

## OPERATING PLAN 2008/09

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# EAST RIDING OF YORKSHIRE PRIMARY CARE TRUST

## OPERATING PLAN 2008/09

### 1.0 BACKGROUND

The Operating Framework 2008/09 set out guidance regarding how PCTs should look to structure their operating plans for 2007/08.

This guidance was utilised to support the final structure of the East Riding of Yorkshire PCTs operational plan around those areas where the PCT needed to consider the development of a performance framework to assess, and monitor, the outcomes of service change initiatives and ensure that areas where investment has taken place demonstrate the expected change in service delivery.

The East Riding of Yorkshire PCT's Operating Plan remains a dynamic document, reflecting the nature of planning and performance management, which sets out the PCTs commissioning priorities and how it intends to effectively utilise it's resources to ensure delivery of the commissioning priorities, value for money, financial balance and the attainment of performance objectives (vital signs).

### 2.0 DEFINITIONS OF COMMISSIONING

Commissioning is the process of securing and managing appropriate healthcare services for relevant populations at value for money for the taxpayer. In its purest form it is composed of three phases:

- Understanding, segmenting and anticipating the needs of local communities and individual patients and planning and prioritising accordingly;
- Defining services to meet these and contracting them from the most appropriate provider
- Monitoring provision and managing contracts to continuously improve outcomes for patients and local communities

The Intelligent Commissioning Board (2006) p13

The outcomes of effective commissioning are:

- Identification of effective and appropriate health service responses to assessed patient need
- Securing National and Local Health Priorities
- Planning the coherent delivery of services
- Securing those services through contracts
- Allocating available resources against competing priorities

### 3.0 PLANNING PROCESSES

The PCT outlined its business planning process back in has devised a gateway process to support the PCT in the delivery of its commissioning agenda. The development work for this process occurred during the summer of 2007 and the final business planning process was agreed by the Board in November 2007.

The business planning process is supported by the Commissioning Assessment, Prioritisation and Procurement (C.A.P.P.) process which is a gateway process designed to ensure that any business proposals, including those arising from Practice Based Commissioners, can demonstrate their compliance with the PCT's commissioning priorities, robustness of projected service change/delivery, achievable and measurable outcomes from the development and a viable procurement route. The gateway process allows feedback at all stages and ensures that only those proposals which meet the PCT's commissioning priorities and are deliverable within the identified timescales are formally considered by the PCT.

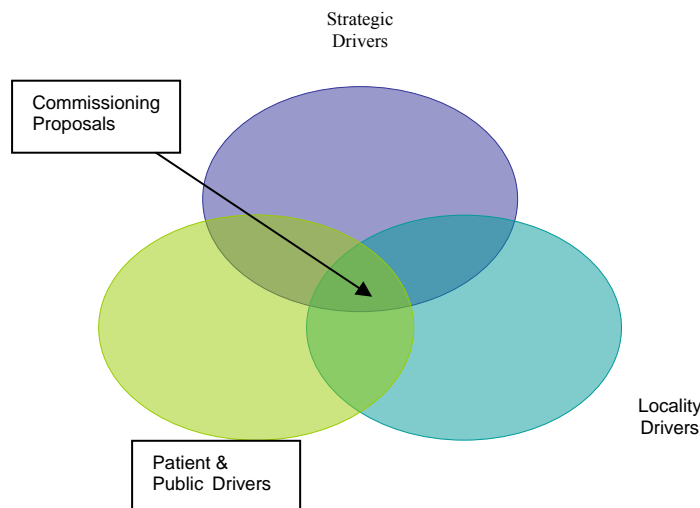
An integral part of the process is the joint working between the Commissioning and Financial Directorates to ensure a two way dialogue to develop both the commissioning and financial plans together to ensure that the financial parameters are well understood and incorporated into the assessment of business proposals leading to a joint planning outcome of identified service developments which are affordable within the PCT's financial parameters.

#### 4.0 PATIENT AND PUBLIC INVOLVEMENT

Patients, and the general public, have a significant role in helping the PCT, and Practice Based Commissioners, identify the local priorities for healthcare. In response to this the PCT, and Practice Based Commissioners, have started to involve patients and the public in the commissioning cycle by:

- Identifying their views on health services
- Identifying their priorities for service delivery and change
- Demonstrably including these views in the final Commissioning Strategy

Fig 1.



In order to support this involvement process the PCT published its first patient prospectus in November 2007 and will continue to do so on an annual basis

as well as looking to develop active liaison with the prospective LINKs and other patient and public involvement forums.

## 5.0 PLANING DRIVERS

Underpinning the development of the operational plan is the analysis of a wide range of factors (planning drivers) that are central to identifying the local and national influences on the services that need to be commissioned. These planning drivers can be split into three main areas:

- Local Need

The changing demographics of the PCT's resident population directly impact upon the service distribution required to meet the changing needs:

Population Growth	< 16 years	Static
	17 – 63	0.5%
	64+	3%

The population growth has been selectively applied to acute sector activity in proportion to the distribution of the age ranges within services.

- Demand

Based upon historical trend lines the underlying growth of acute and specialist services are as follows:

Referrals	3% (underlying differentials between specific contracts)
Outpatients	3%
Elective Services	4%
Non Electives	3%
Removals Other Than Treatment (ROTT)	Static
Conversion rates	Static

These growth rates have been applied to acute sector activity. The main exception to these growth rates is around orthopaedics, both outpatient and elective, where a reduced level of grow has been factored to reflect the impact of the Musculo-Skeletal Triage Service.

- Service Standards

The following service standards have also been factored in:

18 Week Patient Pathway: 100% applicable patients treated within 18 weeks

4 week maximum wait Outpatients

4 week maximum wait Diagnostics

7 week maximum wait Treatment

Diagnostics

Maximum 6 week wait

Patient Choice

Patients able attend their hospital of choice

Choose & Book

All services directly bookable

Agreed service thresholds/pathways

## 6.0 SERVICE DELIVERY AREA

### a) Women's & Children's Services

- Key drivers
  - The implementation of Maternity Matters
  - Making antenatal and neonatal screening systems more robust
  - Ensuring robust systems in place for the review of unexpected child deaths and for vulnerable children
  - Improving Children & Adolescent Mental Health Services (CAMHS)
- Issues
  - The full impact of the implementation of Maternity Matters is still being assessed
  - Take up rates of screening tests are variable
  - The impact of increased identification rates/false positives have not been fully identified
- Commissioning Output/come
  - Increased levels of antenatal and neonatal screening in line with national direction
  - Specialist input into unexpected child death reviews
  - Specialist input into supporting/identifying vulnerable children
  - Increased access to CAMHS

### b) Sexual Health

- Key drivers
  - Prevalence of Chlamydia
  - Improving sexual health & sexual health awareness amongst teenagers
- Issues
  - Increased HIV drug costs
  - Relocation of Goole services – potential incidental impact
- Commissioning Output/come
  - Improving access
  - Meeting national & local targets
  - Workforce reconfiguration to better meet individuals needs

### c) Specialist Services Commissioning

- Key Drivers
  - Nationally designated services must be commissioned across a designated population number in conjunction with partner PCTs
  - Increasing numbers of therapies are becoming available to treat patients with rarer conditions which tend to be low volume, high cost services
- Issues
  - The actual impact of NICE decisions on the area of high cost, low volume treatments can only be approximated
  - As increasing specialisation occurs the range of service providers reduces which impacts upon local accessibility
  - More work is being undertaken nationally on specialist 'top-ups' and specialist tariffs which impact upon the costs of these services
- Commissioning outputs/comes
  - Support/improvement of the specialist burns services

- Development of a paediatric critical care transport service to improve outcomes for critically ill children that need transferring to specialist centres

#### d) Mental Health

- Key Drivers
  - Reducing suicide rates
  - Making mental health rapid response services more robust
  - Introduction of computer based cognitive behavioural therapies
  - Introduction of the 18 week patient pathway to specific areas
- Issues
  - Increasing level of demand, especially associated with substance misuse and its consequences
  - Patients are often referred out of the local area for treatment which is not always in their best interests
  - Increasing levels of dementia as a result of increasingly elderly population
  - Need to increase patient involvement in own care pathway
- Commissioning Outputs/outcomes
  - Increased level of crisis response
  - Introduction of computer based cognitive therapies
  - Development of alcohol services

#### e) Ambulances

- Key Drivers
  - Changes to how calls are handled within ambulance services
  - Requirement to meet national and local targets for call to attendance times
  - Changes in acute service configuration which require increased ambulance support
- Issues
  - Usage, and thereby financial impact, is dependant upon the number of calls received
  - Attendance time targets are getting more robust
  - Impact of NICE guidance often has hidden consequences for transport
- Commissioning Outputs/outcomes
  - Ambulance service increases usage of 'call connect'
  - Patients who have a fall at home are managed more appropriately
  - Ambulance response times met national and local targets

#### f) Primary Care

- Key Drivers
  - Improved access to primary care based services
  - More varied opening hours within GP practices
  - Increased accessibility of NHS dentists
- Issues
  - Relative scarcity of NHS dentists
  - Constraints on practice estates to deliver wider range of services
- Commissioning Outputs/outcomes
  - More varied opening hours amongst GP practices
  - Increased level of services provided within GP practices (enhanced services)
  - Improved access to dentists

#### g) PCT Provider Side

- Key Drivers
  - PCTs Community Services Strategy
  - Redesign of roles and functions with workforce
  - Cleanliness within Community Hospitals and infection control
- Issues
  - Availability of appropriate skill mix to support proposed changes
  - Increasingly complex patients being transferred from secondary care to community based care
- Commissioning Outputs/outcomes
  - Development of rapid response community based teams
  - Increased support and triage for patients with musculo-skeletal conditions
  - Increased support in the community for patients after a fall

#### h) Prisons

- Key Drivers
  - Each Prison has an individualised development plan
  - For 2008/09 these account for over 70 change items
  - Offenders and x-offenders have an equal right to access timely healthcare as non-offenders
- Issues
  - Further work is required to quantify the 70 change items
  - There are risks associated with further changes in how healthcare is provided for offenders
- Commissioning Outputs/outcomes
  - Modernised prison health services
  - Increased access to timely health services

#### j) Acute Services

- Key Drivers
  - 18 week maximum patient pathway
  - Changes to cancer waiting times applicable population
  - Reduction in length of wait for breast screening
  - Improved access to screening services
  - Increasing patient choice and use of choose & book
- Issues
  - Localised changes in tariff due to specialist nature of some services
  - Capacity to meet demand
- Commissioning Outputs/outcomes
  - Improved access to breast screening
  - Improved access to retinal screening
  - Meeting waiting times targets for all patients (cancer & non-cancer)

## 7.0 ACUTE CONTRACTS

The Acute Provider contracts for 08/09 have been negotiated, and will be managed, through the new consortium collaborative arrangements introduced nationally for 08/09. These arrangements have consolidated, and strengthened, the efforts of the PCT commissioners into a single forum to ensure that the key benefits for quality, cost and efficiencies in the delivery of acute services are secured. Also it ensures more robust performance management and compliance with DH, and locally, mandated targets.

To facilitate the introduction of these more robust commissioning consortia Key Performance Indicators (KPIs) have been introduced into the contracts and these will help reinforce the need for improved performance and outcomes and should drive significant improvements around cost and performance management.

The potential impact of the next phase of Choose and Book development, linked with the initiation of free choice is difficult to quantify, however there is the potential that patients may choose to attend a more diverse range of acute providers than we currently hold formal contracts with. The changes to choice and Choose & Book are part of a national patient/public awareness campaign which may impact upon the awareness of, and uptake, of choice and the use of Choose & Book. Therefore the PCT has maintained some caution in commissioning growth from the Acute sector current SLA contracts.

## **8.0 COMMUNITY STRATEGY**

Following extensive public consultation in 2007 on the reconfiguration of Community Services across the county, the PCT has embarked on a major transformational change programme. The Community Services Strategy programme will radically change the way that unscheduled care and elective and diagnostic services are delivered across the East Riding of Yorkshire. In addition the PCT made a successful bid for capital funding [£20M] to redevelop 3 of its community hospital sites. Capital funding has been received to facilitate a rebuild of Beverley Westwood Hospital on a Greenfield site, a redevelopment of health care facilities on the existing Hornsea Cottage Hospital site and refurbishment of facilities at the Alfred Bean Hospital in Driffield.

During 2008/2009 the PCT will develop the Outline and Full Business cases for these capital schemes.

Site feasibility work has commenced to enable a site to be secured for the redevelopment of Beverley Westwood hospital. Other key work which will be undertaken during 2008/2009 includes:

- Finalising the clinical design work for each of the 3 sites
- Working with the Local Authority planners to secure planning permission
- Development and Approval of the Outline and Full Business Case
- Engagement of Partners to work with the PCT on construction etc.
- Progressing testing of the Unscheduled care model through piloting the model in specific localities
- Progression of the first phase shift of elective and diagnostic services into the community through accreditation of providers under the Any Willing Provider model of procurement.
- Development of the 2<sup>nd</sup> phase of elective and diagnostic projects including: community radiology services; integrated heart failure service; integrated community rheumatology service and community pain management service.

## **9.0 NEXT STAGE DARZI REVIEW**

The next stage review (Darzi) presents a whole range of short term, as well as medium/long term, planning and service opportunities which have yet to be fully quantified and incorporated within the overall operating plan, but the

markers are laid and both the commissioning and financial teams are aware of the added parameters associated with developing the next steps in response to the review.

The increase in GP hours, and the development of a new medical facility, is being reviewed by the PCT in relation to the opportunities that have been identified as part of the East Riding Community Services Strategy to ensure that these developments can be used in a manner that is most beneficial to the local population.

The work around palliative care, coupled with the PCT baseline review, is enabling the PCT to develop a more robust palliative care commissioning strategy to ensure that palliation is no longer within the confines of cancer services and cancer networks but is a prerogative of all patients requiring palliation regardless of underlying disease process.

#### **10.0 ANY WILLING PROVIDER**

During 2008/09 the PCT will implement the 'Any Willing Provider Framework' procurement framework. The framework enables the PCT to commission and procure clinical services within primary care offered by a range of providers, NHS and independent organisations, with the aims of introducing new ways of working into localities, resulting in improved effectiveness, efficiency and value for money, whilst at the same time contributing to and meeting key performance targets, for example 18 week waits. A prospective provider will need to satisfy the PCT of its ability to deliver the service and compliance with rigorous service criteria and quality standards before an agreement is reached and the provider is accredited to offer services.

#### **11.0 CLINICAL IMPROVEMENT AND EFFICIENCY**

In order to promote clinical improvement and efficiency, three sub-programmes have been identified:

- **Technical Efficiency:** this sub-programme will look at potential cost releasing efficiency gains in such areas as management costs, joint procurement and shared services. The sub-programme will be led by Jon Swift through the Finance and Performance Committee.
- **Allocative Efficiency:** this sub-programme will look at improving the efficiency of allocation of resources to health and service needs. The sub-programme will be jointly led by Duncan Ross and Tim Allison through the Planning and Procurement Committee.
- **Clinical Effectiveness:** an iterative plan is being developed to promote and apply a continuous clinical quality improvement process covering three key areas:
  - Medicines Management Improvement e.g. use of generic drugs, statin prescribing, NICE implementation
  - Primary care e.g. QOF exclusions
  - Metrics and benchmarks e.g. new to follow up ratios, readmission rates, admissions staying under 24 hours
- This approach ensures the promotion of ongoing clinical improvement and will achieve sustainable system change as the PCT moves out of formal

financial Turnaround. The focus is on areas where local performance deviates from specialty, regional or national benchmark and will translate this into improved quality and more efficient care through appropriate and effective practice. Where this is identified, performance standards will be included in contract negotiations especially where the national contracts have the facility for local stretch targets. The sub-programme will be led by Kate Ireland through the Clinical Executive Committee and QPEX Group.

## **12.0 PERFORMANCE OBJECTIVES**

Appendix 1 outlines the Vital Signs and other indicators which the PCT will be utilising to provide a framework against which to monitor its performance against a range of national and local planning objectives. Those indicators which are part of Tier 1 and Tier 2 provide a broad performance assessment/management framework against which the PCT will self monitor its progress. Part of this process has been to identify the indicator 'owners' and 'delivers' to ensure that the service change required to underpin the delivery of the indicator is incorporated within the appropriate workplans for 2008/09 and beyond.

Those indicators which have been identified as Local Imperative Tier 3 indicators will provide the central framework against which the PCT will performance assess/manage services and service developments to demonstrate that it is responding to locally identified commissioning priorities.

The service priorities, and thereby Tier 3 indicators, have been jointly identified in conjunction with the East Riding of Yorkshire Council and reflect those areas where a broad basis of health/social care experts and other local interested parties have identified that service development/change is required to best service the local population. Also identified are those indicators where the PCT is within the bottom quartile of attainment.

The work is being split into two phases; an initial short term piece of work identifying immediate issues which will be enhanced by medium/longer term planning to ensure that both the PCT and the Local Authority are best utilising their resources to jointly deliver what is a complex and emotive agenda.

Whilst the Vital Signs concentrate on the 'high profile' indicators the PCT has a range of other national and local service delivery indicators which it will continue to work upon and deliver within the agreed timescales.

## **13.0 RISK ASSESSMENT**

The PCT has a robust corporate risk assessment and management process which is being utilised to support the assessment and management of risks associated with the operating plan. In effect the risks can be categorised into three main areas:

- 1) Those associated with operational delivery  
Across all areas of commissioned operational delivery there are a range of often similar risks that need assessing and managing. These include:

- The individual services ability to respond to change and develop the requisite service
  - The constrained workforce pool that exists within the East Riding of Yorkshire, and neighbouring city of Hull, which provides challenges to workforce recruitment and retention
  - Delivery of the requisite activity and outcomes to meet the PCTs strategic objectives
  - The proposed changes to the range of patients who will be eligible to be treated within the cancer waiting times will significantly shorten the proposed pathway for these patients putting extra demand upon capacity constrained services
- 2) Those associated with changes to planning parameters and drivers
- Whilst factors have been put in place to allow for demographic and unmet need growth, this is generally an imprecise art. Also the nature of being a responsive commissioning PCT means that other planning variables may become evident in year which are not contained within the original planning assumptions
  - Changes to patient behaviours/demand generated from shortened waiting times and the growth in patient choice and the use of choose & book
- 3) Those associated with currently known planning factors which have not been fully quantified for potential impact due to differential timescales.
- New National Strategies/NICE Guidance have only been quantified in a limited manner
  - Quantification of the impact of Maternity Matters and the Paediatric services review cannot be made until the reviews are complete

### **13.0 IM&T DEVELOPMENT**

The IM+T plan has been developed around supporting the key planning priorities of the PCT. The work in the first year continues to focus on getting the key building blocks of the Integrated Primary Care solution in place. This includes further GP implementations, Community Hospital functionality and Out of Hours functionality. In addition the first year will see the completion of the Child Health System and the continuing roll out of the community nursing functionality. This then forms the basis towards the end of the first year to implementing key cross organisational usage of the system such as the diabetes functionality and the use of the system to support the services delivering the community commissioning strategy.

### **14.0 CORPORATE PLAN**

The corporate plan sets out a structure which will enable the PCT to develop corporately to meet both internal and external expectations on how the PCT will function during the next three to five years. The PCT is strategically entering a period of service growth and development including becoming a World Class Commissioner and implementing the Community Services Strategy, including developing the PCT estate. This requires a period of growth and skill consolidation amongst the PCT's officers including an organisational refresh to ensure the PCT is 'fit for purpose' and undertaking management development programmes to enhance the skills amongst the workforce.

### **14.0 FINANCIAL PLAN**

The financial plan for the PCT has been developed alongside the PCT's planning processes to ensure that the financial plan reflects the proposed

commissioning priorities and fits with the PCTs Financial Strategy. The planning process has also been informed by the PCTs financial standing orders and the wider financial framework within which the PCT operates.

The 2008-09 plan is based on allocation growth of 5.5% and is the first year of the three year Comprehensive Spending Review. A general indication of levels of growth for the second and third years have been assumed in the Medium Term Plans but until the results of the funding formula review have been published Distance From Target and specific levels of funding can only be estimated.

In accordance with the Finance Strategy this plan includes a contingency of in excess of 1% of the Initial Resource Baseline and is set to achieve a surplus of 0.5% of the Initial Resource Baseline.

Appendix 2 provides a high level breakdown of the current PCT financial plan. As acute and other contracts are finalised there remains some flexibility over elements within these categories however the overall figures will remain unchanged.

A financial risk assessment will be undertaken during April to identify key issues for the PCT and inform any appropriate actions that need to be taken.