



Wolverhampton City Primary Care Trust:

2009/10 Operating Plan – Final Draft

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“Wolverhampton a Smoke-Free PCT”

Table of Contents

1. INTRODUCTION	3
1.1. ABOUT WOLVERHAMPTON.....	3
1.2. PRIORITY & VISION	4
1.3. WOLVERHAMPTON STRUCTURE.....	5
2. NATIONAL DRIVERS	7
2.1. OPERATING FRAMEWORK.....	7
2.1.1. <i>Cleanliness</i>	7
2.1.2. <i>Access</i>	9
2.1.3. <i>Improving Health</i>	16
2.1.4. <i>Staff & Patient Satisfaction</i>	28
2.1.5. <i>Emergency Preparedness</i>	30
2.1.6. <i>Local Priorities</i>	32
2.1.7. <i>Recovery Plan</i>	44
2.2. COMMISSIONING PLAN	45
2.3. PROVIDER SERVICES.....	46
2.3.1. <i>Priority Areas</i>	46
3. QUALITY MEASURES.....	47
4. VITAL SIGNS REFRESHED TRAJECTORIES	48
5. PERFORMANCE & GOVERNANCE	49
6. FINANCE	50
6.1. CONNECTING FOR HEALTH.....	51

1. Introduction

Wolverhampton City PCT is an organisation rooted in local community, their needs and aspirations. As a result, the Trust is committed to working in partnership across sectors, co-production with patients and community organisations and the active participation of local people in determining the future of service planning and delivery.

It is through this partnership approach that the Trust will strive to make Wolverhampton a place where people will want to live, work and spend their leisure time. We work with a broad range of partnerships aimed at improving the quality of people's lives. The Trust is committed to maximising the positive impact that the NHS in Wolverhampton can have to develop the city.

The PCT works with the Wolverhampton Strategic Partnership to develop the community plan, the emerging Sustainable Community Strategy, and the Local Area Agreement. All of these strategies and plans impact on the work of the Trust and how it goes about the development and delivery of services.

The PCT supports the Health and Well Being Partnership Board on behalf of partners across the city. The PCT actively participates in other themed and supporting partnership structures, including:

- Children and Young People's Strategic Partnership
- Safer Wolverhampton Partnership
- Valuing People Partnership
- Older People's Partnership, and
- Long Term Conditions Partnership, as well as
- A range of National Service Framework Local Implementation Teams

The PCT works in partnership to commission services. Practice Based Commissioning has been developed in the city through the creation of the Locality Commissioning Board, and the PCT works to support GPs in the commissioning of local services. The Joint Commissioning Unit has been developed with Wolverhampton City Council and focuses on commissioning for particular care groups.

We have established a robust network of partnerships with local people, either through those systems we have developed in partnership with other agencies in the city, such as the Local Neighbourhood Partnerships (LNPs), or through our own involvement and engagement structures, such as the Locality Health Panels and the Patient Engagement Database.

1.1. About Wolverhampton

Wolverhampton is a city of around 239,000 people, with an ethnically diverse population. Like most cities, there are areas of relative affluence and poverty, but overall, Wolverhampton is one of the most deprived local authority areas in the country.

Wolverhampton is a new city with a strong sense of identity and a long and proud heritage. It is a vibrant and multi cultural community and one of the most densely populated areas in the country. This said it is the 27th most deprived area in England; 12% of the population describe their general health as not good, 35% of households do not own a car and 21% of the population claim income support. Wolverhampton has the 4th highest rate of teenage pregnancy and the 5th highest rate of stroke in 65 – 74 year olds.

The health of Wolverhampton's population is closely linked to levels and nature of deprivation, and overall, health in the city is worse than in less deprived areas. For example, at the moment, 10.2% of the city's population say they feel 'in poor health' (compared with 7.5% nationally). Around 20% of the population have a long-term limiting illness or disability. Life expectancy is in the bottom 20% nationally and male life expectancy in particular is significantly lower than the national average.

1.2. Priority & Vision

Wolverhampton City PCT recognises the need to commission services that have the biggest impact on health according to the needs of the population in each local area, and to enable care to be provided as close to home as possible. Over the next five years we shall commission services that focus on self-help and family care, supported by services based in the community. Services for emergencies and acute care will be available for those that need them, with tertiary care for highly specialised cases only.

The JSNA highlights several areas where inequalities between Wolverhampton and other areas, or within Wolverhampton itself, are particularly stark. These include:

Infant mortality - deaths in the first year of life are much more common in Wolverhampton than the national average, with a rate of around seven infant deaths per 1,000 live births compared to five per 1,000 nationwide

Teenage pregnancy - the rate of conceptions amongst 15-17 year olds is around 50% greater than the national average

The impact of alcohol and harmful drinking - there are some 8,200 dependent drinkers in the city and this translates into high levels of hospital admissions for, and deaths from, alcohol-related illnesses such as chronic liver disease

The JSNA Initial Document also picks up on areas where there are inequalities now, which are likely to grow in future - with implications for service provision. These include:

Obesity and overweight amongst adults and children - rates are similar to national averages, and if the predicted increase in overweight and obesity nationally is reflected in Wolverhampton, the impact on health and other services, and key targets like improving life expectancy and employment rates, will be serious

Needs of the growing older population - rates of stroke and hip fracture are higher than average in Wolverhampton; demand for dementia care will grow as the population aged 80+ expands; most growth in the older population will be amongst BME communities, so services will need to adapt to meet needs

The information collected from the JSNA, World Class Commissioning process, Director of Public Health's Annual Report and the various pieces of consultation with, public, patients, clinicians, partners and other key stakeholders has led to the development of four key priorities.

- Mortality rates will be reduced and the gap in healthcare inequality will be closed, especially amongst infants and those with cardiovascular disease
- Through better partnership working and the integration of services, the problems of alcohol dependence, and the health and wellbeing of young people will be improved
- Access and choice to community services that tackle pressing lifestyle issues and Ambulatory Care Sensitive conditions will be improved
- The quality of outcomes in key clinical domains will improve through a focus on standards of care, and risks to patients' safety will decline

The Operational Plan describes the yearly activity to deliver against these priorities and how Wolverhampton PCT will address the requirements of the National Operating Framework.

1.3. Wolverhampton Structure

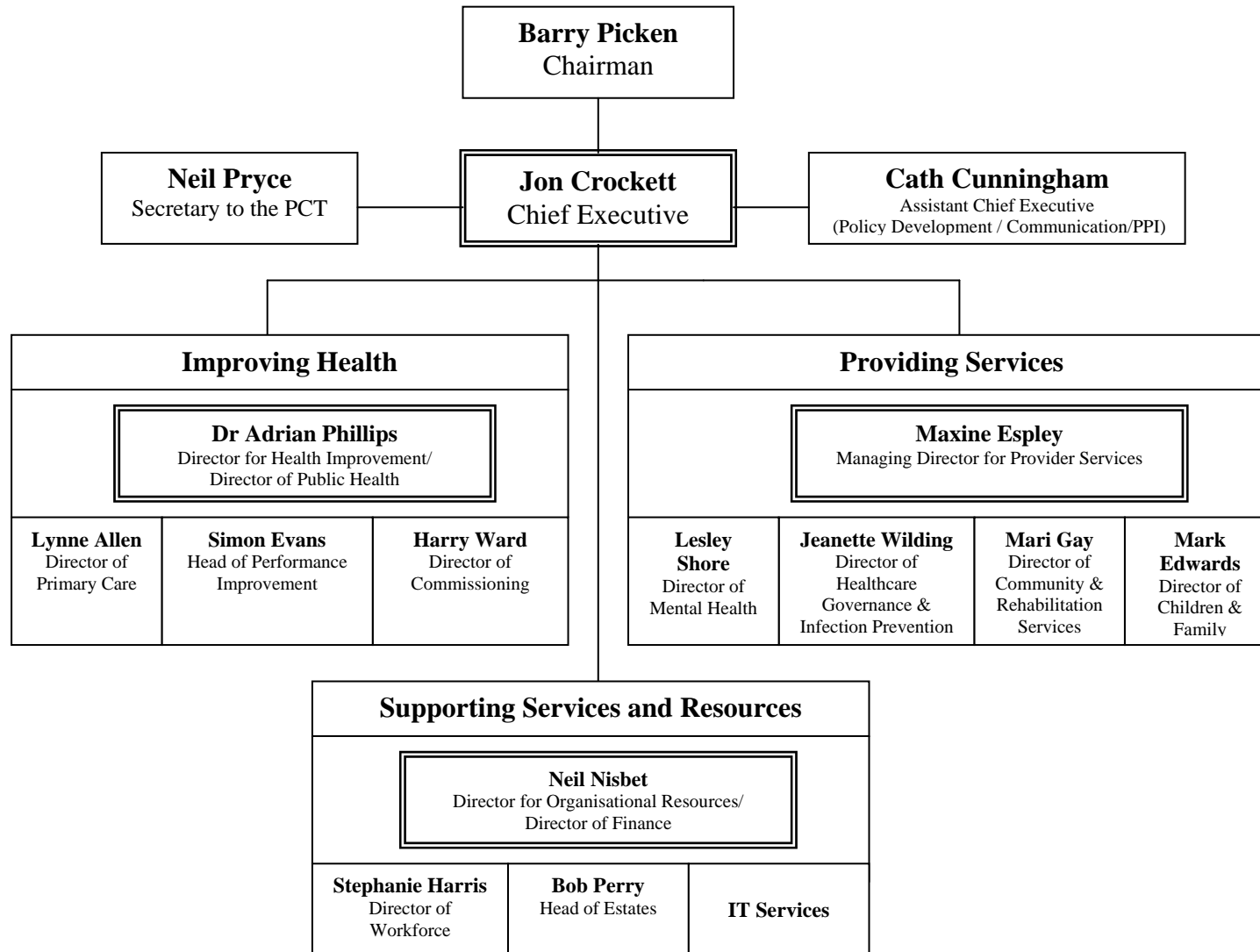
The PCT is governed by a Board which has the responsibility of setting the strategic aims and ensuring that the necessary financial and human resources are in place. The Board sets the standards and values, and ensures the obligations to patients, the local community and the Secretary of State are met. Below Board level the organisation is divided into three main areas of responsibility:

The Provision of services: overall responsibility for this rests with The Provider Board which is a sub committee of the Board. The Provider Board has responsibility for all services directly provided by the PCT including those services where the PCT is the lead Provider Organisation as approved in the Framework Partnership Agreement with the City Council. The Board has overall responsibility for monitoring performance, finance and maximizing the efficiency of provider services.

The Commissioning of services: overall responsibility for this rests with the Professional Executive Committee (PEC). PEC is responsible for leading and guiding the PCT Board through detailed thinking on priorities, service policies and investment plans. PEC makes a contribution to the strategic direction and operational delivery of the PCT and to the wider health care agenda. It provides a professional view on the strategy and operations of the PCT. PEC is responsible for clinical change, clinical engagement, interfacing with acute sector clinical partners, ensuring the whole system approach to care, delivery of the clinical agenda and health improvement. PEC brings together clinical and managerial perspectives and takes a leading role in these functions on behalf of the PCT.

The Supporting Services and Resources: This Directorate brings together finance, workforce, estates and IT Services. These services provide support and professional guidance to the Provider Services, Commissioning and the Board itself.

Wolverhampton City Primary Care Trust Organisation Chart



2. National Drivers

2.1. Operating Framework

Introduction

Wolverhampton City PCT's initial response to the requirements outlined in the 2009/10 Operating Framework is contained in the following section and Section 7 – Action Plans. The narrative section below outlines our over-arching approach to tackling the indicators and the Action Plan section provides high-level detail in terms of milestones, resourcing and partnership working.

2.1.1. Cleanliness

MRSA/MRSA Screening/C. diff – We are adopting a zero tolerance approach to our Infection Prevention Strategy and seek out best practice both nationally and internationally and review for local appropriateness so that we may:

- Meet national standards as set by DoH and Care Quality Commission for infection prevention and decontamination and provide assurance via benchmarking
- Implement MRSA screening as per DOH operational guidance 2
- Pursue Community Screening Programme that is in addition to the national standard for 09-10
- Deliver a work programme to promote best practice in wound and catheter care to address learning from Root Cause Analysis (RCA) in 08-09
- Promote initiatives to support best practice by the independent sector providers – Infection Prevention Charter
- Continue to seek improvement through learning lessons from RCA

Key risks – Performance across RWHT and independent sector care providers

As part of our consideration against commissioning arrangements, we will adhere to the significant KPI in Commissioning for quality arrangements, performance trends and RCA outcomes and also monitor all provider performance for HCAI's via PEC clinical governance committee on a quarterly basis.

Monthly performance data will be monitored and quarterly performance discussed. SUI will be notified as they arise and RCA outcome reports shared.

Patient Safety and Improving Cleanliness and Reducing Healthcare Associated Infection is Goal 9 in our Strategic Plan (detailed in initiative 8). We have chosen these goals because they will make the greatest contribution to the achievement of our strategic priorities. They are relevant to the eight pathways of care described in Lord Darzi's Next Stage Review and are supported by the ten projects outlined in Investing for Health

We shall introduce a programme of pre-admission screening for all patients referred for elective treatments and offer screening to all residents in nursing and residential care establishments.

New guidance on the management of MRSA and C. diff will be implemented at all sites, including NHS and non-NHS providers. In particular, we shall improve the management of chronic wounds and chronic in-dwelling devices (such as catheters) by implementing a systemic approach and better tracking of urgent cases.

To support this work we shall develop a Charter Award as an incentive to independent providers, and we shall improve the quality of prescribing of antimicrobials, including the introduction of Scriptswitch software.

Initiative 8 – Reduce the incidence of healthcare-acquired infections - This initiative will result in a reduction in the incidence of healthcare-acquired infections in nursing and residential homes

and the acute sector. This will increase the safety and quality of healthcare services and improve the experience of patients.

We shall invest in infection prevention and control over 5 years. The impact this investment will have on our goals is that the incidence of healthcare-acquired infections will result in no more than 15 MRSA infections and no more than 182 C. diff infections in 2009/10. As a result, we should expect to see a reduction in the prescription of antimicrobials – not more than 3 GP practices above 10 items per 1,000 STAR-PU for high risk antimicrobials, and not more than 3 above the local target of 0.235 items per STAR-PU for all antibiotics.

We are adopting an innovative approach to this problem and have set very ambitious targets. In time we should expect to see a reduction in the number of admissions for care of infections, fewer deaths from healthcare-acquired infections and fewer complex cases being managed in the community. But we are not yet in a position to be able to estimate what this impact might be, however we will be able to meet the stringent targets set.

Activity for 2009/10

- Follow up of positive MRSA screens from RWHT who have not commenced treatment
- Conclude work programme for wound and catheter practice and commence implementation roll out
- Completed second stage and repeat of community MRSA Screening
- Repeat IP Charter Awards
- Follow up of positive MRSA screens from RWHT who have not commenced treatment
- Conclude work programme for wound and catheter practice and commence implementation roll out
- Completed second stage and repeat of community MRSA Screening
- Repeat IP Charter Awards
- Improve robustness of high risk antimicrobial prescribing monitoring across all providers
- Implement scriptswitch software
- Explore possibility of an Infection prevention Charter scheme for independent contactors – GP, Dentist and optometrist's to support best practice in infection prevention and local audit initiatives
- Award ceremony inclusion of independent contractors if applicable

2.1.2. Access

The changes to our Activity Levels for 2009/10 are reflected in our Vital Signs Trajectories and recognise the impact of our strategic plan initiatives and the changing health needs and services in Wolverhampton. These changes to activity levels will impact on all of our access indicators for 2009/10.

18 Weeks – The 18 weeks requirements are included in schedule 3 of the standard acute contract.

Information Requirements - The Referral to Treatment (RTT) data collections monitor the length of time from referral through to treatment in order to monitor progress towards delivery of this target.

We have already achieved the 18 week target for Wolverhampton patients in 2008/9 and are developing plans to reduce waiting below this level for 2009/10.

Activity for 2009/10

- 18 Week targets were achieved 5 months ahead of the end of December 2008 milestone
- Following approval from the SHA our 18 week project board has now been disbanded and monitoring is now covered at the monthly Contract Monitoring meeting
- Any capacity issues regarding 18 weeks are also discussed at the Contract meeting
- 18 weeks requirements are included in schedule 3 of the acute contract
- Continue to develop local plans to reduce waiting below 18 weeks and extend into other services not currently included within 18 week target

Choose and Book – Any issues, for example slot availability, will be raised at the monthly contract monitoring meeting with our main acute provider. Formal contractual processes have already been utilised in the form of a contract warning on slot availability with RWHT to ensure that slot availability is maintained and improved. This will be complicated due to the introduction of SNOMED coding which will be introduced from 1 June 2009. To ensure clear introduction, a project plan is being developed to incorporate training for GP practices and their teams, a project lead to ensure successful implementation and two workshops across primary and secondary care.

New community provider services will be monitored in the same way (per activity contract requirements) as provider services within the PCT. Provider services are being encouraged to implement Choose and Book (C&B). Two services to date have C&B; others will be added over the coming months.

All new community services will have clearly defined set up processes and technical support. Support teams (both operational and technical) have been identified and lessons learnt will assure smooth implementation. We will ensure excellent communication lines between main acute provider/primary care/community services, this will be key for successful implementation.

All providers will understand reporting requirements. All data capture will be electronic.

While C&B is not specifically identified in WCC documents, the higher percentage of bookings made electronically for Outpatient Appointment (OPA) at a time agreed with patients should add to patient satisfaction levels which will contribute towards competency 3.

Activity for 2009/10

- 2009/10 LES to be developed to assist PCT in meeting targets
- Review Directory with RWHT particularly in light of the SNOMED changes

SUS – The PCT already receives SUS data pertaining to all its acute providers & uses SUS as its primary source of commissioning, monitoring and planning data which is aligned with our commissioning partner the CBSA. SUS data is also used extensively by the Directorate of Public Health. SUS data is reconciled by both PCT and the CBSA and any resulting Stage 1, 2 or 3 queries are addressed with the Providers at monthly contractual meetings.

In addition, SUS data is used to provide:

- The weekly and monthly 18 Week RTT monitoring exercises which the PCT undertakes (including the admitted, non-admitted & admitted {adjusted} categories).
- Appropriate LDP/VS “lines”
- PBC activity information sent each month to the 57 GP practices across the City.

The PCT has appointed a firm of health information consultants to advise on the following with respect to information needed to enable the PCT to become a World Class Commissioner:

- Support the PCT in developing its role as a World Class Commissioning organisation that delivers and commissions improved Health & Wellbeing for the population it serves through its commissioning, performance management and leadership activities
- Provide an assessment of the Information support that will be needed to support the PCT’s development into a World Class organisation
- Understand the Information Services currently undertaken by Wolverhampton City PCT & the information resources available including information systems, staff etc
- Provide a gap analysis by comparing the above, taking into account factors such as the current CBSA & SUS functionalities and the forthcoming developments within each organisation
- Provide evidence-based, audited recommendations as to how this support should be provided including changes & developments around the staffing structure & information systems, cross-referenced to World Class Commissioning (e.g. does the Trust retain all its present data warehouse resources etc).

The results of this project will be developed and rolled-out in 2009. It will necessitate the need to obtain additional information from across the PCT’s Health Economy Partnership elements such as social care deprivation, local social policies, etc as these pertain to all Providers.

The forgoing will require additional resources both technical - in the sense of business intelligence systems, implementation & training plus hardware and most importantly information intelligence – the means of converting information into knowledge. This will be quantified as the implementation strategy develops. The latter will take into account resources from elsewhere such as the CBSA “IAN” information system and the SUS “Comparators” site.

AHPs – The PCT will develop alternative models for Allied Health Professionals and community services, where clinically appropriate, and promote their use to the local population. In agreement with the practice based commissioners and following engagement of the public, new pathways will be developed to support ease of access to services through self referral to AHP services. Effective triage systems will be implemented to ensure appropriateness of clinical assessment and to reduce the risk of an unsustainable increase in referrals. Targets will be set for initial triage and follow on assessment to minimise waiting times. The initial plan is to roll out self referral to musculo-skeletal physiotherapy services in 2009/10. The effect on contractual arrangements will be supported by a redesign of the information collected to ascertain triage numbers and assessment numbers. The contractual arrangements will also need to reflect the need for the telephone based triage system. This is a priority for the PCT as it supports access issues to primary and community based services in the Operating Framework. An evaluation of

the self referral pathway will be undertaken for musculo-skeletal services to determine the effect on the patient experience. The PCT will develop a 5 year plan in 2009/10 to implement self referral in appropriate community services.

Activity for 2009/10

- Develop Strategy & Plan
- Implement for first service October 2009

Audiology – Access requirements are included in the Service Specifications of the contract. Direct Access data collection was introduced in 2008. Direct Access Audiology data is included on DH website. New data to show waiting times from referral to treatment for patients who are referred directly to audiology services is published for the first time by the Department. The publication of these statistics marks a key stage in reducing long waits for treatment for all people with hearing related problems. In 2007, the Department of Health committed to tackling waiting times for patients referred directly to audiology services without needing a medical consultation including for example, those patients who need a hearing aid. Previously, all data published up until this point has shown waits for audiology diagnostic assessments rather than treatment.

Providing timely access to care is central to improving quality, both by ensuring that care is received when it is most needed, and by contributing to a positive patient experience.

Extended Hours – Wolverhampton PCT is committed to providing patients with access to appointments with a GP during extended hours with a view to significantly increasing satisfaction with opening hours in relation to patient demand and the results from the Patient Experience Survey. The aim of the LES is to enable practices to provide improved patient access to general medical services by providing additional booked surgery appointments to those groups of patients who traditionally have encountered problems with access. The PCT exceeded the target of 29 GP Practices for 08/09 and currently has 77% of GP Practices operating with extended hours.

Activity for 2009/10

- May 2009 PCT aspiring to 80% of practices signed up, by Aug – 84%
- Practices are encouraged to sign up for LES to provide a better patient experience and improve access to routine care during extended hours period
- Audit of extended opening added to annual contract review, with periodic in year monitoring
- Practice review of opening times to reflect most recent national or local patient survey results
- Commissioning proposal to be developed for gap commissioning extended hours for those disadvantaged patients registered with practices that refuse to participate in extended opening hours

GP Appointments within 48 hours – The PCT has historically performed very slightly below the national average on this indicator although scoring above in the other national measures. However on the PCAS survey practices report 100%. Irrespective of this the PCT is committed to delivering a responsive service to its community. The PCT's approach is robust and challenges the practices to perform. Work has been undertaken with practices to achieve this goal and the PCT will continue its programme of targeted action. The action is also aimed at ensuring those practices which currently hit the target do not regress.

Activity for 2009/10

- Review practices' performance against action plans developed for 2008-09 who have historic problems with 48hr access outlined in 2007-08 survey
- PCT to review 2008-09 individual practice performance published in 2009-10
- Set individual practice improvement plans for those practices whose performance falls below the national average

- Monitor those practices performance during the year and at the annual contract review
- Maintain PCAS Survey until further instructions received from DH
- Purchase training as per previous years from The Improvement Foundation to help struggling practices to manage demand more effectively
- Where access problems are a result of under doctoring, pressure will be brought to bear using both the contract and performer list powers
- Patients where access remains a problem will be sign posted to new EAPC practices
- PCT will continue to monitor in year individual practice attendances at A+E, WIC, GP Led Health Centre and OOH's service so early indications are identified

Pre-booking of GP Appointments – The PCT has historically performed well above the national average on this indicator. Irrespective of this the PCT is committed to delivering a responsive service to its community. The PCT's approach is robust and challenges the practices to perform. Work has been undertaken with practices to achieve this goal and the PCT will continue its programme of targeted action. The action is also aimed at ensuring those practices which currently hit the target do not regress.

Activity for 2009/10

- Review practices performance against action plans developed for 2008-09 who have historic problems with pre-booking outlined in 2007-08 survey
- PCT to review 2008-09 individual practice performance published in 2009-10
- Set individual practice improvement plans for those practices whose performance falls below the national average
- Monitor those practices performance during the year and at the annual contract review
- Maintain PCAS Survey until further instructions received from DH
- Purchase training as per previous years from the improvement foundation to help struggling practices to manage demand more effectively
- Where pre-booking problems are a result of under doctoring pressure will be brought to bear using both the contract and performer list powers
- Patients where pre-booking remains a problem will be sign posted to new EAPC practices
- PCT will continue to monitor in year individual practice attendances at GP Led Health Centre (pre-bookable appointments for unregistered patients) and OOH's service so early indications are identified

GP led Health Centres – Wolverhampton PCT has one of the lowest numbers of GP's per head of population in the country and as such, has embraced and fully integrated the EAPC programme into its pre-existing Primary Care Strategy and its SSDP. Wolverhampton PCT has signed contracts to provide 3 new GP Practices as well as a GP Led Walk-In Centre. The first GP Practice opened in Graisleigh on time on the 1st April 2009 with the remainder scheduled to be open in Ettingshall and Bilston in June and July 2009. And the walk-in centre in Low Hill to open in summer 2009.

Patient Satisfaction – The PCT's Communication and Engagement Strategy identifies the need to empower patients and local communities, staff, clinicians, providers, contractors and our partners to shape health services, and through effective management of the Trust's brand and reputation to ensure that local people trust that we will deliver high quality services and respond to their views. Of the strategy's key communications objectives, the following elements are particularly pertinent in this instance:

- To ensure that local people have confidence that they can influence us, that we will listen to what they say, and that we will feed back what we can deliver and what we cannot
- To make sure that people understand our services and know how they can access them, targeting communities and individuals in particular need

We will ensure consistency with contracts through Improvement Plans which will be reported through commissioning reporting routes. Locality Commissioning Boards will continue to receive feedback from Locality Health Panels and Local Neighbourhood Partnerships. Actions described are consistent with the PCT's Strategic Plan and our Communication and Engagement Strategy.

Activity for 2009/10

- Ensure surveys are commissioned from appropriate provider
- Identify key issues arising from survey feedback
- Continue to develop Locality Health Panels and to support the development of Local Neighbourhood Partnerships, and work with communities to feedback progress on local priorities

Dental Services – Access to Dental services in the city has always been good in relation to experiences elsewhere in the country. Wolverhampton has always been a net importer of patients from neighbouring PCT's whose accessibility has traditionally been less than Wolverhampton. These neighbouring PCT's have recently significantly improved their access and the Wolverhampton service is now concentrating its strategy on the needs of its local population. The PCT Dental Strategy was refreshed and approved by the Trust Board in September 2008. The Strategy aims to promote and develop NHS dentistry by reducing inequalities in access across the city, improving the quality of dental care and thereby improving the oral health of Wolverhampton residents. The strategy will be delivered through effective commissioning arrangements and shifting appropriate work out of secondary care. Robust contract management will be an important feature of the PCT's work.

Activity for 2009/10

- Continue annual and mid-year contract monitoring
- Formalise monthly data reviews
- April 2009 VFM review and contract re-negotiations
- Set individual practice improvement plans for those practices whose performance (access) falls below local and national average.
- Monitor those practices performance during the year and at the annual contract review with particular regard to those contractors with an improvement plan in place.
- Spot purchasing of additional activity where funding is available
- Increase engagement with DSD using a targeted risk management approach
- Once DPA appointed commence work on service re-design specification linked to the strategy and procurement of new practices
- Reinvestment of funding freed up, such as by retirements, to commission new services

Urgent & Emergency Care –Wolverhampton City PCT will continue to develop access to urgent and emergency care services providing the most appropriate care to the patient in the most appropriate setting and, wherever possible, delivery in primary/community settings. The model is included in the SSDP. It is further supported by the commissioning of extra walk-in capacity in the North East of the city at the Showell Park Medical Centre (due for completion in June 2009) in addition to the increase in commissioned services in the South East at the Phoenix Centre in 2008/09, which is now fully operational. This will improve patient choice and access with the total number of attendances recorded during 2008/09 at the Phoenix Centre standing at 24,048 for nurse led interventions and 45,441 by Doctors on Call. We also intend to improve patient experience through further procurement of GP out of hour's services in 2009/10.

Furthermore, Wolverhampton has worked closely with West Midlands Ambulance Service (WMAS) during the year, particularly over the busy winter months, to further develop the Category C divert plans. The Category C divert scheme in Wolverhampton is a joint initiative between the PCT Provider and WMAS. The service has been designed to prevent unnecessary '999' calls, deemed to be Category C and suitable for care in the community, from being taken to hospital. This service is provided as an outreach from the Walk-in Centre.

The annual activity plan is to prevent 520 admissions. Whilst fully supporting the principle and desired outcomes of this service, WMAS refer very infrequently and the PCT meet regularly with them to promote engagement in the service. In the last financial year, 148 referrals were received and a large percentage of those were actually kept out of hospital. However, 96 of those cases accounted for the issues with WMAS during December 2008.

The PCT consider that with further joint working this service can further contribute towards appropriate care being delivered at the most appropriate venues which can often exclude an acute hospital attendance. This can impact on service delivery during peak activity times e.g. winter months.

We are working with key partners to improve the post acute admission care pathway. We aim to provide rapid progression through the appropriate care pathway. This will ensure that patients get access to early rehabilitation and reduce delays. This is based on LEAN methodology and is externally facilitated.

An initiative within our Strategic Plan is to reduce Ambulatory Care Sensitive Conditions, especially those non-planned admissions. An area of specific interest relates to children's non-planned admissions. We aim to remodel the pathways of care for this particular group.

The above work-streams are overseen by the multi-agency emergency capacity group which maintains oversight of urgent and emergency care in Wolverhampton, including:

- Development of Wolverhampton unscheduled care service model
- Reducing delayed discharges
- Winter planning
- Implementation of LEAN Programme
- Implementation of the Next Stage Review locally.

Major milestones of work for this year include:

- Q1. Sign-off and adoption of revised Major Incident Plan
- Q2. Assessment of roles and responsibilities, identify training needs
- Q3. Start to roll out training program
- Q4. Major Trust exercise

Activity for 2009/10

- Participate in SHA wide review of ambulance services and urgent and emergency care
- Develop strategy including development of single point of access for unscheduled care ensuring all relevant services participate to ensure wide coverage for the whole range of patients requiring care
- Continue to develop Category C divert schemes
- Implement recommendations from Multi agency LEAN Programme
- Remodel children's unplanned care pathway

Emergency Bed Days - To assist in the overall vision for the future of unscheduled/urgent care the PCT will develop a strategy in 2009/10 that incorporates the significant progress to date and sets outcomes and targets which will influence:

- Emergency bed days
- Ambulatory sensitive conditions
- Ambulance journeys to A&E

This will support the operating framework objective of Improving Access.

Activity for 2009/10

- Lean projects including delayed discharges and productive community hospital.
- Continually promoting use of Cat C divert schemes (increase capacity in winter months)

- Continually promoting use of SSDP transfer of acre schemes
- Cellulitis care pathway
- COPD care pathway
- MS care pathway
- EOL care pathway
- Telehealthcare implementation for home monitoring
- DVT care pathway
- CHD care pathway

2.1.3. Improving Health

Cancer – In line with the WCC Strategic Plan we will reduce delays in referrals to specialists from a median of 9.5 weeks to not more than 6 weeks. The uptake of screening for bowel cancer will increase from 49% to 62%. We will target an increase of 25% (750) for rapid access clinics for lung cancer.

We have worked with our main provider and Greater Midlands (GM) Network to identify issues with cancer waits as well as a 2 week wait for breast symptoms. We have invested in service improvement activity as well as improved IT systems to help monitor and diagnose troublesome areas. We recognise the considerable capital investment required to modernise the screening equipment. We have delivered cervical screening target.

We will monitor performance around waits through our regular contractual meetings as well as through the GM Network. We are working with Dudley in the commissioning of the new breast screening commitments and other Black Country partners on bowel screening.

We are mainly reliant on trust data for performance data. This has improved with the new Somerset system. Unfortunately cancer mortality data is significantly lagging behind service activity data.

We are concerned with the rapid decline in cervical screening in the younger age group. Whilst we have successfully implemented HPV vaccine, we recognise that a cohort of women may experience increased cervical cancer. The ageing population means that we will need to consider more capacity for the breast screening service

Cancer is included as a specific issue within our Strategic plan, especially delays in referral from primary care and increasing bowel cancer screening. These are priorities as local research has identified specific issues with delays in lung cancer. Bowel cancer screening is a quick win on reducing mortality.

Activity for 2009/10

- Trajectories mapped into 2009/10 Provider Contracts
- Action Plans to address non-compliance with IOG guidance from Providers.
- Develop plan to improve Bowel cancer screening uptake.
- Plans agreed to modernise and expand the breast cancer screening service.
- Agree plans to link pathology IT system with PCT (cervical screening)

Stroke – The implementation of the national Stroke Strategy is progressing well. Areas for development for 2009/10 are:

- 7-day therapy provision in Rehabilitation services
- Further development of the Wolverhampton Stroke register integration with Community services and GP registers
- Enhanced use of GP Stroke registers
- Further development of early supported discharge service within CICT Rehab
- Increase access to SALT in Rehab services to include comprehensive access to Communication therapy and not just swallowing assessments
- Ensuring increased ranking in the next RCP Sentinel audit (currently in upper quartile nationally).

Maternity – Development of maternity services and interventions to deliver against targets will be co-ordinated through the Healthy Start to Life programme board. This will be a partnership board with a line of accountability to the Wolverhampton Children's and Young Peoples Strategic Partnership. Under this board will be multi-agency project groups to develop and deliver services in order to tackle specific priorities. This will include; smoking in pregnancy, early access to antenatal services, promotion of breastfeeding, maternal obesity and antenatal/

neonatal screening. There will be universal services with targeted services for families identified as requiring increased support. This work will be in line with Investing for Health project 2c. Alongside this will be the development of a service model to deliver these services. This will be based on the development of integrated start to life teams with key members being midwives, health visitors and Sure Start children's centres. Each integrated team will be responsible for a geographically identified cohort of families. This is likely to be based on children's centre catchment areas.

Key performance indicators will be clearly defined and incorporated into contracts with relevant providers. This will include reducing smoking at delivery, increasing breastfeeding initiation rates, increasing proportion of women booking before 12 completed weeks of pregnancy, continuity of antenatal carer and compliance with NICE guidelines regarding antenatal and postnatal screening.

Information gathered during antenatal booking is currently inputted onto the maternity Euro King system after the baby is born. This contains information such as smoking status, maternal BMI and other potential risk factors important in targeting antenatal interventions. Information systems need to be redesigned to input this information onto the system at time of delivery and share with relevant services to provide antenatal support to the mother.

Information systems need to be redesigned to provide West Midlands Perinatal Institute with the information required for Investing for Health Project 2c while maintaining current PCT access to births data. More information is required on what influences choices such as breastfeeding and smoking, especially in high risk groups such as mothers under the age of 20 years. A social marketing approach may provide the information required to target interventions more effectively. Information systems and information sharing protocols need to be developed to provide integrated teams with the information they require to work together effectively.

Service user and public involvement in service design and delivery is currently through the MSLC. This requires development as a reference group to the programme board. As part of the healthy start to life programme, service user involvement will also be developed through children's centre parent and user groups. Development of the peer support programme will involve the recruitment of volunteers from previous service users and members of the public.

Breastfeeding support services across partners need to be reviewed to identify the best model for achieving the required outcomes. There has been a recent increase in birth rates. This needs to be monitored to evaluate potential impact on services and implications for level of service commissioned. Capacity of staff to maintain the current level of service to families during the change to the new ways of working will be monitored. Technical constraints to providing information systems will be analysed as required.

Activity for 2009/10

- Development of a fast-track free pregnancy testing service based in community pharmacies
- Range of access routes for women to maternity services including home antenatal booking
- Community midwives to be community based in Sure Start children's centres
- RWHT to achieve Baby Friendly stage 2 in line with existing development plans
- PCT to achieve Baby Friendly first stage in line with existing plans
- Implementation of a breastfeeding peer support programme with a full time peer support co-ordinator

Children – The priorities listed in the Action Plan have been under partnership development in most cases, for a number of months with some work ongoing from 2008/09. The related strategies are Maternity, Sexual Health and CAMHS - a number of these link into LAA plans agreed within the Wolverhampton community. Partnership is at the core in most of the developments through 2009/10.

Risks will be managed through various health and partnership performance management arrangements. With the levels of investment proposed as detailed in the Action Plan, resource related risks are minimised and with a number of developments there will be aligned benefits - an example will be development of Common Assessment Frameworks for families in Wolverhampton generated from health.

Commissioning arrangements will be applied through contract management between the PCT commissioner and provider and across broader initiatives through LAA monitoring. As part of the performance management of contracts and targets linked to Public Health, the provider will develop robust performance management arrangements (linked to the Children, Young People & Maternity NSF) to provide internal and external assurance.

The increase in birth trends has been considered as part of the 'Start to Life' work, developments in sexual health and the demographic data available on prevalence of disease. The plans listed have significant relevance to WCC and to the priorities identified by the commissioner within the Strategic Plan. This work is critical to addressing health needs within the City of Wolverhampton and will be aligned to partnership working with a number of agencies across all sectors.

Regarding Paediatric Palliative Care, the PCT is currently considering providing additional financial support for Acorns Hospice for 2009/10. The future recurrent funding will need to be considered as part of a wider review of the Palliative Care Service for children.

Activity for 2009/10

- Consider development of Family Support Workers to compliment the current RWHT establishment of Maternity Support Workers in delivering seamless family support from birth through early years
- Establishing the 'Journey to Gem Centre' as a mainstream service
- Development of Sexual Health Service provision targeting young people and access. Increased Chlamydia screening and uptake of LARC where indicated
- Partnership development work on CAMHs monitoring through the commissioning function the implementation of the CAMHs strategy
- Develop work plan on transition
- Review with commissioner the development of 16 to 25 yrs service and developing a clinical model for this group
- Imms targets from public health
- Programme within each school year for height and weight recording of children entering reception and year 6
- Established MEND programme linked to Healthy Schools

Obesity – The Food Dudes programme has been commissioned for a 3 year period and was officially launched in January 2009. All primary age pupils will have the opportunity to take part in the programme to encourage increased consumption of fruit and vegetables using evidence based approach identified by the Psychology Department, Bangor University. This involves the use of role models and repeated tasting and rewards. 43% of primary pupils will have undertaken the Food Dudes programme by March 2010. A key risk is refusal of schools to take part in the programme. Engagement of Head teachers, at least one term ahead of expected delivery, will be undertaken by the Food Dudes Project Manager. Risk to data collection to enable information to be gathered on parental involvement and perception of the programme will be minimised by offering incentives for the return of questionnaires (either as a child reward built into the programme or a supermarket shopping voucher).

During the academic year 2008/09 school nurses will continue to provide parents with standardised health information for each child, sharing information with parents where an overweight/obese child is identified. From September 2009, it is anticipated that the service will adopt the Department of Health standardised letter. The Change4Life leaflet to accompany the letter is currently being obtained and will be used routinely by school nurses when received. The market segmentation tables recently received from Regional Office will be used to inform the

obesity strategy group for children and to firm up plans for engaging with Clusters 1-3 in identified priority areas across the City.

The tender process for weight management programme for children and young people is currently in progress and will be commissioned in 2009. This will enable 540 places for overweight/obese clients to receive support through a provider organisation. The resulting contract will ensure the provider delivers outcomes to enable monitoring and progress for each individual. A risk to the service is poor take up. This will be minimised using social marketing techniques to engage with the target group and also use of effective communication with referral agents to maximise uptake of the service. This will include raising awareness with local neighbourhood management, letters sent to parents regarding child measurement and ongoing publicity in One City News/Health Focus.

Capital funding provided at the end of 2008/09 will see the introduction of enhanced physical activity opportunities in 2009/10 to support the target of offering 5 hours of physical activity to 5-16 year olds per week. These include the following:

- Young people gyms across 10 sites in school, community and leisure facilities
- 14 outdoor gyms in parks and outdoor spaces
- 7 sites for the use of dance mats
- A computer linked wellness system in 3 school gyms to identify individual fitness levels and progress
- Boogie boxes in 160 sites, including all schools.

Appropriate marketing techniques will be applied by the local authority to raise awareness of the opportunities in leisure facilities. This will reduce risk of equipment and facilities not being used to their full potential.

Measurement of Reception Year and Year 6 weight will be undertaken to ascertain progress on halting obesity rates. Data collection processes are currently being reviewed to ensure an efficient system is implemented in September 2009. Robust monitoring and evaluation of the Food Dudes programme will ascertain impact of the rewards, parental involvement and provision of extra fruit and vegetables long term and overall sustainability of the programme once the rewards are reduced. Individual progress of participants in the weight management programme will be tracked by the provider organisation and reported to the commissioner, enabling a database of information to be established. The Local Authority will provide engagement data of the target group for physical activities.

The PCT Strategic Plan identifies that the number of young people is predicted to fall progressively over the next 15 years. BME population rates are predicted to increase.

Obesity in children is a rapidly growing problem. At present, 12.1% of children in reception year are obese, rising to 22.1% in year 6. Childhood obesity is a target and priority in the Local Area Agreement (LAA). National projections produced by the Foresight project suggest that by 2025, 47% of men and 36% of women will be obese. Reducing obesity is a regional priority in the West Midlands, where rates of childhood obesity are some of the worst in the country. The Strategic Plan identifies that the PCT is commissioning new services through formal competitive tendering to develop an obesity programme for children. The plan makes reference to the need to reduce the impact that obesity has amongst the Asian population and the effect it is having on the increasing prevalence of diabetes.

Activity for 2009/10

- 60% of pupils undertaking the Food Dudes programme will have a sustained increased fruit and vegetable consumption
- Robust data collection arrangements for NCMP will be implemented by September 2009 to enable a complete data set
- 70% of young people completing a weight management programme to have a reduced heart rate in the Step Test

- 33% of children/young people aged 5 – 16 years will have taken part in 5 hours of school and community sports activities

AAACM – Analysis of local data shows that excess mortality compared to the national average are in 6 key areas: Infant Mortality, CHD, Stroke, Suicide, Alcohol-related disease and Cancer (mainly lung cancer). The health inequality toolkit (London Public Health Observatory) has confirmed this view. Our approaches in these areas are: better prevention, new services and improving quality of existing services. AACM will be dynamically monitored through monthly death data from ONS.

Our approach to infant mortality is mainly covered under the World Class Commissioning Outcomes section. Additionally we aim to increase the number of women quitting smoking whilst they are pregnant (and in the first year of life) with a 1% target drop each year over the next 4 years (from a baseline of 21% in 2008). This will be included in our contracts with maternity providers and monitored appropriately. We will commission additional services within our specialist smoking service to provide additional capacity. Information is available from the EUROKING database on smoking. We will increase our childhood vaccination to WHO standards over the next 3 years and include this within contract discussions with providers including Primary Care Contractors.

CHD and Stroke (collectively CVD) will be addressed firstly by better prevention. In 2009 our new services for adult weight management aims to support nearly 10,000 per year. We aim to improve 2nd degree prevention of CVD by working with individual practices using intelligence from our procured IT support, using evidence-based clinical standards. Additionally we will improve flu vaccination which will reduce winter mortality from CVD. We aim to maintain the high standards of CVD care commissioned from our main provider (RWHT).

By far the biggest challenge in reducing <75 CVD mortality rate is to tackle the main risk factors for people known to have CVD. We can do this by improving access to secondary prevention. In particular, we will target communities (in particular those from Black and Ethnic Minorities) at high risk with information about smoking, high cholesterol, raised blood pressure, diabetes, obesity, lack of exercise and poor diet. Those at risk must also be educated to understand the key symptoms and what to do if they develop acute chest pains. By 2013, we should see 40 fewer deaths from CVD in people under 75 each year.

The initiative to support the management of cardiovascular disease will develop primary and especially secondary prevention of cardiovascular disease (CVD) and improve the quality of information held in general practice clinical systems. This will result in better targeting of patients at risk and earlier interventions to influence lifestyle factors. Where rapid access to acute services is needed, we shall ensure effective pathways of care to reduce the risk of death and disability. The overall impact will be a reduction in health inequalities and lost years of life.

A GP data extraction and reporting system has now been procured. The reports from this system will support secondary and primary prevention of CVD. The data from this system and clinical evidence will be used to develop a standard based on the proportion of patients who are being optimally managed in five key clinical areas.

Secondary prevention of CVD is already a priority for General Practice and supported by the Quality and Outcomes Framework (QOF) – improvement in this area would be rewarded through improved QOF payments. The secondary prevention reports will enable practices to consider their patients in a different way. Where practices fall below the secondary prevention standard, support will be offered through the Disease Management Team (this has been developed through increased investment in the Medicines Management Team).

Primary prevention is a new priority for General Practice. The reporting system will identify patients at 20% or greater risk of a CVD event in the next 10 years. In the next year a model will be developed to provide primary prevention clinics to reduce these patients' level of risk. This model is likely to include a Local Enhanced Service, further development of the Medicines Management Team, procurement of an external provider or a combination of these.

The Vascular Risk Checks programme is a Department of Health priority. The PCT is developing plans of how it will address this target and how it will integrate with the other CVD prevention programmes. The procured GP extraction and reporting system will enable the commissioners to monitor the above programmes. A baseline will be set for secondary prevention and the impact of the Disease Management Team measured against this. It will produce primary prevention registers which will enable the PCT to meet target VSC23 - *All GP Practices within WCPCT will have a populated CVD register*. These registers will provide the information required to identify and prioritise patients in need of primary prevention.

Although age standardised mortality from circulatory disease in under 75s is falling in all wards in Wolverhampton, mortality is higher in the priority wards (an electoral ward that is in the 10% most disadvantaged ward in the country) than in non-priority wards. Age Standardised emergency admissions for CHD and Stroke are higher for Asian and Black patients.

This is being addressed in a number of ways:

- Support from the disease management team for secondary prevention will be prioritised based on the deprivation of the population served by General Practice
- A local enhanced service has been developed to encourage recording of ethnicity data. Improved ethnicity data will enable secondary and primary prevention to be targeted on specific groups
- The commissioners are exploring working with third sector organisations (particularly those who target BME groups) to develop plans for the Vascular Risk Checks

One of the 11 goals in the Strategic Plan 2008-2013 is to reduce mortality from coronary heart disease in <75s by 40 deaths per year. CHD accounts for 15% of the gap in life expectancy in Wolverhampton. It is the biggest killer and commonest cause of early death. But most premature deaths from CHD can be avoided.

Other drivers of our increased AAACM rate relates to alcohol. This is covered in another section

Information will come from routine sources as well as our commissioned IT solution. We will also develop a new system to monitor this indicator on a dynamic basis.

The impact of the economic downturn may increase the suicide rate as well as alcohol misuse. We are working within the LSP to develop more resources within the community e.g. CAB.

Infant mortality, tackling deaths from CVD and alcohol are included within the Strategic Plan, as well as smoking and action for better care for patients with lung cancer.

Smoking – The strategy is to maintain and increase the current level of smoking cessation activity and to engage with previous hard to reach groups. The current gap in service is related to access to smoke free workplaces and providing smoking cessation in workplaces. The strategy also needs to focus on young people to stop teenagers and young people smoking long term leading to a life long habit. The risks around delivery are commitment from primary care providers to achieve targets, lack of expertise with social marketing within the PCT to support the strategy and non hard to reach groups already targeted. Hard to reach groups remain as a significant challenge. No Health Trainers are currently in post although this is being addressed for 2009/10.

Activity for 2009/10

- Continue to develop specialist smoking cessation service
- Gaps identified as young people and workplace, further work to prioritise this group within the city
- Secondary care 'stop before the op' referral pathways, link nurses in all wards and departments, opt-out scheme for all TIA, Respiratory and Cardiac patients
- Development of social marketing strategy for hard to reach communities including routine and manual workers

- Achieve national targets for smoking in pregnancy
- Working with Children's centres to develop smoke free homes
- Develop educational programme for health professionals to ensure that smoking cessation becomes a normal and routine part of everyone's role and responsibility
- Continue to support GP practices and pharmacists in achieving targets including regular feedback
- Motivational texting service to be established
- Review the benefits of incentivised schemes for stopping smoking i.e. vouchers, gifts

Drug Addiction – The PCT is aware of the increase in young people taking drugs. Under-representation of BME Groups in treatment apart from referrals from Criminal Justice which show an over-representation of individuals from an African Caribbean background will be given attention as part of our reaction to the changing socio-demographic make-up of the PCT's geographical boundary. The indicator 'Drug mis-users in effective treatment' is a LAA target and Darzi priority.

Contracts will be performance managed against service specifications and these reflect the national drug strategy and local treatment plan.

Activity for 2009/10

- Tier 1, 2 and 3 services need to strengthen the care pathways to ensure individuals can access treatment safely – opiate based and stimulant services
- Services must 'reach out' to hard to reach communities. Individuals with dual diagnosis need to be targeted and offered appropriate treatments.
- Treatment agencies need to be viewed within the broader context of Wolverhampton services in order to ensure that individuals have access to services outside of drug treatment. For instance, housing, leisure, educational, vocational opportunities.
- Termination of Pregnancies (TOPs) need to be completed whilst individuals are in treatment to ensure treatment is effective
- Drug mis-users who 'drop out' of treatment need to be followed up appropriately
- Individuals who are misusing and referred by the Criminal Justice System need to be allocated appropriate case workers and treatment. services must target persistent and prolific offenders
- User satisfaction needs to be ascertained in order to ensure that treatment is effective
- Increase in young people using stimulants recreationally – these services need to pro-actively engage young people as early as possible.

Sexual Health – The bi-monthly Commissioning Network Meeting reviews sexual health performance. Recovery plans are produced for any deviation from the contract. All existing and new services are scrutinised by the Commissioning Network Meeting, thus ensuring a systematic approach. Additional Chlamydia screening activity has been commissioned to increase the screening rate. Furthermore, the PCT has successfully engaged in a direct mail shot to all registered 19-24 year olds across the health economy to offer a home-based Chlamydia screening process. The benefit of this approach is that individuals may bypass the perceived social stigma associated with this type of screening. The entire delivery model will be reviewed in light of the Chlamydia screening target to 25% in 2009/10 and increasing to 35% in 10/11. Activity reports are presented at the bi-monthly Commissioning Network.

A sexual health needs analysis was completed in December 2008. This analysis will assist the commissioning intentions and will be reviewed on a regular and timely basis

"Improve young people's use of high quality sexual health services" is one the key goals within the Strategic Plan. Wolverhampton is a persistent outlier for teenage pregnancy, both regionally and nationally. It is a national priority because of the adverse effect it can have on outcomes for young people. Some of our wards have very high prevalence, with conceptions in teenagers most likely to occur among girls brought up in poverty and social exclusion. The problem is also closely associated with ethnicity, alcohol abuse, infant mortality and learning disability. The PCT will develop initiatives with our partners (local schools in particular) to raise the quality of sexual

health services for young people, improve understanding of the problems among young people, increase the uptake of long-acting reversible contraception (LARC) and reduce the number of second pregnancies. We hope to see a near trebling of the number of contacts with the service.

“Sexual health services for adolescents” is also highlighted within our Strategic Plan. This initiative will develop a predominantly school-based service which will provide high quality advice on contraception and sexual health, and easy options for using prescribed contraception. Large reductions in teenage conception rates can only be made by working closely with our partners, and reorganising the way we work in partnerships. We calculate that we can reduce teenage conceptions by targeting young people who are more likely to have an unplanned pregnancy through risk-taking (such as alcohol misuse) and by increasing access to high quality contraception services for young people.

Activity for 2009/10

Contraception

- The GUM Service and Community Contraceptive Service (CCS) are moving toward a fully integrated service model. This will include re-branding and increased outreach and in reach services
- The GUM Service and CCS have a reciprocal agreement whereby a GUM clinical session takes place within the CCS and a CCS session takes place within the GUM
- Recent successful bids to the SHA will fund:
 - Extension of the Nurse Advisor Service within Further Education settings (providing LARC, oral contraception, Chlamydia screening, pregnancy testing, sexual health advice etc)
 - Implementation of the Medi+Vend machines (condom distribution, education resource etc)
 - The implementation of a Sexual Health Facilitator (support of service users on the TOP Pathway. Ensure a contraception method is adopted post TOP. Provide life coaching and signposting to other services. Assertive outreach model.
- The PCT has undertaken a Sexual Health Training Needs Analysis. From the results of the analysis the PCT has commissioned a level 0 sexual health training course delivered by Staffordshire University. This will be rolled on a priority basis and encompass contraception elements
- The Teenage Pregnancy Unit is in the process of transferring from the LA to the PC
- The delivery model is being reviewed in order to optimise the benefits of the service
- The PCT is providing LARC training for GPs/Practice Nurses this commenced in February 09
- The PCT has completed a LARC marketing strategy and was presented at the Commissioning Network in February 09

Termination of Pregnancy (TOP)

- Access to TOP Services is facilitated by all of our static and peripatetic health services in addition to the Youth Service, LA, Terrence Higgins Trust (THT) etc

Chlamydia

- The PCT has completed the mail out to all 15 – 24 year olds to aid the marketing of the Black Country Chlamydia Programme
- THT have been commissioned to undertake additional screening
- The PCT has completed the process to send a Chlamydia test to all 19 – 24 year olds in Wolverhampton (21,630) in order to increase the screening rate
- Pharmacy and GP LES's are being constructed in addition to the identification of a GP Clinical Champion
- Chlamydia Visioning Day in February 09. One of the outputs was a strategy for the service to attain the increasing screening target

Mental Health – In addition to the Improving Access to Psychological Therapies (IAPT) ref World Class Commissioning – Cognitive Behavioural Therapy, there are opportunities to review equitable access in a number of ways. Through the Mental Health LIT and the PCT provided services we continue to reflect on national guidance regarding the delivery of 'race equality in

mental care action plan', linked to the local learning from the Mental Health Equity audit and 'count me in' census data.

Work on equitable access is targeted via the Mental Health LIT subgroups and the PCT provider governance board and service redesign board focussing on work during 2009/10 across the following areas:

- BME focussed work on developing a city wide model which is culturally sensitive
- Using information widely available to service providers to enable the planning phase to run efficiently
- Implementation of services focussed on need

The LGBT sub group is supporting a range of inclusive views to enable development of a city wide strategy. This will lead to a model being developed to outline need, monitor and record gender and sexuality and improve staff development, a working approach and delivery of care.

The focus on women in mental health has established a forum that will influence future development of services. This will help to map information across services in Wolverhampton and look at gender sensitive service developments (particularly looking at an acute model of inpatient care that delivers single sex accommodation and facilities). We will be reviewing assessment processes for women in police custody and A&E departments to ensure that they meet excellent standards.

The provision of improved physical care for people with severe mental illness will be delivered through development of a care pathway for physical health needs. This will provide the severe mental illness service user who is registered with a specialist mental health service a full physical health check, which will be included in their plan of care.

Mental health services will be provided as close to home as possible via the deployment of effective crisis, home treatment, early intervention and assertive outreach teams. This will be supported via revised pathways of care and clear operational standards.

Activity for 2009/10

- Implementation of IAPT stage one development of service 2009/10
- Development of CBT diploma training to develop therapeutic approach to care across acute ; community and primary care services 10 staff trained by end 2009/10
- Further development of Crisis/ HTT / EIS and AO models of working to support revised acute care pathway/operational standards and lead to reduction of in patient bed numbers and occupancy levels
- Physical health checks : care pathway development/ operational standards
- Review of equitable access linked to outcomes of mental health equity audit linking to citywide delivery of services ; monitored via the LIT

Alcohol – An Alcohol Strategy & Action Plan 2009-2011 is currently progressing through its approval process by all key stakeholder organisations across the City. The anticipated start date for the City-wide Strategy and Action Plan is May 2009. Three strategic priorities have been identified which are:

- Crime reduction and Community safety
- Licensing & Regulation and
- Access to treatment services.

The action plan details activities and the roles of key organisations for the delivery of targets associated with each priority. This is in-line with the PCT's Strategic Plan 2008-2013, which evidences that reducing the harm caused by alcohol is critical to the PCT achieving its vision through the commissioning of services that will have the biggest impact on health.

The Public Health Directorate is currently appointing an Alcohol Project Manager and Commissioning Support Officer to support the Consultant in Public Health (Alcohol Lead). These posts will provide additional capacity to deliver improvement to both access and to the range of alcohol treatment services available in Wolverhampton identified within the Trusts' Strategic Plan 2008-2013 and the draft Alcohol Strategy & Action Plan for Wolverhampton.

A consistent approach to commissioning will be maintained through joint working between Public Health, the Substance Misuse Joint Commissioning Team and the Commissioning Directorate within the PCT and service providers.

Routine data such as alcohol-related admissions, mortality data and NDTMS is regularly accessed and analysed, however access to additional datasets such as alcohol-related A&E attendance data, ambulance data, police data and licensing information from the Licensing Authority would be beneficial. Currently not all of this intelligence is available.

Through implementation of initiatives within both the Alcohol Strategy and the Strategic Plan we will:

- Reduce the alcohol-related admission and readmission rate
- Reduce the number of violent assaults and violent crimes related to alcohol
- Halt the observed year on year rise in all age all cause mortality rates.
- Reduce repeat incidents of domestic violence

'Reducing the impact of alcohol abuse' is one of the 9 strategic initiatives. It aims to reduce the impact that alcohol has on health through a services of both short-term and longer-term activities. In addition this initiative supports 4 strategic goals.

Activity for 2009/11

- 2009/10 increased use of medication to prevent relapse
- From 2010 Improved abstinence or reduced (measurable) drinking levels by those assessed as having severe alcohol dependence
- Reduction in number of alcohol-related violent assaults, especially repeat domestic violence incidents. Currently approximately 195 alcohol-related violent assaults occur every month in Wolverhampton.
- From 2010 increased provision and use of community-based detoxification and intervention services
- From 2010/11 set appropriate baselines and measurable targets around the harms caused by alcohol (supported improved intelligence and systems for collecting data)
- An initial halt to the proportion of people admitted twice or more per year and from 2010/11 a measurable reduction to 19% by 2012/2013.
- An initial halt to the observed year on year rise in mortality rates and from 2011/12 a measurable reduction in the number of premature deaths due to alcohol-related disease (measured as mortality rate per 100,000)
- Targets detailed within the Performance Assurance Plan which supports the City-wide Alcohol Strategy 2009-2011 (will require robust multi-agency collaboration)

Older People – Over the next 20 years, older age groups will make up a bigger proportion of the population of Wolverhampton. But while life expectancy is likely to increase, maintaining a good quality of life in older age is challenging. Healthy life expectancy at age 65 is lower than national averages – 11.4 years for men and 13.2 years for women. In Wolverhampton, there is evidence of some potential problems in older people's health.

The information requirements concerning maintenance of levels of independence and avoidance of hospital admission are critical to determining the successful outcomes. These need to be incorporated into the CFH/IPM reporting system for community services. Also required is regular reporting of acute admission by age band and admission to long term care by age band.

With the rising elderly population and the reducing younger population maintaining an independent population is important to improve quality of life in later years and minimise the impact on families/carers and statutory services.

Activity for 2009/10:

Telehealthcare

- Mainstream Telehealthcare for COPD and CHD in 2009/10 and participate in research to evaluate effectiveness
- Develop a plan for a telephone outreach service
- Undertake a trial of lifestyle monitoring service
- Develop a strategy for the use of Telehealthcare in 2009/10 for the city

Intermediate care

- Increase the capacity of intermediate care services in the community at peak times
- Identify the independence levels of older people
- Undertake the first stage of nurse led intermediate beds project
- Evaluate the nursing home project in SW locality of the city.
- Ensure the diversity issues of intermediate care are addressed

Falls

- Analyse the benefit of the self referral system
- Vestibular rehabilitation evaluation
- Anxiety management classes evaluation

Walking for health

- Increase the capacity in walking for health service for 2 years.
- Encourage over 50 age group to become walk leaders and recruit walkers from the over 50 age group

Health Trainers

- Ensure older people will have equal access to the support and advice a health trainer can provide

Audiology

- Introduce Hearing and Balance Services

Long Term Conditions – Over the next 2 years we will ensure that those living with a long term condition receive a high quality service and help to manage their condition; everyone with a long term condition will be offered a personalised care plan. Personalised care plans are also advocated by 'High Quality Care for All - NHS Next Stage Review'. The approach to achieving this in Wolverhampton will commence with those individuals with Long Term Conditions who have been identified as high risk through the use of a risk stratification system (PARR ++). It is predicted that this risk stratification tool will be superseded by the 4D risk stratification model being developed by the SHA and Bupa Dialogue in Oct 09.

The approach will target those under the care of a community matron. This has been identified within the Long Term Conditions Commissioning Strategy 2009-20012. A joint commissioner and provider project facilitated by HMSC (sponsored by the SHA) has developed the necessary documentation which is currently being piloted by the Community Matron Team (CMT), Jan-Feb09. The final version will be implemented post April 09, with both new and existing referrals.

An early perceived risk that has been identified in the change management process with the CMT is the need to provide consistent personalised self care information prescriptions. A potential solution to this has been identified in a web based software tool that is cross referenced to NICE guidance.

It is proposed that an evaluation of the use of the tool be undertaken and future application for recurrent funding to be decided upon dependent on the outcome. Further work will need to take place over 2009/10 to enable Section 36 to be fully realised and all individuals to be offered a personalised care plan. It is expected that this will form a measurable outcome for 10/11.

Initial monthly monitoring meeting to identify numbers of individuals with personalised care plans and progress to Quarter 1 and Quarter 2 will be implemented. A code will be established on IPM to enable data collection to be undertaken regarding the percentage of total caseload that has a personalised care plan. Personalised care plans have been identified as being linked to achieving WCC competencies within the DH publication, 'Supporting people with Long term Conditions - Commissioning personalised care planning'. (Jan 2009)

Activity for 2009/10

- Joint Commissioner/provider project to develop necessary documentation. Final version completed April 2009
- Identification of SNOMED code to enable monitoring of numeric outcomes
- Provision of software tool to enable self care aspect of care plan

Carer's Breaks – There is already a set of commissioned services for holiday breaks, transport and advocacy which are commissioned from the voluntary sector and cater for a variety of client groups and communities. There is a dedicated team to provide support to carers including the development of carer's breaks. A new service is currently being commissioned to support carers of stroke victims. All services have an outcome focused service specification that reflects national and local performance targets. These are monitored as part of the ongoing programme of contract monitoring.

The new Joint Carers Strategy planned for 2009/10 will develop new approaches to identifying hidden carers. The Emergency Respite Service being developed for carers provides as part of the application process, enhanced data on those cared for and individual emergency plans which will provide the evidence base for future commissioning arrangements.

National evidence outlines the impact of an ageing population and increases in those with long term impairments, long term conditions and autism that have increased carer support needs.

This target reflects the need to commission services based on good evidence that recognises individual carer experiences, user and carer involvement and provides best value and quality.

Activity for 2009/10

- In collaboration with the LA establish a strategic vision for the development of carers breaks for carers within the city
- Establish jointly agreed protocols for the use of carers breaks
- Establish an integrated commissioning plan including financial plan to support the development of carers breaks

2.1.4. Staff & Patient Satisfaction

Consultation – The PCT's communication and engagement strategy recognises that we need to engage our diverse community, patients, staff, contractors and providers in shaping services so that we are truly coproducing them. This equally relates to the programmes we will develop in response to the eleven goals and nine initiatives contained within the Strategic Plan. The Communication and Engagement Strategy also identifies the following objectives:

- Make sure that people understand our services and know how they can access them, targeting communities and individuals in particular need.
- Help people make healthier choices in everyday life that will improve their health and well being, and understand our vision, goals and our role in commissioning services – what the PCT does and what we are trying to achieve

Feedback on all consultations will be made through appropriate routes to the PCT Board, PEC and Locality Commissioning Boards. All actions are consistent with the PCT's Strategic Plan and Communication and Engagement Strategy.

Activity for 2009/10

- Ensure engagement structures and processes are in place to effectively communicate strategic plan priorities and initiatives to local people
- Continue to develop and support Locality Health Panels and Local Neighbourhood Partnerships as key consultation routes
- Undertake engagement activities and consultation with all local stakeholders in relation to the Future of Provider Services programme and Transforming Community Services
- Ensure the Trust's duty to report on consultation is met

Near Real-Time Feedback – The NHS Constitution, World Class Commissioning and the NHS Next Stage Review all signal the importance of involving local people in decisions about care and listening to their experiences as an essential step to improve services. This is also reflected locally in the Trust's Strategic Plan, Communication and Engagement Strategy and the Citywide Engagement Strategy. The Communication and Engagement Strategy lays out a detailed 37 stage implementation plan which is already underway.

We will ensure that feedback from communication and engagement events is fed into Locality Commissioning Boards in a timely and consistent way. The actions identified are consistent with the Trust's Strategic Plan and the Communication and Engagement Strategy.

Activity for 2009/10

- Ensure the implementation of Involving People and Communities
- Ensure the duty to involve is understood across the Trust
- Continue to develop and support Locality Health Panels and Local Neighbourhood Partnerships
- Develop more interesting engagement methods for the public, taking advantage of technology, where appropriate
- Carry out public surveys and polling activities drawing on best practice

Staff Engagement / Quality of Work – The PCT is the 3rd largest employer in the City and recognises that its biggest asset is its staff. We have a well motivated, committed and highly skilled workforce with a shared sense of purpose and organisational aims. This supports the PCT in improving the health and wellbeing of our local population and helps to create the kind of working environment that provides our staff with challenging and rewarding jobs.

By working with our partners in the City we are enhancing the skills and knowledge base of our staff, by meeting the requirements of the Skills Pledge. Volunteers are also supported to participate in skills development programmes to enhance their own competences.

We are focusing on building leadership capabilities within our staff, by incorporating succession planning and talent management processes into our leadership strategy. We are also continuing to develop our workforce planning processes (both strategic and operational) to ensure we have the capacity and capability to deliver both our commissioning and service delivery requirements.

It is also essential that we remain focused on the health and wellbeing of our staff. We are in the process of implementing several initiatives to support this including a cycle to work scheme, healthy option choices in our restaurants and "healthy living clinics". It is important that we work collaboratively with our local schools and colleges using our Health-Tec facility especially around the new national diplomas to ensure we have a future workforce that understands the type of roles we need and has the skills and competencies that we require.

As the PCT embarks upon a period of significant change, it is essential that we develop effective communication and engagement arrangements with staff and trade union colleagues to ensure that they are involved and have the opportunity to influence these changes.

The PCT continues to work towards meeting its workforce equality requirements by improving the quality of recruitment, training opportunities and workforce data, to support us in identifying where we need to undertake positive action.

Activity for 2009/10

- Review staff engagement arrangements and communication to ensure they are FFP
- Ensure there are effective mechanisms in place to communicate with staff face to face, paper-based and electronic formats
- Review formal staff partnership and consultation arrangements
- Review and amend Staff Opinion Survey action plans in the light of last staff survey results
- Ensure NHS Constitution requirements (including staff pledges) are incorporated into the staff charter

2.1.5. Emergency Preparedness

Major Incidents – The major Incident Plan for the Trust has been rewritten over the last nine months. It has been co-ordinated with the approach to business continuity to ensure a single invocation, escalation and response structure and is in the process of being taken through the Trust's emergency preparedness governance process to be signed off and put into place for use.

It will also take account of the pandemic influenza work stream dealing with command and control to ensure that the proposals for a new incident management infrastructure are written into the major incident plan.

We will clarify roles and responsibilities for all those involved in any major incident, or business continuity response to ensure that all officers are familiar with the organisational level they will be working at. The PCT's Major Incident Response Group is also in the process of compiling a training schedule for all staff involved in major incident planning and response. This process will be followed by the development of an exercise programme to test the trust's ability to respond, not only as a single organisation, but also as part of a multi-agency response. This will be both across the city and also as part of a wider NHS response under the Emergency Response Management Arrangements for the NHS.

The Trust actively participates in planning for emergencies/major incidents at a local level and is a partner in the Wolverhampton Resilience Forum, a multi-agency group of Category 1 responders under the Civil Contingencies Act 2004 in addition to key partners across the City. The Trust is also represented through both the Local Resilience Forum and the Local Health Resilience Forum.

Activity for 2009/10

- Sign-off and adoption of revised MIP
- Assessment of roles and responsibilities. Training needs identified
- Start to roll out training program
- Major Trust exercise

Pandemic Flu - The Trust has recently carried out and submitted to the Strategic Health Authority a Pandemic Influenza Planning self assessment questionnaire. This was accompanied by a number of documents including a business continuity strategy for the Trust, an integrated health and social care strategy to deal with a pandemic influenza outbreak in Wolverhampton and also ten key projects.

These projects have been identified from the self assessment referred to above and are the basis of the planning strategy for the City. The ten work streams are:

- Surge capacity
- Medicines management
- Anti Viral Collection Points
- Staffing
- Vulnerable Groups
- Communications
- Mass fatalities
- Command and Control
- Procurement
- Infection Prevention and Control

All ten groups are multi-agency and the project plans have been designed and written to provide a seamless and co-ordinated response to an outbreak of pandemic influenza. Organisationally, the ability to respond to pandemic influenza is through robust business continuity plans dealing with up to fifty percent staff absence in addition to the usual range of service interruptions.

The plans have been written for critical services, as identified by the trust, and are currently being signed off through the use of a plan walk through with each team to ensure familiarity and accuracy.

Activity for 2009/10

- More detailed assessment of resources required
- Pan flu conference, ongoing project plan development
- Redo self assessment to determine progress, ongoing training
- Exercise of pandemic preparedness

2.1.6. Local Priorities

Tier 3 Vital Signs

NB - only includes those Tier 3 targets which are not captured elsewhere in this document

Hospital Admissions for Ambulatory Care Sensitive Conditions - Our initiative to reduce admissions will ensure that the ACS conditions with the biggest adverse impact on secondary care in Wolverhampton are tackled, namely COPD, cellulitis, coronary heart disease, CHF, influenza and the admission of children. Our efforts will concentrate on targeting those most at risk, with dedicated teams available to provide support, early access to key interventions (such as scans), and preventative action (such as influenza vaccination).

The initiative to support the management of CVD will help to reduce the number of admissions related to heart disease and heart failure. It combines a range of measures for primary and secondary prevention that will ensure that at least 70% of patients with CHD receive all common, evidence-based secondary prevention interventions (smoking cessation, use of aspirin, cholesterol control, blood pressure control and influenza vaccination). To support this, we shall provide 6,000 interventions by health trainers and 3,000 weight management courses by 2011/12.

Activity for 2009/10

- Ensure SSDP COPD and Cellulitis schemes achieve desired reductions in hospital admissions.
- Implement new World Class Commissioning strategy schemes for influenza, Coronary Heart Disease and children to reduce admissions.

Proportion of Deaths that occur at home - The strategy for End of Life Care (EOLC) for the PCT, once agreed aims to ensure the provision of reliable, high quality, efficient care at the end of life for all individuals with an end stage condition to enable them to live well and die well in a place of their choosing. This is a 4-year strategy. The model of care and pathway it proposes supports the further development of community based EOLC services to strengthen the ability for individuals to die in their own home which is in line with previous consultations with the public and recognises evidence that individuals, if given the choice, would choose to die at home. Strengthening community services will provide the capacity and capability to make dying at home a realistic option. The strategy assumes a 20% reduction in the use of acute beds for EOLC within 4 years and the acute contract will reflect this. The community information systems will need to reflect the individuals accessing the supportive care and EOLC pathway and record those individuals who actually died in their own home or nursing home. The rapidly ageing population and the reducing younger population necessitate the ability to have a sustainable infrastructure for EOLC that is not totally reliant on in-patient beds.

Activity for 2009/10

- Consolidate new community end of life care service. Continue to promote its use within the city
- Finalise and agree end of life care strategy
- Development and delivery of a communications plan with public in relation to preparing for EOLC
- 100% GP practices and Nursing homes providing EOLC signed up to highest level of GSF
- 100% of practitioners providing EOLC to undertake competency based training
- 100% use of supportive and EOL care pathway across city
- 30% increase in individuals dying at home where that is their wish
- 20% reduction in acute bed usage for EOLC
- 24 hour response in community to specialist medical support and 48 hour response to specialist OT support
- Increase day care and respite beds by agreed percentage for the population

- 100% of families and carers who need specialist bereavement support will receive an assessment

Reduction in Delayed Discharges - To support the capacity issues facing the NHS and Local Authority (LA), the three statutory organisations in the city have committed to support developing a redesigned pathway for individuals who are using acute services and who require ongoing NHS and LA care. This project entitled “improving flow eliminating waste” is using lean principles to redesign the pathway. One of the key objectives of the project is to reduce the amount of delayed discharges by implementing processes that reduce the barriers to effective, efficient discharges. A potential barrier to delivery is the need to understand the impact on the tariff payments to RWHT of increasing the patient flow.

Activity for 2009/10

- Development of a project plan for lean project
- Review of delayed discharge reporting
- Confirm criteria for delayed discharges
- Analysis application of criteria for reporting delayed discharges
- Complete implementation of productive community hospital to facilitate patient flow
- Appoint to jointly funded project manager March/April 09
- Utilise external support in interim to develop transformational plan
- Plan to increase capacity in community services at times of year with known issues of capacity

Patients admitted with a heart attack taking appropriate medicine - The provision of high quality care and advice on discharge is important after a heart attack because it can substantially reduce the risks of having another heart attack and dying. The NSF published in 2000 identified the following milestone:

“By April 2002, improving the use of effective medicines after heart attack (aspirin, bet-blockers and statins) so that 80-90% of people discharged from hospital will be prescribed these drugs”.

The initial prescribing of these medications is undertaken by the Provider at RWHT as patients are admitted to and subsequently discharged from the Heart & Lung (H&L) centre. All patients admitted to the H&L centre with a heart attack generate a MINAP form ensuring that the patient’s details are entered for clinical audit purposes. The MINAP database which in April 2008 contained over 596,000 records has allowed clinicians to examine the management of myocardial infarction within their hospitals against targets specified by the National Service Framework for Coronary Heart Disease (NSF). It also helps to monitor patient outcomes and support improvements in training and care delivery. MINAP also provides data to the Wolverhampton LIT, the Strategic Health Authority and the cardiovascular networks for monitoring purposes and supports service improvement. As this strategy is exceeding achievement of these targets it will continue unless there are any significant performance issues to be addressed.

The current MINAP database is more than sufficient to meet the information requirements and is capable of expansion to meet future developments, for example although it initially focussed on the hospital management of ST elevation Acute Myocardial Infarction (AMI) the dataset has been expanded to cover other acute coronary syndromes (ACS), the introduction of pre-hospital thrombolysis and primary angioplasty.

One of the goals in the Strategic Plan is to reduce mortality from coronary heart disease in <75s by 40 deaths per year. CHD accounts for 15% of the gap in life expectancy in Wolverhampton. The death rates are not reducing rapidly enough in the priority neighbourhoods of Wolverhampton; a priority neighbourhood being defined as: “an electoral ward that is in the 10% most disadvantaged wards in the country”. This reduction in mortality rates will be achieved through the continuation of high standards of prescribing and improved access to secondary prevention services. In particular, we shall be improving the quality of care for those who already have CHD and targeting those at high risk because of poor quality care to gain the quickest impact on mortality rates. All patients will be assessed with a particular focus on the

control of blood pressure and cholesterol. The Medicines Management Team has been developed to provide focused disease management support in general practice, backed up with contractual action where appropriate.

Activity for 2009/10

- Adherence to National Service Framework (NSF) for Coronary Heart Disease (CHD) – Chapter 3 heart attacks and other acute coronary syndromes
- Adherence to CHD Local Implementation Team (LIT)
- Clinical Audit supported by the Myocardial Ischemia National Audit Programme (MINAP)
- No new actions identified as targets are currently being met consistently due to continued monitoring of the NSF

Achievement of NHSLA Risk standards – This is a key component of Risk management and clinical governance frameworks to deliver patient safety. Our approach to achieving this standard will include:

- Project planning to deliver NHSLA standard award as assurance of best practice locally
- Patient Safety campaign based on NPSA registration requirement
- SFBH compliance

We will monitor performance through commissioning for quality performance monitoring meetings with NHS providers and require providers to have appropriate NHSLA attainment standards. Furthermore, we will encourage participation in national campaigns. We will provide external assurance through annual notification of award attained and the Outcome of Patient safety campaign initiatives. This indicator contributes to our Strategic Plan Goal 9 – Improve Patient Safety

Activity for 2009/10

- Project Plan progress
- Award Attained

NHS estates energy/carbon efficiency – The PCT will be implementing a Trust wide strategy and carbon management programme. Additionally the LIFT programme will deliver new buildings that will be designed to be carbon efficient. There is a mandatory requirement on the developer to achieve an excellent standard against a BREEAM assessment.

Activity for 2009/10

- Base line assessment of carbon footprint for the Trust
- Develop strategy to reduce carbon consumption
- Set up user groups to share energy consumption data

Vascular Risk - Work around vascular risk and primary prevention registers will support primary prevention of cardiovascular disease (CVD) and improve the quality of information held in general practice clinical systems. This will result in better targeting of patients at risk and earlier interventions to influence lifestyle factors.

The GP extraction and reporting system (CDR Intell) has been procured through an OGC framework. Contracts have been written and will be closely monitored. This was implemented in GP practices during January to March 2009. The commissioning arrangements for developing primary prevention services will depend on the model or models adopted.

CDR Intell provides all the information needed to:

- Produce primary preventions registers which will enable the PCT to meet target VSC23
- Support General Practice in identifying and prioritising patients at risk of CVD; and
- Enable the commissioners to monitor the primary prevention programme

Although age standardised mortality from circulatory disease in <75s is falling in all wards in Wolverhampton, mortality is higher in the priority wards (an electoral ward that is in the 10% most disadvantaged ward in the country) than in non-priority wards. Age Standardised emergency admissions for CHD and Stroke are higher for Asian and Black patients.

Primary prevention will be able to address this in a number of ways:

- Development of the model will take into consideration the socio-demographic impact and ensure that populations in priority wards are prioritised for primary prevention
- The reporting system will be able to identify patients from BME groups and enable the developed services to prioritise these groups

Activity for 2009/10

- At least 47 practices have given consent for extraction of data
- Data extracted from GP systems
- At least 47 practices with PCT-validated registers of patients without symptoms of cardiovascular disease but who have an absolute risk of CVD events greater than 20% over the next 10 years
- Development of model to address primary prevention of CVD (LES, investment in Disease Management Team, procurement or combination of models)
- Implementation of model to address primary prevention. Primary prevention clinics started

Adults with learning difficulties in settled accommodation – Contracts will be performance managed against outcome focused service specifications and these will reflect national and local performance targets. All services will have updated and fit for purpose service specifications and contracts in place.

Further analysis of data linked to the JSNA is being undertaken by the Public Health Directorate to improve the evidence base for commissioning arrangements.

National demographic evidence suggests an increase in adults with significant learning disability as part of the total adult population of 1% per year for the next 10 years. Within this there are increases in the number of adults with autism and those people who have increased health care needs

Our approach to delivering this indicator reflects the outcomes set out in 'Valuing People Now'. This target highlights the need to commission evidenced based services for best value and high quality.

Activity for 2009/10

- Identify groups of people who will be at a high risk of living in unsettled accommodation
- Maintain a Risk Register via the Joint Funding Panel – ongoing
- Assess people who are currently in hospital/assessment and treatment who will require future accommodation
- Review people living in residential accommodation and identify alternative more settled options to be completed by September 2009
- Commission and procure appropriate and cost affective accommodation based services for those people identified as "At Risk"
- Implement two current housing schemes for adults with Autism and Mental Impairment. In response to increased numbers of people in both these areas of service
- Autism service due to open in October 2009
- Mental Impairment service in January 2010

Adults who receive secondary mental health services in settled accommodation -

The PCT Provider will ensure that all individual's accommodation status will be reviewed. This will be performance monitored through the contract meeting. The PCT Provider will report accommodation status on a monthly basis to the Commissioner. The current economic environment will have an impact on individual's housing status.

Activity for 2009/10

- All in-patients to be discharged to a stable environment in order to avoid homelessness
- Single Referral Forum to work with individuals with highest level of need
- Implement new Housing Model ensuring that individuals with highest level of need are able to access most appropriate support
- Review / re-assess individuals in residential and nursing care in order to ensure that they are placed appropriately. If not identify more suitable accommodation
- Ensure through CPA that individuals accommodation status is reviewed
- Jointly commission with Supporting People for individuals who have complex needs

Patients with diabetes - As a result of the activities in the Action Plan, the PCT will have access to higher quality intelligence regarding the care of its diabetic population. HbA1c is an indicator of the quality of diabetes care and CDR Intell will, in conjunction with information provided through D3 and the NDA analysis, enable GP's and support the disease management team prioritisation and management of patients. The strategy will make use of the benchmarking facilities of CDR Intell and the NDA to educate GP's about the benefits of improving care. The NDA also identifies rates of diabetic complications which are as a result of poor diabetes care.

Monitoring of this target will become more robust through CDR Intell and the findings will be reviewed by the Diabetes LIT and form part of its own NSF self-assessment through a national tool, 'DiabetesE'. The LIT is responsible for looking at future actions and advising the PCT Professional Executive Committee (PEC) for commissioning purposes. High quality training will be developed to underpin the strategy.

The GP extraction and reporting system (CDR Intell) has been procured through an OGC framework. Contracts have been written and will be closely monitored. It has been implemented in GP practices during January to March 2009. The contract will also be monitored with RWHT.

CDR Intell, QMAS and D3 will provide all the information needed to:

- Identify achievement of the target to enable the PCT to meet the target of 41% for VSC27, the percentage of patients with diabetes in whom the last HbA1c is 7 or less in the previous 15 months
- Support General Practice in identifying and prioritising diabetic patients with suboptimal management of blood glucose
- Enable the commissioners to monitor the NSF for Diabetes

The burden of diabetes falls disproportionately on members of minority ethnic groups, older people and the poor. Wolverhampton has an aging and ethnically diverse population with about a quarter being of Black and Minority Ethnic origin. It also has worrying levels of childhood and adult obesity which is leading to a quarter by quarter increase in the numbers of newly diagnosed diabetics.

The provision of good quality diabetic care will support the World Class Commissioning goals of: Goal 2 – Reduce mortality from coronary heart disease in <75s by 40 deaths per year. Goal 10 – Improve the management of risk factors for coronary heart disease by 5% within the diabetic population.

Activity for 2009/10

- Continued monitoring of the National Service Framework (NSF) for diabetes – Standards 4 and 5 management and treatment of diabetes – Blood glucose
- HbA1c is a clinical indicator in the Quality and Outcomes Framework (QOF) of the GP contract generating payment for achievement. There are new targets for 2009 / 10
- Central register Diabeta 3 (D3) hosted in the acute sector
- Diabetes training programme for primary care delivered in 2008 to be developed via the PCT training depot during 2009
- Participation in the National Diabetes Audit (NDA)

Number of vulnerable people who are supported to maintain independent living / Independence through Rehabilitation – for 2009/10, our Strategy and approach will be based on several joint strategies including:

- Every Adult Matters, Older Persons Strategy, Physical & Sensory Strategy, Mental Health Strategy, Learning Disability Strategy, Supporting People Strategy

The overall vision agreed between the Local Authority and the PCT is “to enable all adults in Wolverhampton to live fulfilling lives, by enhancing their independence, health and quality of life through co-ordinated action by all agencies providing services in the city”. The action includes promoting:

- A shift from crisis intervention to long term preventative strategies
- Maintaining peoples independence in their own homes
- The development of services around locality bases, utilising a community involvement and neighbourhood approach to commissioning and delivery services

Activity for 2009/10

- Establish base line data and agreed projections with LA
- Agree monitoring and data collection process
- Develop services aimed at maintaining people living independently including:
 - Implementation of productive community hospital to facilitate patient flow
 - Development of transformational plan
 - Increase capacity in community services at times of year with greatest demand

World Class Commissioning Outcomes

NB - only includes those WCC targets which are not captured elsewhere in this document.

Introduction - In order to identify the outcomes for World Class Commissioning the PCT underwent a thorough prioritisation exercise. This identified a long-list of goals that were congruent with the priorities in the vision. The goals were then prioritised by the application of a set of criteria.

The most important criterion is that a goal should reflect the most pressing health needs of Wolverhampton. From this the following criteria were used:

1. Public Health Report – the goal is an evidence-based priority for public health
2. JSNA – the goal is an evidence-based priority in the Joint Strategic Needs Assessment
3. Identified in data sources – the goal is supported by evidence in the WCC data packs and local sources of data

In order to ensure the views and preferences of the public and partners the following criteria was also used:

1. Preference of local users – the goal is a priority for the public and users of healthcare services in Wolverhampton
2. Partners' interest – the goal is a priority for strategic partners, clinicians and joint commissioners
3. Practice-based commissioning – the goal is a priority for practice-based commissioners

Cognitive Behavioural Therapy – One of the 11 goals in the Strategic Plan 2008-2013 is to increase access to mental health services in primary care, especially talking therapies. This will be achieved through a talking therapies initiative to provide early intervention mental health services. This initiative aims to increase access to primary mental health services which will address a current gap and potentially reduce the dependence on acute mental health services. The initiative will implement a range of talking therapies in primary care, with a particular focus on cognitive behavioural therapy (CBT). Care will be brought closer to home and will ensure that access is more sensitive to issues such as age, gender and ethnicity. The initiative to improve mental health services targeted at early intervention will allow 5,000 referrals per year in primary care for people with depression and anxiety by 2012/13, resulting in 4,000 completed interventions. 50% of those treated will experience a clinically significant improvement in their mental well-being (defined as at least a 5-point improvement on either the PHQ9 or the GAD7 assessments). This service fills a gap in capacity and therefore does not displace activity elsewhere. However, over time we should expect to see a shift of emphasis away from crisis-based, in-patient care towards the planned management of care in outpatients and community settings. Repeat attendances in general practice should decline.

Low level mental illness (such as depression and anxiety) is more prevalent amongst adults in Wolverhampton than elsewhere in the region, and there are gaps in primary mental health provision for people with these conditions. Because many sufferers do not meet the criteria for referral into secondary care, they find themselves without a suitable service to use. Even when referred, many are unhappy about the stigma associated with their condition, so they do not always attend,

We must therefore develop a range of interventions, based around talking therapies, that increase access in primary care and that reduce the impact of escalating mental health problems. These can manifest themselves in alcohol abuse (and its associated problems) and increased acute presentations in secondary care.

Through a mixture of redesign and investment, Wolverhampton City PCT plans to improve access to psychological therapies over the next five years (2008-2013). The long term commissioning intentions of the PCT are to procure this service through open tender. However, in the short term (until April 2010), current providers have been invited to expand their contracts to develop this service. This will ensure timely development of services and supports the development of our local providers. The PCT's targets for the service are based on number of completed interventions. (Year 1 – 200, Year 2 – 1200, Year 3 – 2000, Year 4 – 3000 and Year 5 – 4000).

As part of the PCT provider expanded Service Level Agreement an IT solution will be identified to ensure all data is routinely collected as part of this service on an ongoing basis. As part of the PCT commissioned specification, monthly returns have been requested providing the following information on any patients, who have been referred, started treatment and completed treatment during the period including:

- **Summary:** No. of sessions offered, No. of vacant appointments, No. of inappropriate referrals.
- **At referral:** Date of referral, Demographic data (Name, address, GP, age, sex, ethnicity), Source of referral
- **Assessment:** Date of assessment, PHQ9, GAD7, Disorder specific measure (if applicable), CORE 10, W&SAS, Inclusion and Employment Questionnaire, Patient Experience Questionnaire (Part 1)

- **At each session:** PHQ9, GAD7, Disorder specific measure (if applicable), DNAs
- **Review session before discharge or referral to next step:** PHQ9, GAD7, Disorder specific measure (if applicable), CORE 10, W&SAS, Inclusion and Employment Questionnaire, Patient Experience Questionnaire (Part 2), DNAs
- **Follow up after 6 months:** - PHQ9, GAD7, Disorder specific measure (if applicable), CORE 10, W&SAS, Inclusion and Employment Questionnaire, opportunity to join an ex-user group to inform service developments.

Around a quarter of Wolverhampton's population are of Black and Minority Ethnic origin. Data from the Ethnic Minority Psychiatric Illness Rates in the Community Survey 2002 (EMPIRIC) would suggest an additional 7,633 cases. It has high unemployment, 4.7% compared to national figures of 2.3%. In the first year the service aims to increase referrals from Black and Ethnic Minority groups. The PCT provider is sub-contracting some of the completed interventions to two 3rd sector providers targeting Black and Ethnic Minority groups. In addition to referrals from GPs this should increase the number of completed interventions in BME groups by approximately 250. In future years other groups will be targeted. Groups who are under represented in the service will be identified via the service data.

Infant mortality: rate of mortality per 1,000 live births under 1 year old - Reducing infant mortality is the first goal in the PCT Strategic Plan. Achieving this will deliver the greatest increase in life expectancy in Wolverhampton. Development of the strategy to tackle infant mortality has been informed by local public consultation, by consideration of the evidence for effective intervention and by reference to the extensive policy drivers relevant to this area. There is significant inequality in infant mortality across the city with higher rates in deprived areas and in some segments of the population, a key high risk group being young mothers under 20 years old.

The approach to be taken is a co-ordinated strategy involving all key partners. This will be achieved through the development of a 'Healthy Start to Life' programme board which has a line of accountability to the Wolverhampton Children's and Young Peoples Strategic Partnership. Under this board will be multi-agency project groups to develop and deliver services in order to tackle specific priorities. This will include; smoking in pregnancy, early access to antenatal services, promotion of breastfeeding, maternal obesity and antenatal/ neonatal screening. There will be universal services with targeted services for families identified as requiring increased support. This work will be in line with Investing for Health project 2c.

Alongside this will be the development of a service model able to deliver these services. This will be based on the development of integrated start to life teams with key members being midwives, health visitors and sure start children's centres. Each integrated team will be responsible for a geographically identified cohort of families; this is likely to be based on children's centre catchment areas.

Service user and public involvement in service development and delivery will be central to this approach. The MSLC will be a reference group for the programme board. Children's centres have established parent and user groups. Initial contact has been made with these and this needs to be developed further to develop a service user and public involvement group. Further work is required to identify how to access groups less likely to be contacted through these routes.

Key gaps to be addressed:

- Workforce development to enhance the skills and capacity of the current workforce, to identify opportunities for new ways of working and to develop a more co-ordinated workforce
- Current service delivery models will not support integrated working, these need to be reviewed and redesigned to meet the needs of the new ways of working
- Development of partnership agreements to support integrated working. This will include shared use of facilities for the delivery of services, for example midwives being based in children's centres, antenatal and well baby clinics being delivered from a range of venues, information sharing protocols between organisations

- Development of information systems that will provide practitioners with the information they require at the point of service delivery. Interim arrangements are being tested at present but there is a need to develop long term IT solutions and information sharing systems
- Work has started to develop the required basket of key performance indicators. This will require the development of information systems to ensure access to the information required to monitor progress and delivery against targets. This work needs to be completed and the indicators incorporated into contracts with providers and agreements with partner organisations

Key risks:

- Capacity to deliver the work required in service review, redesign and implementation in the timescales required
- Healthy start to life will involve significant service and workforce changes. Staff and providers must be fully consulted and involved in the change processes
- Capacity of workforce to undertake integrated team working while current service models are undergoing review and redesign. Families must continue to receive all relevant services and support while the service change is implemented

Activity for 2009/10

- Development of a fast track free pregnancy service based in pharmacies in priority wards
- Co-ordinated approach to smoking cessation delivering a reduction in smoking during pregnancy
- Increased breastfeeding initiation rates and prevalence of breastfeeding at 6 weeks
- Development of a strategy to reduce maternal obesity
- Development of an integrated service model across relevant providers and partner organisations

Health inequalities – average score on the index of multiple deprivation - Many of the health actions are included in other sections, especially Infant mortality, CVD mortality and alcohol mortality as well as suicide and lung cancer.

There are two additional areas which merit attention. The first relates to crime, especially violent crime, which is an important variable in the IMDR. The Safer Wolverhampton Partnership has developed an alcohol strategy which aims to reduce the impact of alcohol on the city including violent crime. Partners have already worked to develop a multi-agency approach to controlling alcohol in 2008. We aim to extend this in 2009 with the aim of reducing alcohol-related crime, including violent attacks and domestic violence.

Another factor in the IMDR is access to public services. The significant expansion in health services through the procurement of additional primary care practices will impact upon this indicator.

We will work with providers to ensure that there is an appropriate response to domestic violence and that the NHS collects robust information on the harm caused by alcohol within the city. Better information is required on alcohol related health incidents, both about the victim and where such events occur. The PCT will invest in new systems in partnership with the health community. The increase in unemployment and social pressure is likely to increase domestic violence as well as other alcohol related violence. The greatest impact will be in our more disadvantaged areas.

Additional resource may be required to develop a “co-located” team for a multi-agency response to Domestic violence as well as further non-recurrent funding to trial new approaches to managing alcohol-fuelled violence especially in the city-centre.

Life Expectancy at time of birth – The PCT has examined the reasons for its low life expectancy using the Health Inequalities tool supplemented by its own analysis. There is great overlap with our actions on AAACM and maternity services. Areas specifically not covered in this section relate to smoking in pregnancy and obesity in pregnancy.

The PCT aims to ensure that all women who smoke are offered evidence based support as a routine. This bespoke service will be expanded in 2009 to be able to offer support to the estimated 600 women who smoke through pregnancy each year. We will develop our social marketing in this group and consider novel approaches including 'peer mentors' as well as reward for cessation. We aim to continue this service into the first year of life.

The PCT will re-model its food health team to provide focussed support to pregnant women who are obese (as national reports identify this to be a significant risk factor). We aim to provide help to these women who are clinically obese before and after delivery.

Services for other adults who smoke will also be expanded and focussed on those areas with high prevalence. This additional capacity will be an important resource for Health Trainers (to start in 2009).

Good information on risk factors in pregnancy is available from our main provider. Better information is needed after delivery on smoking status as well as weight gain.

Estimates of smoking prevalence within the community are more difficult. Better information may be derived from additional information available from primary care sources.

Wolverhampton has seen a rise in birth rate over the last 3 years. A significant proportion has been in new migrants (who tend to have better lifestyle behaviours). The economic downturn is likely to reduce the number of new migrants entering the city.

Tackling smoking in pregnancy is included within the Strategic Plan as is expanding our smoking services. Re-modelling our food health team was not included but is another important step in improving both infant and maternal health.

High Quality Care for All

The Operational Plan describes our key activities for improving the quality of services for the year, and ensures our activities are effectively aligned with both the West Midlands Strategic Health Authority and national Next Stage Review – High Quality Care for All.

In addition to this, the PCT have identified "leads" for each of the clinical pathways who will steer the action planning process for each of the pathways.

Lord Darzi's Next Stage Review describes 8 pathways of care. These pathways accord strongly with our goals in the Strategic plan.

We have mirrored the SHA process by having local clinical leads who meet as a local "NSR Board" and these have included the additional 2 clinical pathways of Learning Disability and Dementia.

Activity for 2009/10

- End of life ~ Implement improvement to community support for EOL care to improve Quality of Service for both patients and their families
- Mental Health ~ Annual Physical Health checks for severely mentally ill
- IAPT to provide individuals with common MH problems opportunities to address their anxiety, depression and enable them to access vocational opportunities, as well as assisting individuals to maintain their employment
- IAPT involves BME Providers to ensure individuals from BME communities can access appropriate CBT services – in line with DRE and operating framework
- Further develop inpatient environment to ensure female patients are 'safe' within the wards, as well as intensive care unit
- Learning Disabilities ~ 500 Enhanced Health Checks to be completed via the DES and LES by the end of March 2010
- Improved data on the health needs of adults with LD in the JSNA by June 2009
- This will be collated by the Performance Improvement team

8 pathways of care in Next Stage review – High Quality Care for All								
	Staying Healthy	Maternity and newborn	Children	Acute care	Planned care	Mental health	Long-term conditions	End of life care
Reduce Infant mortality to the West Midlands average	✓	✓	✓			✓		
Reduce mortality from coronary heart disease in under 75's by 40 deaths per year	✓			✓	✓		✓	
Halt the epidemic of childhood obesity	✓	✓	✓					
Improve access to mental health services in primary care, especially talking therapies					✓	✓		
Reduce the impact of alcohol abuse	✓					✓	✓	
Improve young people's use of high quality sexual health services			✓					
Reduce the gap in mortality from strokes between priority and non-priority wards from 65% to 45%	✓			✓	✓		✓	
Reduce admissions from Ambulatory Care Sensitive conditions	✓				✓		✓	✓
Improve patient safety				✓	✓		✓	
Improve the management of risk factors for coronary heart disease by 5% within the diabetic population	✓			✓	✓		✓	
Intervene earlier in the prevention and diagnosis of lung and bowel cancer					✓		✓	

Partnership Working and the Local Area Agreement – The PCT works with the Wolverhampton Strategic Partnership to develop the Community Plan, the emerging Sustainable Community Strategy, and the Local Area Agreement. All of these strategies and plans impact on the work of the Trust and how it goes about the development and delivery of services.

The PCT is the lead partner on the Health and Well Being Partnership Board, on behalf of partners across the city, and actively participates in other themed and supporting partnership structures, including:

- Children and Young People's Strategic Partnership
- Safer Wolverhampton Partnership
- Valuing People Partnership
- Older People's Partnership, and
- Long Term Conditions Partnership, as well as
- A range of National Service Framework Local Implementation Teams

The PCT works in partnership to commission services. Practice Based Commissioning has been developed in the city through the creation of the Locality Commissioning Board, and the PCT works to support GPs in the commissioning of local services. The Joint Commissioning Unit has been developed with Wolverhampton City Council and focuses on commissioning for particular care groups.

The Framework Partnership Agreement with Wolverhampton City Council delivers integrated mental health, learning disability and community equipment services and is an example of how the PCT works in partnership to deliver health and care services for the City.

The following table provides an overview of the shared targets within the LAA:

	Indicator	NIS	Vital Sign
HWB Partnership Lead	Early access for women to maternity services	126	VSB06
	Number of vulnerable people who are supported to maintain independent living	142	
	All age all cause mortality rate	120	VSB01
HWB Partnership Support	No. of conceptions per 1,000 females aged 15-17	112	VSB08
	CO ² reductions	185	VSC34
	Substance misuse by young people	115	
	PE and sport in schools	57	
	Repeat incidents of domestic violence	32	
	Rate of serious violent crime per (No. of offences)	15	
#	Obesity among primary school children (Year 6)	56	VSB09

Shared goal led on by Children and Young Peoples Partnership.

2.1.7. Recovery Plan

Wolverhampton PCT acknowledges that there will be some targets from the 08/09 Operating Framework which may not be achieved. Where this is the case, the Performance Improvement department will initiate a robust system of recovery planning to bring 2009/10 performance targets in line with expectations.

The PCT anticipates that it may under-achieve against the following indicators:

- Chlamydia Screening
- Choose & Book
- Recording of Childhood Obesity
- Dental Activity
- Incidence of MRSA
- Breastfeeding at 6-8 weeks

Any target that has under-performed in-year is reported to the Board with a red RAG rating. To provide assurance with respect to governance the Board are provided with an improvement plan for each of these failing targets.

In the event that any of the above targets are failed, the Accountable Director will be required to submit a formal Recovery Plan. This will be robustly monitored during the 2009/10 timeframe and extra scrutiny will be given by a Performance Board to ensure step by step remedial activity is prioritised.

Acceptance criteria for signing-off recovery plans will include detailed corrective actions, evidence of control measures to be enacted and milestones recorded with expected date of completion. In addition, further sources of assurance will be required to be submitted with justification and evidence of how revised controls and assurance will be fit for purpose.

An example of how the PCT recovery plans impact on turning around performance can be evidenced in the recovery plan for Digital Diabetic Retinopathy Screening (previously issued to the SHA), as the PCT fell 12 months behind on delivery of this indicator at the beginning of 2008/09. The recovery plan and robust monitoring of performance against this target during 2008/9 has resulted in the PCT having turned this performance and successfully achieving the target.

2.2. Commissioning Plan

The biggest challenge facing Wolverhampton City is in Health Inequalities. We are in the bottom fifth of English Local Authorities and PCTs for life expectancy and within this we have inequalities across our wards. We are taking a number of steps to achieving significant improvements in health inequalities across the city and this work is evidenced in our Strategic Plan.

The Director of Public Health's Annual Report has identified the factors that contribute to these inequalities. The 'Big 6' conditions that impact on life expectancy are:

- Infant Mortality
- Coronary Heart Disease (CHD)
- Stroke
- Lung Cancer
- Suicide
- Alcohol Related Liver Disease

Our Strategic Plan has been developed with significant focus on these 6 conditions. This plan is our strategic commissioning document for 2008-13 and Wolverhampton City PCT recognises the need to commission services that have the most significant impact on health inequalities according to the needs of the population in each local area, and to enable care to be provided as close to home as possible.

Over the coming years we shall commission services that focus on self-help and family care, supported by services based in the community. Services for emergencies and acute care will be available for those who need them, with tertiary care for highly specialised cases only

For this approach to be effective, we will have to work in collaboration with the people and organisations that have a vested interest in the outcome. Building lasting partnerships throughout the city has been, and will continue to be, a cornerstone of our vision for effective healthcare services for the future.

The following elements will be included as planning requirements for commissioning activity levels for 2009/10

- Commissioning intentions for 2009/10 will reflect the 2008/9 recurrent over-performance. (e.g. recognising uplift for increase in birth rate in 2008-09 etc)
- Additionally we will plan for a small increase in non elective activity of 1% on 2008-09
- Commissioning intentions provide for meeting current national performance objectives – i.e. 18 weeks referral to treatment
- Commissioning intentions for 2009/10 reflects the transfer of activity into the community as agreed in the Wolverhampton SSDP Delivery Plan

Other initiatives to be considered for 2009/10 are:

- Equitable Access Schemes (4 new G.P. practices)
- Minimum Waits (Implications of this initiative are currently being scoped)
- PBC Inequalities(Moving practices closer to fair share of resources)

The timeline for contract agreement will follow the pre-existing arrangements with the final contract signed in March.

2.3. Provider Services

The PCT Provider Services has an annual turnover of £80million and employs some 2000 staff in the direct delivery of community based services including:

- Mental health/addiction
- Rehabilitation
- Children, young people and families
- Community nursing
- Allied Health Professionals

Almost 90% of the services delivered by the PCT Provider operate within the City of Wolverhampton. In 2009/10 the PCT Provider will drive forward the 'Future of Provider Services' programme to:

- Establish a clear vision and set of values
- Ensure future business preparedness
- Identify, evaluate and consult upon potential service and organisational configuration options
- Implement a programme of change management

In addition to this programme the PCT Provider has identified a number of key deliverables for 2009/10.

- Delivery of the action plan arising from the Mental Health Peer Review
- Participate in the SHA Productivity and Improvement (PIP) programme for mental health services and continue to implement service changes resulting from the Community Services PIP which commenced in 2008.
- Deliver Year 3 of the 'Transfer of Care' programme, as outlined in the PCT Strategic Services Development Plan (SSDP)
- In conjunction with the commissioner, implement the new national contracts for community and mental health services, including the further development of local currencies and the establishment of a Quality Framework

We will continue to reduce waiting times and improve access to services, as part of the PCT 'zero waits' initiative.

2.3.1. Priority Areas

The PCT provider has undertaken an external review of the key drivers of performance for providing organisations and supplemented this with an organisational analysis that included a review of strengths, weaknesses, opportunities and threats; from this the organisation has established the key theme areas around which all operational activity will be based for the 2009/10 period. These are:

- Communication and relationship management
- Key Performance Indicators
- Developing safe and effective services
- Governance
- Business development and infrastructure
- Workforce

3. Quality Measures

The operating framework and the “Next Stage Review” for the NHS have placed a heavy emphasis on quality. The NSR has identified 3 elements, that, when brought together, can help to define quality: safety, effectiveness and patient experience.

Quality is at the very heart of our recently produced Strategic Plan and is one of our four key priorities for the period 2008-13. Quality can be evidenced in all elements of our plan and underpins much of what we do either explicitly in terms of the goals and targets we set, or embedded in the processes and ways in which we work.

Each of these elements has been considered within the planning requirement of the Operational Plan. Patient satisfaction and experience has a number of measures contained within the Operational Plan. In addition to these national requirements, the PCT regularly consults with patients and potential users on service experience, particularly when commissioning new services or when establishing the extent to which current services are satisfying current needs. This approach will be maintained in 2009/10. Of these, the most significant are the monthly meetings of the 16 LANAs, two direct-mail newspapers, ‘One City News’ and ‘Health Focus’ and our work with the OSC.

The drive for further reductions in Health Care Associated Infections is an excellent example of where the Wolverhampton Health Economy is working together to improve safety. This is further emphasised as it is one of the outcomes specifically chosen as part of the World Class Commissioning process. Continued work for 2009/10 in this area includes:

- To maintain MRSA at the 2005 level of only 15 cases across the whole health economy
- Reducing even further the number of cases of Clostridium Difficile to below national requirements of 7.8 per 10,000 to 7.64 per 10,000

In order to improve the effectiveness of services we are developing our approach to CQUIN (Commissioning for Quality and Innovation).

The Strategic Plan is the starting point for commissioning decisions, for example, those explicit in the Operating Plan or through Practice Based Commissioning. Thus our CQUIN payments are related to what we are trying to do in the City. In line with SHA guidance, our CQUIN initiative will not be used to achieve baseline targets nor in those circumstances where targets are already being met. Through the CQUIN payments, it will be obvious what the PCT is trying to improve and we will be able to demonstrate a clear “line of sight” to our priorities.

Whilst the process will continue to develop throughout the year the following is the proposal for the five CQUIN areas:

1. Safety

It is proposed that an indicator of infection is used. The PCT and its main provider have focussed significantly on C. diff and MRSA. It is proposed to use a different indicator, namely the reduction of healthcare acquired bacteraemia (not MRSA). Whilst we are gathering the baseline data it is suggested that we look to reduce by 25% over the next 12 months. This sits entirely in line with our Strategic Plan to reduce the risk to patients from healthcare associated infection.

2. Effectiveness

It is recognised that in several key areas RHWT is a high performer, e.g. stroke and TIA. Therefore it is proposed to use smoking in pregnancy as an indicator, looking to reduce from a background rate of 21% to 19% in the next 12 months. Smoking in pregnancy is crucial to reducing the infant mortality rate in Wolverhampton, a key issue in our Strategic Plan.

3. Patient Experience

It is proposed to use the new methodology "PROMS" to gain patient experience of some common elective conditions.

Two other indicators are required to make up the five CQUIN indicators. Two possible indicators relate to the following:

1. To reduce white script prescribing by 75%.
2. To reduce cancelled appointments by 50%.

The first indicator is an issue which is being discussed increasingly at PEC which provides a clear clinical governance issue. It can be argued that it is also a patient experience consideration as it removes the need for patients to visit their GP as well as outpatients. The final indicator has been chosen because patients, through our various consultation mechanisms, commonly complain about cancelled appointments.

It should be noted that CQUIN indicators will be measurable and should be attainable. These five indicators can be linked to our Strategic Plan or other crucial issues raised by Practitioners and patients in the City.

Our CQUIN scheme was formally agreed and signed off with the SHA in February 2009.

The PCT has sought to further enhance its reputation as a provider of quality services by registering with the Care Quality Commission as part of the Healthcare Associated Infection Registration process.

The PCT has been registered "without conditions" by the Care Quality Commission, this is the highest possible standard. This falls in line with our previously stated commitments, in both the Strategic Plan and this Operational Plan, regarding tackling HCAs and going further than the national minimum requirements in relation to hygiene and infection targets.

4. Vital Signs Refreshed Trajectories

All of our Vital Signs refreshed targets have now been mapped into the PCT Summary Outcomes document as part of the Business Operating Plan and was previously submitted to the SHA.

5. Performance & Governance

In its simplest form, performance management consists of the following activities:

- Understanding what the organisation wants to achieve and why
- Identifying the actions necessary and barriers to delivery and putting in place the steps to get there
- Allocating resources to support the delivery of the plan
- Monitoring and measuring the outputs delivered
- Evaluating progress against target and taking corrective action where appropriate
- Evaluating the outcomes to ensure the plan achieved its objectives

This framework has been adopted by the PCT and helps to provide greater internal control and ultimately turn ambition into delivery; this will lead to better service delivery for our patients and public. As an organisation, effective and embedded performance management will also lead to increased levels of skill and staff competence, increased morale and will lead to a culture of continuous improvement.

Wolverhampton applies a robust process to managing performance with each target indicator having milestones set for performance in a 'Performance Assurance Plan'. These plans enable indicators to be given profiled targets and milestones recorded at an appropriate level of detail to allow the Performance Improvement department to track performance progress at suitable intervals and levels of scrutiny. Performance monitoring takes place on a monthly/quarterly basis, depending upon data refresh frequencies and areas giving potential cause for concern are identified. In the event of under-performance, the Accountable PCT Director is required to provide a corrective action plan for the next period of assessment or until performance against the target trajectory is brought back on track – please refer to section 2.1.7 'Recovery Plan' for further information.

Each of the Performance Assurance Plans for 2009/10 Business Operating Plan activity will be accompanied by a Risk Assurance Framework which will provide the PCT Board with an overview of the risk mitigation activity associated with the plan. It also provides the PCT Board the assurance they require as outlined in the DH guidance '*Building the Assurance Framework*'.

To support the delivery of this Operational Plan a detailed and more comprehensive Business Operating Plan will be developed which details the actions required to deliver each of the priorities.

6. Finance

The baseline revenue resource limit for the PCT in 2009/10 is £441.011 million and it is estimated that the PCT will under spend in the year by a sum amounting to £27.3 million.

In setting the medium term plan, the PCT has been mindful of the need to maintain financial stability in future years. In doing so the PCT financial plan retains a recurrent balance (or better) over the next five years whilst at the same time allowing for a significant reduction in the level of growth funding.

Financial surplus 2008/9 to 2013/14

£000's	Recurrent surplus	Non recurrent surplus	Total surplus	In year Surplus/ (deficit)
2008/9	9,731	15,269	25,000	11,100
2009/10	2,819	14,565	17,385	(7,615)
2010/11	6,742	3,028	9,770	(7,615)
2011/12	4,705	(2,550)	2,155	(7,615)
2012/13	3,102	(947)	2,155	-
2013/14	3,865	(1,710)	2,155	-

Growth funding 2009/10 to 2013/14

%	Gross Growth	Inflation	Net Growth
2009/10	5.5	2.2	3.3
2010/11	5.5	1.7	3.8
2011/12	4.00	2.75	1.25
2012/13	4.00	2.75	1.25
2013/14	4.00	2.75	1.25

In setting the financial plan for 2009/10 to 2013/14, the PCT

- Makes available recurrent funding of £4.787 million and non-recurrent funds of £30,983 million to support the cost of delivering new spending plans as described within the recent World Class Commissioning Strategic Plan,
- Increases funding to support the cost of continuing care by £1.0 million,
- Funds new specialised drugs and devices as recommended by NICE to the value of £5.0 million,
- Continues to support the delivery of care provided through the hospital sector by making available additional recurrent funding amounting to £9 million,
- Increases the prescribing budget annually by 7%,
- Covers the cost of commissioning specialist services through increased funding of £4.55 million in 2009/10 and £1.55 million in each of the years 2010/11 to 2013/14,
- Supports the transformation of mental health services through the availability of funding amounting to £2 million
- Improves access to Primary Care services through the establishment General Practices
- Sponsors a free school meals programme in Wolverhampton over a 2 year period at a cost of £3 million,
- Facilitates the delivery of more care to be provided in a community setting or in patients home through the expansion of community services costing £1.939 million per annum; and
- Establishes a central reserve of £5.0 million to enable work to be undertaken to minimise waiting times across secondary care and all community services by 2012/13

The PCT has recognised that in taking forward these developments, it is necessary to maintain the financial stability of the PCT. In doing so, the PCT has established contingency reserves of £2.0 million for each year of the plan and also proposes to underwrite the plan by lodging with the Strategic Health Authority funding amounting to £3.6 million.

Increase funding	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's	2013/14
Reduce Infant mortality to the West Midlands Average	1,085	1,085	1,085	1,085	445
Reduce mortality from coronary heart disease in the under 75's, strokes and better manage risk within the diabetic population	3,265	2,865	2,865	1365	365
Halt the epidemic of childhood obesity (Post MEND)	0	300	300	300	300
Talking Therapies	682	1,317	1,866	2,053	2,053
Reduce the impact of alcohol abuse	720	858	888	888	832
Improve sexual health services	890	762	762	762	622
Reduce admissions from ambulatory care	775	775	775	600	600
Improve patients safety – particularly Infectious diseases	574	574	524	524	524
Intervene earlier in the prevention and diagnosis of lung and bowel cancer	475	475	475	445	140

6.1. Connecting for Health

The PCT has mapped all of its strategic objectives and business operating plan activity in to the Connecting for Health Strategic Alignment Tool this document was formally submitted to the SHA in January 2009.