussions with providers; these are attached as appendix A.
- b) An outpatient tariff excluding the cost of imaging (This leaves the outpatient provider carrying the financial risk associated with any imaging tests they decide to repeat).

Unbundling in 2007/08 – to be agreed with providers

The three options for arriving at a price for b) above and implementing unbundling, to be agreed with providers, are as follows;

- i) Agree value of credit by diagnostic test to be applied to outpatient attendances and provide patient level back up to support each credit requested.

- ii) Agree a baseline for the % of people likely to access scans via direct access arrangements and use this to inform a deduction to the First Attendance Tariff.
- iii) Agree a bottom up costing for outpatient attendances that exclude imaging costs.

The PCTs preferred option is option 1.

Prior Approvals Schemes

BEN PCT has been working to deliver Prior Approval (PA) schemes with its major Acute Trust since the summer of 2006 under the auspices of the July Commissioning Framework; in September 2006 the DoH agreed pilot status for this work.

Prior approval is being introduced in a number of areas.

Prior Approval Level 1 – GP Practice Peer Review

Clusters of GP's are currently reviewing referrals to ensure the benefit of clinical knowledge around referrals is maximised. Therefore reducing the possibility of inappropriate referrals and redirecting referrals to primary care services where possible. This was implemented from 1st April 2006 with a 12% reduction in GP referrals to outpatients in the first 6 months of the year (compared to same period last year) resulting in a saving reduction of 7,004 new outpatient attendances and a saving of £1m.

Prior Approval Level 2 – Elective procedures

Work is on going to agree a range of acute procedures that will not routinely be commissioned and will require PA from the PCT; this work has been progressed through a joint group of Clinical Directors from the Trust and the PCT. The initial list is being used to test PA during the last quarter of the year with an agreement that we fully implement from 1st April 2007. The PCT has already signalled to its Acute Providers that further work to expand the PA list will be undertaken during 2007/08.

Based on the existing list of procedures it is estimated that activity will reduce by 824 and realise a saving of £882k.

Prior Approval Level 3 – Consultant to Consultant Referrals

We are working with our major Acute provider to agree how we will apply PA to referrals between outpatient specialties to ensure that there is PCT approval for these referrals whilst allowing those patients who require urgent treatment to be referred. Trusts will also be performance managed via the national benchmarks available for the % of consultant to consultant referrals.

Prior Approval Level 4 – Outpatients following elective surgery

Work is ongoing to agree a range of acute procedures where the patient will not routinely receive an outpatient follow up; this work has been progressed through a joint group of Clinical Directors from the Trust and the PCT. The initial list is being used to test PA during the last quarter of the year whilst new clinical pathways are developed with an agreement that we fully implement from 1st April 2007. The PCT has already signalled to its Acute Providers that further work to expand the PA list will be undertaken during 2007/08. Based on the existing list of procedures it is estimated that outpatient activity will reduce by 5,382 and realise a saving of £406k.

Coding and Counting

The guiding principals adopted within these measures are:

- Coding rules must be applied consistently across providers, according to the coding rules, to ensure an equitable context for Payment by Results
- The key information within the patient journey is the clinic / discharge letter as this is the record that informs the care co-ordinator and the funder (under PBC)

Transfer of information to Primary Care

A complete discharge letter (for elective or non elective care) or clinic letter for outpatient care must be received within the patients GP practice within 15 working days for discharge letters and 15 working days for clinic letters. These are seen as maximum times with a much prompter letter desirable. It is viewed that if information is not provided within this timescale it compromises a patient's recovery and ongoing treatment as well as increasing the risk of complications and readmission.

- If a letter is not received within standard the PCT will be able to not pay for that activity

Validation of information in CMDS / SUS

Coding guidance is clear that only conditions or problems that are dealt with during a given episode of health care should be coded. Conditions that relate to an earlier episode, *that have no bearing on the current episode*, should not be recorded (Coding Clinic March 1999.) Accuracy and relevance of recording is important as "a properly completed record is essential for good patient management and is a valuable source of epidemiological and other statistical data on morbidity and other healthcare problems (Coding Clinic March 1999.)

As discussed above the discharge letter and clinic letters are seen as the definitive record of the patient episode within Primary Care conveying all relevant information to the patient's primary care professional.

- Where conditions or procedures have been entered onto a Patients CMDS record but are not mentioned in the clinical letter these will be removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescale
- Where conditions have been entered onto a Patients CMDS record but are challenged by the PCT the Trust must provide evidence to support the coding within 2 weeks or the coding will be removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescale
- Where an outpatient letter does not mention a procedure being carried out but this is shown in the OP CMDS this will be removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescale
- Where a Trust identifies 2 outpatient attendances on the same day in line with prevailing NHS guidance two letters should be received by the patients GP, where this does not occur the lower cost attendance will be removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescale

Completeness of coding

Trust should complete all mandatory fields of CMDS in line with the West Midlands Regional policy. This is vital to allow the PCT and practice to accurately validate information and plan care accordingly.

- Where mandatory fields are not completed the record should be either completed or removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescale

Coding of Antenatal Admissions not Related to Delivery Event (HRG N12)

The principles of Payment by Results are clear that Trusts should be appropriately remunerated for the level of input provided. For N12 admissions with zero day length of stay the level remuneration (£461 at 06/07) is disproportionate with the care provided and compared to other N family HRGs (e.g. N07 Normal delivery w/o cc £842.) The DoHs recent Care and resource utilisation: ensuring appropriateness of care guidance (p. 26) clearly states that the appropriate coding for this is as a ward attender at the outpatient tariff of £66 (06/07 prices)

- All zero LOS Antenatal Admissions not Related to Delivery Events will be coded as Obstetric Ward Attenders

Coding of Planned Procedure not Carried out

The coding manual states that the Z53 ICD should be used in the secondary diagnosis position. If it appears in another position the HRG may be inappropriately grouped to an HRG.

- Records where a Z53 code is not placed in the secondary diagnosis should be corrected or removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescale

Use of outpatient only codes

Coding Clinic Vol 3 Issue 1 identifies a number of ambulatory codes which should only be used in relation to outpatient care. These are regularly being used in relation to day case and inpatient care disproportionately rewarding the Trust for the activity they carry out.

- Where specified outpatient only codes appear in the IP CMDS the spell should be removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescales and represented in the OP CMDS

Use of elderly living alone code

The ICD-10 code **Z60.2** Living Alone, must only be used to identify those patients who, due to the fact that they live alone and would have been unable to care for themselves at home, remain in hospital beyond the normal length of stay for the condition being treated. Coders must ensure that the casenotes clearly state that the patient's length of stay increased specifically due to them living alone before this code is assigned. (Coding Clinic Vol 3 Issue 6 p. 3.)

- Where Z60.2 appears in IP CMDS in relation to patients whose stay was not excessive the code should be removed from the CMDS re-submission by the Trust in line with the SUS flex and freeze timescales

Outpatients while inpatients

The coding manual makes clear that outpatient activity cannot be coded and charged while a patient is an inpatient. The Trust is fully remunerated through the PbR Tariff for costs incurred relating to the inpatient episode and it is inappropriate to charge additionally through the outpatient system.

- All outpatient records occurring while a patient is an inpatient should be removed from the OP CMDS re-submission by the Trust in line with the SUS flex and freeze timescales

Coding of infusion therapy

There is considerable variation in the coding of infusion therapies across and within Trusts which can result in similar patients being recorded as day cases, new outpatients, review outpatients, regular day attenders and ward attenders. Work needs to be completed in year, coordinated through the cancer network to consolidate and standardise coding. Where clear guidance is available this should be applied.

- ICD 10 code X35 should only be used where patient must be attended at all times, otherwise use X29 (Coding Clinic March 1999)
- Intravenous infusions / injections should only be coded “if the patient is admitted specifically for the administration of intravenous infusions / injections

Ward Attenders

Ward Attenders should not automatically be coded as outpatients. Trusts and commissioners need to consider the most appropriate method for remunerating the Trust for activity carried out as Ward Attenders.

- For each area of ward attender activity the trust and their co-ordinating PCT will agree the rates of funding

Post procedural disorders

Where it is shown that a patient's excess length of stay relates to post procedural disorders within the control of the Acute Trust it is appropriate that the financial risk of this care should fall on the Acute Trust and not the PCT.

- PCTs should not be liable for XS OBDs for patients with a coded post procedural disorders
- PCTs liability for critical care for patients with a coded post procedural disorders should be limited to the average length of stay in critical care for that HRG

Public Statement

LOCAL DELIVERY PLAN (LDP)

All PCTs are required to produce a Local Delivery Plan (LDP). This plan sets out how the PCT intends to achieve key targets and identifies how annual funding allocations are to be used to achieve such delivery.

Birmingham East and North Primary Care Trust (BEN PCT) are currently developing the LDP for 2007/08. BEN PCT's two predecessor organisations, Eastern Birmingham PCT and North Birmingham PCT, previously had a three year LDP process, for which 2007/08 is the last year. In 2006/07, plans for the two organisations came together to set out joint priorities and processes for the new organisation, which came into place on 1st October 2006.

For 2007/08 the plan is being updated and refreshed to ensure that within the financial constraints the PCT focuses on key strategies that will enable progress towards the core purpose and key goals of the organisation. These priority areas will form the foundation for a vision of innovative service delivery for the next four years.

The emphasis of the 2007/08 LDP 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 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.

Within the LDP process, great emphasis is also placed on the development of a PCT Commissioning Plan, which clearly outlines how national and local priorities will be delivered and developed according to the identified need of local populations.

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

Appendix 6

IM&T Investment Plans

Note

1 Local CfH liabilities (to SHA/South Birmingham PCT)

(see separate worksheet for 2007/08 details)

- 1 SHA CfH team
- 2 Main End User Training Environment (EUTE) pool
- 2 Additional 6 EUTES
- Total**

2007/08 2008/09 2009/10
000's 000's 000's

	99		
	3		
	31		
	133	0	0

Forecast

Outturn

2006/07 2007/08 2008/09 2009/10 *Example*
000's 000's 000's 000's 000's

3 Total PCT Resource Limit (£000)	539,060	597,009	613,641	632,050	180,000
4 0.5% of Resource Limit (calculated)	2,695	2,985	3,068	3,160	900
4 Cumulative local IM&T increases since 2004/05 (inclusive)	3,245	3,344	3,445	3,549	1,000
4 Comparison of cumulative increase to 0.5% of resource limit	550	359	377	389	100

5 Total CfH value of PbR Tariff in local acute hospitals

Please select Acute trust name from each drop-down list

HEART OF ENGLAND NHS FOUNDATION TRUST

CfH value of PbR Tariff in local acute hospital 1	245	87	89	91	500
Amount of PbR Tariff explicitly badged for NPfIT implementation - value	245	87	89	91	250
Proportion of PbR Tariff explicitly badged for NPfIT implementation	100%	100%	100%	100%	50%

GOOD HOPE HOSPITAL NHS TRUST

CfH value of PbR Tariff in local acute hospital 2	215	76	77	79	300
Amount of PbR Tariff explicitly badged for NPfIT implementation - value	215	76	77	79	300
Proportion of PbR Tariff explicitly badged for NPfIT implementation	100%	100%	100%	100%	100%

Blank

CfH value of PbR Tariff in local acute hospital 3					150
Amount of PbR Tariff explicitly badged for NPfIT implementation - value					125
Proportion of PbR Tariff explicitly badged for NPfIT implementation	0%	0%	0%	0%	83%

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CfH value of PbR Tariff in local acute hospital 4					
Amount of PbR Tariff explicitly badged for NPfIT implementation - value					
Proportion of PbR Tariff explicitly badged for NPfIT implementation	0%	0%	0%	0%	0%

6 IT uplift in local Mental Health Trust if applicable

Blank

IT uplift in local Mental Health Trust	105	112	118	124	110
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7 Total Revenue increase over 2003/04 IT baseline

	3,810	3,619	3,729	3,843	1,785
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Increase in IT funding since 2003/04 as a percentage of overall RL

	0.007068	0.006062	0.006077	0.00608	0.99%
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8 Local Capital spend on IT

(NB Excluding SHA Strategic IT capital)

	573	260	267	274	2,000
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9 Total GP IT budget

	550	564	578	592	850
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