

# **NHS WAKEFIELD DISTRICT 2010/2011 OPERATIONAL PLAN**



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## **SECTION 1      CONTEXT**

### **1.1      National Context**

“NHS 2010 – 2015 From good to great: a preventative, people-centred, productive NHS<sup>1</sup>” and NHS Operating Framework for 2010/11<sup>2</sup> highlight that the NHS is entering a new era requiring it to keep moving forward, focussing its efforts on getting more for the public from a much expanded, more capable and resilient system.

Whilst 2010/11 provides a year of growth it has been announced that during 2011/12 and 2012/13 NHS frontline spending will only rise in line with inflation. The Framework requires the NHS to focus on three things:

- Improving quality whilst improving productivity using innovation and prevention to drive and connect them;
- Local clinicians and managers working together across boundaries to spot opportunities and manage change; and,
- Acting now and for the long term.

### **1.2      Local Context**

The Wakefield district compared to others in England has consistently poorer health outcomes than even its statistical peer group. In addition, inequalities in health across the communities within the district mean a large number of people will suffer health problems that will affect their quality of life and prospects.

The Joint Strategic Needs Assessment 2008/11, Health Equity Audit and Health and Lifestyle Survey confirm that 28% of the district is in the most deprived quintile in England and that 56% of the district is in the bottom two quintiles in terms of deprivation. The population demographics project that the population will increase by a further 15,000 people by 2017. Overall, health in the Wakefield district is generally worse than England as a whole, with early deaths from heart disease, stroke and cancer being particular concerns. There are also high rates compared to the England average for smoking in pregnancy, teenage pregnancy, children classified as obese and children’s tooth decay. Harmful or hazardous alcohol intake is also a growing problem as is obesity and breastfeeding initiation rates are low.

Our World Class Commissioning priorities have been chosen in response to these challenges.

### **1.3      Commissioning Capacity, Demand and Gaps 2010/11**

NHS Wakefield District undertakes a process of demand planning annually for the oncoming year; the aim is to predict the activity requirements for acute secondary care, community services and mental health services, and as such it is used to inform contract negotiations.

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<sup>1</sup> NHS 2010 – 2015 From good to great: a preventative, people-centred, productive DH 2009

<sup>2</sup> NHS Operating Framework for 2010/11

### 1.31 Commissioning Acute Hospital Services in 2010/11

In broad terms, the local acute health care market is characterised by a small number of dominant health providers – The Mid Yorkshire Hospitals Trust for general hospital and some specialist services, and The Leeds Teaching Hospitals NHS Trust for small amount of general hospital services and a large proportion of other specialist services.

Over the last few years secondary care activity has steadily increased across all the categories from outpatients through to non-elective and elective in-patient episodes. The following table identifies this increasing activity trend and includes data from all NHS secondary care providers.

	2006/07	2007/08	2008/09	2009/10 Forecast	Percentage increase since 2006/7
<b>A&amp; E attendances</b>	119,746	116,963	117,614	121,612	1.6%
<b>Outpatient First</b>	76,331	83,627	91,905	95,620	25.3%
<b>Outpatient Follow up's</b>	237,525	234,423	239,372	232,451	-2.2%
<b>Elective admissions (inpatient and day case)</b>	41,898	45,541	46,965	48,469	15.7%
<b>Non Elective admissions</b>	43,138	44,178	45,010	45,150	4.7%

As outlined in our Strategic Plan probably the most significant strategic issue which NHS Wakefield District is currently dealing with is the ability to cope with activity levels at Mid Yorkshire Hospitals Trust, particularly in the context of the new PFI hospitals which are opening in 2010 and 2011.

There are two distinct methodologies adopted for the demand planning of acute services, firstly a complex detailed process is used for Mid Yorkshire Hospitals NHS Trust (MYHT) involving a software forecasting tool, data on historic activity, additions to list and impact on waiting lists along with any expected access targets for the coming year. This level of detail is used for MYHT because they account for approximately 90% of the PCTs acute demand.

For all other providers, unless commissioning knowledge predicts any dramatic changes, then the following years demand is based on forecast outturn using the latest up to date figures.

2010/11 demand planning forecast for all acute secondary care services (and MYHT separate) is in the region of:

<b>Point of Delivery (POD)</b>	<b>10/11 Forecast (all providers) (000)</b>	<b>10/11 Forecast (MYHT) (000)</b>
Outpatient 1 <sup>st</sup> appointments	100	86
Elective procedures	48	41
Non elective procedures	46	42
Outpatient Follow-ups	190	140

These demand figures are then reviewed internally for affordability. This process may lead to slight changes to the figures in line with budget constraints or availability; changes of this nature are documented and saved. This demand is then compared to capacity plans prepared by providers to determine whether there are any capacity gaps.

At the time of writing the only acute provider that is identifying any capacity constraints for 2010/11 is MYHT.

The current gaps identified by MYHT at a POD level are detailed in the table below.

<b>Point of Delivery (POD)</b>	<b>Demand/Capacity Gap (000)<sup>3</sup></b>
Outpatient 1 <sup>st</sup> appointments	18
Elective procedures	5.7
Non elective procedures	8.7

At a speciality level the largest gaps identified are in:

- Outpatient first appointments for ophthalmology (4948), orthopaedics (2773), and dermatology (1818);
- 2872 day case procedures in gastroenterology;
- 5070 non elective general medical procedures;
- The movement of patients between MYHT and LTHT for Urgent Suspected Cancer (USC) patients requiring tertiary care opinion within the 62 day standard;
- Learning disability expertise in autism has become a gap due to the retirement of a MYHT consultant with a specialist interest and leaving a gap. This will be supported through enhanced community services; and,
- Spinal Injuries relating to lower back pain and slipped disc will need capacity identified in alternative provider as the MYHT has given notice

The approach that is being adopted to address these gaps, and all others identified in the capacity demand process for acute services, is to either:

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<sup>3</sup> These figures are based on MYHTs first version of their capacity plan and are expected to be spread over all of the PCTs that refer to MYHT (NHSWD will account for approximately 67% of any agreed gap). Furthermore this is the starting position, it would be expected that during the contract negotiation phase that this gap will reduce.

- i. Negotiate strict best practice performance targets in the contract; such as first to follow up ratio's for outpatient appointments or reduction in cancelled clinics or appointments and therefore maximising current capacity; and,
- ii. Develop project work streams through the Portfolio's as described in Section 2 of this plan that will either lead to increased local capacity available for NHSWD patients or reduce demand on secondary care services.

The work streams described in Section 2 also are designed to focus on specific pressures around A & E Attendances, Emergency Admissions and Emergency Bed Days in MYHT.

### **1.32 Leeds Teaching Hospital**

In partnership we have completed a joint demand and capacity modelling exercise in preparation for the national requirement to have plans in place to extend the ages for breast screening and to introduce digital equipment. The work was completed and the findings are being used to inform the commissioning of breast screening services from 2010/11 onwards. To ensure local capacity we have also secured a static breast screening site at the Primary Care facility in the centre of Wakefield.

### **1.33 Contract Negotiations**

The formal contract negotiations are continuously reviewing the capacity gaps and working with providers to reduce this and to identify sources of alternative capacity. The negotiations are focused on encouraging improved productivity and efficiency to ensure that the available capacity is being utilised as effectively as possible. It is anticipated that through the negotiations the capacity gap will be significantly reduced by the contract signature deadline (15 March 2010).

### **1.34 Commissioning Mental Health Services in 2010/11**

*High Quality Care for All*<sup>4</sup> requires us to having national mental health currencies available for use in 2010/11.<sup>5</sup> Whilst there are no specific capacity issues identified for 2010/11 the introduction of Payment by Results (PbR) to Mental Health services means that work will be undertaken in 2010/11 to prepare locally for the introduction of PbR and 'clusters' as units of care this will form new perspectives on how we describe capacity and cost of Mental Health Services

This year the PCT and Wakefield Metropolitan District Council (WMDC) will invest £28.6 million for local adult secondary care mental health services and approximately £3m on child and adolescent mental health services. We will also invest £10.9 million in the commissioning of older people's mental health services from South West Yorkshire Partnership Foundation Trust.

NHS Wakefield District currently commissions these services through:

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<sup>4</sup> High Quality for All

<sup>5</sup> Available for use means that people will have the opportunity to use them for the 2010/11 financial year with most health economies including Wakefield District considering their use in shadow form in year

- A contract with the Wakefield District Community Healthcare Services (WDCHS) for the provision of community based CAMHS and an independent sector provider for in-patient provision; and,
- A major contract with South West Yorkshire Partnership Foundation NHS Trust.

The service report and activity summary from SWYPFT for Month 9 of 2009/10 overall suggests there is capacity for the current demand (Appendix 1).

### **1.35 Commissioning Community Services in 2010/11**

The PCT currently invests £55 million per annum in these services NHS Wakefield District currently commissions these services through:

- A contract with the PCT provider arm for the majority of community based services including district nursing, health visiting, school nursing;
- General Practitioner with Special Interest Services which help move care closer to home and out of acute hospital services; and,
- A range of contracts with third sector organisations including Little Angels a breastfeeding support service.

The PCT's Transforming Community Services Strategy articulates our strategy for Primary Care and Community Services in Wakefield and provides a vision identifying their role in delivering 24/7 patient centred primary and community healthcare in the local community. This will be realised through seven high levels transformational change programmes. In 2010/11 the focus for community services will be maintaining the current capacity and stability of the services as the work programmes to deliver the transformational changes are identified and implemented.

### **1.36 Commissioning Primary Care Services in 2010/11**

The vast majority of NHS patients have contact with the NHS through primary care, either for one-off advice or as part of ongoing, long term treatment. Primary care services in the Wakefield district are of a good standard. Most patients can make an appointment at a GP practice within 48 hours get advice from a local pharmacist and access to Dental care easily.

To reinforce this and ensure the capacity and the quality of primary care services are maintained in 2010/11 we will:

- Continue to develop services and registrations at the King Street GP Led Health Centre (GPLHC) and to focus on access to services for walk in and unregistered patients;
- Complete the PMS contracts review with specific emphasis on improving access to GP services and reducing Health Inequalities. Then issue the revised PMS Contracts to Practices;
- Review of all Local Enhanced Services for 2010 -11 and include specific services in the revised PMS contract;
- Review of GP and Primary Care services in Castleford;
- GP Extended Hours LES will continue in 96% of Practices. National baseline funding already fully committed to this scheme and also to the 7 day per week, 12 hour per day pre bookable and Walk In service at King Street GPLHC.

- Continue to develop additional capacity to meet Vital Signs for Dental Services;
- Develop and implement additional contract management and monitoring for General Dental Services and Personal Dental Service contractors to ensure they demonstrate value for money, improved access and to achieve vital sign trajectories;
- Develop Pharmaceutical Needs Assessment programme in line with national and local targets and timescales;
- Complete Electronic Prescription Service, release 2, project to meet implementation date of 30 September 2010;
- Ensure that the remaining Pharmaceutical budgets devolved to PCTs are appropriately managed and monitored;
- Implement additional Enhanced service to pharmacists recently agreed on MRSA and to consider additional in conjunction with the Local Pharmaceutical Committee;
- Ensure that devolved ophthalmic budgets for 2010-2011 are appropriately managed and monitored; and,
- Work with other PCTs across West Yorkshire to explore opportunities to optimise and develop work with West Yorkshire Central Services Agency

### 1.37 QIPP projects and efficiencies

PCT is developing plans to deliver QIPP cost improvements and has identified 11 QIPP projects. Full details are in the 2010/15 Strategic Plan.

Potential QIPP Efficiencies	2010/11 £000
Reduction in strategic investments	7,487
QIPP - Admission and Discharge criteria	
QIPP - Incentivising Primary Care	1,000
QIPP - HQ budgets	1,000
QIPP - Mental health	500
Other QIPPs:	
<b>Adults Portfolio</b>	
Investment in primary prevention	320
Investment in falls prevention	70
<b>Planned Care Portfolio</b>	
Managing variations in surgical thresholds / outpatient attendances	310
Developing criteria based commissioning for planned care procedures	787
<b>Unplanned care and LTC Portfolio</b>	
Reduce number of emergency admissions and readmissions	1,166
Excess bed days	250
Reduction in management costs (estimated)	1,230
<b>Total</b>	<b>14,120</b>

A benefits realisation and mapping programme is in early development and will enable the tracking of efficiencies throughout the organisation. More detail on framework and process at Appendix 2.

#### 1.4 Key Priority Areas

The PCT is accountable for delivering a range of targets:

- **The NHS Wakefield District Strategic Plan 2009/10 – 2012/13:** The Strategic Plan sets out the eight local outcome goals selected for the World Class Commissioning Assurance process that will improve outcomes for the population of the Wakefield District;
- **Healthy Ambitions-** *Delivering Healthy Ambitions - Better for Less 2010* identifies specific opportunities to deliver the best patient care more efficiently. This is reflected in our portfolio work programmes and through a set of performance indicators developed across the Yorkshire and Humber Region;
- **Vital Signs:** These reflect the national requirements set by the Department of Health (DH) that all PCTs must meet, and the local Vital Signs selected by the PCT;
- **CQC Periodic Review** – This pulls together a selection of key performance targets for all PCTs and annually compares and marks our progress using a national score card; and,
- **Local Area Agreement** - These reflect the local priorities being taken forward with partners through Wakefield Together.

## Our World Class Commissioning outcomes and expectations

Based upon our Joint Strategic Needs Assessment (JSNA), the PCT Board agreed the following set of outcome measures and expectations for use in the WCC assurance process. These are a sub-set of the overall priorities of the PCT. Key actions against these outcomes for 2010/11 is identified further in this Operational Plan.

Reflecting the key challenges, this year we have identified a new outcome goal for 2010/11, reducing smoking. This is the single action which will have the biggest impact on health in the district. The local outcomes are shown in the table below.

Outcome Goal	2010/11 World Class Commissioning Outcomes
1	Improving life expectancy adding years to life by 2015 through: raising average life expectancy for men from 76.3 years in 2005-2007 to 79.8 years in 2014-16.raising average life expectancy for women from 80.6 years in 2005-2007 to 82.8 years in 2014-15
2	Maintain the health inequalities gap between the best and worst off in the district in terms of the difference in life expectancy recognising that in doing so the current trend of a worsening health inequalities gap will have been reversed
3	Reduce the level of smoking in pregnancy from 23.64% in 2008/09 to 17.1% in 2015 meaning 160 less women smoking during pregnancy;
4	Reduce the level of obesity in reception class children from 10.51% in 2007/8 to 8.2% in 2015
5	Reduce COPD mortality from a 2007-09 estimated level of 40.47 deaths per 100,000 to 36.19 by 2013-15, against a backdrop of increased diagnosis
6	Reduce under 75s CVD mortality from the 2007-09 estimated level of 89.7 per 100,000 to 51.4 per 100,000 by 2013-15
7	Reduce all age CHD mortality from the 2007-09 level of 95.2 per 100,000 to 72.0 per 100,000 by 2013-15
8	Increase the percentage of patients with diabetes whose HbA1c is 8.0 or less from a target of 71% in 2009/10 to 76% by 2015 meaning approximately 4000 more people will achieve this crucial measure of care
9	Reduce the number of acute emergency bed days from 209,489 in 2008/09 to 200,000 by 2015
10	Increase the number of smoking quitters per 100,000 of population aged 16 or over from 1152 in 2008/9 to 1568 in 2015 meaning over 20,000 people will have quit smoking over the five years of this plan

### 1.5 Organisational Performance

The PCT has an established approach to performance improvement which is integrated in all aspects of its work. There are clear performance and improvement frameworks with a scorecard of indicators that are reported on a regular basis. Areas of poor performance are reported on an exception basis to the Senior Management Team and the PCT Board on a monthly basis with the full scorecard reported quarterly. These scorecards include a mix of measures looking at outcomes and business processes to provide in-year indication of whether the PCT is in a position to deliver its expectations.

This is important given the selection of a number of mortality rate targets as our WCC local outcome measures as these are lagging indicators with national reporting often based on information collated over a three year trend. To further support this we have developed Performance Improvement Maps which measure the interventions which impact on COPD, CVD, CHD and Cancer Mortality rates. By mapping out the interventions, efforts can be better co-ordinated and their impact reviewed as a whole. Local targets are then set with a sense check to ensure all is being done to improve the health of the District. Performance can be monitored more regularly and more effective decision making can be made regarding the interventions which have larger impacts on the final outcome. Further Performance Improvement Maps for all of our WCC local outcome measures are being developed. A set of Improvement Maps are provided in Appendix 3.

Benchmarking is integral to the PCT way of working and we have robust mechanisms that compare and challenge how we measure up nationally and locally. We utilise the tools, databases and comparators available to the NHS on our desktops and actively seek best practice from other areas that are doing better than us to see if we can implement ideas locally to improve performance.

The Director of Public Health actively contributes to Wakefield Councils performance clinics to ensure the Local Authorities role in health improvement is maximised.

## **SECTION 2      COMMISSIONING THROUGH OUR PORTFOLIOS AND PRIMARY CARE**

Implementing the 2010/11 Operational Plan will be driven through the four commissioning Portfolio Groups:

- Planned Care;
- Adults;
- Unplanned Care and Long Term Conditions; and,
- Children, Young People and Maternity

Their primary function is to drive the commissioning processes through the existing directorate structures. They ensure that all parts of the PCT are co-ordinated in each area and that there are appropriate resources, timescales and milestones set to ensure effective implementation and the delivery of the WCC competencies and key priorities (these are broken down in more details for each Portfolio in Appendix 4).

### **2.1      The NHS Constitution**

The NHS Constitution was published in January 2009 and set out new requirements around choice and transparent decision making. During 2009/10 the Portfolio Groups:

- Developed a General Commissioning Policy which outlines the PCTs approach to commissioning services;
- Reviewed and updated all processes and policies related to Individual Funded Requests and the Exceptional Case Panel;
- Improved links with the Specialised Commissioning Group (SCG) and Yorkshire Cancer Network (YCN) groups to ensure PCT policies are consistent with the latest NICE, SCG and YCN guidelines; and,
- Participated in the SHA 'Choice Road show' which involved a Choice mobile trailer (staffed by PCT Choice, PALs and Public Health staff) visiting five localities across Wakefield District to raise awareness of Choice with our local populations.

In 2010/11 we will:

- Ensure compliance with the NHS Constitution;
- Increase electronic referral and booking via Choose and Book (C & B) by 10%;
- Get C & B slot availability in line with the national tolerance;
- Include referral via C&B in the PMS review process;
- Deliver 18 weeks across all services and specialties ensuring patients do not wait any longer for reasons other than choice or clinical exceptions;
- Investigate efficiently and respond to all patients who believe they have exceeded 18 weeks ;
- Ensure all commissioning decisions are made to ensure the implementation of NICE guidance; and,
- Implement our 'patient friendly' elective access policy.

## 2.2 Planned Care

The primary objective of the Planned Care Portfolio is to ensure all planned care commissioned services are in the best percentile range against all appropriate benchmarks (national/or similar PCT demographics).

### 2.21 Elective Care Services Programme

This will provide the strategic framework for commissioning of all elective medical and surgical services inclusive of cancer and diagnostic services.

Key achievements In 2009/10 were:

- Providing prostate injection therapy in a primary care setting. This has enabled our patients to receive care more locally and has reduced the number of follow-up appointments in secondary care;
- Improving access to diagnostic services with our Practice Based Commissioners and procured a direct access community ultrasound service;
- Working in partnership with NHS Leeds PCT, Mid York Yorkshire NHS Trust and Leeds Teaching Hospitals Trust on the Going further on Cancer Waits initiative to systematically review and map the lung pathway across primary, secondary and tertiary care (using lean methodology). Upper gastrointestinal and urology cancer pathways are now being reviewed.
- Developing an information leaflet in partnership with Mid Yorkshire Hospitals Trust for use by patient referred by their GP as a suspected cancer diagnosis. This has been considered an exemplar by peers; and,
- Implementing a local incentive scheme which looks at the role of primary care in supporting the earlier detection of cancer.

In 2010/11 the Elective Care Programme will:

- Audit urgent suspected cancer referrals and make recommendations on future commissioning;
- Develop the direct Access Diagnostic Services Project including AWP Community Ultrasound procurement with a view to new services commencing during the first quarter and direct Access MRI and direct Access Dexa scan in quarter 2;
- Implement the Orthopaedic Service Transformation Project;
- Complete the service review of Musculoskeletal Services and develop and implement the service specification and make available on Choose and Book;
- Work with PBC and other key stakeholders to develop a service specification for orthopaedic procedures and cataract and minor lid procedures delivered in a community care setting;
- Work with PBC to investigate practices that are outliers against National benchmarking data for referrals to orthopaedics to understand what support is necessary to bring them in line with the referral patterns of the rest of the practices in the District;
- Implement the Ophthalmology Service Transformation Project;
- Implement the Dermatology Service Transformation Project;
- Implement the *Going Further on Cancer Waits Service Transformation Project*;

- Develop a matrix approach (which incorporates the NHS Institute for Innovation and Improvement seven dimensions of performance) to inform future prioritisation of resources to help us improve cancer care for local patients in line with the Cancer Reform Strategy;
- Manage variation in surgical threshold (Review and evaluate effectiveness of prior approval policies related to Tonsillectomy, Hysterectomy, Lower Back Surgery and Myringotomy; and,
- Develop referral criteria and policies for procedures not previously defined (e.g. the Croydon List approach).

## **2.22 Planned Care and Screening**

This programme will provide the strategic framework for commissioning amongst others bowel, breast and cervical cytology screening services.

In 2009/10 our key achievements were:

- Launching the new bowel screening service in Wakefield district to reduce the number of deaths from bowel cancer. Residents in Wakefield and Kirklees aged between 60 and 69 are now being sent self-testing kits at home by their local NHS, as part of a national programme;
- Completing a joint demand and capacity modelling exercise in preparation for the national requirement to have plans in place to extend the ages for breast screening and to introduce digital equipment. The work was completed and the findings are being used to inform the commissioning of breast screening services from 2010/11 onwards;
- Securing a static breast screening site at the Primary Care facility in the centre of Wakefield; and,
- Agreeing the Abdominal Aortic Aneurysm (AAA) screening footprint.

In 2010/11 we will:

- Lead collaborative work in relation to Retinal Screening Services;
- Commission the (AAA) screening programme for men 65 years;
- Commission breast screening, age extension and static site provision in line with national requirements; and,
- Extend bowel screening to men and women aged 70 – 75 years.

## **2.23 Palliative Care and End of life pathway programme**

This programme will provide the strategic framework for commissioning end of life care for patients with either malignant or non malignant diagnosis.

In 2009/10 our key achievements were:

- Developing “The Bridge” pilot bereavement project as an output from the end of life locality groups work on prioritising the End of Life pathway implementation. The project is a partnership project with Age Concern and other voluntary organisations;
- Developing of the End of life Care Strategy using the feedback from some of our more excluded communities;

- Participating in the National after Death Analysis Audit of the use of the Gold Standards Framework in primary care. 83% of practices participated which was the second highest participation rate in the country. The audit recommendations will inform 2010/11 actions;
- Securing a dedicated Primary Care Palliative Care and End of Life GP lead post; and,
- Participating in the sub-regional End of Life Group and developed a Wakefield District draft Palliative Care Strategy.

In 2010/11 we will:

- Take forward the key recommendations from the National Audit of the Dying;
- Complete a strategic review of all palliative care and end of life provision in the District and undertake an evaluation of year one of the Bridge Bereavement Project;
- Participate in the SHA End of Life Care Social Marketing project (one of only three PCTs involved in the project);
- Complete and implement the Palliative Care and End of Life Service specification and ensure robust contract monitoring and evaluation mechanisms are in place; and,
- Make available the palliative care component of “SystemOne” to general practice.

## **2.3 Adults**

The Adults Portfolio has a broad focus that includes commissioning for prevention, mental health and vulnerable groups.

### **2.31 Reducing Smoking during Pregnancy**

In 2009/10 our key achievements were:

- Securing funding for an extra specialist smoking in pregnancy adviser;
- Launching our quit 4u2 programme using social and marketing research to encourage and support pregnant mothers to quit using advertising, a magazine, website and texting;
- Training all midwives in brief interventions around smoking; and,
- Launching our significant other supporter scheme.

In 2010/11 we will:

- Reduce the number of women smoking in pregnancy to 21%;
- Support mothers who quit till the end of pregnancy;
- Undertake some participatory research into why referred patients do not participate in a quit attempt;
- Encourage primary care to give brief advice and support to pregnant women;
- Continue our Significant Other Supporter Scheme subject to positive evaluation of the pilot; and,
- Reduce smoking prevalence in our population.

## 2.32 Smoking Quitters

This is a new WCC priority for the PCT and in 2010/11 we will:

- Increase the rate per 100,000 of smoking quitters aged 16 and over from a 2008/9 baseline of 1152/100,000 (3007 quitters) to a rate of 1279/100,000 (3434 quitters)
- Implement our smoke free action plan;
- Train a higher percentage of front line staff in brief advice;
- Train Health Trainers as smoking advisers;
- Respond to the findings of smoking health equity audit which is currently underway;
- Increase the availability of smoking cessation advisers and the venues across district; and,
- Set a quitters target for PMS practices to achieve.

## 2.33 Childhood Obesity

In 2009/10 our key achievements were:

- Drafting the *Healthy Weight, Healthy Lives* strategy with partners;
- Improving nutrition through implementation of schools standards;
- Increasing physical activity in schools to levels above the England average;
- Increasing breastfeeding uptake;
- Commissioning breastfeeding support through Little Angels;
- Increasing personalised support through Connect3 to include under 8's, children with learning disabilities and children from ethnic groups;
- Commissioning our 3 rugby league clubs to deliver healthy lives messages to all schools; and,
- Halting the increase in prevalence.

In 2010/11 we will:

- Reduce the number of obese children in reception from a baseline of 9.5% to 9.3% (293 children)
- Continue to commission the rugby league schools to deliver healthy lives messages;
- Undertake participatory research into those who do not take up the offer of Connect 3 or do not complete the programme;
- Continually improve the delivery of Connect3 personalised weight management services to children;
- Deliver and evaluate the projects commissioned through the Three Areas Project; and,
- Implement our Healthy Weight Healthy Lives Strategy and action plan.

## 2.34 Mental health

Approximately 15,000 health contacts take place in a secondary care mental health setting with approximately 12000 contacts per annum in the Child and Adolescent Mental Health Services (CAMHS).

In 2009/10 our key achievements were:

#### Adult Services

- Implementing the Adult Attention Deficit Hyperactivity Disorder (ADHD) service which commenced taking patients in April 2009;
- Procuring Improved Access to Psychological Therapies (IAPT) through a significant procurement process where a third sector organisation was chosen as our partner to deliver;
- Re-providing low-secure forensic services for people with learning disabilities;
- Decommissioning a 12-bed residential rehabilitation unit with reinvestment of the funding into an enhanced intensive rehabilitation service;
- Implementing a dedicated mental health crisis support team in the A&E departments at the local acute Trust; and,
- Investing in clinical psychology to address waiting list issues working towards achievement of the 18-week guarantee.

#### Child and Adolescent Mental Health Services

- Reducing the number of occupied bed days in in-patient units resulting in a cost saving to the PCT;
- Improving significantly the waiting times for access to services; and,
- Advancing the implementation of the 'Targeted Mental Health in Schools' agenda in partnership with WMDC.

In 2010/11 we will:

- Increase (all-basis) acute mental health in-patient service productivity, continuing to reduce average lengths of stay for local people;
- Provide all mental health care as close to home as possible;
- Work with provider partners to extend and enhance the IAPT service model, including the identification of 'medically unexplained symptoms', and the availability of *SHARP* (Self Help in Routine Primary Care) as a resource for primary care clinicians;
- Develop new and innovative solutions to the problems caused by worklessness and debt, jointly with our Local Authority; and,
- Explore opportunities work with the acute sector to improve recognition of, and access to specialist services for people with dementia.

### **2.35 Prison Health services**

Our two local prisons are HMP & YOI New Hall (a female prison for juveniles, young offenders and adults) and HMP Wakefield (a high security prison for men). Wakefield district has a disproportionately large local prison population relative to other comparable areas. In addition, the prisons accept prisoners with complex and serious health problems. This leads to unpredictable demand, high levels of need, and high costs. There is also a very high prevalence of long-term conditions, serious mental disorder, and substance misuse within the prisoner populations. Our commissioning programme aims to address this by improving the health of this vulnerable group through transforming offender health commissioning and provision.

The Offender Health Commissioning Programme is captured within the scope of the local strategy for transforming primary care and community services, and will deliver the continued development of primary care services within the prisons.

In 2009/10 our key achievements were:

- Transforming prison healthcare through continued development of primary care services and an increase in services traditionally provided in secondary care within the prisons. This has led to an improvement in the quality of services provided. Prisoners now experience seamless healthcare, improved access to health services and improved services for long term conditions. In addition, reductions to the level of escorts and bed watches have led to cost improvements;
- Developing prison telemedicine in the women's prison with a tele-link between the prison and an acute hospital; and,
- Developing an innovative custodial care integrated service for the care and management of vulnerable female prisoners which included a partnership agreement to manage risk in terms of hospital escorts and bed watches.

In 2010/11 we will:

- Focus on commissioning a comprehensive range of health services for prisoners, equivalent in terms of access to services, quality of provision and value for money to the health services which people in the local community receive in Wakefield District; and,
- Tender for an integrated prison mental health service for prisoners. This is a live tender and NHS Wakefield District expects to procure a provider of a new integrated mental health services for prisoners by December 2010.

## **2.4 Unplanned Care and Long Term Conditions**

The Unplanned Care and Long Term Conditions (LTC) Portfolio aim to deliver better health care and care 'closer to home' for people living within Wakefield district by ensuring that:

- Patients receive a timelier, consistent, effective and seamless response to their expressed need by delivering the right care, in the right place, by a person with the right skills; and,
- Those people with a long term condition are more in control of their condition and have access to a range of high quality services which offer more personalised care closer to their home and which reduces their reliance on episodic and unplanned secondary or institutional care.

## 2.41 Unplanned Care Programme

This programme will provide the strategic framework for commissioning of all unplanned care services i.e. ambulance, urgent care (out of hours) and A&E.

In 2009/10 our key achievements were:

- Opening a GP-led health centre in Wakefield, providing 'walk-in' minor illness services from 8am to 8pm, 7 days a week, improving patient access to 'urgent care';
- Commencing the newly procured West Yorkshire-wide urgent care service ensuring that the urgent care system responds consistently and appropriately 24 hours a day, 7 days a week;
- Commissioning and implementing a new integrated nurse led primary care service at the Pinderfields General Hospital Emergency Department. The service is for patients presenting with a primary care need, in particular those with a minor illness and operates from 10.00am to 10.00pm. 7 days a week thus providing additional clinical capacity at peak times;
- Reducing significantly the number of calls received by the Yorkshire Ambulance Service (YAS) from frequent users as a result of the PCT's frequent callers report and the subsequent development of a systematic process to address the care needs of these patients;
- No increase in demand for emergency ambulances within the Wakefield District in the year to date against a backdrop of significant demand increases (approx 4.3%) across the region as a whole; and,
- Improving performance for the 4 hour A&E target in comparison with 2008/09.

In 2010/11 we will:

- Ensure that all GP practices/primary care services have systems in place for same day urgent care primary care access;
- Utilise Practice Base Commissioning as a lever to encourage clinical ownership of emergency admission activity by practices;
- Focus on reducing the overall time it takes an ambulance to have handed over patient at hospital and be ready for next journey (turnaround time), to increase resource availability to meet YAS key performance indicators and clinical performance indicators;
- Develop alternative pathways to hospital conveyance by analysing YAS data; and,
- Develop and implement an agreed admission and discharge protocol for emergency admissions jointly with Practice Based Commissioners and Mid Yorkshire Hospitals Trust.

## **2.42 Out of Hospital Care Programme**

This programme will provide the strategic framework for commissioning of out of hospital care incorporating intermediate tier services.

In 2009/10 our key achievements were:

- Implementing the recommendations of the Intermediate Tier Review to support the HDP and reduce costs via reduced admission tariff and excess bed days;
- Securing additional transport for existing provider contracts meaning that patients are now better able to access community based alternatives;
- Commissioning a community based adult speech and language therapy and dietetics to support early discharge and prevent unnecessary hospital attendances;
- Commissioning a further 28 intermediate tier beds in a non-acute setting to support step-up and step-down patients for a range of pathways/ conditions and freeing up acute beds in MYHT;
- Securing an additional Community Geriatricians to provide a service in a number of care settings;
- Completing a service review of the current Intermediate Tier Beds in light of DH guidance (Intermediate Care – Halfway Home 2009);
- Completing a service review of Single Point of Contact (SPOC) in line with TCS timeframes; and,
- Working with the Local Authority, Mental Health Trust and local housing organisation to develop 13 Integrated Networks across the district.

In 2010/11 we will:

- Continue to develop the 13 Integrated Care Networks across the district;
- Continue to implement a community rehabilitation service for all LTCs, including redesigning "front-end" triage and assessment by primary care nurses of all GP referrals to the Acute Trust with a view to sign-posting to Community Based Alternative Services (CBAs).;
- Re-procure 70 Intermediate Tier beds to replace and increase the capacity of current provision; and,
- Following a service review of the Single Point of Contact (SPOC) evaluate the recommendation for reconfiguration through the Transforming Community Services (TCS) working group to ascertain the future model of delivery.

## **2.43 Long Term Conditions Programme**

This programme will provide the strategic framework for commissioning of services for those with long-term conditions excluding cancer and mental health.

### **Respiratory Disease**

Our key achievements in 2009/10 were:

- Developing the community respiratory service to provide services for all long term respiratory conditions (excluding lung cancer); including specialist services such as nebuliser, oxygen assessment and monitoring, diagnostics, self management

advice and support, a 24 hour advice line; and developing better and more effective collaboration across interdisciplinary teams and integrated networks;

- Health forecasting information for patients;
- Investing in long term community rehabilitation;
- Increasing the capacity of the community-based service delivering evidence-based exercise and education programmes for patients with COPD with an MRC dyspnoea score of 3 and above;
- Further investing in the End of Life Breathless Management;
- Increasing capacity and skills in community rehabilitation to support respiratory, pulmonary rehabilitation, cardiac rehab, neurological conditions and falls; and,
- Commissioning a community respiratory service team.

In 2010/11 we will:

- Reduce recorded COPD mortality from its 2006/07 level of 41.2 to 35.42 deaths per 100,000. We will also reduce emergency admissions for COPD, as reported in bed days, to 7,688 and increase the number of people enrolling for health alerts by 1,000;
- Further develop the community respiratory service to provide services for all long term respiratory conditions (excluding lung cancer);
- Further roll out of health forecasting information for patients so that they know when air quality may affect their health so they can take steps to cope with it;
- Increase the capacity of the community-based service delivering evidence-based exercise and education programmes for patients with COPD with an MRC dyspnoea score of 3 and above;
- Improve access to symptom management programmes and reduce inappropriate respiratory admissions through the End of Life Breathless Management Programme;
- Continue to promote early diagnosis and COPD case finding, in line with the expected recommendations in the forthcoming COPD national strategy;
- Ensure high quality and evidence based respiratory care by implementing agreed clinical guidelines and commissioning respiratory training and development; and,
- Conduct an asthma health needs assessment.

## **Circulatory Disease**

Our key achievements in 2009/10 were:

- Developing a cardiovascular risk assessment service in primary care to assess 40% of patients aged between 40-74 years (50,000 patients); and,
- Commissioning an integrated and coordinated cardiology services delivered in community and secondary care settings to provide additional capacity.

In 2010/11 we will:

- Reduce under 75 CVD mortality to 70.2 deaths per 100,000 from 89.12 per 100,000 in 2007; and reduce all age CHD mortality from 107.40 deaths per 100,000 in 2007 to 80 per 100,000. 80.1% of stroke patients will spend at least 90% of their time on a stroke unit;
- 60% of people who have a TIA will be scanned and treated within 24 hours;

- 30% annual reduction in admissions and readmissions for heart failure in those on the heart failure nurse caseload;
- A further 20% of eligible patients between 40-74 receiving an NHS Health Check;
- Commission an implantable cardiac device service at MYHT including additional nursing capacity to support arrhythmia/heart failure patients, in support of NICE guidance;
- Closely collaborate with the West Yorkshire Stroke Network, developing a hyper acute stroke pathway and offering a stroke service, 8am to 8pm, 7 days a week;
- Improve access and providing timely care closer to home by commissioning a Percutaneous Coronary Intervention (PCI) service at MYHT (currently provided at Leeds for Wakefield patients);
- Commission integrated and coordinated cardiology services delivered in community and secondary care settings to provide additional capacity, improve access to diagnostics and care closer to home;
- Commission the Abdominal Aortic Aneurysm screening programme;
- Review the post discharge patient pathway after stroke to ensure seamless transfer of care and co-ordinated rehabilitation; and,
- Encourage primary care to identify all patients with atrial fibrillation and optimise medication.

## **Diabetes**

Our key achievements in 2009/10 were:

- Strengthening care for those with diabetes within primary care by redesigning the diabetes service;
- Developing a highly skilled primary care workforce to work in an integrated way with specialist diabetes teams;
- Ensuring education programmes were accessible to 90% of people with diabetes;
- Offered all patients diabetic retinopathy screening; and,
- Ensured that 79% of all diabetes patients will be cared for in primary care.

In 2010/11 we will:

- Increase the percentage of patients with diabetes whose HbA1c is 8% or less from a target of 71% in 2009/10 to 73%;
- All patients will be offered diabetic retinopathy screening;
- 80% of all diabetes patients will be cared for in primary care;
- Continue to implement the diabetes service redesign and conduct an interim evaluation of the service from both health care professionals and patients who have used it;
- Continue to support primary care colleagues with regard to education and training in order to develop a highly skilled workforce;
- Continue to deliver on the Diabetes Education Strategy, ensuring that education programmes are accessible to 90% of people with diabetes, supported by an education strategy for health care professionals and the delivery of health care professional education and support;
- Implement a self referral scheme for people with diabetes to refer into the DESMOND modules;

- Share learning from the Care Planning pilot and looking towards further 'roll out' to other practices; and,
- Disseminate and promote the revised District Diabetes Guidelines and Integrated Pathways (2009) in line with new NICE Guidance.

## **2.44 Other Long Term Condition Programmes**

In 2010/11 we will:

- Reduce the number of acute hospital emergency bed days from a target of 214,039 in 2009/10 to 209,458;
- Implement a community rehabilitation service for all LTCs, including redesigning sub-acute beds and step-down beds;
- Commission GP Health Checks for people with severe learning disabilities, including a comprehensive health needs assessment and using community development to connect people with learning disability with their communities;
- Further develop 'self-management' to support individuals with long term conditions, introducing a self management tool kit for professionals and self management plans for patients, supported by information prescriptions;
- Assess the needs of patients with chronic kidney disease and commissioning enhanced model of renal care in order to provide services closer to home and reduce unnecessary out-patients appointment;
- Taking forward joint work via the Healthier Communities Fund to implement the local action plan for Carers with particular reference to work with Primary Care;
- Progress an integrated approach to the commissioning of falls and bone health services and pathways across the Wakefield health economy, in order to reduce falls and fractures and strengthen bone health amongst people living in Wakefield;
- Continue to support the improvement of healthy ageing focusing on prevention and influencing attitudes and behaviours to health, including focused and co-ordinated support for Carers, promotion of physical activity opportunities, promotion of health improvement activities, and a programme of support for people to manage their long term conditions in the community, thereby promoting independence; and,
- Consolidate and evaluate prevention and early intervention initiatives to prevent conditions worsening, and/or causing complications by developing integrated health and social care networks.

## **2.5 Children, Young People and Maternity**

The Children, Young People and Maternity Portfolio Group is committed to delivering the right start for healthier communities within Wakefield by ensuring all women, children and young people have access to high quality services and personalised care, which supports them achieving their best possible outcomes.

### **2.51 Maternity and Newborn Care**

Our key achievements in 2009/10 were:

- Achieving very high performance in assessing expectant mothers by 12 weeks of pregnancy (in excess of target);

- Increasing midwifery levels enabling achievement of improved midwife: pregnant woman ratio;
- Improving the 6-8 week breastfeeding initiation rates and achieving a high level of data completeness; and,
- Becoming the first district in the SHA region to successfully implement the Combined test for Down's Syndrome.

In 2010/11 we will:

- Implement the Newborn Physical Examination in line with NSC Guidance;
- Continue to audit Newborn Bloodspot Screening performance and act on findings to improve the service;
- Consolidate and further improve breastfeeding rates; and,
- Implement a Maternity Support Worker service to assist in effectively utilising the skills of qualified midwives.

## **2.52 Children and Young People**

Our key achievements in 2009/10 were:

- Increasing the number of people screened for Chlamydia;
- Achieving reductions in the proportion of children who are overweight or obese;
- Re-establishing a downward trajectory in teenage conceptions – based on 2008 conceptions reported in 2009;
- Completing an extensive Health Related Behaviour Questionnaire in children and young people in school years 6,8 and 10 which will be used to underpin school based health service delivery ;
- Reviewing Paediatric Therapy provision with recommendations which will inform TCS;
- Making excellent progress in implementing the Child Death review processes. These are now fully embedded; and,
- Increasing the Children's Public Health workforce.

In 2010/11 we will:

- Ensure the Children's Public Health workforce is effective in improving health outcomes in line with the expectations in the Healthy Child Programme;
- Sustain the downward trend in teenage conceptions;
- Complete a comprehensive Children and Young People's JSNA;
- Consolidate the significant improvement in CAMHS delivery through the development of a community based CAMHS forensic service; and,
- Further reduce levels of overweight and obese children.

## **2.6. Primary Care**

Our key achievements In 2009/10 were:

- Successfully engaging PBC in delivering the PBC strategy, re-energising PBC, enhancing clinical engagement within the PCT and the service priorities for change over the forthcoming year;
- Developing GP Led Health Centre;

- Commenced a comprehensive PMS review;
- Over achieving on target for GP extended hours; and,
- Gaining an excellent Primary Care response to the Swine Flu (H1N1) Pandemic including the development of GP clusters to maintain business continuity and the availability of anti-virals through community pharmacies.

In 2010/11 we will:

- Continue to develop services and registrations at the King Street GP Led Health Centre (GPLHC) and to focus on access to services for walk in and unregistered patients;
- Complete PMS contracts review with specific emphasis on improving access to GP services and reducing Health Inequalities. Issue the revised PMS Contracts to Practices;
- Review of all Local Enhanced Services for 2010-11 to be completed. Specific services to be included in the revised PMS contract;
- Review of GP and Primary Care services in Castleford;
- GP Extended Hours LES will continue in 96% of Practices. National baseline funding already fully committed to this scheme and also to the 7 day per week, 12 hour per day pre bookable and Walk In service at King Street GPLHC.
- Continue to develop additional capacity to meet Vital Signs for Dental Services;
- Develop and implement additional contract management and monitoring for General Dental Services and Personal Dental Service contractors to ensure they demonstrate value for money, improved access and to achieve vital sign trajectories;
- Develop Pharmaceutical Needs Assessment programme in line with national and local targets and timescales;
- Complete Electronic Prescription Service, release 2, project to meet implementation date of 30 September 2010;
- Ensure that the remaining Pharmaceutical budgets devolved to PCT's are appropriately managed and monitored;
- Implement additional Enhanced service to pharmacists recently agreed on MRSA and to consider additional in conjunction with the LPC;
- Ensure that devolved ophthalmic budgets for 2010-2011 are appropriately managed and monitored; and,
- Work with other PCT's across West Yorkshire to explore opportunities to optimise and develop work with West Yorkshire Central Services Agency.

## **SECTION 3 FINANCIAL PLANNING**

### **3.1 Financial background**

NHS Wakefield District has a robust record of sound financial management and an underlying balanced position. This section provides a comprehensive overview of financial planning in 2010/11.

The PCT has made surpluses in each year since its inception and has proposed a contribution of £6.2m to the SHA Strategic Investment Fund (SIF).

In 2008/09 the PCT secured a score of 2 within the new Use of Resources assessment process and is striving to achieve a 3 in the 2009/10 assessment process.

The PCT also achieved a green rating on financial governance from the World Class Commissioning independent review panel in 2008/09 and the current assessment for 2009/10 continues to be green subject to evaluation

### **3.2 Financial income assumptions**

The 2010/11 allocation included within the plan is per the notified allocation. For the two years, 2009/10 - 2010/11, the PCT's allocation has increased by £66,463m (12.6%).

For 2010/11 growth is £31,025m (5.5%), providing a recurrent baseline of £595,118m. The PCT is planning for the £5m balance in the SIF to be returned, and there are other non recurrent allocations which bring the total resources for 2010/11 to £628,010m. The PCT is also planning to make a surplus of £6.2m and will deploy £3.1m of this non -recurrently. Planning assumptions are shown below.

#### **Planning assumptions**

- Uplift on tariff is 0%, and 1.5% for Quality and Innovation. 0% has been assumed for non-tariff services.
- The PCT plan meets the 3.5% national efficiency target on tariff , and 1% dental and GMS/PMS efficiency
- Prescribing inflation is included at 5%, in line with national guidance.

### **3.3 Expenditure**

The PCT has revisited the Commissioning Intentions proposed for 2010/11 in the Strategic Plan, based on forecast outturn assumptions for 2009/10 and a robust deliverability review. Cost pressures and developments are reflected within the relevant budgets following a PCT business planning process considering all commissioning intentions to meet demand, local targets and achievement of Vital Signs.

<b>Programmes</b>	2009/10	2010/11	2011/12
	£`000	£`000	£`000
Reducing Smoking during Pregnancy *	0	0	0
Childhood Obesity	770	800	900
Respiratory Disease	513	689	689
Circulatory Disease	2,475	1,377	1,377
Staying Healthy	3,845	2,981	3,320
Diabetes	645	847	947
Long Term Conditions	4,850	4,178	4,228
Maternity and Newborn	800	1,600	2,000
Children	2,595	2,875	3,800
Planned Care and Cancer Care	5,671	5,515	5,450
Acute Episode	1,900	1,970	1,970
Mental Health	2,547	2,494	2,999
End of Life	570	545	570
Reconfiguration of Acute Services	0	0	0
<b>All Programmes</b>	<b>17,376</b>	<b>25,871</b>	<b>28,250</b>

\* Funding for this programme is part of the Staying Healthy funds for overall smoking reduction.

Investment is also associated with MYHT to support improved coding and with SCG to support service developments.

### 3.4 Contracts and activity

Contracts for 2010/11 are based on securing and maintaining targets and standards during the year.

### 3.5 Capital

The PCTs capital allocation for 2010/11 is £1.2m. The majority of the 2010/11 allocation is being utilised to complete a planned short breaks development which commenced in 2009/10 plus the completion of the GP Led Access Centre which also started in 2009/10.

The PCT is planning to dispose of three health centres which may generate further resource being made available in 2010/11.

### 3.6 Cash

The PCT is planning to live within its cash limit and to fund its plans from internally generated resources.

NHS Wakefield District continued to invest in Safeguarding Children and safeguarding adults with the appointment of a Head of Safeguarding, the strengthening of the Safeguarding Children department with a secondment of a specialist practitioner, and an increase in the number of trained supervisors for Safeguarding Children. This has enabled the organisation to increase the provision of training for trust staff, and provide additional support and supervision for key personnel.

## SECTION 4 Supporting Activities and Themes

### 4.1 Commissioning for Quality

In 2009/10 our key achievements were:

- Board engagement and commitment to the *High Quality Care for All* agenda and the three dimensions of the Darzi triangle – ensuring care is safe; clinically effective; and provides patients with the most positive patient experience. Quarterly reports on commissioning for quality have been integrated into the Commissioning and Performance Report to the Trust Board;
- Commissioning for Quality and Patient Safety Group established to ensure providers have robust clinical governance arrangements in place and ensure commissioning decisions are based on evidence of effectiveness;
- Local Quality Framework developed with MYHT in 2008/09, which financially incentivised the Trust in such areas as healthcare associated infections, access and booking and local quality indicators were rolled forward into the 2009/10 contract. The majority of these indicators are now part of the Yorkshire and Humber Quality Assurance and Improvement Scheme, the mechanism to deliver the national Commissioning for Quality & Innovation (CQUIN) policy for 2009/10;
- Director-level Quality Boards with MYHT has further developed to be a more effective and functioning group, and Quality Boards with WDCHS and SWYFT as part of the formal contracting arrangements have been set up;
- Quality and Regulation is included in all service specifications and specific quality standards are added dependent on the service;
- Action plans linked to the privacy and dignity agenda, including mixed sex accommodation, feedback from patient surveys and the productive series, have been developed;
- Stage Two accreditation for specialist or traditionally secondary care services delivered in primary care, to ensure appropriate competence, quality and safety standards are met;
- Quality assurance visits for non-NHS providers being undertaken to ensure that services meet required standards, and patients receive high quality care and
- Agreed an action plan with MYHT to deliver same sex accommodation (DSSA) by March 2010. MYHT have successfully implemented a daily breech reporting system, enabling evidence of compliance to be monitored, early identification of problem areas and quick resolution and investigation of potential incidents/complaints. This system has been recognised as good practice regionally.

In 2010/11 we will:

- Continue to report to the Board on a quarterly basis, strengthening reporting to evidence improvements in quality outcomes quantitatively wherever possible;
- Continue to develop the role of the Commissioning for Quality and Patient Safety Group to provide organisational assurance of the quality of services commissioned;
- Develop and implement a robust local CQUIN scheme in line with guidance for 2010/11 which supports the delivery of QIPP as well as improving the quality of care for patients. The local scheme will be run in tandem with the Yorkshire and Humber Quality Assurance and Improvement Scheme;

- Develop a programme of topic-specific areas of discussion for the quality boards and establish the offender health quality board;
- Further develop the quality assurance framework for all non-NHS providers, and integrate accreditation and re-accreditation and quality assurance visits into the framework; and,
- Establish quality profiles for each provider to give commissioners intelligence in one place on areas of quality, risk and safety.

#### **4.11 Health Care Associated Infection (HCAI)**

Key achievements in 2009/10 were:

- Significant improvements, and therefore, reduction in the number of patients with MRSA bacteraemia. Development of a screening and decolonisation policy and the implementation of the process have gone well. The PCT monitors performance against this and areas of the Hygiene Code at the Health Economy HCAI Strategy meetings;
- The rate of Clostridium Difficile amongst the population has also been monitored and is within agreed trajectories for 2009/10;
- Two significant assurances from the Department of Health (DH) and Strategic Health Authority (SHA) are; further evidence on the improvements being made, the robust governance arrangements and the implementation of actions from the outcomes of root cause analysis findings;
- DH exited the support being provided to Mid Yorkshire Hospitals Trust (MYHT)
- NHSWD successfully undertook the DH HCAI review;
- Our approach to minimising HCAI and governance arrangements has been identified as good practice; and,
- NHSWD is now working with the DH in providing advice and support to NHS organisations specifically on the commissioning role of the PCT in regard to HCAI.

In 2010/11 we will:

- Revise the health economy plan to embed the learning and support the further reduction of HCAI required;
- Continue to implement screening and decolonisation plan for MRSA to include screening of emergency admissions; and,
- Continue to review and monitor the infection prevention and controls process and outcomes through the local health economy Strategic and Operational meetings with our commissioned services. This will include monitoring against MRSA and C.diff trajectories to ensure current trajectories are maintained, monitoring MRSA screening for elective procedures and monitoring compliance with infection prevention and control audits, and uptake of infection prevention and control training.

## **4.12 Safeguarding**

Our key achievements in 2009/10 were:

- NHS Wakefield District provider declared compliance with the CQC standard C2; and,
- Work undertaken through the year has provided assurance to the Strategic Health Authority in relation to the findings of the Laming Inquiry (post baby P).

In 2010/11 we will:

- Strengthen commitment to the Local Safeguarding Children Board with the involvement of the Lead Director, and the supporting of a Local Medical Committee representative;
- Provide of regular reports to the PCT Board highlighting Safeguarding Children performance in services commissioned by the PCT;
- Provide additional support to Primary Care and the Third Sector to assure their performance in Safeguarding Children;
- Develop a Safeguarding Forum within provider services to assure Safeguarding Children and Safeguarding Adults performance;
- Ensure inclusion of Safeguarding Children and Safeguarding Adults responsibilities in contracts subject to renegotiation; and,
- Develop a Safeguarding Children specification to underpin all service delivery.

## **4.2 Information Management and Technology**

Our key achievements in 2009/10 were:

- Supporting the implementation of the Care Records Service (CRS) to improve operational efficiency and improve patient safety during 2009/10;
- Realising more benefits from SystmOne as a clinical information system rather than an activity recording system;
- SystmOne used by the new Equitable Access Centre and the West Yorkshire Urgent Care Service, improving both access to clinical information and communication with GPs using SystmOne and WDCHS;
- Positive changes in the referral management process for the Community Nursing Service via the Single Point of Contact, and a set of approved care plans have been implemented for use by the 13 community nursing teams working across the district.
- Implemented SystmOne at Mid Yorkshire Hospitals Trust to support the delivery of palliative care services and.
- The implementation of the Summary Care Record has been underpinned by the ongoing support to practices to achieve data accreditation; currently 76% of practices have achieved this standard with a target of 100% by the end of March.
- Implementation EMIS Web Access to provide equivalent reporting capability for our 16 practices that use an EMIS system significantly improving transfer of intelligence with GP practices;
- Migrated a further 5 practices to SystmOne, increasing the total of practices using SystmOne to 24;

- Implemented SystemOne in the Wakefield and Prince of Wales Hospices to facilitate the delivery of integrated palliative care services with appropriate information sharing; and,
- Uploaded key information from 22 practices to the Summary Care Record system in, thereby extending access to clinical information for patients requiring urgent care services and allowing patients to view their Summary Care Record.

In 2010/11 we will

- Provide A&E and MAU staff in Dewsbury Hospital with access to the GP record for patients registered with a practice using SystemOne in line with an agreed protocol and subject to the patient's consent to access their GP record. The benefits will be evaluated prior to the rollout being extended to Pinderfields and Pontefract Hospitals;
- Continue to implement the Care Records Service with a step-change in benefits realisation now that there is a critical mass of services using SystemOne;
- Extend the Palliative Care development to primary care services;
- Implement EMIS Web Access to provide equivalent reporting capability for our 16 practices that use an EMIS system;
- Implement the enhanced Data Sharing Model in SystemOne, which will facilitate information sharing in line with patients' preference, improve efficiency, effectiveness and patient safety;
- Implement the second stage of the Optimisation Project. WDCHS envisage particular benefits of having access to the GP record for practices using SystemOne or to the Summary Care Record for the remaining practices; and,
- Implement mobile technology for use by specific community services to improve access to information and facilitate the transition to electronic record keeping.

### **4.3 Intelligence and information**

Our key achievements in 2009/10 were:

- Developed our capacity and capability as part of our WCC approach
- JSNA refreshed and revised. Used to inform Transforming Community and Primary Care Services Strategic Plan and the PCT 2010/15 Strategic Plan;
- Commissioned a Children, Young People and Maternity Services JSNA;
- Completed a comprehensive Health Equity Audit to measure health outcomes and inequalities in Wakefield using information from a range of sources, showing analysis by geographical area, deprivation, disease type, and gender. This provides invaluable insight into the major causes of inequalities within Wakefield and highlights areas where health outcomes need to be improved;
- Commissioned a Health and Lifestyle Survey. Delivered to 85,000 households district-wide in June with a 30% response. Data being used to inform commissioning and target interventions;
- Provided detailed information by provider, activity type, specialty to Practice Based Commissioners on a monthly basis;
- Completed a comprehensive profile of cancer services showing health outcomes (mortality rates), referral rates, screening uptake, and expenditure based on programme budget categories, by geographical areas within Wakefield. This has enabled the PCT to better understand factors influencing health outcomes for cancer and can be used to highlight where resources need to be targeted;

- Strengthened our partnership with Wakefield Council by transferring management of the intelligence team to the Joint Public Health Unit;
- Significantly improved the level of information support to the commissioning Portfolio Groups in relation to outcomes, key indicators and activity trend including benchmarking against national and peer group (e.g. ONS cluster) averages; and,
- Commissioned the development of a Data Warehouse.

In 2010/11 we will:

- Continue to develop capacity and capability in line with WCC competencies;
- Implement the Data Warehouse;
- Complete Children's JSNA and disseminate findings;
- Undertake a pilot of an Asset Based JSNA in partnership with DH Inequalities Unit;
- Develop a robust approach to research governance and increase the research readiness of the PCT and our providers; and,
- Develop a transformational approach to demand planning.

#### **4.4 Patient experience**

In 2010/11 we will:

- Focus on developing our patient experience strategy and refine the mechanisms and processes used to deliver this to ensure patient experience is embedded in the commissioning cycle.
- Ensure we have effective systems in place to measure and improve patients' experience of local health services by working in partnership with our providers.
- Develop appropriate measures in provider contracts to ensure patient experience is monitored and continually improved, complimenting the introduction of CQUINS.
- Ensure patients' views and experiences are an integral part of work to develop service specifications for all community services
- Support the delivery of patient experience agenda through the PCT's Public Involvement & Patient Experience Committee (PIPEC); and,
- Deliver a quarterly report on all sources of patient experience data, including information from PALS, Complaints, NHS Choices, patient surveys and consultations will be received by PIPEC who will oversee actions to address key themes and areas for improvement.

#### **4.5 Involving and engaging our stakeholders**

Involving patients and the public in all aspects of our work is a key priority for the PCT, and at the heart of our aim to be an open, accountable and responsive organisation. As well as meeting our statutory responsibilities, we have set out to make this an integral part of our approach and ensure it forms the basis of all our commissioning activity.

Our key achievements in 2009/10 were:

- Implementation of our long-term listening programme called 'A Question of Health' to involve local people and patients in decisions relating to their healthcare. The first stages of this programme have provided a wealth of information that is being used to underpin our commissioning activity and work to improve health, helping to ensure services are tailored to meet local needs and to improve patient care; and,
- Leading the consultation on a proposal to create specialist centres for four areas of care at The Mid Yorkshire Hospitals. The work has been recognised as good practice by the local Overview & Scrutiny Committee and the independent analysts who assessed the responses.

In 2010/11 we will:

- Develop the programme to involve people in decisions regarding prioritisation of services and investment and to facilitate more in depth discussions on specific service areas and the development of service specifications for community services;
- Ensure effective involvement in the reviews of community services and development of service specifications, to support the delivery of our Transforming Primary Care and Community Services strategy
- Work with the community development team to develop a network of community ambassadors to help ensure the views of the more hard to reach groups are fed in to our commissioning activity;
- Continue to strengthen our relationship with the local LINK and explore how they can be more directly involved in the commissioning process and any consultations that take place;
- Lead consultation around review of MYHT plans drawing on the learning and successes of previous work, which was In addition to working with patients and the public, the PCT aims to engage all our partners and key stakeholders in our work, including our staff;
- Engage staff in the QIPP agenda;
- Improve the way we communicate with and engage our partners, including the community and voluntary sector, including the production of a stakeholder newsletter, the Ambassadors for Health programme where non-executive directors attend community group meetings to discuss local health issues, and improving channels and mechanisms for communicating with GPs;
- Provide more information on the outcomes of our work to improve health to key stakeholders;
- Deliver the next phase of the PCT's PPI strategy, which focuses on driving forward engagement in both commissioning and provider services, and developing staff capabilities to help embed PPI in their work;
- Ensure patient and public views inform the PCT's priorities and commissioning plans through the development and delivery of the next stage of the PCT's engagement programme; and,
- Continue to focus on working with service users to develop a more detailed understanding of their needs and views on specific services and areas of healthcare.

## 4.6 People and Organisational Capability

NHS Wakefield District is committed to working with providers and commissioners in its health and social care system on key workforce and employment issues that are system wide.

Our key achievements in 2009/10 were:

- A workforce risk assessment has been completed and a five year plan produced. This was done in conjunction with finance to ensure workforce plans for the next five years meet the financial resources available.
- Further developed the KSF Core Competency Framework thereby enabling the organisation to more fully assess roles to ensure they fulfil the needs of the organisation. The pilot has enabled the PCT to:
  - Embed a cycle of continuous quality improvement, raising standards of quality and performance in services, teams and individuals, in line with Quality;
  - Introduce a standardised approach to KSF incorporating core skills, competencies and learning and development;
  - Define and describe services in a practical way that demonstrates career pathways and progression routes;
  - Significantly improve the uptake of Joint Development Review against the 100 per cent target;
  - Assist with workforce planning, role redesign, introduction of new roles and skill mix;
  - Inform the commissioning of training so that it is more responsive to staff needs;
  - Links performance and personal development with team and organisational objectives;
  - Provides confidence for managers that their staff can deliver high quality care in a relevant and timely manner;
  - Provides clarity regarding rewards available in terms of role satisfaction and career progression; and,
  - Provides a starting point for further workforce planning, skill mix and service redesign and is currently being rolled out to the rest of the PCT.

Line managers are now using the competency frameworks with staff to measure and demonstrate improvements in the performance of individuals and teams through the JDR process.

In 2010/11 we will:

- Develop a district-wide Strategic Workforce Planning Forum has been established led by the PCT which includes representation from the PCT, Mid Yorkshire Hospitals NHS Trust, Wakefield District Community Healthcare Services and South West Yorkshire Partnership Foundation Trust. Plans to increase membership to include the Local Authority, University providers, Prison Services and Yorkshire Ambulance Service are currently being explored. The PCT sees the development of a strong workforce as a major component of its role as a local leader of the NHS and envisages that this type of forum will provide an opportunity to minimise duplication, identify workforce implications,

qualify, validate, prioritise and manage risks and increase collaboration across the local health economy;

- Review roles and capacity within the organisation in response to the requirement to save 30% on the management cost envelope put in place a number of initiatives to make the necessary savings;
- Establish a Strategic Unit to lead our work around secondary care capacity and longer term planning around the Mid Yorkshire health economy, and to support the commissioning aspects around transforming our provider services. These are business critical issues for us over the short to medium term, and we have recognised the need for some dedicated resource to focus on these areas. This Unit will be led by one of our existing Directors, and will be resourced by re-focussing the roles of some senior managers and seconding other staff into the Unit on a short term basis to take on focused responsibilities around these key strategic agendas. OD support will be provided to support team development around the new teams created by these changes;
- Focus on three core OD programmes, complemented by a range of other OD interventions to support the delivery of our Strategic Plan. The core programmes are Practice Based Commissioning; Information and Intelligence and Commissioning Portfolios OD project; and,
- Continue to provide strategic development activities detailed in our OD Plan.

Full details of these core programmes can be found in our Organisational Development Plan.

#### **4.7 Emergency Preparedness and Business Continuity**

Our key achievements in 2009/10 were:

- Significantly developed our capacity and capability as a Category One responder;
- Revision of the Wakefield District Pandemic Flu Plan in partnership with key stakeholders;
- Successfully leading the Wakefield District Swine Flu response;
- Playing a key role in managing the Wakefield response to the severe winter weather;
- Led a table top exercise 'Autumn Breeze' to test Wakefield District response to Pandemic;
- Developed Business Continuity Plans for all PCT services and those of WDCHS; and,
- All Directors, CE and other key senior managers undertaking GOLD training.

In 2010/11 we will:

- Lead a Wakefield District Multi Agency Pandemic review and report on the lessons identified from the Swine Flu Pandemic, including the vaccination delivery strategy. Lessons learned will provide the basis of an Action Plan which will be implemented throughout 2010/11;
- Reassess the potential risks for NHS Wakefield District including CBRN threats, fuel and supplies disruption, flooding and adverse weather; and,
- Revise and test command and control arrangements in conjunction with the Lead PCT, NHS Kirklees.

## 4.8 Community Development (CD)

Our Community Development team meaningfully engage with local people in order to unlock their potential and energy to become partners in improving health. Their work engages communities in their own health and well being and aims to develop their capacity to support change for healthier lifestyles. The team build partnerships between organisations and communities; and develop innovative practice for community based health improvement. Through this work they ensure sustainability through building the capacity of communities to take positive action for health improvement. Their work contributes to our JSNA through the use of qualitative and participatory research. engagement and asset based approaches.

Our key achievements In 2009/10 were:

- Aligning our work to the commissioning portfolios, the WCC competencies and priorities and to the local area agreement, our Wakefield Together priorities;
- Leading the training and development programme in participatory research methods for frontline staff across the district;
- Leading a participatory research project related to end of life, engaging excluded groups in the development of commissioning priorities;
- Developing over 300 local initiatives with communities and partners;
- Leading the development of a Well Being Consortium for the district. This will build the strength and infrastructure of the Voluntary Community and Faith sectors so that they compete as potential providers;
- Leading the development of the district wide Duty to Involve Strategy;
- Winning two national awards for innovation partnership working- 'Hot Spots' a project to address fuel poverty and 'Pugwash'- a health literacy project. Both projects were able to demonstrate more effective use of resources.
- Developing a successful Diversity and Racial Equality (DRE) project this project accesses vulnerable BME communities;
- Commissioning a debt counselling service in GP practices in response to local intelligence; and,
- Commissioning health inequalities case workers to work within Wakefield District Housing. This project gives us increased access to the most socially deprived people within our communities.

In 2010/11 we will:

- Continue to develop locally led health improvement initiatives;
- Develop a programme of community champions;
- Develop a network of clinical champions to support community development initiatives;
- Roll out the participatory research process to gain more insight into our communities and inform intelligent commissioning;
- Develop CD approaches to gain insight in relation to screening and early detection of cancers;
- Lead an asset based research programme which is a component of the JSNA refresh 2010/11;
- Support the development of a locally led health and well being project in conjunction with the mosques; and,
- Develop a business case for CD in response to the Marmot Review.

#### **4.9 Sustainability**

Following the publication of the NHS Carbon Reduction Strategy for England 2009 in response to the need to take action on climate change and setting the ambition for the NHS to play a leading and innovative role in ensuring the shift to a low carbon society.

Our key achievements in 2009/10 were:

- Establishment of Board approved multi directorate Sustainability Committee whose primary task is to co-ordinate the implementation of the Sustainable Development Management Plan and report to the board on progress;
- Identified key areas for action congruent with the Trusts overarching Sustainable Development. Key areas include energy and carbon management, procurement and food, low carbon travel, transport and access, water, waste, designing the build environment, organisational and workforce development, partnerships and networks, governance and finance;
- Recognition of the impact of energy use in its broadest sense and the impact this has on the organisation and members of the community especially relating to Fuel Poverty and Affordable Warmth which impacts upon the health of our patients;
- Utilising the Good Corporate Citizenship Assessment Model, a online resource designed to help NHS organisations assess and improve their contribution to sustainable development;
- Development a Quarterly monitor, review and report on carbon issue to Trust Board; and,
- Actively raising carbon awareness at every level of the organisation

In 2010/11 we will:

- Develop a Board Approved sustainable development management plan and have already started measuring and monitoring progress towards a 10% carbon reduction by 2015 using baseline data;
- Work in partnership with Wakefield Council in to plant trees as part of the NHS Forest Project;

- Incorporate sustainable development criteria within all its service contracts;
- Undertake surveys to look at replacing old, inefficient boilers and lighting;
- Re-launch the 'Lift Share' Scheme and a metro pass scheme where staff can travel by public transport and have the yearly amount taken from salary monthly; and,
- Develop a PCT Sustainable Development Plan Action Plan.

#### **4.10 Risk**

The PCT Board takes seriously the need for risk assessment and management of day-to-day activities and strategic issues. The PCT's Assurance Framework shows risks, the likelihood and severity of risks, and the controls and assurances in place. The PCT has a Risk Management Strategy which sets out the systems and processes in place that drives forward, manage and deliver the risk management agenda across all areas of the PCT.

The PCT has an organisational structure in place to help manage and implement risk management systems. The committee and reporting structures of the PCT are designed to work together to ensure a concerted and integrated approach to the management of risk.

The reporting structures include:

- The Trust Board
- The Governance Committee
- Audit Committee
- Risk Management Group/Health and Safety Committee
- Medical Devices Group
- Commissioning for Clinical Quality and Patient Safety Group
- Regulation and Performance Group
- Integrated Governance Group for WDCHS
- Emergency Preparedness Committee

Key risks and the assurances in place to meet them are given in the 2010/15 Strategic Plan.

## APPENDIX 1                      Mental Health

### Performance Overview

National Audit Commission benchmarking data shows that overall, the number of occupied bed days per 100,000 population for SWYPFT is about average.

The number of referrals exceeds the number of discharges in month 9. The trend to date has been for the number of referrals to be more than the number of discharges. Further work is planned in 2010/11 to understand demand and capacity & to drive up efficiency and productivity in line with QIPP.

National Audit Commission data shows that the number of admissions per 100,000 is slightly below average values (October 2009 Best in Class report).

Readmissions within 28 days, is a national indicator of the effectiveness of the community support provided following discharge. The October 2009 Best in Class report shows that the Trusts readmission rate is higher (upper quartile) than average. However, the average re-admission rate for mental health Trusts in Yorkshire and the Humber (Q2 2009/10) is 8.5%, in month 9 the Trust rate was 4.4%.

The majority of Trust services are provided within people's homes or in the community. 97.7% of their service users were managed within a community setting as at the end of month 9 with only 2.3% managed within an inpatient setting.

### Wakefield Month 9 Performance

Service Users Receiving Inpatient and Community Services (all Trust Services as at 31 <sup>st</sup> December 2009)						
Month 9				Year to date monthly average		
Number services users	Number Inpatients	Percentage Inpatients		Number services users	Number Inpatients	Percentage Inpatients
3092	57	1.8%	Calderdale	2986	54	1.8%
7120	91	1.3%	Kirklees	6965	99	1.4%
6225	108	1.7%	Wakefield	5972	110	1.8%
16635	385	2.3%	Trust wide	16095	394	2.4%

## Wakefield Month 9 Performance

Wakefield Only Adults of Working Age - Inpatient Acute Units					
Month 9	Plan	Actual	Wakefield 44 Beds	YTD Plan	YTD Actual
Occupied bed days	1032	1145		1032	1145
Bed occupancy	85%	84%		85%	85%
Average Length of Stay	30	41		30	30
Delayed transfers of care	<7.5%	2.3%		<7.5%	0.9%
Wakefield Only Adults of Working Age - Inpatient Non - Acute Units					
Month 9	Plan	Actual	Wakefield 15 Beds	YTD Plan	YTD Actual
Occupied bed days	499	277		499	303
Bed occupancy	85%	60%		85%	45%
Average Length of Stay	N/A	0		N/A	836
Delayed transfers of care	<7.5%	0%		<7.5%	0%
Wakefield Only Older People Services - Inpatient Acute Units					
Month 9	Plan	Actual	Wakefield 16 Beds	YTD Plan	YTD Actual
Occupied bed days	521	385		521	417
Bed occupancy	85%	75%		85%	77%
Average Length of Stay	65	66		65	63
Delayed transfers of care	<7.5%	0%		<7.5%	0%
Wakefield Only Older Peoples Services - Inpatient Non - Acute Units					
Month 9	Plan	Actual	Wakefield 40 Beds	YTD Plan	YTD Actual
Occupied bed days	1086	998		1086	1000
Bed occupancy	85%	80%		85%	83%
Average Length of Stay	N/A	94		N/A	28
Delayed transfers of care	<7.5%	1.3%		<7.5%	1.63%
Wakefield Only People with a Learning Disability Inpatient Unit					
Month 9	Plan	Actual	Wakefield 4 Beds	YTD Plan	YTD Actual
Occupied bed days	N/A	75		N/A	103
Bed occupancy	N/A	60%		N/A	85%
Average Length of Stay	N/A	217		N/A	186
Delayed transfers of care	<7.5%	16.1%		<7.5%	12.45%
HM Prisons – Forensic Services					
Month 9	Plan	Actual	HMP New Hall YOI	YTD Plan	YTD Actual
Discharges	TBD	42		TBD	38
Crisis visits	TBD	39		TBD	50
Referrals	45 – 70	34		405 – 630	626
Caseload	100 – 130	170		100 – 130	155
Month 9	Plan	Actual	HMP Wakefield	YTD Plan	YTD Actual
Discharges	TBD	0		TBD	4
Crisis visits	TBD	38		TBD	45
Referrals	5	3		45	81
Caseload	50 - 75	54		50 - 75	63

## **APPENDIX 2                      Benefits Management Realisation**

**Product:** Benefits Map

Purpose: demonstrates the relationship between benefits, outcomes and outputs so that benefits can be managed and tracked

**Product:** Benefits Profiles

Purpose: used to define each benefit (and any disbenefits) and provide a detailed understanding of what will be involved and how the benefits will be realised

**Product:** Benefits Realisation Plan

Purpose: Used to plan and then track realisation of benefits across the programme/project and set controls to keep on-track

**Product:** Benefits Progress Reports

Purpose: enables benefits to be measured and tracked during lifespan of project

**Product:** Benefits Evaluation Tool

Purpose: evaluates success of realising benefits by measuring against patient benefit, clinical benefit, national priorities, local priorities and financial benefit.

### **Risk Management**

**Product:** Risk Potential Assessment

Purpose: an early assessment of risk for your programme/project which enables early identification and mitigation of those risks up-front and in good time before any resources are committed

**Product:** Local Risk Register

Purpose: identifies project risks in terms of commissioning risks, measures and ranks the risks, produces mitigating/corrective action to be taken and review points – complies with NHSWD Risk Management Strategy

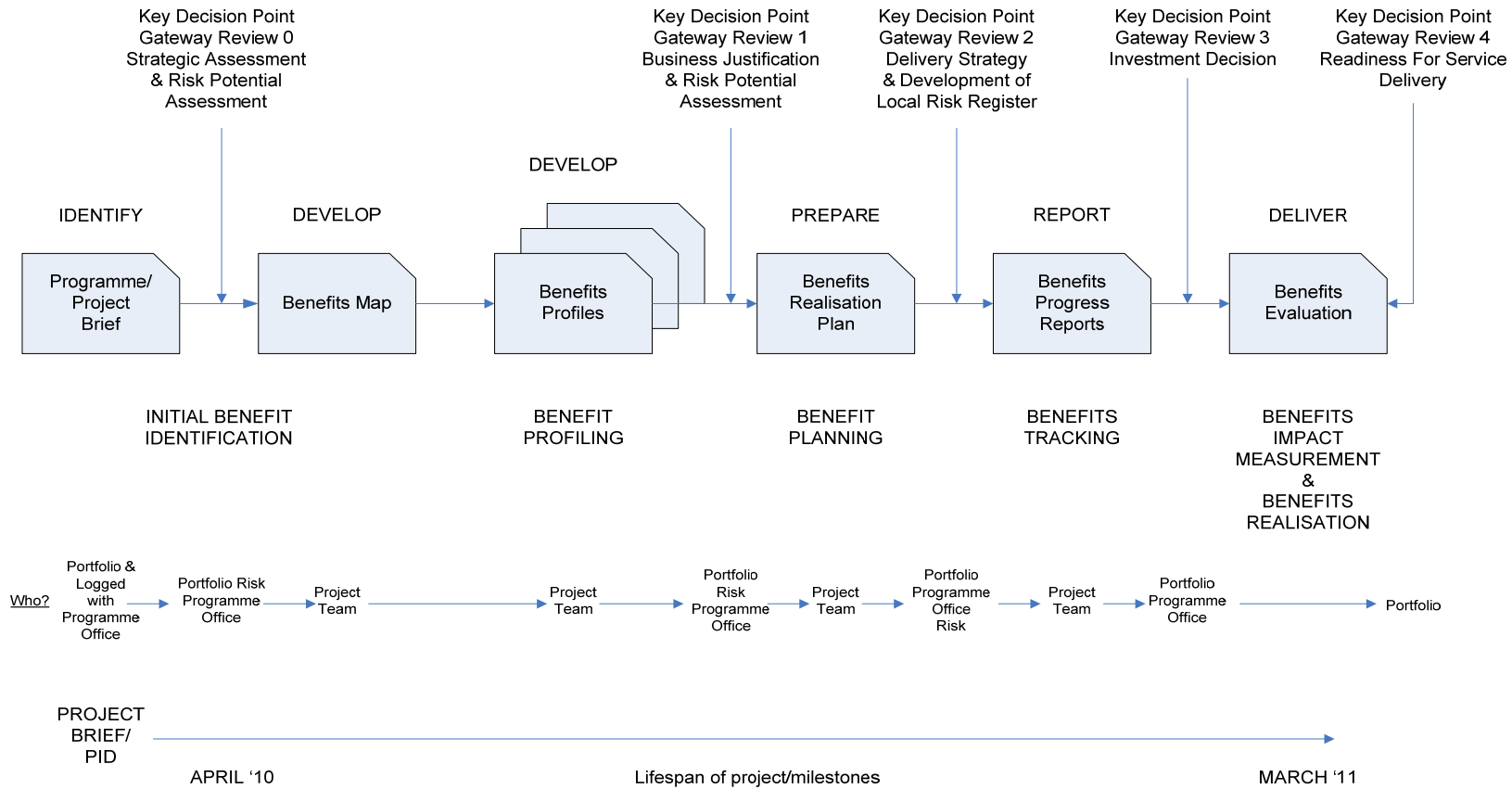
### **Gateway Reviews**

**Product:** Gateway Reviews

Purpose: provides timely reviews of progress of your project at specific key decision points during the lifespan of your project, i.e. GR 0: strategic assessment; GR 1: business justification; GR 2: delivery strategy; GR 3: investment decision; GR 4: readiness for service; GR 5: operations review and benefits realisation

## BENEFITS REALISATION MANAGEMENT PROCESS FOR INDIVIDUAL TRANSFORMATIONAL CHANGE PROGRAMMES AND PROJECTS

NAME OF PROGRAMME/PROJECT:  
 PORTFOLIO:  
 LEAD:



## **APPENDIX 3                      Performance Improvement Maps**

The piece of work outlined was developed to explore the following questions in relation to the WCC outcome measures but focused initially on the complex mortality targets to identify answers to the following:

- Do we know all the activities we are doing to achieve the required outcome and are they coordinated?
- Will more of the same improve the outcome?
- Are they the right things and are we currently doing them to the right magnitude with the necessary resources invested?
- What is the evidence base that tells us the actions we are doing will have the desired outcome?
- Is there anything else we should be doing
- Is anyone else doing it better and should we replicate this?
- Are we duplicating efforts across working groups, Portfolios, partnerships?

By mapping out all of the actions we have been able to identify gaps, have conversations about duplication and incorrect assumptions made about who is doing what and identify actions that will result in greater improvement that need to be pushed, harder, faster.

Mortality figures are commonly used as outcome measures for a number of disease areas such as Cancer, Cardiovascular Disease (CVD) and Chronic Obstructive Pulmonary Disease (COPD). Due to the data capture and information processing mechanisms used, validated and nationally standardised data is generally only available annually and there is an 18-19 month time lag between the reporting period and publication.

This makes it difficult to use as a performance mechanism. It has not previously been possible to identify local proxy measures that help to indicate the in-year performance and therefore the PCT has not been able to modify practice throughout the year to provide a better outcome. Performance Improvement Maps have been developed to address this.

Of the ten outcome goals outlined in the Strategic Plan, three are mortality based:

1. CVD Mortality
2. COPD Mortality
3. CHD Mortality

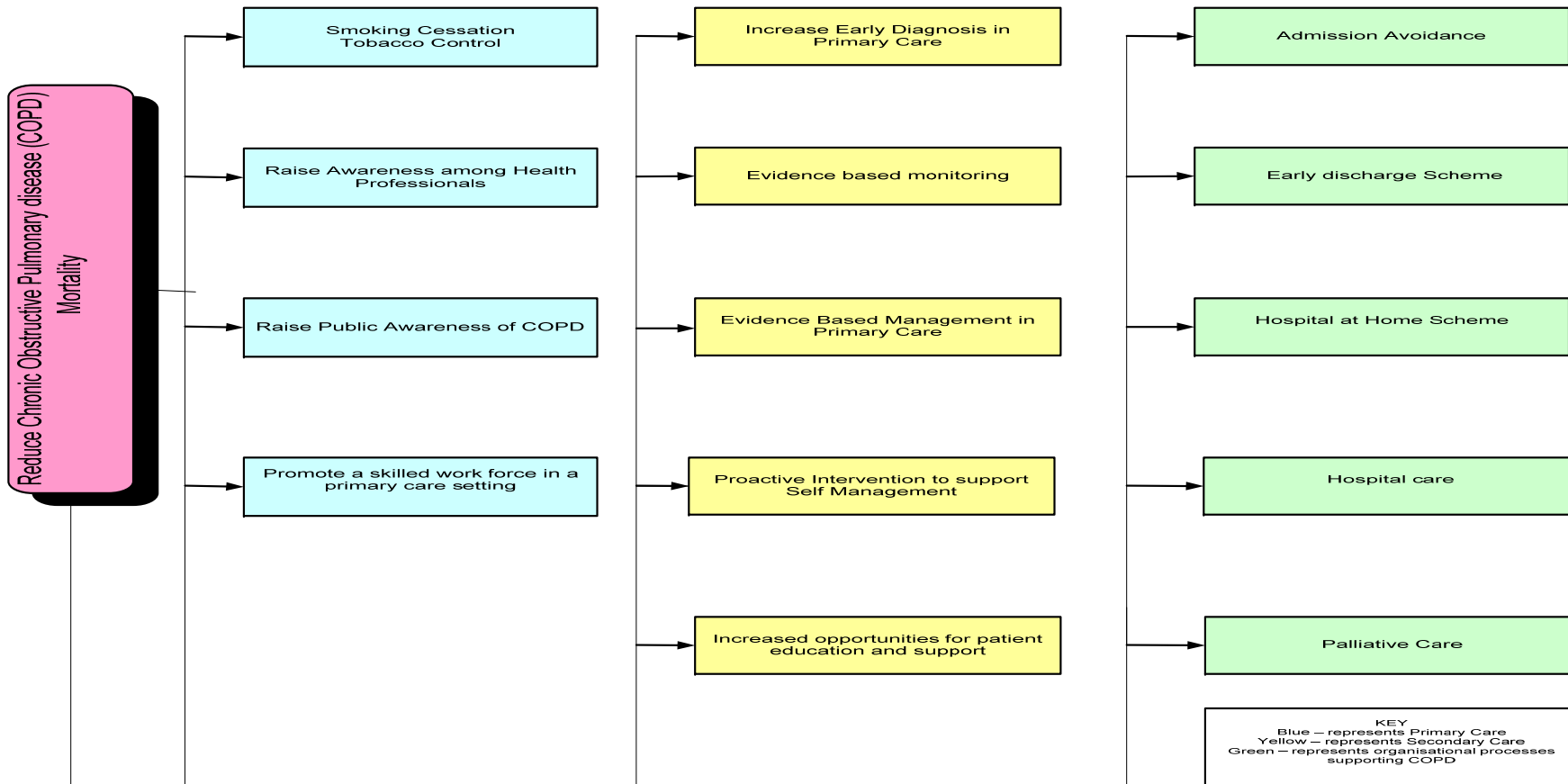
These, added to the Cancer Mortality measure and the All Age All Cause Mortality (AAACM) widely used by the Care Quality Commission means the use of Performance Improvement Maps is a key mechanism by which the PCT is able to measure and track impacts on the five key mortality rates.

The Performance Improvement Maps measure the interventions which impact on these mortality rates. By mapping out the interventions, efforts can be better co-ordinated and their impact reviewed as a whole. Local targets are then set with a sense check to ensure all is being done to improve the health of the District. Performance can be monitored more regularly and more effective decision making can be made regarding the interventions which have larger impacts on the final outcome.

There are a wide range of interventions which reduce mortality. In some of these, for example, smoking cessation and blood pressure control there is sufficient evidence to estimate the likely impact on mortality with confidence. In other areas such as the self care of people with long term conditions, evidence is sparse and this estimate is much more uncertain. The piece of work focuses on those interventions where impact is best understood. The co-ordinated provision and measurement of a range of interventions is key to increasing life expectancy and reducing mortality.

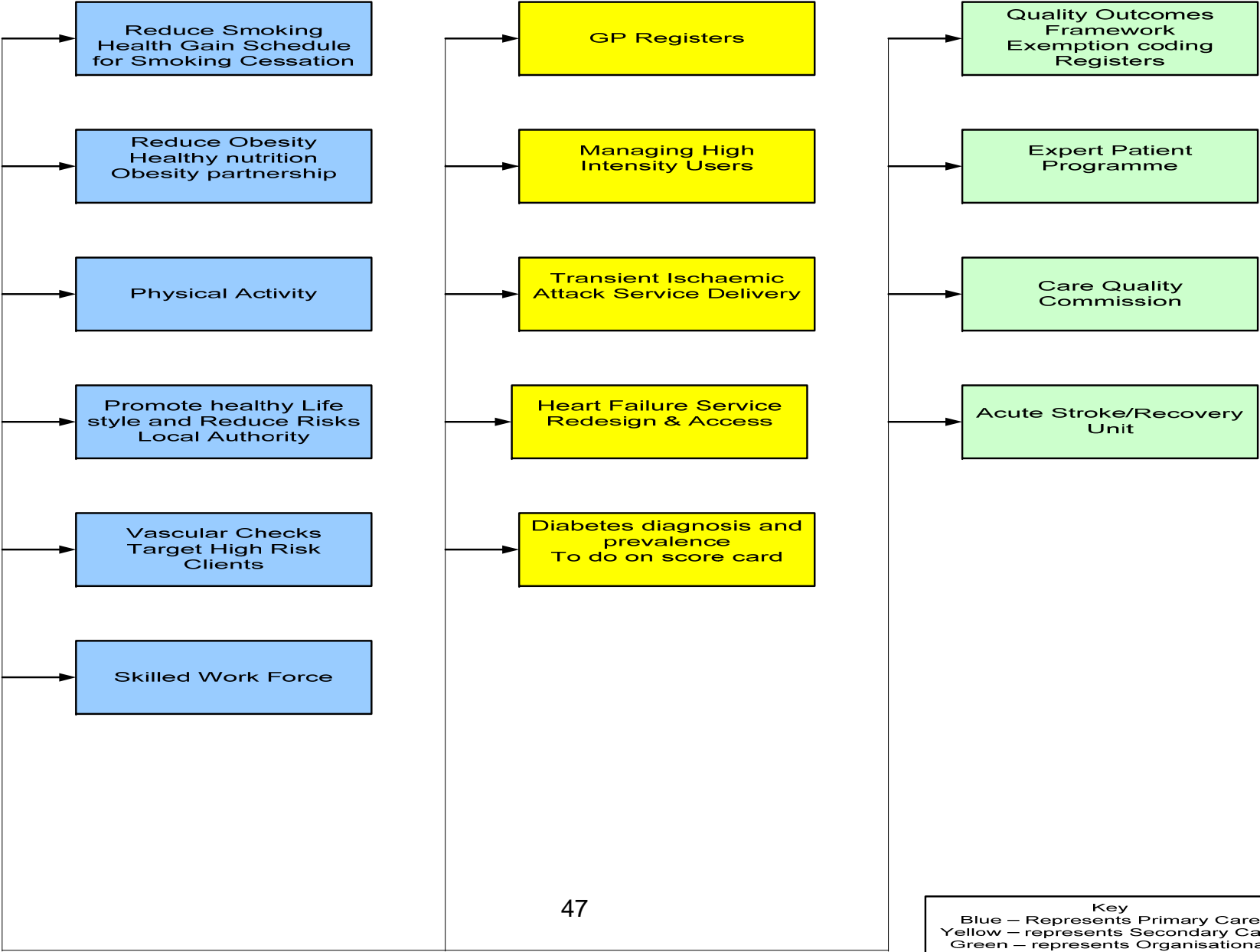
For each mortality indicator, a framework of recognised interventions has been developed that potentially impact on mortality. Performance Improvement Maps for the remaining World Class Commissioning Outcome measures will be developed in year.

Chronic Obstructive Pulmonary Disease Mortality Performance Improvement Map

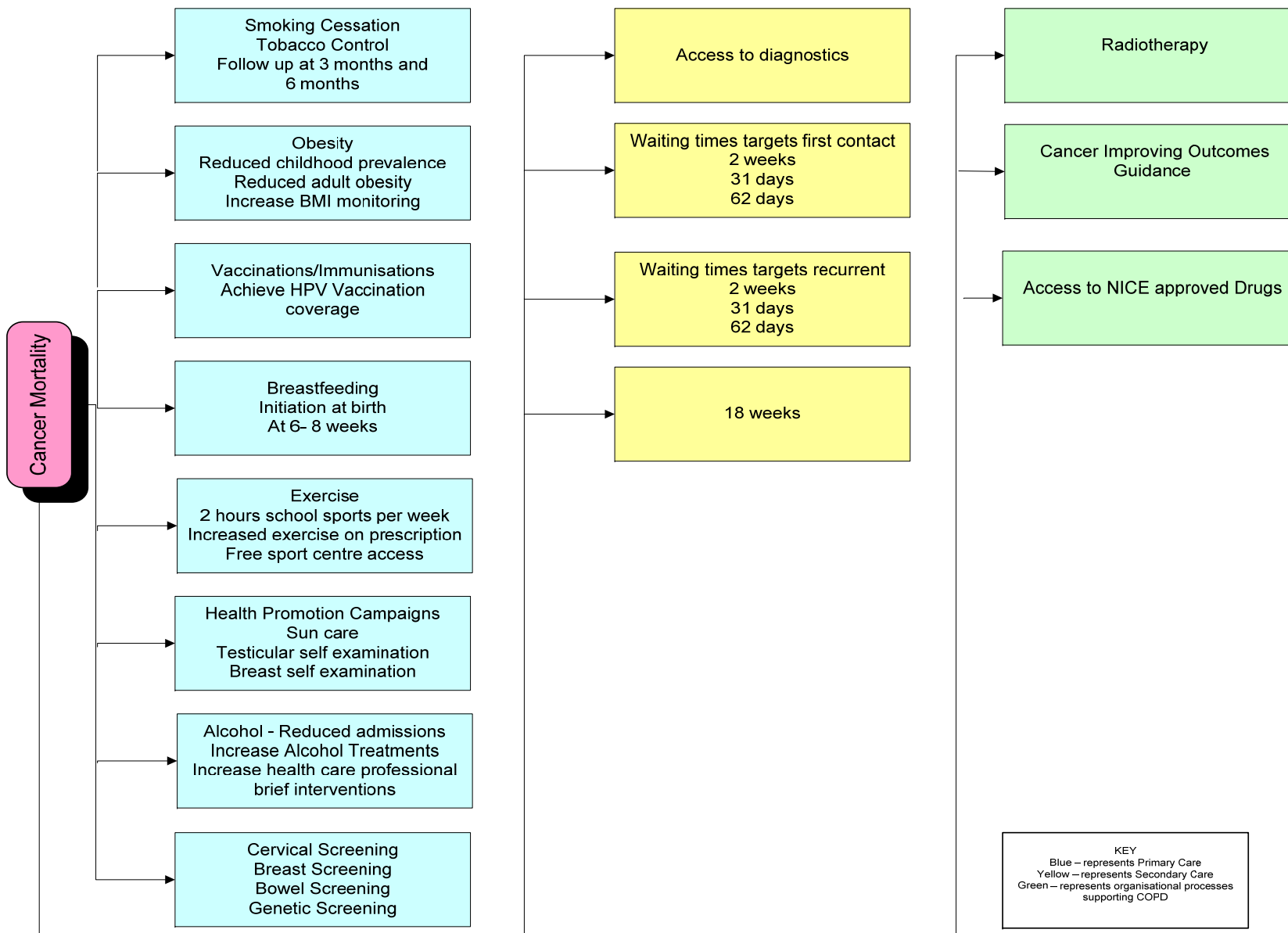


Cardio Vascular Disease Mortality Performance Improvement Map

Reduce Cardio Vascular Disease (CVD) Mortality



Key  
 Blue – Represents Primary Care  
 Yellow – represents Secondary Care  
 Green – represents Organisational  
 Processes to support CVD



## **APPENDIX 4                      WCC and Healthy Ambitions Matrix**

This section provides a matrix that summarises the action plans for 2010/11 for each portfolio and cross references these plans to WCC and healthy ambitions priorities,

## Priorities for Maternity Children and Young People Portfolio 2010/11

Maternity Children & Young People		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Maternity & Newborn Care											
Healthy Ambitions pathways : Maternity and Newborn Care and Staying Healthy											
Project	Timescale										
Ensure all midwives are trained in providing smoking cessation advice and brief interventions.	By 2011	•	•	•		•	•	•			•
Implement social marketing and media campaigns promoting healthy lifestyles for all women of a child bearing age especially expectant mothers.	2010 onwards	•	•	•	•	•	•	•	•		•
Year on year increase the number of participants in the 'significant others initiative' to encourage mothers to quit and stay non-smokers.	2010 onwards	•	•	•		•	•	•			•
Year on year increase in the numbers of women initiating and sustaining breastfeeding	2010 onwards	•	•		•		•	•		•	
Achieve Baby Friendly Initiative Status within the district	By 2011	•	•		•		•	•		•	
Implement Healthy Start Scheme for families receiving Income support or IBJSA.	2010 onwards	•	•		•				•		
Implement New Maternity IT System (EUROKING) in order to improve measurements of performance indicators.	2010 onwards	•	•	•							

Maternity Children & Young People		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Healthy Lifestyles											
Healthy Ambitions pathway : Staying Healthy, Children and Young People											
Project	Timescale										
Commence implementation of wider scope 0-19 Public Health, Early Intervention and Family Support Service increasing capacity and better targeting of resource to areas of greatest need.	2010 onwards	•	•	•	•	•	•	•	•	•	•
Increase the number of young people who meet the access criteria using the Connect3 specialist weight management programme.	2010 onwards	•	•		•		•	•			
Undertake participatory research into local barriers to participate in cycling.	2010	•	•				•	•			
Develop a Family Activity Walks toolkit for use by various groups and professionals.	2011	•	•		•		•	•			
Develop and implement a Healthy Cycle Ride Leader training programme.	2011	•	•				•	•			

<b>Maternity Children &amp; Young People</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in pregnancy</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed Days</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area: Psychological &amp; Emotional Well-being Healthy Ambitions pathway : Children and Young People and Mental Health</b>											
<b>Project</b>	<b>Timescale</b>		•								
Implement a community based Forensic Children and Adolescent Mental Health Service (CAMHS).	Dec 2010										

Maternity Children & Young People		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Physical Health Needs Healthy Ambitions pathway : Children and Young People											
Project	Timescale										
Review of Consultant led Paediatric medical services and development of commissioning implementation plan.	2010									•	
Review of Paediatric Therapy services and development of commissioning implementation plan.	2010									•	
Paediatric unplanned care pathway redesign and service reengineering.	2010 onwards									•	
Strengthen children’s community nursing services to support children’s continuing care packages.	2010									•	

<b>Maternity Children &amp; Young People</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in pregnancy</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed Days</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area: Special Circumstances Healthy Ambitions pathway : Children and Young People</b>											
<b>Project</b>	<b>Timescale</b>										
Ensure acute and community based organisations including GPs operate appropriate paediatric liaison systems to support identification of children at risk.	2010		•								
Issuing of safeguarding system specification to all provider organisations, adult and children including primary care contractors identifying commissioner's expectations for the safeguarding of young people.	2010		•								

## Adult Portfolio Priorities

Adults		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Mental Health Healthy Ambitions Pathways: Mental Health, Children & Young People											
Project	Timescale										
Work with SWYPFT to improve local district services, providing care as close to home as possible and utilising out of area placements only where there is a clinical need, including enhanced rehabilitation and step down pathways.	Dec 2010		•								
Review provision of current local services, benchmarking provision against national best practice to drive efficiency and value for money within the inpatient bed base, forensic services. Did not attend (DNA) rates and Community Mental Health Teams.	Dec 2010		•								
Reshape older people's mental health services to improve support for those with dementia and their carers in response to the National Dementia Strategy.	Mar 2012		•								
Support the work of Positive Choices in Mental Health to provide and develop clinical leadership in primary care, promote emotional resilience of children and young people and links to employment for those with MH problems.	Mar 2011		•								
Expand the availability of SHARP (Self Help in Routine Primary Care) materials and embed their use in primary care practice.	Jun2010		•								

<b>Adults</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in pregnancy</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed Days</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area – Mental Health Healthy Ambitions Pathways: Mental Health and Staying Healthy</b>											
<b>Project</b>	<b>Timescale</b>										
Work jointly with WMDC to develop a strategy for providing supported employment opportunities for those with common, or long-term mental health problems.	Dec 2010		•								
Commission additional care coordination and clinical advisory capacity to ensure that the continuing healthcare needs of some the most vulnerable people in the district are both appropriately and speedily met.	Mar 2011		•								
Work with our partners to implement the Improving Access to Psychological Therapies (IAPT) model, contributing to projects reviewing the prescribing of drugs and treatment of medically unexplained symptoms.	Mar 2012		•								
Review regional arrangements for specialist mental health commissioning.	Mar 2011		•								
Continue to support the work of the BME community development workers and Shared Leadership Programme in ensuring the implementation of Delivering Race Equality.	Mar 2011		•								

Adults		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Primary Prevention Healthy Ambitions Pathways: Mental Health and Staying Healthy	Timescale										
Project	Timescale										
Monitor smoking prevalence across the district producing up to date information creating a health equity audit map to support targeting of interventions at those with the greatest need.	2010 onwards	•	•	•		•	•	•		•	•
Promote and regulate smoke free environments and exposure to second hand smoke.	2010 onwards	•	•	•		•	•	•			•
Continue to monitor and regulate the access and availability of tobacco products including reducing illegal sales to minors, reducing sales of counterfeit and smuggled products.	2010 onwards	•	•	•		•	•	•			•
Provide and promote education and media campaigns aimed at promoting the stop smoking service and the benefits of not smoking.	2010 onwards	•	•			•	•	•			•
Increase the role of Health Trainers to become intermediate advisors achieving smoking quitters.	2010	•	•			•	•	•			•
Raise awareness of sensible drinking to reduce the levels of harmful, hazardous and dependent drinkers in Wakefield district.	2010 onwards		•							•	
Review the alcohol treatment service to ensure that it delivers high quality services, which contribute to a reduction in alcohol related hospital admissions.	2010 onwards		•							•	

Adults		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Primary Prevention Healthy Ambitions Pathways: Mental Health and Staying Healthy											
Project	Timescale										
Implement a consistent and coordinated approach to adult weight management using the Wakefield District pathway.	2010 onwards	•	•				•	•	•	•	
Commission Community Specialist Obesity Triage Service (CSOTS).	May 2010 onwards	•	•				•	•	•	•	
Develop a marketing strategy with CSOTS to increase awareness and uptake of services offered by CSOTS.	October 2010 onwards	•	•				•	•	•		
Develop Long term maintenance weight management pathways.	October 2010 onwards	•	•				•	•	•		

Adults		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Falls prevention Healthy Ambitions Pathways: Staying Healthy, Planned Care, and Acute Episode											
Project	Timescale										
Deliver a local Health Needs Assessment and Wakefield Falls and Fracture Prevention Strategy.	December 2010		•								
Better understand current service delivery and develop local integrated care pathways.	December 2010		•								
Reduce ambulance call-outs, A&E attendance and hospital admissions and increase access to timely surgery through enhanced prevention strategies and improved bone health programmes.	December 2010		•								
Improve local understanding and improve local coding of falls including YAS and A&E data.	December 2010		•								
Work with local GPs to improve rates of osteoporosis detection, diagnosis, and treatment in Primary Care.	December 2010		•								

<b>Adults</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in pregnancy</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed Days</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area – Sexual Health Programme Healthy Ambitions Pathways: Staying Healthy, Planned Care, and Mental Health</b>	<b>Timescale</b>										
<b>Project</b>	<b>Timescale</b>										
Reduce waiting times for GUM services and extend the provision of level one and two support services.	2010 onwards		•								
Undertake a full review of the Contraception and Sexual Health service.	March 2011		•								
Undertake a review of third sector and independent agency sexual health provider services.	March 2011		•								
Explore the integration of (or elements of) the GUM and CaSH services.	March 2011		•								
Establish a clinical governance framework and referral pathways for the sexual health network.	March 2011		•								
Develop a local sexual health services directory and centralised website.	June 2010		•								
Increase the provision and availability of psychosexual counselling in general practice and establish new services in areas of greatest need.	2010 onwards		•								

Adults		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Prison healthcare Healthy Ambitions Pathways: Staying Healthy, Planned Care, Acute Care and Mental Health											
Project	Timescale										
Review escorts, bed-watches, and constant observations (HMP Wakefield and HMP Newhall).	March 2011		•								
Tender prisons integrated mental health service.	March 2011		•								
HMP Wakefield SLA - contract price reduction following review of custodial delivery model to support healthcare.	March 2011		•								
Explore regional procurement of Telemedicine.	March 2011		•								
Support integrated approach to planned commissioning reviews of care provision in prisons, to include Wakefield District Community Healthcare Services, Mid Yorkshire Hospitals Trust, and other providers.	March 2011		•								
Develop local acute sector additional capacity to deliver MRI scanning and dermatology services.	March 2011		•								
Deliver appropriate prison health needs assessments.	March 2011	•	•								
Support regional tender of death in custody clinical reviews.	March 2011	•	•								
Develop metrics against the Prison Health Performance Quality Indicators and CQUIN indicators for both prisons.	March 2011		•								
Deliver Integrated Drug Treatment Services (IDTS) for both local prisons.	March 2011		•								

Adults		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Learning disability Healthy Ambitions Pathways: Staying Healthy, Planned Care, Acute Care and End of Life											
Project	Timescale										
Conduct clinical and managerial review of out of area / continuing care placements.	Oct 2010		•								
Review the mainstream activity being performed by specialist teams including a review of Community Teams Learning Disability structure.	Oct 2010		•								
Evaluate GP health checks (DES) - diagnostic overshadowing – primary care focus on early intervention and prevention.	Oct 2010	•	•								
Review of support for partnership arrangements to include joint posts and current Health Act flexibilities.	Oct 2010		•								
Develop specification to include local diagnosis and treatment for Autism within established local ADHD service.	Oct 2010		•								

<b>Adults</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area – Substance misuse Healthy Ambitions Pathways: Staying Healthy, Planned Care, Acute Care and Mental Health</b>											
<b>Project</b>	<b>Timescale</b>										
Review residential rehabilitation commissioning and placements.	March 2011		•								
Commission broader social support networks for clients in the community and in prisons.	March 2011		•								
Work in partnership with the Supporting People team, and local housing providers to review data for homeless and vulnerably housed clients.	March 2011		•								
Enhance services to deliver improvement in the local management of those clients whom (through substance misuse and offending behaviour) are causing the most harm to communities.	March 2011		•								
Develop a comprehensive local communications campaign.	March 2011		•								
Develop and implement a locally agreed harm reduction strategy, specifically responding to recommendations from the annual drug-related deaths confidential enquiry panel.	March 2011	•	•								
Develop services to increase numbers of service users experiencing healthier attitudes, behaviour and lifestyles.	March 2011	•	•								
Support the development of the Balanced Score Card to identify outcomes for commissioning substance misuse services which improve the individual health and well-being of service users.	March 2011		•								

## Planned Care and Long Term Conditions Priorities

Planned Care and Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Elective Care Services Programme Healthy Ambitions Pathways: Staying Healthy, Planned Care, Acute Care and End of Life	Timescale										
Project	Timescale										
Direct Access Diagnostics Services Project Community ultrasound procurement	By 2011 Quarter 1 2010										
Direct Access MRI	Quarter 2 2010	•	•								
Direct Access Dexascan	Quarter 2 2010										
Orthopaedic Service Transformation Project	March 2011	•	•								
Ophthalmology Service Transformation Project	March 2011	•	•								
Dermatology Service Transformation Project	March 2011	•	•								
Cardiology Service Transformation Project	March 2011	•	•				•	•			
Going Further on Cancer Waits Service Transformation Project.	March 2011	•	•								

Planned Care and Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Elective Care Services Programme Healthy Ambitions Pathways: Staying Healthy, Planned Care, Acute Care and End of Life	Project										
Commissioning of the Abdominal Aortic Aneurysm (AAA) screening programme for men aged 65 years - expected to begin in 2010/11.		•	•				•				
Commissioning of Breast Screening Age Extension and Static Site Provision.		•	•								

Planned Care and Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area: Elective Care Services Programme Healthy Ambitions Pathways: Staying Healthy, Planned Care, Acute Care and End of Life	Timescale										
Project	Timescale										
Strategic Review of Palliative and End of Life Care Provision	Quarter 1 2010	•	•								
Palliative Care and End of Life Education Project	March 2011	•	•								
Bereavement Services Project	March 2011	•	•								

## Unplanned Care and Long Term Conditions Priorities

Unplanned Care and Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Unplanned Care Healthy Ambitions Pathways Planned Care, Acute Episode	Timescale										
Project	Timescale										
Ensure that all GP practices/primary care services have systems in place in line with their PMS contract for same day urgent care primary care access.	March 2011		•							•	
Utilise Practice Base Commissioning as a lever to encourage clinical ownership of emergency admission activity by practices.	March 2011	•	•							•	
Develop and implement an improved tool for the risk stratification of patients with a high risk of emergency admissions to secondary care.	March 2011	•	•							•	
Ambulance Turnaround time- Focus on reducing overall time it takes an ambulance to have handed over patient at hospital and be ready for next journey (turnaround time), to increase resource availability to meet YAS KPIs and Clinical Performance Indicators.	March 2011	•	•							•	

Unplanned Care and Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Unplanned Care Healthy Ambitions Pathways Planned Care, Acute Episode	Timescale										
Project	Timescale										
Develop alternative pathways to hospital admission, using analysis of YAS data, the top four pathways are:											
a. Falls	Q3 2010	•	•							•	
b. Diabetes (review)	March 2011	•	•							•	
c. Epilepsy	Q3 2010	•	•							•	
d. COPD/Asthma	March 2011	•	•							•	
Implement primary care streaming of minor patients at PGH Emergency Department on a reduced PbR tariff basis.			•								
Develop and implement an agreed admission and discharge protocol for emergency admissions jointly with Practice Based Commissioners and Mid Yorkshire Hospitals Trust.		•	•							•	
Review Patient Transport Services (PTS) and work collaboratively with West Yorkshire PCTs to write a regional service specification for commissioning in 2010.			•								

Unplanned Care and Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Key Area – Unplanned Care Healthy Ambitions Pathways Planned Care, Acute Episode											
Project	Timescale										
Develop a Percutaneous Coronary Intervention service at DGH (MYHT).	March 2011	•	•				•	•		•	
Use Better Care Better Value and other sources of information to analyse potential areas for redesign resulting in innovative alternative care pathways into existing or new community services.	Q2 2010 Analysis 2011 redesign in priority areas commences	•	•							•	

<b>Unplanned Care and Long-term conditions</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area – Unplanned Care Healthy Ambitions Pathways Planned Care, Acute Episode</b>	<b>Timescale</b>										
Introduce clinical streaming to community based alternative services from the GP Assessment Unit.	2011	•	•							•	
Undertake a strategic review of the existing Intermediate Tier bed base and re-commission long-term bed provision in line with the requirement of the HDP.	Review 2010 Procurement October 2010	•	•							•	
Undertake a strategic review of the existing Wakefield District Community Healthcare Services single point of contact and explore opportunities to redesign and improve the service based on best practice.	Q2 2010	•	•							•	

<b>Unplanned Care and Long-term conditions</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in pregnancy</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed Days</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area – Unplanned Care Healthy Ambitions Pathways Planned Care, Acute Episode</b>	<b>Timescale</b>										
Raise public awareness about the links with smoking and symptoms of COPD.	2010 onwards	•	•			•				•	
Work with local employers to reduce exposure to COPD risk factors by reducing smoking rates, occupational exposure and environmental pollution.	2010 onwards	•	•			•					•
Promote early identification and case finding by using screening spirometry and symptom questionnaires in general practice.	2010 onwards	•	•			•				•	
Continue to work with primary care multi-disciplinary teams to identify gaps in qualifications and expertise and identify relevant training opportunities.	2010 onwards	•	•			•				•	

<b>Unplanned Care and Long-term conditions</b>		<b>WCC Outcome 1 – Life Expectancy</b>	<b>WCC Outcome 2 – Health Inequalities</b>	<b>WCC Outcome 3 – Smoking in pregnancy</b>	<b>WCC Outcome 4 – Obesity in Year R</b>	<b>WCC Outcome 5 – COPD Mortality</b>	<b>WCC Outcome 6 – CVD Mortality</b>	<b>WCC Outcome 7 – CHD Mortality</b>	<b>WCC Outcome 8 – Diabetes, HbA1c</b>	<b>WCC Outcome 9 – Emergency Bed Days</b>	<b>WCC Outcome 10 – Smoking Quitters</b>
<b>Key Area – Unplanned Care Healthy Ambitions Pathways Planned Care, Acute Episode</b>	<b>Timescale</b>										
Continue to work with colleagues to implement recording templates for computer systems, which include markers of good practice.	2010 onwards	•	•			•				•	
Introduction of structured self management plans for all patients with COPD.	March 2011	•	•			•				•	
Increase the number of patients utilising the health forecasting information to 1000.	March 2011	•	•			•				•	
Widen the End of Life Breathless Management Programme, improving access to symptom management programmes.	March 2011	•	•			•				•	
Further develop the community respiratory service to offer a comprehensive service.	March 2011	•	•			•				•	
Extend the scope of community based rehabilitation services delivering exercise and evidence based programmes to include patients with an MRC dyspnoea score of 3 and above.	March 2011	•	•			•				•	

Key Area – Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Project	Timescale										
Continue implementation of the Diabetes Service Redesign across all the practices, delivering joint Specialist Primary Care Clinic and further developing the competencies of primary care staff.	2010 onwards	•	•						•	•	
Develop e – consultation between Specialist care and Primary Care once the IT systems are in place to begin this work and following the evaluation of the Diabetes Service Redesign.	2010/2011	•	•						•	•	

Key Area – Long-term conditions		WCC Outcome 1 – Life Expectancy	WCC Outcome 2 – Health Inequalities	WCC Outcome 3 – Smoking in pregnancy	WCC Outcome 4 – Obesity in Year R	WCC Outcome 5 – COPD Mortality	WCC Outcome 6 – CVD Mortality	WCC Outcome 7 – CHD Mortality	WCC Outcome 8 – Diabetes, HbA1c	WCC Outcome 9 – Emergency Bed Days	WCC Outcome 10 – Smoking Quitters
Project	Timescale										
Assess the evidence base concerning the potential of technology to support those people with LTCs in their own homes including a review of current telecare and assistive technology available in the district.	Q 2 2010	•	•							•	
Develop a single outpatient clinic type for Dizziness and Blackouts.	March 2011		•							•	
Improve the capacity for management of chronic kidney disease (CKD across the health care community.	2012		•							•	
Implement and monitor the Vascular Checks programme to ensure vascular risk assessment is undertaken for 40-74 years olds at least once every five years, targeting those at most risk in the initial roll out of the initiative.	2011	•	•				•	•		•	
Community cardiology - commission a community cardiology service for diagnosis, treatment and management of patients within defined cardiology pathways.	Q2 2010	•	•				•	•		•	