STOCKPORT PRIMARY CARE TRUST

STRATEGIC PLAN

2007-08 to 2009-10

Your Health   Our Promise

Incorporating
The Annual Local Delivery Plan 2007-8
V4

Copies and contact

Lead : Alison Tonge	Email: Alison.tonge@stockport-pct.nhs.uk	Copies Elaine.biglen@stockport-pct.nhs.uk	Phone 0161 426 5600

EXECUTIVE SUMMARY

The Ambition

NHS reforms are fundamentally about transforming services to become more patient centred. This requires new services to be delivered closer to peoples' communities, choices for patients of treatment and location and NHS staff and organisations to listen to patients views and experiences. It also requires new incentives, partnerships and commissioning strength to act for patients interests in gaining the best care possible.

Stockport is at the forefront of introducing such reforms. In the past three years changes and investments have been made in a series of new community based services which are focused on assessing, treating and caring for patients and in line with best professional practice avoiding unnecessary hospital admission. Two examples of these services are Clinical Assessment and Treatment services (CAT's) specialists, and active case managers working with patients who have a number of chronic health conditions, both of which provide high quality care, reduce reliance on hospitals and offer savings.

The programme of NHS wide reform must accelerate to guarantee 18 weeks from referral to treatment by December 2008 and to increase the support provided to people with long term and acute conditions, who need better integrated, responsive, round the clock access to specialists so that they avoid relying on hospitals.

Our investments in services are ambitious. A range of new diagnostic and treatment services in GP practices and in community locations will be available to choose from, more disease screening, health advisors and trainers will be targeted to support practices in the most needy areas. Investment in new Intermediate Care and Rehabilitation Services will support older people to stay out of hospital or get home quickly to recover from illness.

At the same time as reforming services, those responsible for commissioning care for Stockport patients (Stockport PCT and Stockport Managed Care) must also strengthen their capabilities . A far reaching development programme which will enhance strategic planning, change management and clinical engagement in commissioning is now underway which will further enhance the effectiveness of the PCT.

This plan therefore provides details of the service improvements expected and planned for, the health improvements as well as plans and capability of the commissioners to deliver on this vision.

The Plan

Better Services	Improving Outcomes and Productivity
Mental health services for those in crisis, more primary care workers and psychological therapy **Long term conditions** further development of active case management, new primary care based services, dedicated call centre support. **Rehabilitation** and intermediate care reforms and strengthening these services to allow the transfer of care from hospital to the community **Clinical Assessment and Treatment services** further developed and a range of choices including diagnostics to enable patients to be rapidly treated. **Health promotion** screening for Chlamydia and Hepititis C, access to sexual health services within 48 hours, 'brief' intervention services for alcohol users, obesity management – health trainers, social marketing information. **Reducing waiting times** through more hospital procedures, diagnostics, CAT's, improving audiology services	**Improving health lifestyle** Increase physical activity in deprived communities Reduce smoking, through increasing number quitting Reduce obesity in adults and children **Lengthen life** Men to live longer on average by 2 years and women by 1 year in 2010 Reduce mortality from Cardiovascular disease by 40% and Cancer by 20% Target these reductions in the areas of greatest need **Increasing services in the community** by 2010 Reducing hospitalisation by 50% for those conditions suitable for community services, reduce 30% of outpatients in hospital and transfer to community, reduce by 80% those treatments still given which are not effective **Improve mental health** Reducing suicides, improving mental health status
Providing good commissioning	**Engaging with others**
Strategy – set out our ambition and strategies for long term conditions, unscheduled care, quality improvement and community services **Prioritise services** for reform, investment and disinvestment based on a rigorous review process. **Manage providers** – set out clear information to providers on what we need them to develop and how to access the health care market, further develop performance improvement systems, quality and accreditation **Care pathways** – develop improved skills and programmes of work for pathway design, redesign and specification for procurement **Strengthen infrastructure** through investment in estates and Information technology as well as further training and staff investment	**With Patients** in designing services, acting on feedback and patient experience, needs assessments, consultation and providing useful information on quality, value and choice **Partnerships** - developing strategic alliances with local authority, pooling resources and reducing barriers to integrated care **Clinicians** – enabling practice based commissioners to lead service design, productivity and innovation. Ensuring other providers and contractors are engaged in commissioning as clinicians and expert advisors

Delivering Value

This vision will not be delivered with out a combined effort on investment and reform. Commissioners must demonstrate that health care resources are being directed to where this is most needed, and that this is generating the maximum benefit for every pound spent.

Whilst there is more money available to improve services next year over 8% additional money, this will reduce to a lower level of around 4% in the following two year period. This new funding therefore has to be spent in ensuring that improvements and efficiencies are realised. Reviews of key services are also required where existing levels of investment compared to the outcomes for patients is not congruous, these reviews will be cross cutting hospital, intermediate care, community and primary care to understand the opportunities for improvement and to commission these.

This approach of releasing efficiencies at the same time as investing has been a central approach for Stockport Commissioners for the last three years. In total around £4m to £5m of efficiency savings from redesigning services not reducing them, has been released for reinvestment in each and every year for the last three years. In the next three years a target is set which will see around 4% efficiency savings targeted as the reform initiatives start to be fully implemented across health and social care systems.

It is important to emphasise that these efficiencies are released by offering care that patients need in the right setting, and ensuring that the most cost effective care is offered in every setting. It is about improving care and targeting our resources for the benefit of all in Stockport.

The total investment in health services for 2007-8 is £386m. Investment in new reforms and service improvements is planned at £15m after cost increases in services have been recognised. This level of investment is being supported by a £7m efficiency saving plan which relies upon excellent working with clinicians to deliver. This productivity plan identifies £3m from delivering services in the right settings and pathway reforms so avoiding unnecessary hospital treatment, £2m from more cost effective treatments such as prescribing more cost effective drugs, and £2m from gaining better value for money from services for stockport patients. It is important to note that the investments planned to improve services and health outcomes cannot be afforded without these efficiencies.
A surplus of £ 3.2m is planned for and retained by the Strategic Health Authority as a strategic reserve.

Conclusion

Stockport people deserve a world class standard of health care, responsive and high quality, which enables people to live long healthy independent lives. Stockport PCT has the capacity to rise to this challenge, with its partners, and intends to deliver on this vision.

Foreword

This document sets out the strategic priorities for the next three years 2007-8 to 2009-10. These priorities are drawn from National policy direction, the PCT's Fitness for Purpose assessments, external and internal service reviews, national and regional benchmarking and local needs assessment and inequalities reviews.

The consolidated priorities for improvement in services and in strategy development provide the PCT's Strategic Plan.

This plan is further detailed in terms of specific delivery work in 2007-8 which includes new services to be commissioned, performance management work , audits and system process improvements. These 'interventions' both new and existing form the PCT's Local Delivery Plan for 2007-8 which includes a financial plan, efficiency plan, estates and workforce plan.

It is envisaged that this document will be updated annually, however the PCT's development, planning and performance management system will provide for a live update to this plan at the PCT and PBC Boards each month. As the economies development work progresses, new strategic documents will be written and approved and as such will initiate new interventions which will meet the PCT priorities.

It is therefore clear that this document cannot, nor is intended to be, a full analysis of all such interventions envisaged over the next three years. This is a document written based on the current status of analysis, prioritisation and strategic development and as such sets out this programme fully for 2007-8 but will be further enhanced as the strategic development work of the PCT and other partners progresses.

CONTENTS

1 STOCKPORT'S HEALTH 1

1.1 Stockport people and their health 1

2 NATIONAL CONTEXT FOR STRATEGIC PLANNING 3

2.1 Commissioning Framework 3
2.2 National Operating Framework 8
2.3 Practice Based Commissioning (PBC) : Practical Implementation 9
2.4 Payment by Results and Contracts 9
2.5 Consolidation of National Drivers 11

3 STOCKPORTS PCT – PRIORITIES 2007-2010 12

3.1 Health improvement 12
3.2 Health inequalities 13
3.3 Productivity and value for money 15
3.4 Access 24
3.5 Long Term Conditions (LTC)/Older Peoples 24
3.6 Mental Health 24
3.7 Quality Improvement 25
3.8 Summary of Local and National Strategic Priorities and Outcomes to be Commissioned 25

4 PRIORITIES FOR CREATING A WORLD CLASS COMMISSIONER 28

4.1 What is a development priority? 28
4.2 Development priorities 28
4.3 Summary Development plan – accountabilities 30

5 INTERVENTION PRIORITISATION APPROACH 31

5.1 Introduction 31
5.2 Investment and Reform Interventions 31
5.3 Future work 31

6 DELIVERY PLAN 32

6.1 New interventions commissioned 32
6.2 Productivity Plan 38
6.3 Summary delivery plan – accountabilities 40
6.4 High risk Areas 40

7 THREE YEAR OPERATIONAL AND FINANCIAL PLAN 41

7.1 Introduction 41
7.2 Financial Schedules 41
7.3 Workforce Planning 46
7.4 Estates 47

8 PBC ACCOUNTABILITY 49

8.1 Stockport Managed Care Commissioning 49
8.2 Accountability Agreement 49
8.3 Incentive Scheme 49
8.4 Budgets 49

8.5 Management Services Agreement 49

9 PROVIDER MANAGEMENT 50

9.1 Market Management Issues 50
9.2 Provider Contracts and Plans 52
9.3 Provider contract management and engagement 53

10 PERFORMANCE MANAGEMENT 54

10.1 Approach 54
10.2 Delivery plan Management 54
10.3 PBC Accountability Agreement 54
10.4 Provider Management reports 54
10.5 Development Plan management 54

Contents : Figures and Tables

Figure 1 Reform Framework....3
Figure 2 The commissioning cycle....6
Figure 3 The inequality gap....14
Figure 4 19 ambulatory sensitive conditions....16
Figure 5 Programmes....19
Figure 6 Programmes of Care - benchmarking....20
Figure 7 Top 5 Programmes after Investment and Reform....21
Figure 8 Key Areas for Prioritisation Review....31
Figure 9 New Interventions....32
Figure 10 Excluded Investments....38
Figure 11 Productivity plan....39
Figure 12 Inflation and Growth....41
Figure 13 Operating Cost Statement 07-8....42
Figure 14 Capital programme 07-8....43
Figure 15 Balance Sheet....44
Figure 16 Source and Application of Funds (add in yr 2/3)....45
Figure 17 Risk Management....46
Figure 18 Estates Strategy....47
Figure 19 Estates three year Investment Plan....48
Figure 20 Providers....52

Appendices

Please refer to separate documentation file

A Inequalities case finding

B 18 week delivery plan

C Targets and Trajectories

D Care pathway work

E Development plan accountabilities

F Prioritisation tool – new interventions

G Delivery Plan accountabilities and risk assessment

H financial schedules – three year plan

J Practice Based Commissioning Suite of Agreements

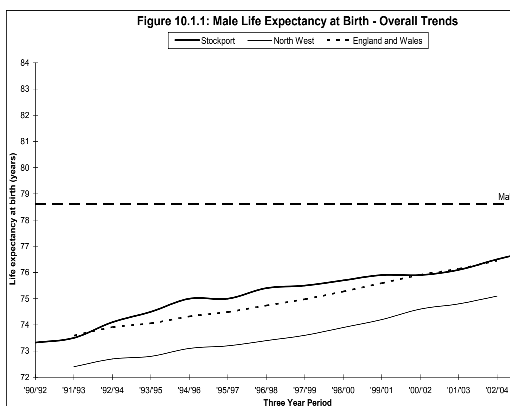
1 STOCKPORT'S HEALTH

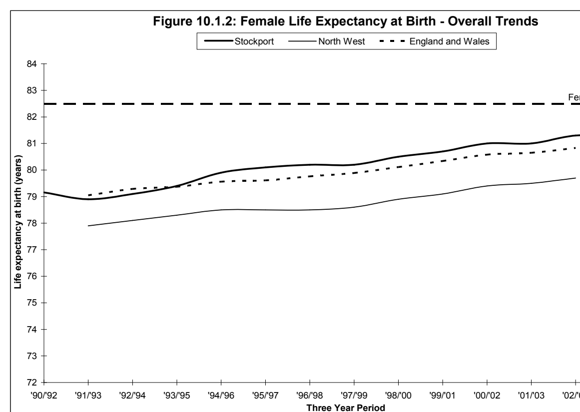
1.1 Stockport people and their health

1.1.1 It is vital that before any discussion of money, services or targets we do not forget why we need to continue to strive to improve services. We must therefore initially set the scene in terms of the overall health of Stockport people. Stockport is one of the most highly polarised local authorities in the country. It has a substantial mixture of deprived and affluent areas. The national life expectancy targets are for improvements in the health of the county as a whole. In Stockport, though, the situation is more complex because of our internal inequalities.

1.1.2 Reducing inequalities in health within Stockport is a major goal of Stockport PCT

1.1.3 Life expectancy in Stockport, as in the rest of the country, has increased over the last 15 years, having moved from slightly worse life expectancy having slightly better life expectancy.





1.1.4 For both males & females the average life expectancy overall in Stockport is currently at national average life expectancy However there are large differences in the average life expectancies for different communities within Stockport with a powerful relationship between life expectancy and local measures of deprivation. In the areas in the centre and north of the Borough such as Brinnington, Adswood and South Reddish, the average person lives 4 to 6 years less than the Stockport and England average.

1.1.5 The 2006 Annual Public Health Report analysed how effective interventions have been and concluded that some problems, especially relating to coronary heart disease in women and to alcohol-related diseases, have emerged in Stockport, as they have elsewhere, to undermine progress.

1.1.6 Life expectancy overall is made up of various causes of death. In order to be able to plan for and undertake effective interventions it is critical to understand and track these components. The major drivers in differences in life expectancy are currently, circulatory disease (28%), cancer (16%) digestive disease (15%) and with smaller contributions made by accidental poisoning (9%) and respiratory conditions (8%).

1.1.7 If we look at trends over time we can also see significant changes in contributing causes which is why we now need to revisit and refocus attentions within this plan.

1.1.8 It follows therefore that to address the problem of inequalities we need to confront the challenges of smoking, alcohol, cardiovascular disease (including the growing problem of obesity) and cancer.

1.1.9 To augment this work, and particularly to focus on the growing problems of alcohol and obesity, the plan includes investment in health trainers and brief interventions (both for

alcohol and obesity). It is also intended to identify resources to augment primary care capacity. The LDP also contributes to Greater Manchester plans for social marketing and for community-based cancer interventions.

1.1.10 Our alcohol strategy focuses on:-

- developing targeted screening and brief interventions in a range of settings
- exploring the potential of social marketing techniques to influence drinking levels and patterns
- training provision for frontline staff in a range of public services e.g. housing, job centres
- targeted work in Brinnington based on an appreciative inquiry approach which seeks to actively engage the community in problem solving and delivering solutions

1.1.11 To achieve faster decreases in mortality from cancer in our most deprived areas will require:

- Intensifying efforts to reduce smoking among routine and manual groups
- Better matching of need to service provision. A health equity audit on the cancer pathway will be used to inform decisions about service investment and organisation.
- Reducing the delay in patients in disadvantaged groups first going to see the GP
- Increasing the uptake of screening and investment in the cancer screening programmes including bowel cancer screening
- Increasing the consumption of fruit and vegetables.
- steps are being taken, within existing resources, to shift the balance of specialist health promotion services towards a greater emphasis on supporting primary care in deprived areas.

1.1.12 The PCT and partner organisations are clearly focused on achieving improvement in health and health outcomes, this plan sets out the Strategic efforts to deliver on this aim. This report firstly however moves on to examine the National targets to which the PCT must deliver.

2 NATIONAL CONTEXT FOR STRATEGIC PLANNING

2.1 Commissioning Framework

2.1.1 Published in July 2006 it sets out the vision for development of first-rate commissioning. Commissioners need to work with providers to secure the best health outcomes and the best services with best value for the public's money.

2.1.2 The document updates on the National reform agenda and sets out in more detail the roles, relationships and functions in a high quality commissioning process. Capacity and capability requirements for this role have been picked up through PCT's Fitness for Purpose assessments. Stockport PCT undertook this assessment in 2006 and later in this document are a set of targets and workstreams over the next 2 years to address development needs.

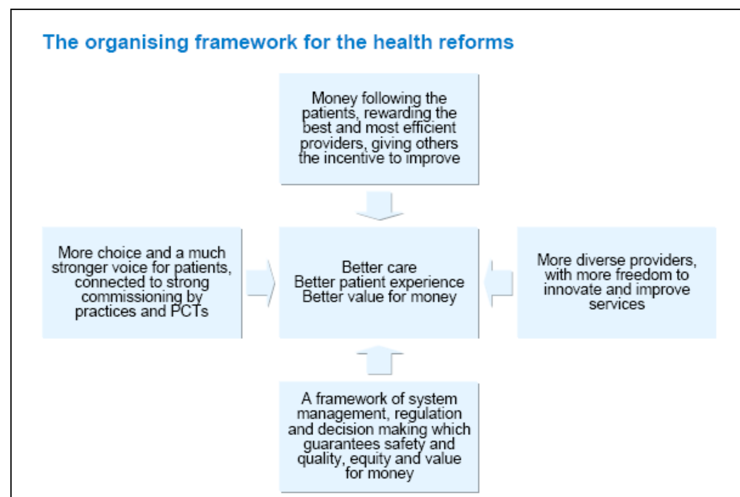
Why is reform so important ?

2.1.3 The NHS faces considerable challenges now and in the future. Rising expectations, advances in medical technology, variations in quality of service, ageing populations. Meeting these challenges will require a truly patient–led NHS that uses resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible health care.

2.1.4 The reforms are organised into these main strategies, consisting of

- Choice and Voice
- Payment by Results (PbR)/Incentives
- Diversity and Contestability
- Quality
- Regulation

Figure 1 Reform Framework



2.1.5 The drivers for achieving reform should come from three main dimensions:

1. Patient driven reform – choice and competition /provider development
2. Commissioner driven – contracting, tendering , service redesign
3. Nationally driven- standards, and regulation

2.1.6 None of these approaches are 'self contained' but act in concert to improve quality, patient experience and value for money. Patient driven reforms have a high profile currently in particular in the context of choice and PbR.

Choice

2.1.7 The National consultation on choice provided 5 principles for choice

1. **Choice is for everyone**

   Everyone is entitled to make choices about their health, to have their preferences listened to and to receive the support they need to make their choices.

   The views of patients, carers and the public should be sought, listened to and acted on when health services are planned, developed and commissioned.

   Some people may choose to have their clinical professional make the choice on their behalf. This is a valid choice.

2. **Choice is shared decision-making and shared responsibility**

   Patients (and/or carers where appropriate) and health and social professionals should make decisions about health in a partnership marked by respect and dignity. They also share responsibility for the choices made.

   Health and social care professionals should explain the implications of choices.

3. **Choice needs information**

   Patients must receive the information and support they need in time to allow them to take part in shared decision making.

4. **Choice is personal**

   Choice is personal and may mean different things to different people at different times.

   Choice includes choice of treatment as well as choosing where that treatment takes place.

   Individuals should be able to choose services that best suit their needs and reflect their lifestyle, circumstances and preferences.

5. **Choice must be fair and safe**

   Choices must be safe and evidence-based.

   Choices must be affordable taking into account the needs of the community and the individual.

2.1.8 Our own feedback to this consultation highlighted

Decision points for choice

2.1.9 The key issue to address is the need for a documented and understood care pathway in place up front when discussing choice with patients, the more decision points there are, the more complex this discussion becomes. Choices therefore must be for a reason not just a principle as this may result in unintended consequences such as poor clinical governance or confusion and poor patient experience

2.1.10 The PCT's position is that we will offer choice for assessment and diagnostic services on the elective pathway as a next step in expanding choice. Choice of post acute care is also important where feasible.

Equity of choice/Information for Choice

2.1.11 Advocacy for patients will be essential particularly in areas such as mental health and for older people. Providers will no longer be able to undertake that role fully.

2.1.12 We will need to develop navigators and look at developing the role of Patient Advisory and Liaison Services in this regard.

2.1.13 There should be formal training programme for all health professionals discussing choice with patients and include out-reach to charitable bodies such as help the aged.

2.1.14 Governance of the care co-ordination needs to be excellent to ensure that patients are transferred across services and providers effectively.

2.1.15 IT systems should be shared and information flowed across systems to benefit patients.

2.1.16 Information on choice needs to be more nationally directed in terms of minimal requirements, more details on clinical outcomes rather than softer issues of patient experience. information on quality should be at a service level not an organisational level.

2.1.17 The PCT is working actively with GP practices to ensure that referrals are made through choose and book– a national software programme which provides desk top access to a range of providers from which a patient can choose advised by the GP and other professionals. Stockport PCT target is for 90% of referrals to be made by March 07 the PCT ranked 97 out of 303 nationally at the end of February 2007.

Provider Development, Choice and Competition

Stockport PCT recognises the importance of provider development in the reform programme. Stockport was at the vanguard of Foundation Trust development, Stockport NHS Foundation Trust was authorised in April 2004.

2.1.18 The Government intends to build on success of Foundation Trusts working with NHS Trusts to move them to FT status where possible by 2008. A new Director of Provider Development has been appointed to oversee the roll out of FT's.

2.1.19 In addition the PCT along with other Greater Manchester Commissioners contracted with a new Independent Sector Treatment Centre : Greater Manchester Surgical Centre in Trafford, (Netcare Ltd) demonstrating our support for choice, and competition in elective care.

2.1.20 The PCT offers at least 4 hospitals of choice including usually one or two Independent sector hospitals. This choice offer is made by NHS Direct based in Nantwich on the policies of the PCT.

2.1.21 Our future challenges in provider development relate to the PCT's own Provider Arm, partnership opportunities with the Local Authority, new Assessment, Diagnostic and Treatment providers and enabling innovation and enterprise with Practice Based Commissioners locally.

2.1.22 The feasbility of a **'Community FT'** is being considered in response to a number of calls from PCT's, a first set of pilot Community FT's have been called for and Stockport PCT expressed and interest in this programme. A development programme is underway – outlined later in this document, for establishing a clear Community Services Commissioning Strategy, a Service Level Agreement with the PCT provider arm and further development of devolved governance structures and provider 'board' development.

2.1.23 There is also potential for NHS FT's to bid for community services if PCT's wish to bring in new or different providers of care, along with other providers. The PCT has not formulated a community service market management plan and is responding to gaps in service by ensuring there is a plural response and competition is considered. In addition to FT's, new social enterprises are also encouraged nationally and more engagement of the third sector – voluntary/charitable organisations.

2.1.24 A new community hospital fund has been announced (september first tranche of bids) £750m nationally to assist in development of infrastructure in support of new social enterprise initiatives. Stockport PCT has submitted a bid for this fund to revitalise St Thomas's Hospital and create a Managed Care Resource Centre under the umbrella of a new Social Enterprise company along with Practice Based Commissioning. Stockport Managed Care Commissioning is established to work with Practice Based Commissioners providing support, education, management services and growing the commissioning

capacity of practices. It is established as a Society for the Benefit of the Community built on a membership base held by practices. Savings and efficiencies generated by better commissioning from PBC will be reinvested in this charity and enable new ventures and innovations to be developed for the community. Stockport Health Enterprise is a Community Interest Company established for the purpose of development of the community estate and innovation in service delivery. These two new Social Enterprises will work along side existing arms length bodies of the Local Authority and new organisational structures in a more regulated environment aimed to support social entrepreneurs for the public good.

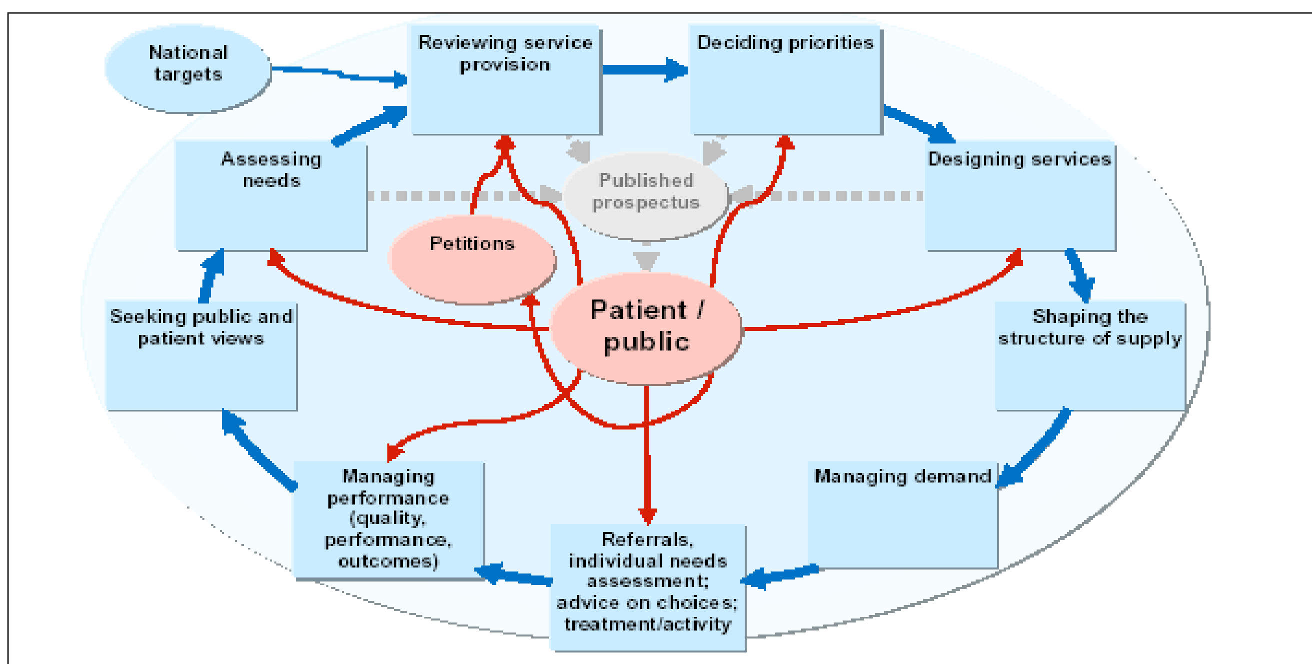
2.1.25 The development of these new provider structures will strongly align to the strategic commissioning of a shift in care closer to home and the vision of service integration outlined in the White Paper on Care out of Hospital.

2.1.26 The PCT is also preparing to contract with other PCT's in two further National Independent Sector Contracts. Clinical Assessment and Treatment Centre provided by Care UK and Diagnostics provided by ATOS. These will focus on increasing capacity and choice in the patient journey for elective care both will be based 'out of hospital' and accessible directly from GP referral. This additional capacity is vital in delivery of the promised 18 week maximum referral to treatment time for patients by December 2008, 85% of patients will be experiencing these journey times by March 2008. A plural market is being commissioned for these community based diagnostic, assessment and treatment providers. These providers will be available on choose and book and will compete for patients under common quality, standards and price regulation. The PCT's own assessment services will be included in such arrangements.

Commissioning development

2.1.27 Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean: the best possible health outcomes, including reduced health inequalities; the best possible healthcare; and within the resources made available by the taxpayer.

Figure 2 The commissioning cycle



2.1.28 This cycle sets out the processes of commissioning. The strategies uses to drive reform such as improving and standardising Quality of services for example, will be delivered through a framework of tools and approaches such as information, PBC, PCT Prospectus, community voice, choice, and incentives to deliver on objectives of commissioning.

2.1.29 The PCT will publish a prospectus during 2007 which sets out the needs assessment, rationale for priorities, patient experience target improvements, development and investment plans. A much stronger voice and accountability to the public is proposed through Local Involvement Networks and Overview and Scrutiny Committee processes. The PCT recognises the importance of information to improve accountability and is seeking to establish a focal point for consultation, complaints, quality and patient advise together with an integrated set of information systems which promote strategic review and improvement in services. for example the use of Programmes of Care which integrates public health outcomes, resources and benchmarking is a powerful tool along with Social Marketing information promoted by Dr Foster and other providers.

2.1.30 ***Comprehensive services*** : the PCT has the opportunity to use new incentives to reduce the risk for providers to enter an area to provide services needed, therefore ensuring a comprehensive set of services for patients to access. These include supplement to tariff, guarantees on volumes of activity, reducing capital investment required by offering land/buildings. The further use of 'mandatory service listings' as in FT terms of authorisation is also under consideration. The PCT has used these incentives for CAT's offering funding grants for set up, equipment, capital refurbishment and training.

2.1.31 ***Quality and effectiveness of care***: a minimum level of quality must be specified and delivered by providers. It is envisaged that there should be a range of incentives and approaches to deliver improved quality and reduce the variation in quality between providers. Improvements in clinical outcomes can be driven through contractual standards, national or local quality bonus scheme as well as the national regulation and HCC processes which are reinforced through commissioning processes. Stockport PCT has taken this approach in establishing a minimum and enhanced level for quality – identifying over 20 core quality criteria to measure and improve and reward accordingly. Where quality is of concern PCT must publish quality improvement plan- this already features as an element of the quarterly report to the PCT Board on quality assurance. The pay for performance initiative is now being taken up by the Northwest SHA and nationally, this initiative is based on work undertaken in the US by Premier and the local model implemented in Stockport which has National attention.

2.1.32 Information is critical in driving effective commissioning- use of referral and utilisation information, benchmarking and use of information by the PCT/PBC Board through 'intelligent' board processes are vital. A more systemised approach to information which demonstrates benchmarked performance on access, utilisation, referral management and quality must be a key development aim – benchmarking is the critical missing factor in much of our current reporting to the Board when comparing PCT to PCT, (PBC practices are being benchmarked and compared). This plan redresses some of this gap where later in this report consideration is given to key benchmarking information.

- Programme costing and outcomes
- Inequalities and case management
- Productivity indicators

2.1.33 ***Health and wellbeing*** : social care commissioning, health commissioning and joint commissioning all contribute to improving health and wellbeing. Commissioning which is effective in improving health focuses on promoting needs assessment, whole system working through the vehicle of Local Area Agreements and Local Strategic Partnerships, reducing health inequalities across the population and assesses the equity impact in any commissioned service change.: Stockport PCT needs a greater focus on integrated and

jointly developed and published commissioning strategy is needed between health, local authority and 'third sector' commissioning partners. Building on the LAA to develop a more co-hesive medium term strategy is a high priority for the PCT. The key areas for this focus are Older Peoples/Adult services, Childrens Disabilities and Childrens services, Learning Disabilities. A new Public Service Commissioning Board is to be established to steer this programme of work forward between key partner organisations.

2.1.34 ***Best Value*** : achieving better value care through focusing care in the community to reduce unnecessary referrals and improve value for money. Strategies employed must include prevention work, appropriateness of setting/service/pathway, accurate planning and forecasting of service needs/demands, PBC engagement, securing clinically effective services, developing referral and treatment protocols and utilisation management approaches. It is recommended that PCT's consider a more 'interventional' approach if required due to challenges in the economy including

- Referral management centres
- Prior approvals
- Utilisation review

2.1.35 These areas are a current major focus of work for the PCT, however there are significant challenges and gaps in ensuring that the PCT has a best value approach

- Implementation of the PCT Care and Utilisation of Resources policy – this has been significantly redrafted over the last 12 months with chapters on Effective Use of Resources – treatments funded or not and pathways required, admission charging policies relating to admissions for short periods from A&E, consultant to consultant referrals. This policy will be continually updated and reviewed.
- Referral management and compliance with pathways requires significant communication training and development of information systems to support practices in best practice management of patients. This is a primary focus of work for PBC in 2007-8 which is taking the lead in pathway development, training and patient management processes for the PCT.
- Development of integrated services for long term conditions, unscheduled care and older people is a major theme of work and development in this strategic plan and requires system modernisation and integration to achieve best value.

2.2 National Operating Framework

2.2.1 2007-8 marks the start of the second phase in reform of health care. By 2008-9 we will have an NHS characterised by free choice, competition on quality, money following patients. Lower growth in NHS funding will follow from 2008-9 and new disciplines and responsibilities are required on all parties which moves the NHS into a self improving system in which change is led and driven by clinicians and other staff. The NHS must become more responsive to patients needs. These reforms have been highlighted in the commissioning framework, the operating framework sets out the parameters within which local organisations will work in 07-8. Accountability for delivery of these priorities will sit between the PCT and the SHA however the nature of local accountability is expected to evolve during 2007-8 and for PCT's to become more outward facing organisations, accounting to their local communities, becoming proactive to challenges.

National Health and service priorities

2.2.2 Maximum 18 weeks from referral to start of treatment for 85% of admitted patients and 90% of non admitted patients by March 2008 and 100% of patients by December 2008. Specifically maximum waiting times of 11 weeks for inpatients, 5 weeks for outpatients, and 6 weeks for Diagnostics.

2.2.3 Reducing MRSA rates through clear commissioning plan and contracting mechanisms with providers.

2.2.4 Reducing health inequalities, promoting health and well being., using local area agreements, delivery plan and incentives to promote inter agency working on this agenda.

2.2.5 Achieving NHS financial health through delivery of a minimum £250m surplus in 2007-8. The PCT will achieve a surplus in 2007-8 from release of productivity savings in the delivery plan and PBC Accountability Agreement. The PCT is specifically focusing on work around productivity using both.

2.2.6 Improvements to Mental Health services are targeted Nationally in particular in relation to community development workers for black and minority patients.

2.2.7 The priorities for 2008-9 are also flagged in this framework document and PCT's encouraged to commence development planning work on choice in maternity services, end of life service review with the aim of increasing choice in these services, commissioning for minority groups, childhood obesity measurement programmes with schools.

2.3 Practice Based Commissioning (PBC) : Practical Implementation

2.3.1 PBC plays a vital role in health reform. It places GP's nurses and practice teams, working alongside secondary care clinicians and other primary can allied health professionals, at the heart of decision making to commission services for their local population.

2.3.2 The National guidance outlines processes for budget setting, management support under a specific agreement with the PCT, expected productivity improvements and details on governance and incentives.

2.3.3 Stockport GP's have taken up PBC fully during 2006-7 with full coverage in budget devolvement, a new information system for analysis of utilisation, a dedicated PBC Board with elected GP members. Performance management has been developed with peer review together with awards for innovation and a monthly communication letter and network meetings.

2.3.4 Practice Based Commissioning in Stockport will develop further in 2007-8. A new corporate membership vehicle has been established Stockport Managed Care Commissioning which is a Society for the Benefit of the Community and to which all PBC practices will be invited to join and receive access to training, risk pools, incentives and venture funds. PBC will focus significantly on development of care pathways, training and communication with practices to further enhance practice skills and best practice management of patients.

2.3.5 A corporate approach has been taken to savings in PBC with agreement on £6.9m of savings to fund PCT wide initiatives which meet jointly agreed priorities for the coming year. Practices will access savings above this level through a dedicated venture fund approach.

2.3.6 The PCT is supportive of PBC development and regards this as a progressive partnership for improving health outcomes and improving services for Stockport people.

2.4 Payment by Results and Contracts

PbR Terms 2007/2008

2.4.1 2007/2008 will be the fourth year that SPCT has operated under National Tariff (NT) within the PbR framework, whilst the policy is still developing it is now an established and tested element of PCT processes. The constituent elements are

- Price schedule of National Tariff
- NHS Operating Framework
- PbR Code of Conduct

PbR Scope

2.4.2 In 2007/2008 the current scope of tariff is retained unchanged, this also means that the threshold payment for emergency activity remains. The threshold payment guidance states that variances from a nationally set plan for emergency activity are at 50% of national tariff. In the current year and for 07/08, at least, the financial benefit of reducing emergency activity is not fully recoverable in year. SPCT have negotiated more favourable terms with SNHSFT whereby activity below a tolerance level is deductable at 100%.

Key Changes

2.4.3 In 2007/2008 there are four key changes to National Tariff that impact on SPCT.

1) Stability

2.4.4 In previous years the tariff has been directly linked to the national reference cost exercise, this has led to significant fluctuations in unit prices and hence impacted on planning assumptions and business case viability. In 2007/2008 the tariff is simply a 2.5% uplift of the 06/07 tariff with no changes in scope or structure. This simple change has meant that the tariff was published on time and also means that the financial impact of PBC target changes is not compromised. It is also a potentially significant movement froma cost based pricing system to a normative pricing system.

2) Unbundling

2.4.5 The most significant change to the tariff and technical guidance in 07/08 is the emphasis on unbundling. Unbundling or tariff sharing is the process that recognises that there may be more than one provider of a single patient episode. The most relevant examples are:-

- Diagnostics – if primary care commissions or provides diagnostic tests prior to a patient presenting as a first out patient attendance then the tariff paid to secondary care should be reduced by an agreed amount to account for this. Consistent with the policy the LDP does not assume dual funding of diagnostics.

- Rehabilitation – DH have looked at a number of conditions eg stroke and fractured neck of femur and identified the expected acute length of stay. They have then published a separate tariff for this element of the spell. This allows commissioners to separately commission acute and rehab care either from the same provider in discrete units or from two different providers. It is not envisaged that this will be implemented in 07/08 with SNHSFT.

- Patient Transport Costs – SPCT have already managed to ensure that the national guidance allows for a deduction from National Tariff where, as is the case in Stockport, the PCT manages the PTS/PES contract. This results in a reduction to tariff that has already been built into the PCT financial position in 2006-7

3) Critical Care

2.4.6 The National guidance sets out a framework for commissioning critical care. SPCT has successfully argued that the National guidance exposes PCTs to financial risk and allows Providers to make windfall gains due to differential marginal rates (20% for u/perf and 100% for o/perf). NHS North West have issued a revised framework in their planning guidance with all variances at a common rate of 50%. There is no National Tariff for critical care and as such there is an element of price negotiation. SPCT are seeking assurance from Providers that Local Price does not exceed their published Reference Cost.

4) Host Commissioning for A&E and Genito-Urinary Medicine

2.4.7 At present the above services are commissioned on a host basis as opposed to the PCT commissioning for its registered population. This both restricts the ability of the PCT to manage risk and restricts the scope of PBC.

2.4.8 In 2007/2008 it has been agreed within Northwest SHA that PCTs will commission on a registered patient basis. Contractually the impact is that our contract with Stockport FT will decrease but will increase with other Providers. More importantly it means that we are commissioning more complete patient pathways and that practices at the borders of Stockport are not restricted in the scope of their PBC budget.

Contracts

2.4.9 The DH have published both a new model contract and introduced a proposed new contracting structure whereby there would be one single contract between a provider and its host PCT, now known as the co-ordinating commissioner. There would then be a separate series of inter-PCT agreements setting out the role and responsibilities of the co-ordinating commissioner.

2.4.10 The most significant changes to the contract are: -

- A new Care and Utilisation schedule, this would incorporate much of the work currently undertaken within the PCT EUR policy in terms of prior approval, demand management and setting out agreed criteria for specific procedures.
- A new schedule 2 incorporating planned activity profiling and the ability to flex plans for changes in referral levels or conversion ratios. Associated with this is the ability for PCTs to make financial penalties for non delivery of 18 week targets, up to a maximum of 5% of relevant income.

2.4.11 The national target for contract sign off is 31st March 2008. Details are provided in the Provider Management section of this plan regarding contract key issues, investments, targets and performance

Contract Format

2.4.12 Foundation Trusts have the option to maintain existing contracts or move to the new format. Stockport, South Manchester and Salford have all indicated that they wish to maintain the current format. The PCT is therefore seeking to agree contract variations to incorporate the Care and Utilisation schedule and 18 week delivery levers.

All other providers will be contracted with through the co-ordinating commissioner role.

2.5 Consolidation of National Drivers

2.5.1 The table below sets out the drivers from the national policy directives. These clearly indicate the need for a combination of continued reform and development as well as a focus on delivery

Development drivers	Delivery drivers
Commissioning competency and capability – development of specialist tools and skills	Productivity
Practice based commissioning – engagement and development	Financial balance
Service reviews and pathway development	Health improvement
Provider development and market management	Inequalities
Quality improvement processes	Mental health
Choice , patient experience	18 weeks
Partnership working	MRSA
Local accountability and information provision	Patient experience/older people

2.5.2 To this national list of areas the PCT is required to deliver on there are a number of priorities arising from local needs assessments, service reviews and external review. These are outlined in more detail in the next section of this paper along with further detail on the national imperatives and details of the challenge in each.

3 STOCKPORTS PCT – PRIORITIES 2007-2010

These have been grouped into 6 priority areas

Stockport Delivery Priorities
1. Health improvement
2. Health inequalities
3. Productivity and Value for Money
4. Access
5. Long Term Conditions and Reform of Non Acute Older Peoples services
6. Mental Health

Each will be discussed below.

3.1 Health improvement

The primary function of the PCT is to improve the Health of Stockport's population. As set out in chapter 1, we need to confront the challenges of smoking, alcohol, cardiovascular disease (including the growing problem of obesity) and cancer

National Targets have also been established
Life Expectancy
Improve the health of the population by 2010 increase life expectancy to 78.6 years for men and 82.5 yrs for women.

This is a national target. There is no official target for Stockport but if Stockport were to experience the same target increases as nationally the target for 2004/06 would be 77.3 for males and 81.6 for females. Currently Stockport has a life expectancy of Males is 76.8 years Females is 81.3 years. Therefore the overall life expectancy position is broadly on target however as will be set out below the key issue is one of inequalities in this life expectancy across the Borough.

Cardiovascular disease
Cardiovascular disease (CVD) mortality and inequalities reduce mortality by 40% in people under 75 with a 40% reduction in inequalities gap. CVD was also identified under the value for money indicators as a key area for the PCT to conduct a service review in terms of cost, outcome and inequality outcomes. This will therefore be a significant area of work over the next 3 years.
For Stockport this would mean a reduction in circulatory disease mortality rate per 100,000 to 70.3 by 2008 (3 year average) Stockport's current position is 91.9.

Cancer
Cancer reduce by 20% in people under 75 with a reduction in inequalities gap of at least 6%
For Stockport this would mean a reduction in cancer mortality rate per 100,000 to 101.8 by 2008 (3 year average) and the current position is 122.2. this is therefore a high risk area. The programme budget analysis shows a higher than average spend with average outcomes and deprived areas with poorer outcomes. When efficiency targets are overlaid to this analysis for expected improvements arising from the work (discussed in the VFM/productivity section) this expenditure

drops to around the average for the peer group. It therefore appears that the real challenge in this area lies in the target reductions expected in both the average and deprived areas. Much of the interventions commissioned to deliver on this target has historically been in specialist services, more training is now anticipated however for primary care as a recent review of referral levels highlighted Stockport as one of the highest referrers for suspected cancers and with a very low (7to 10% confirmation rate) this means that only 1 in 10 of cancer referrals are actually cancers. If improvements are to be attained in this area then a much greater emphasis must be placed on targeting efforts in primary care and in ensuring that pathways for treatment in 31 and 62 days are achieved

Mental Health
Mental health reduce mortality rates from suicide or undetermined death by 20%, crisis resolution services are to be invested in, benchmarked analysis on mental health confirms that more resources must be targeted in these services. Modernisation work has been undertaken with Pennine care in the last two years notably a new centralised Drug and Alcohol service, Heathfield house – rehabilitation allowing transfer of patients from expensive out of area placements to a local secure service, reforms in older peoples services reducing bed numbers for a more community based service.

Smoking : reducing adult smoking rate to 21% or less by 2010, reducing prevalence in manual groups to 26% or less. The PCT must achieve the target for 4 week quitters and further promote stop smoking. The use of 'stop before the op' as an approach in elective care will further increase efforts in this area.

Obesity – tackle underlying determinants of health by halting year on year rising of obesity in children under 11 by 2010. the table below shows that the PCT is on high or medium risk on the recording of obesity, this is a first step on the process of establishing a strategy for obesity management which will include interventions through health trainers.

Childhood obesity	89% 11%	Achieve targets of 91.1% school nurse recording of BMI for children under 11 years and 11.9% recorded as obese by September 2008
Obesity	30% 26%	Achieve targets of 65% GP recording of BMI for age 15-75 years and 19% recorded as obese by March 2008

The Local Delivery plan for 07-8 will target resources of the PCT into key programmes for health outcome improvement and new investments in services to those practices which have the highest needs.

3.2 Health inequalities

Nationally there are specific targets relating to reduction in health inequalities (outlined above for **Cancer, Cardiovascular disease, Smoking**)
Overall PSA target is to reduce health inequalities by 10% by 2010 measured by infant mortality and life expectancy at birth.

Two key significant additional local drivers exist for prioritising reduction in health inequalities as a significant local target in this LDP

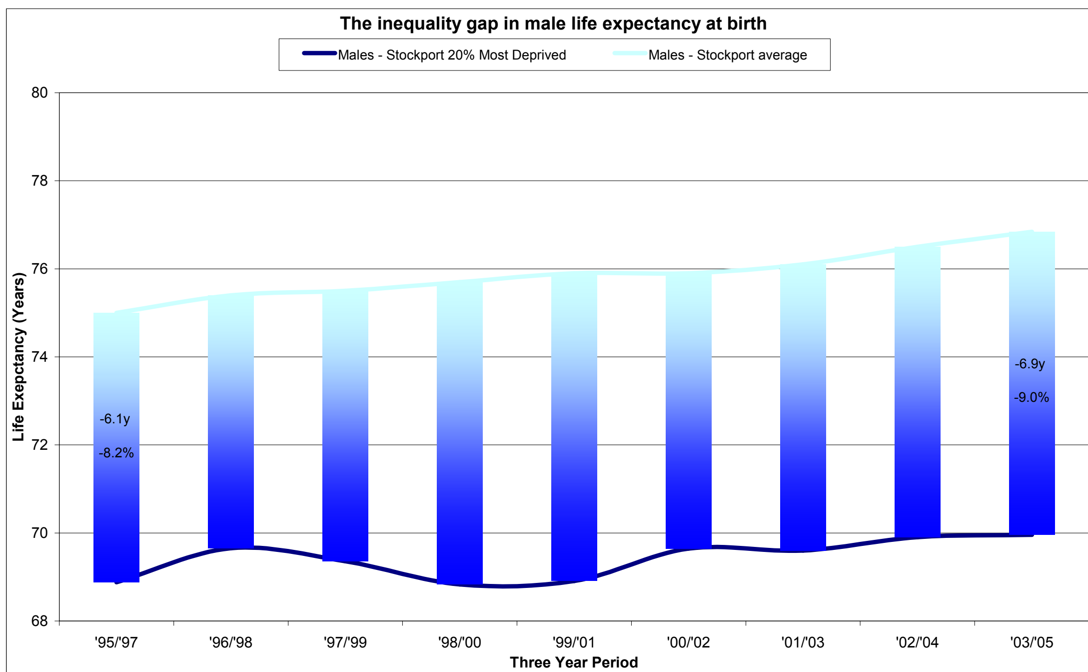
Firstly the growing gap in inequalities in the Borough.

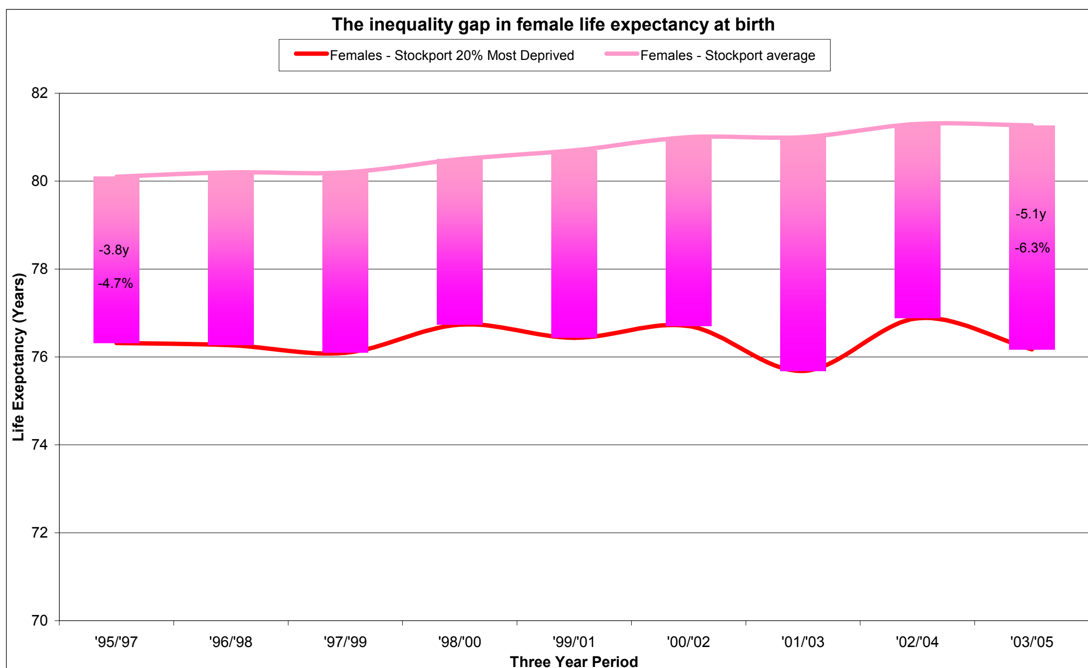
For both Men and Women there is a growing gap between the expected age of death in Richest and poorest in Stockport.

Stockport is the 7th most polarised district in terms of life expectancy.

For women the difference in life expectancy between the most deprived quintile and the Stockport average is 5.1 years and for men 6.9 years.

Figure 3 The inequality gap





It is understood that there are many factors driving inequality – housing, jobs, social infrastructure. Therefore the focus for health services must be to ensure that resources are targeted with front line professionals and that these health workers have rapid access to health improvement, intervention, diagnostic and treatment services. At the same time health must work in concert with other public sector bodies to ensure commissioning resources are working to maximise the outcomes from this investment in an integrated strategy on reducing inequalities. The primary vehicle for this strategy is the Local Area Agreement.

Case finding
A piece of work has been undertaken to review individual practices level of mortality on a disease, the number of patients registered and managed on this disease and access to hospital and other resources.
Practices in the most deprived wards have been targeted in this work and results from this will be used to initiate further 'case finding' work on practice patients to ensure these patients are brought into services, registered and access the right care for their disease whether this be a new drug regime, health intervention or treatment at hospital.

Further detail on this programme of work can be found in **Appendix A**

These key practices will therefore have individualised targets identified for reducing inequality in disease management which should in turn deliver the PCT wide target.

3.3 Productivity and value for money

Two main drivers have been examined for improvement targets in this area. The national *Productivity Improvement* targets and local *Value for Money review* through programme budget benchmarking.

3.3.1 National productivity targets

Productivity and Efficiency Indicators in the PBC national framework

Is PBC resulting in changes to services and outcomes ?

A score card is proposed which is to be centred around the National Institute for Innovation and Improvement productivity analysis

a) admission rates for 5 procedures with evidence of over use

a. myringotomy
b. hysterectomy
c. lower back surgery
d. tonsillectomy and dilation
e. curettage

Our position is benchmarked nationally and identified as a potential saving of £905k. the PCT was highlighted as 117.9 with mid point 100, December 2006.
Our best way of delivering on this indicator is for us to amend the Effective Use of Resources policy (EUR) which identifies criteria for referrals accepted or not for these conditions.

This can be reinforced through the incentive scheme for evidence of appropriate referrals against criteria. The EUR policy has been updated and extended and incentives are to be incorporated into the PBC incentive scheme to reinforce compliance with this.

b) emergency admissions for 19 ambulatory care sensitive conditions

These conditions are deemed suitable for non inpatient care, usually in the community or extended primary care settings. These conditions were identified nationally from work originating in Australia.

Figure 4 19 ambulatory sensitive conditions

COPD	Angina
Ear Nose and Throat infections	Convulsions and Therapy
Congestive Heart Failure	Asthma
Flu and Pneumonia >2 months	Dehydration and gastroenteritis
Cellulitis without major procedure	Diabetes with complications
Pyelonephritis	Iron deficiency anaemia
Perforated/bleeding ulcer	Dental conditions
Hypertension	Gangrene
Pelvic inflammatory disease	Vaccine preventable conditions
Nutritional deficiencies	

Nationally we were identified as a below average performer out of 305 PCT's we were 100.85 (mid point is 92) with an estimated saving target of £1.9m

Locally we have reviewed this information to see if we can identify the major opportunities for service improvement.

Our TOP 5 are
Flu and Pneumonia
COPD
Diabetes with complications
Dehydration and gastroenteritis
Convulsions and therapy

In terms of addressing these conditions the PCT and PBC needs to ensure the right range of services are commissioned and are in place
The corner stone to *preventing* these admissions is

a) reform of Older Peoples services to enable greater step up care and co-ordinated single assessment and access – rapid response to needs is essential
b) active case management – further development
c) development of a long term conditions strategy
d) co-ordination of unscheduled care providers

PBC must engage and drive these reforms and ensure that the LDP encompasses the right investments and reforms in the next three year to address this. We are for example looking at a 24 hour call centre for long term conditions as one strand of this framework.

e) Overall Referral Rates and for 6 specialities identified for care outside hospitals

The white paper on out of hospital care identified six specialities where it is expected there is a significant transfer of outpatient assessment and treatment services in the community. This national objective fits well therefore with the PCT strategy for commissioning new Clinical Assessment and Treatment services (CAT's) in the community.

It is anticipated that over the coming year around 30% of these specialities outpatient activity will be transferred to the community setting. This transfer enables two important objectives to be delivered
a) reducing pressure on hospitals and streamlining the patient pathway for 18 weeks – the more that can be done at the start of a patient journey in terms of assessment, diagnostics and review the better the pathway will be in terms of speed and efficiency through to any required hospital treatment within the 18weeks.

The 6 specialties are

- ENT
- Orthopaedics
- Dermatology
- Urology
- Gynaecology
- General Surgery

The overall referral rates is measured national by a outpatient appointment rate in the Institute Productivity tables. Here we have been identified in Quarter 2 06-7 at 106.5 the average is 99, the savings identified at £1.9m.

<u>PBC/PCT approach</u>

a) appropriateness of referral – the PBC incentive framework includes a continuation of funding for referral review work in practice, and compliance with a minimum referral letter standard

b) minimum referral standards – this will mean that where a pathway in each of the 6 specialities has been agreed by PBC Board this will highlight the minimum 'work up' of patients in a primary care setting prior to any community specialist referral (or CAT's). this is clearly all before the offer of a hospital of choice and PbR environment. A major part of this will include mini health screen and pre-op assessment, direct access diagnostics.

The PBC incentive scheme includes an incentive relating to this work up per patient on key critical pathways for 18weeks.

Both of these measures will work together with the further potential investments in local CAT's services in each of these specialities initially located at Kingsgate but if successful in the community hospital bid St Thomas's may offer additional accommodation and focal point for services.

The referral rates therefore will be improved in terms of appropriateness and the level of activity in the community setting as required nationally. In order to also meet 18 week compliance this emphasis on practice based work up is essential. It will therefore be a key requirement that there are target practice based work up maximum time as well as the final referral to treatment time tracking.

f) First to Follow Up Ratios

The number of follow up attendances at hospital following a first consultant visit can be reduced or transferred to primary care.
This will be tracked nationally as a score card indicator for PBC

This was a key focal point for practices in 2006-7. it is therefore wise to continue to have an incentive element in the scheme for continuation of call and recall system and for implementation of best practice systems.

The contract terms for our hospital providers include a standard ratio of first to follow up as a trigger point for review and denial of payment should the cause be due to change in practice by the hospital

g) Average length of stay

This will be tracked nationally as a score card indicator for PBC

Practices will pay for patients if admitted, in order to reduce the length of stay of patients and avoid Excess Bed Day charges then better co-ordination on discharge planning , step down intermediate care and rehabilitation is required. Also the drive to better day –case rates in hospital environment

The central initiatives from a PCT/PBC perspective is around reform of intermediate care and rehabilitation services. Secondly care pathway and service specification which dictates the setting for procedures to be undertaken and increasing outpatient procedures and day case rates. Further development of CAT's which may take up day case work from hospital trusts however may have a counter impact on this indicator.

h) Emergency Bed Days

This will be tracked nationally against total emergency bed days and 0-1 day admissions.

In 2006-7 a series of targets was established for *emergency care* from 05-6 base
5% reduction in emergency admissions (this is being achieved)
50% reduction in 'in appropriate admissions' (not achieved)
10% reduction in frequent flier re-admissions (not achieved)

The strategic response for this whole area includes

- A revised unscheduled care strategy is under formulation between the PCT and PBC Board, including a review of out of hours care.
- Continued development of case management for high intensity users
- Admission charging policy for 0-1 day admissions – now in place resulting in non payment for in appropriate admission

3.3.2 Value for Money review

The PCT has identified a value for money assessment to include the following elements

a) **targeting : are PCT resources allocated to maximise health improvement?.** here a review of expenditure on health programmes and on localities is important. The expenditure on resources should match the priorities for health improvement and should be targeted in the populations of greatest health need.

b) **outcomes** : **is expenditure on key health programmes delivering outcome commensurate with this investment ?** here health programme expenditure is matched to health outcome indicators through the National Centre for Health Outcomes Development. Whilst the analysis is in early stage of development some important messages can be determined. Secondly are effective treatment s being commissioned, the Effective Use of Resources policy when applied fully will ensure that interventions which are not cost effective are excluded.

c) **efficiency : is the cost of services delivered good value?** Here a review of productivity opportunities has been used for excess hospitalisation which can be reduced and funding released to develop community alternatives, such as assessment

services in the community . Secondly review of services outside tariff such as Rehabilitation where working with partner organisations, re-tendering and reconfiguring /integrating services releases savings for reinvestment. A critical priority for the PCT in relation to Long Term Conditions, Unscheduled Care and Older Peoples services.

The Efficiency Plan set out later in this report identifies savings in

(i) Pathway efficiency – reducing hospitalisation rates
(ii) Scope of effective treatments – reducing expenditure in areas of non proven cost effectiveness
(iii) Lowering cost for existing services – tendering and reconfiguring services at a lower cost for same or improved outcomes

Programme budget analysis
Programme Budget information has been collated for 2004-5 and 2005-6 which sets out the PCT expenditure on health services by broad disease groups.

Programmes are set out below together with the analysis of Stockport PCT's expenditure and outcomes :

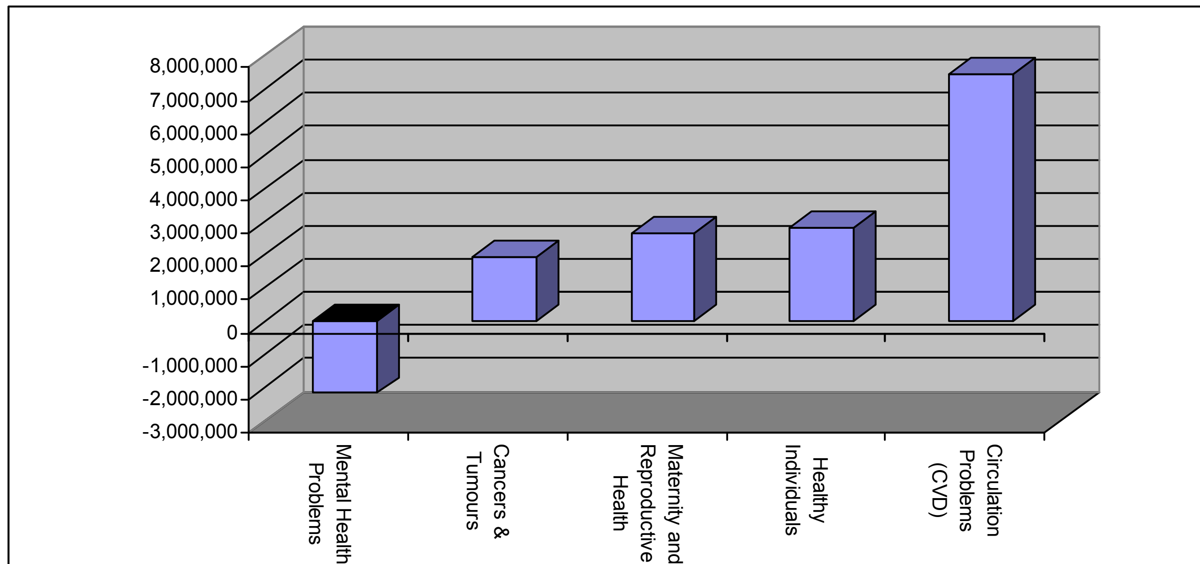
Figure 5 Programmes

Prog Code	Programme Budget	Net Spend per 100,000 of popn 2005/2006	SMR 2002/2004
10	Circulation Problems (CVD)	16,053,514	103.9
23	Other Areas of Spend/Conditions:(GMS)	15,560,325	
5	Mental Health Problems	13,662,350	
2	Cancers & Tumours	9,856,306	99.2
13	Gastro Intestinal System Problems	8,915,918	100.8
16	Trauma and Injuries	8,218,948	96.2
11	Respiratory System Problems	7,635,272	93.1
17	Genito Urinary System Disorders (	7,445,325	
15	Musculo Skeletal System Problems	7,057,579	
18	Maternity and Reproductive Health	6,676,937	
12	Dental Problems	5,073,231	
4	Endocrine, Nutritional and Metabolic	4,285,399	
7	Neurological System Problems	4,268,947	
21	Healthy Individuals	3,583,193	
6	Learning Disability Problems	3,439,238	
8	Eye/Vision Problems	2,928,474	
14	Skin Problems	2,368,355	
22	Social Care Needs	2,244,590	
1	Infectious Diseases	2,097,643	
4a	Diabetes	1,878,531	
20	Poisoning	1,334,490	
3	Blood Disorders	1,291,116	
19	Neonate Conditions	888,040	
9	Hearing Problems	785,588	
		137,549,309	

The Programmes have been compared to the PCT peer group to assess relative spend and outcomes.
This approach of benchmarking investments with peers and linking levels of expenditure to outcomes has helped target investments and efficiency areas in 2007/2008. This process, linked to service reviews, will be further developed and pursued in 2007/2008 and beyond.

The graph below shows the benchmarked variances to expected levels of investment for 5 key programme budgets. The PCT is significantly above peer group average investment for Cardio vascular disease, Healthy Individuals, Maternity, Cancer, with a below average investment for Mental Health.

Figure 6   Programmes of Care - benchmarking

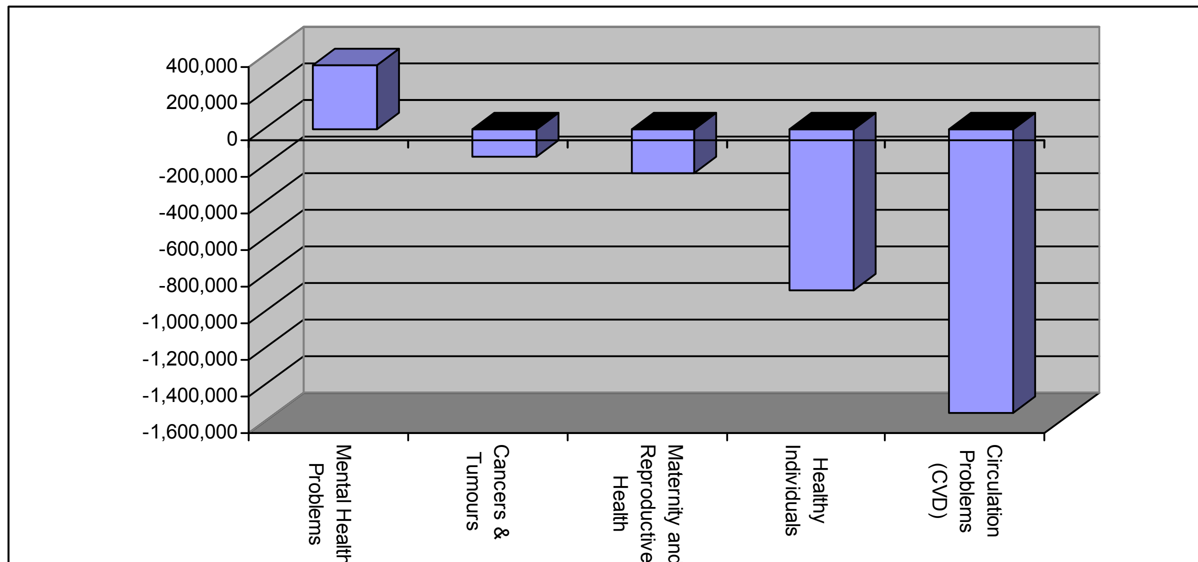


This analysis gives priority to **Circulatory Disease** and **Mental Health** as whole review and reform areas

3.3.3 The second table then shows how the investments (excludes collaborative commissioning)and expected productivity savings will impact on these programmes in 2007/2008, more detail on these investments and savings are found later in this document

3.3.4 It can be seen that these reform and investment areas move the PCT toward a more equitable position on each programme.

Figure 7 Top 5 Programmes after Investment and Reform



CVD has been reviewed nationally for Stockport PCT as part of the Governments pilot project on using such information to inform decision making

Key findings on Cardiology

- Non elective admissions are **higher** than average
- **Below** average day case rates
- Significantly **above average** Length of Stay for non elective admissions 14.5 days versus average of 11.5
- One of the uk's **highest** number of items prescribed per head 4.8 versus average of 1.2
- **High** cost per head, driven by number of items above
- **Below** average cost per item
- **Low** position on low cost statins 43%

So the messages for the service review are both in terms of a review of primary care prescribing and disease management and the management of patients in hospital referring onward to other specialist centres and access to treatments.

Mental Health is recommended for a 1% increase in investment in each of the next three years and targeting on improving access and reducing inequalities. More detail on this is provided below

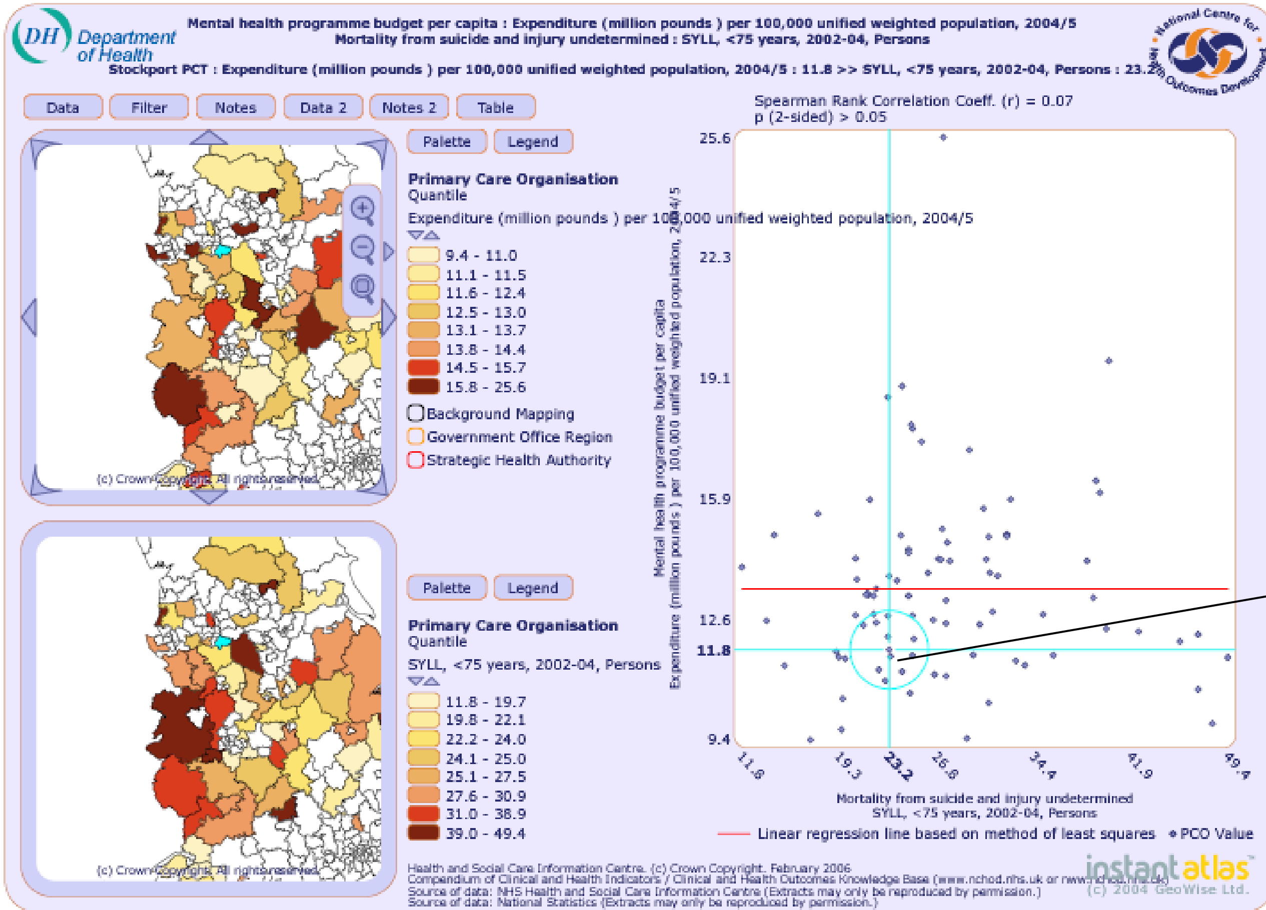
Circulatory Disease is recommended for a **whole service review** as the impact of moving to a usage basis and addressing any unnecessary admissions does not improve the overall value for money status, in this analysis there are poor outcomes for the relatively high investment

These two priority areas are re-confirmed in the National Centre for Outcomes Development as key outliers.

The first map shows mental health against outcomes, in a peer group of 'small prospering towns' there is not a strong correlation in these data sets but the PCT is mapped in the lower quadrant

The second map shows Circulatory Disease with the PCT having high spend and relatively poorer outcomes than PCT's in this cluster. In this analysis there is a stronger correlation between spend and outcomes than that shown in the Mental Health graph.

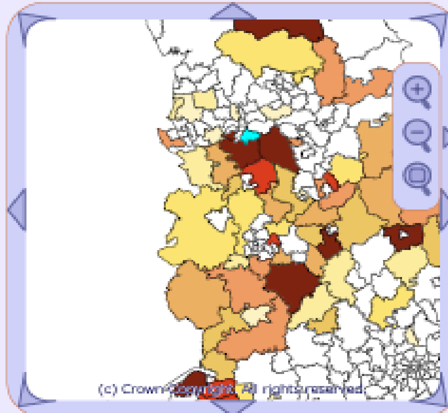
Address http://nww.nchod.nhs.uk/NCHOD/PB_MH_PCO_Snapshot_Double.nsf/SVGViewForm?OpenForm



Stockport

Circulatory system programme budget per capita : Expenditure (million pounds) per 100,000 unified weighted population, 2004/5
Mortality from all circulatory diseases : SYLL, <75 years, 2002-04, Persons
Stockport PCT : Expenditure (million pounds) per 100,000 unified weighted population, 2004/5 : 14.4 >> SYLL, <75 years, 2002-04, Persons : 117.8

Data | Filter | Notes | Data 2 | Notes 2 | Table



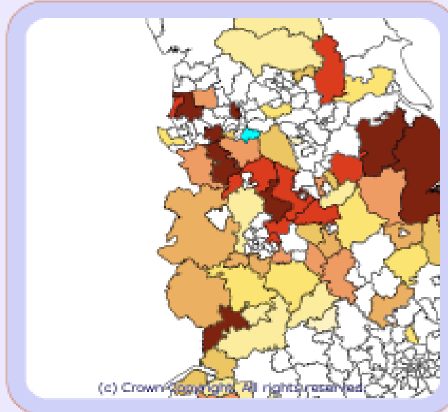
Palette | Legend

Primary Care Organisation
Quantile

Expenditure (million pounds) per 100,000 unified weighted population, 2004/5

- 7.3 - 10.7
- 10.8 - 11.6
- 11.7 - 12.3
- 12.4 - 12.8
- 12.9 - 13.4
- 13.5 - 13.9
- 14.0 - 15.1
- 15.2 - 16.9

Background Mapping
Government Office Region
Strategic Health Authority

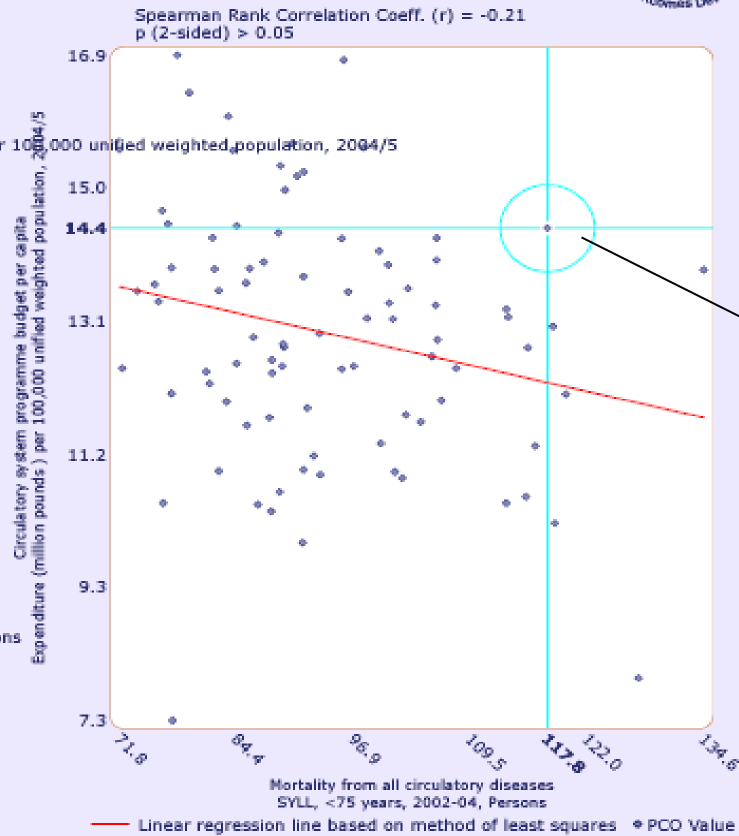


Palette | Legend

Primary Care Organisation
Quantile

SYLL, <75 years, 2002-04, Persons

- 71.8 - 77.4
- 77.5 - 83.9
- 84.0 - 88.1
- 88.2 - 91.4
- 91.5 - 96.3
- 96.4 - 102.5
- 102.6 - 113.3
- 113.4 - 134.6



Stockport

Health and Social Care Information Centre. (c) Crown Copyright. February 2006
Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or www.nchod.nhs.uk)
Source of data: NHS Health and Social Care Information Centre (Extracts may only be reproduced by permission.)
Source of data: National Statistics (Extracts may only be reproduced by permission.)

instant atlas
(c) 2004 GeoWise Ltd.

3.4 Access

The key national targets for Access relate to

- 18 weeks from referral to treatment by December 2008,
- GUM access to service within 48 hours,
- Cancer 31 and 62 day compliance,
- Crisis Resolution,
- Audiology

The PCT has produced a detailed 18 week delivery plan which is summarised in **Appendix B.** The key issues to note are

85% of patients must have treatment commenced within 18 weeks from referral by March 2008. the PCT plan has secured capacity sufficient for 5 weeks maximum outpatient wait, 6 week diagnostics, 11 week inpatient. These maximum waits together with reduced waits in CAT's of 4 weeks will be sufficient to deliver these targets. The PCT's approach focuses on investment in primary care based assessment, new community based assessment and treatment services to accelerate patient journey, diagnostics and additional NHS and Independent sector inpatient capacity. The key risks are in Orthopaedics which is currently at a 40week referral to treatment average wait, this will require significant reform and management to achieve the target reduction.

Two additional Programme Specific areas based on Local Priorities

3.5 Long Term Conditions (LTC)/Older Peoples

3.5.1 Stockport is currently developing a Long Term Conditions Strategy. This is therefore a key priority to address in 2007. The development of such a strategy will ensure that services are 'joined up' in terms of meeting the needs of patients with multiple diseases and conditions. Such a strategy requires close partnership working with all agencies but in particular with Stockport MBC.

3.5.2 The PCT is currently leading a consultation process to commission a new model of care for non acute older peoples services focused on current Cherry Tree hospital. This revised model envisages closure of hospital beds and reprovision into a community rehabilitation and intermediate care service, this together with new investments in prevention and closer working with social services will provide efficiency savings for reinvestment in this area.

3.5.3 The productivity targets identified for the PCT on 19 Ambulatory Sensitive Conditions highlight the opportunity to improve efficiency in management of patients with LTC's. The key strategies in response to this target include Active Case Management, investment in Rapid Response and a LTC Call Centre

3.6 Mental Health

3.6.1 The NHS Operating Framework for 2007/08 identifies the following for mental health

Early Intervention and the recruitment of Community Development Workers.
Locally a further 4 areas are priorities

- Development of Crisis Service Model
- Primary Care Mental Health Services
- Alcohol Services
- CAMHS, particularly the provision of services for children with learning disabilities

3.7 Quality Improvement

3.7.1 There is a clear national drive for PCT's to seek improved quality in each and every provider contracted and accredited to provide care to patients. This is done through nationally organised systems such as the Health Care Commissions standards and compliance systems. PCT's however have an important role in ensuring that quality standards and expressed in each contract and that there are a range of monitoring and evaluation systems to determine quality of providers care.

3.7.2 This process of standard setting, monitoring and addressing quality issues is an important new task for the PCT. The work programme commissioned for Stockport includes a detailed quality schedule included in each contract, incentives and rewards for achieving enhanced levels of quality, a range of information and evaluation systems to check on progress against these standards is really key. Finally the publication of providers quality standard and achievements as part of the PCT prospectus is planned during 2007-8.

3.7.3 Under the quality heading the primary drivers nationally are the drive to improve patient safety and reduce infection rates, particularly for MRSA and Clostridium Difficile. This emphasis will be reflected within quality schedules and in developing joint arrangements and standards for investigating serious untoward incidents and cases of infection.

3.8 Summary of Local and National Strategic Priorities and Outcomes to be Commissioned

3.8.1 The analysis of drivers outlined above leads the PCT to consolidate the service improvement priorities for 2007-8 to 2009-10 and move to a clear performance framework relating to outcomes.

The table enclosed below summarises these priority areas and the targets for improvement together with a high level assessment on risk.

1. Health Improvement

Benefits:	
Increase average life expectancy of men in Stockport to 78.6 by 2010	
Increase average life expectancy of women in Stockport to 82.5 by 2010	
CVD Mortality to 70.3 per 100,000 by 2008	
Cancer mortality to 101.8 per 1000,000 by 2008	
17% smoking prevalence by March 2008	
21.6 under 18 conception rate per 1000 by 2010	
17.2% gonorrhea rate per 100,000 by March 2008	
11.9% child obesity prevalence	
21% adult obesity prevalence	
Number of woundings reduced to 1807 by 2008/9	
Number of incidents of criminal damage down to 5050 by 2008/9	
Outputs:	
100% GP practices with validated registers of those at high risk of CVD by March 2008	
90% of patients with CHD to have BP reading of< 150/90 by March 2008	
80% of patients with CHD to have cholesterol reading < 5 mmol/l by March 2008	
91.1% of children with BMI recorded; [this target being queried]	
75% smoking status recorded at GPs by march 2008	
3647 quitters per 100,000 2007/8	
15% of all 15-24 year olds screened for Chlamydia	
65% adult BMI recorded	
70% of women aged 50-70 having breast screened for breast cancer	

Comment [a1]: Already at or better than this so need to look at this

2. Health Inequalities

Benefits	
The Health inequalities gap narrows by 10% by 2010 as measured by life expectancy at birth	
The gap for CVD mortality closes by 40% by 2010	
The gap for Cancer mortality closes by 20% by 2010	
Outputs	
941 smoking quitters from deprived areas	
10% of mothers smoking during pregnancy	
95% of mothers with smoking status recorded	
71% of mothers initiating breastfeeding by 2008/9	
59% of mothers continue to breast feed at first visit by 2008/9	
95% recording of breastfeeding initiation status	
26.6% of adults in deprived areas participate in 30 minutes of physical activity 5 x per week	
Reduced prevalence rates in practices in socially deprived areas	
Improved management of chronic disease in socially deprived areas	
Homelessness primary care service established	

3. Access to Services

Benefits	
All patients commence treatment within 18 weeks of referral by Dec 2008 85% of patients admitted in March 2008 commence treatment within 18 weeks. No patient waiting more than 5 weeks for outpatients, 6weeks diagnostics, 11 weeks inpatients	
All patients accessing GUM clinics are seen within 48 hours	
All people with enhanced CPA seen within 7 days of discharge	
Outputs	
50% of remaining appropriate minor surgery procedures transferred from hospital to primary care	
No patients waiting more than 6 weeks for MRI and CT scans	
No patients waiting more than 13 weeks for any diagnostics including first audiology assessments	
All audiology reassessments seen within 18 months by March 2008	
Increased % abortions taken place at or before 10 weeks	

4. Productivity

Benefits	
Saving on effective use of resources procedures with highest admission rate	
Saving emergency admissions for top 5 ambulatory care sensitive conditions	
Saving on referrals for 6 care outside of hospital specialties	
Reduced cost of emergency bed days	
Reduced high cost statin prescribing – reducing cost of prescribing	

5. Long Term Conditions and Older people

Benefits	
Saving on top 5 emergency admissions	
Reduced emergency bed days by 6.5%	
10% of older people (65+) supported to live in own home	
Outputs	
1760 very high intensity users on ACM caseload by March 2008	
22 Community Matrons by March 2008	
Reduced number of supported admissions to permanent residential nursing care to 1221 over three year period to March 2009.	
96 % of equipment and adaptations provided within 7 days by 2008/9	

6. Mental Health

Benefits	
Suicide mortality rate reduced to 7.4 per 100,000 by 2008	
Outputs	
562 people seen by crisis resolution/home treatment service	
42 new psychosis diagnosis receiving early intervention	
100% of people on enhanced CPA receive follow-up within 7 days of discharge	
883 drug misuers in treatment in treatment for 2007/8	
71% of drug misusers sustained in treatment for 2007/8	
3 Community development workers to support BME by December 2007	
6 primary care graduate workers for psychological therapy	

7. Quality Improvement

Benefits	
Improved patient satisfaction scores for all providers	
Reduction in significant untoward incidents across economy	
All service providers receive good/excellent in annual rating	
Outputs	
Improved performance across local quality indicators	
Reduction in MRSA and Clostridium Difficile rates across Stockport PCT	

Appendix C contains the **detailed targets and trajectories upon which this plan will be monitored**. This report now moves forward to consider the development priorities for this organisation and partners in the health economy to drive higher standards and performance.

4 PRIORITIES FOR CREATING A WORLD CLASS COMMISSIONER

4.1 What is a development priority?

4.1.1 The PCT undertook a Fitness for Purpose review during 2006 which involved a number of self assessments, external reviews and consultancy support to develop a programme for strategic development. These programmes of work are designed to improve processes, strategic planning and clarity of direction for future delivery programmes of the PCT. Many of these programmes of improvement will have stages of improvement over 1 or 2 years and therefore are important to recognise in this three year strategic plan.

4.1.2 Each of these programmes will result in a strategic document which will be approved at PCT/PBC Boards and will initiate additional delivery plans. These will be added to the PCT delivery plan dependent on prioritisation of these and available capacity.

4.2 Development priorities

There were a number of key priorities identified within the plan requiring work:

4.2.1 **Organizational development**. The PCT has a major change programme to deliver commissioning new services, developing and training PBC, enabling provider development. Specific training needs for these change leaders are therefore also needed to be successful. These include project management skills, business process redesign, business planning and business case skills. The way that the PCT manages performance of strategic change is also to improve. New systems are needed to ensure that accountability is clear and that delivery of targets is on track.

4.2.2 Prioritization. It is a key responsibility of PCT's to ensure that services are commissioned as 'best value' offering the most cost effective care and optimising outcomes. New approaches are needed for reviewing the Programmes of Care commissioned by the PCT how cost effective are these?, how are these programs targeted to reduce health inequalities ? This work is of vital importance in a forthcoming period of reduced growth in the NHS where prioritisation of resources is needed.

4.2.3 Care Pathway, Service Review and Service Specifications (Appendix D highlights these pathways and service review work). New and redesigned care pathways are to be developed in particular in relation to delivery of 18 weeks and development of the primary care and intermediate tier of assessment and diagnostic services. in addition to care pathway work a number of whole sale service reviews are proposed relating cost efficiency issues, choice or quality. The PCT will further develop skills in specifying services in terms of commissioning standards, indicators and outcomes using more sophisticated levers and incentives for driving quality in these services.

4.2.4 Practice Based Commissioning. The next stage for PBC development will see the creation of a social enterprise for commissioning under an accountability agreement with the PCT. Key development tasks for this new organisation relate to training and education of GP's in following best practice pathways and policies designed to improve management of patient care. New management capacity is required along with specific training and accreditation. PBC will take the overall lead for those priorities identified in 4.2.3.

4.2.5 Unscheduled Care. There is a large overlap in work concerned with unscheduled care, older peoples non acute service reforms and long term conditions. This specific work programme seeks to ensure integration of service providers whose primary objective is addressing urgent care. This will encompass out of hours care services as well as ambulance, walk in and A&E review.

4.2.6 Quality. Significant work has already been progressed in developing a standard approach to measurement of quality across the providers of care. Work here will progress this to a

complete set of quality standards and schedules as well as embedding a process for improvement and escalation of quality issues in terms of commissioning approaches.

4.2.7 **Patient Experience and Engagement.** A greater focus is required on assuring and ensuring patients are managed through the health and social care systems well and that their needs are assessed and delivered in an integrated way. This will require a greater co-hesion between the PCT services which for example offer Patient Advise and Liaison, Complaints, Referral management information centre, Patient booking and choice advisors, and the local GP who needs to be aware of how each patient is progressing in their care packages at any point in time. These care navigators will be a major point for strategy development along with greater accountability and information from the PCT to the public through the (to be published) PCT Prospectus on services. Further, effective consultation with patients and the public over improvements and changes to service is essential in ensuring their design meets the needs of the population. A clear approach linked to the change process and training and tools to support those leading change are within the work plan.

4.2.8 **Long- Term conditions** Chronic diseases including coronary heart disease, diabetes, and asthma for example and other conditions that once acquired can only be managed not cured such as MS, form a major area of demand from health services. Therefore the development of a strategic approach to prevention, self-management and effective treatment within primary and community care is a cornerstone of the PCT approach to managing demand and improving health outcomes.

4.2.9 **Market Management and provider development** . PCT's must demonstrate capacity for proactive market management. Taking a planned medium to longer term assessment to requirements for services to meet patients needs and an setting out for providers clear strategies and processes for securing such services. Recent examples undertaken by the PCT include C.A,T's services, Diagnostics. This workstream aims to consolidate and horizon scan regarding these requirements as well as setting out the potential service scope, range and performance parameters. In this workstream the development of alternative social enterprise vehicles will be considered along with partnership integration with local authority.

4.2.10 **Community Services Strategy.** This work specifically works alongside the development of community service providers. Setting out a strategic vision based on health needs, best practice, and service models this strategy will provide a blue print for the market assessment and analysis of future community service provider requirements.

4.2.11 **Partnership Strategy**. The Health and Wellbeing policy agenda will be implemented through this workstream which will specifically set out the future vision, structure and systems for integrated commissioning and closer partnership working with the Local Authority. Further development of Local Area Agreement structures and the Public Service Commissioning Board are key envisaged milestones in the coming year.

4.2.12 **Data Managemen**t. Working with national systems such as SUS, Choose and Book, Lorenzo further work will be progressed on a more integrated approach to data management and usage of such in integrated and joined up patient management integrated performance management and monitoring of provider quality.

4.2.13 **Estates Development.** A significant enabler for care to be delivered out of hospital relates to the development of fit for purpose estates. A strategic plan for estates development is to be refreshed setting out programmes for a new community hospital, resource centres and infrastructure for a range of community services. A dedicated estates development vehicle has been established to progress this work.

4.2.14 **Workforce Strategy and Electronic Staff Record.** Getting the right staff skills and expertise is vital in delivering the strategic agenda set out in this plan. A workforce strategy will be formulated and capacity and capability gaps identified for the next three years with a view to informing the provider and market development workstream. Specifically a new

electronic staff record will be introduced which will enable greater information on and planning to be undertaken for workforce needs.

4.2.15 **IM&T**. The continued roll-out of Lorenzo and the implementation of the National Programme for IT (connecting for Health) is essential in efforts to improve the transfer of information across the multiple providers of healthcare; driving up clinical standards; and monitoring of performance. Rolling out clinical systems that communicate effectively to each other is the next challenge.

4.3 Summary Development plan – accountabilities

Appendix E identifies the Development plan accountabilities and leads

5 INTERVENTION PRIORITISATION APPROACH

5.1 Introduction

5.1.1 This plan has identified drivers, priorities and detailed these into clear targets and accountabilities. This plan now considers how to ensure those targets are delivered through investment in new services, and reforming services. Commissioning leads in the PCT identified these interventions for consideration and funding. In order to select the most effective balance of investment prioritisation is required.

5.2 Investment and Reform Interventions

5.2.1 A tool has been developed which enabled the PCT and key stakeholders to prioritise interventions against the improvement targets.

5.2.2 This tool (set out below) was established with stakeholders taking part in a weighting process for each of the key priorities.

5.2.3 Each intervention was scored in a 'live' planning event using voting technology on the interventions and the respective scores. These scores were seen as part of the overall process for ranking of investments.

5.2.4 In addition to this process the PCT undertook a review on invest to save potential, degree of commitment and contractual sign up, and the need for investment in 'must do's '.

5.2.5 The tool is contained in **Appendix F**

The results of this scoring analysis is presented as part of the financial plan section 8 below.

5.3 Future work

5.3.1 The PCT development plan identifies the need for a systematic review of programmes where evidence of improved value for money exists.

5.3.2 The following programmes are therefore to be reviewed and a prioritisation plan identified in each in terms of resource release, investment and reform

Figure 8 Key Programme Areas for Prioritisation Review

Circulatory Disease
Cancer
Respiratory
Maternity
Healthy Individuals

6 DELIVERY PLAN

6.1 New interventions commissioned

6.1.1 The PCT published its priorities in January 2007. Commissioning leads for the key priority areas identified a number of new interventions which would assist in securing the service improvements identified.

6.1.2 The table below sets out the intervention, the score assigned from the prioritisation workshop and an outline of this proposal and which priorities are addressed by this reform.

6.1.3 It should be noted that some of the interventions commissioned do not score highly in the ranking undertaken by stakeholders, this reflects the implication of nationally derived targets against local imperatives.

Figure 9 New Interventions

Intervention	Priority assessment	Summary	Delivers on priorities	Investment in 07-8 £'000s
Access and 18 weeks				
18 weeks hospital capacity	50%	Additional hospital capacity for treatments With an 11 week maximum waiting time, once patients have been listed for a procedure.	Access Health improvement	£2,250
18 weeks diagnostics and CAT's	50%	New diagnostic capacity in the community which will allow GP's directly to refer and receive results, supported by a new Clinical Assessment and Treatment service run by GP's and nurses who can assess patients, use the diagnostics and undertake simple treatments. Maximum wait 5 weeks and 6 weeks for diagnostics	Access Health Improvement Productivity	£3,020
Practice Based assessment and health screening pre referral	60%	Assessment of patients, mini health screening, first line diagnostics and 'stop before the op'	Access Health Improvement Productivity	£540

Intervention	Priority assessment	Summary	Delivers on priorities	Investment in 07-8 £'000s
		interventions based in practice prior to direct listing.		
Audiology	47%	New pathways and services to work towards the 13 week assessment milestone. Reassessments to be undertaken with new providers with dedicated capacity and a shortened pathway.	Access Health improvement Long term conditions	£448
Health Improvement and Inequalities **'Choosing Health '**				
Chlamydia Screening	30-35%	Deferred entry to GM screening programme	Health improvement	£180
Hep C Screening	30-35%	Screening programme as set out by directors of public health and nationally required	Health improvement	£180
Social Marketing	30-35%	Information to be made more accessible to patients and public regarding health services, outcomes and equity of access to encourage accountability and promotion of patient 'voice'	Health improvement Access Inequalities	£137
Alcohol Brief Intervention	65%	A new service targeted at those most needy areas where following assessment patients can be quickly referred and lifestyle advise and support provided	Health improvement Inequalities Productivity Mental health	£125

Intervention	Priority assessment	Summary	Delivers on priorities	Investment in 07-8 £'000s
Obesity Management	58%	Capacity for specialist assessment and treatment and health trainers	Health improvement Access	£393
Inequalities enhanced Service	67%	Targeted enhanced service for practices in deprived wards to undertake additional audit and case finding over and above QoF to increase appropriate management of diseases and reduce mortality in these key areas.	Inequalities Access	£100
G U M service access	54%	Development of new community based services to enable guaranteed access within 48 hours to this specialist service	Health improvement Access	£194
Mental Health				
Child and Adolescent Mental Health	54%	Priority investments developing a full range of CAMHS services for (i) C&YP who have a Learning Disability need and (ii) 16 & 17 year olds.	Mental health Health improvement	£185
Crisis resolution and home treatment team	79%	Additional members of crisis resolution team	Mental health Health improvement	£330
Primary Care Mental Health link workers	58%	Additional workers assigned to each locality to develop interface with practices	Mental health Health improvement	£102

Intervention	Priority assessment	Summary	Delivers on priorities	Investment in 07-8 £'000s
GP Access for the homeless	56%	Access to GP service through homeless refuge and thus avoiding A&E	Mental health Productivity	£20
Older people and Long Term Conditions				
Additional community rehabilitation capacity	62%	To enable the closure of cherry tree hospital rehabilitation wards, additional rehabilitation teams and investment in nursing home capacity is proposed	Long term conditions /older people Productivity	£350
Long term conditions call centre pilot	62%	Pilot in 5 GP practices across Stockport utilising existing call centre targeted on advise for patients with long term conditions 24 hours 7 days a week	Long term conditions Productivity	£70
Continuing Care	60%	Recognition of new eligibility criteria will require assessments of patients for funding and a greater number will be brought into this funded care environment	LTC /Older People	£1,000
Enhanced Primary Care Services inc Falls	63%	Investment in enhanced primary care services in both LTC , practice treatments and mental health initiatives focused on invest to save approaches	LTC Productivity	£581
PBC incentive and training				

Intervention	Priority assessment	Summary	Delivers on priorities	Investment in 07-8 £'000s
Incentives for delivery of priorities	67%	An incentive scheme which requires practices to review referrals, reduce follow up outpatients, follow effective use of resource policies Follow prescribing formulary Case find for long term conditions services and ensure personalised care plans are in place	Productivity Access Long Term Conditions	£796
Training and Development	67%	New training courses to ensure practices are skilled in new pathways and protocols	Access	£150
Productivity reviews				
Primary Care DVT Service	50%	Triage and assessment including blood tests and doppler scan and appropriate treatment for patients referred with symptoms of DVT	Productivity	£64
Midwifery triage	36%	N12 admissions for no birth events have grown to a very significant level. This midwife led triage service will telephone triage and manage at home where appropriate to avoid unnecessary admissions to delivery suite and reduce cost impact at tariff.	Productivity	£30

Intervention	Priority assessment	Summary	Delivers on priorities	Investment in 07-8 £'000s
A&E follow ups to Community Setting	54%	Opportunity to transfer consultant follow up visits post A&E treatment to a community setting and avoid tariff.	Productivity	£46
Collaborative /Specialist				
Investment package for Cancer, Renal , Cardiac, Secure MH, diabetic retinopathy	Not scored already prioritised by CE's	Overall package of investment related to business cases, quality, targets and access	Health improvement Access Mental Health	£2,740
IMT				
Investment	Not scored but recommended from management	Help desk and infrastructure investment locally to support national programmes including GP support	Access	£102

In addition to these specific Commissioned interventions there are funds set aside for

a) ISTC increased cost of contract
b) NPFIT programme (connecting for health)
c) New Drugs and treatments to be pronounced by NICE

A number of interventions were not prioritised for investment and these are listed below

Figure 10 Excluded Investments

Schemes not within prioritised list for 2007/08 Investment EXCLUDED

Scheme Details	Priority Score	Investment Type In-Year
	No	£'000
Contraception	276.4	148.00
Community IV Therapy service	276.3	82.00
Review of Purchase Management for Dressings (Prov Productivity)	265.1	25.00
Downs Syndrome Screening - Change in local Pathway	262.2	135.00
Childrens' Therapy service	259.7	152.00
Health of Looked After Children	247.1	20.00
A&E Pilot - Further week	241.1	13.00
Physio for Respiratory needs of Children	238.0	39.00
Increase Provision of Psycholigical therapies	233.6	56.00
School Nursing	230.1	76.00
Training Post for Safeguarding Vulnerable Adults	222.0	20.00
Neuro Physio for Young Adults with complex disabilities	218.4	52.00
Children with Co-ordination Difficulties (DCD)	210.7	40.00
Comm Nurse in Palliative Care	204.7	53.00
Cancer	196.6	500.00
New Bereavement Co-Ordinator	194.7	59.00
New Palliative Care Educator Role	191.7	53.00
CFS/ME Spec Multidisciplinary team	144.9	25.00
Total		**1,548.00**

6.2 Productivity Plan

6.2.1 Interventions have been commissioned which enable services to be improved, health outcomes improved and efficiencies offered where ever possible.

6.2.2 The table below summarises those interventions which will realise savings and also a range of other system changes which will ensure savings are achieved.

6.2.3 The activity reductions required for each has been identified thus tying the financial reduction and activity /demand management together.

Figure 11 Productivity plan

Table- Efficiency Plan – savings from budget levels				**Upper range Activity Impact**			
Efficiency plan scenarios	**Investment?**	**Upper range**	**realistic**				
		£'000	£'000	Elective Spells	Emergency Spells	Out Patient Attendances	A&E Attendances
Right pathways and settings							
ICAT's deflection target	☑	4,300	1,250			45,800	
admission charging policy	☒	500	500		900		
Ambulatory Care (LTC)/unscheduled care	☑	1,900	950		1290		
Obstetrics Triage	☑	300	150		634		
Alcohol intervention	☑	280	140				3800
Primary Care DVT	☑	160	80	138			
A&E follow ups	☑	130	65				2350
Cost effective treatments							
Care and Utilisation /EUR	☒	1,500	750	1,500			
Statins prescribing/glucose	☒	2,300	1,150				
Value for money							
Older Peoples reforms	☑	2,000	-				
Collaborative commissioning	☒	3,712	1856				
Total		**17,082**	**6891**				

6.3 Summary delivery plan – accountabilities

6.3.1 **Appendix G** contains a detailed set of interventions existing and new against each of the 6 delivery areas for the PCT strategic plan. Many interventions contribute to a number of the PCT priorities therefore these are mapped in terms of primary target and contributory.

6.3.2 A traffic light system has been used to indicate whether this delivery priority is high risk, medium risk or low risk in terms of challenge of delivery and range /strength of interventions commissioned.

6.3.3 It should be noted that the following are on RED and will require particular performance management attention during 07-8 and beyond to ensure delivery

6.4 High risk Areas

6.4.1 Health Improvement /inequalities

- Cancer
- Smoking and during pregnancy
- Abortion service
- Obesity

6.4.2 Access - 18 weeks

6.4.3 Mental health

- Suicide
- Crisis Resolution

6.4.4 Long Term Conditions – number of patients on high intensity management programmes

7 THREE YEAR OPERATIONAL AND FINANCIAL PLAN

7.1 Introduction

7.1.1 2007-8 represents the last year of significant new resource growth to the NHS.

7.1.2 Funding and cost increase assumptions are set out below. As can be seen growth funding is estimated to reduce from 8.43% in 2007-8 to around 4.5% in the two years beyond. This will be confirmed as part of the follow up work from the Comprehensive Spending Review in March 2007.

Figure 12 Inflation and Growth

Inflation Rates	06/07	07/08	08/09	09/10
Growth on notified opening allocation	8.16%	8.43%	4.50%	4.50%
Growth on other recurrent allocations	2.50%	2.50%	2.50%	2.50%
Tariff (Mandatory)	4.00%	2.50%	2.50%	2.50%
Collaborative / Specialist Commissioning	3.70%	2.50%	2.50%	2.50%
Non Mandatory	4.00%	2.50%	2.50%	2.50%
Acute Independent	4.00%	2.50%	2.50%	2.50%
Ambulance	4.00%	2.50%	2.50%	2.50%
Mental Health	4.00%	3.50%	3.50%	3.50%
Prescribing	9.00%	9.00%	9.00%	9.00%
Provider / Community	4.00%	2.50%	2.50%	2.50%
GMS/PMS	4.00%	4.00%	2.50%	2.50%
NPFIT/CFH	2.50%	2.50%	2.50%	2.50%
NWSHA Transitional Fund (Strategic Reserve)	0.00%	1.50%	0.00%	0.00%
No Inflation	0.00%	0.00%	0.00%	0.00%
Other	2.50%	2.50%	2.50%	2.50%

The financial plan has been based on these uplifts however it is recognised that pay review body proposals are out for consultation and prescribing uplifts can be reduced with medicine management of the PCT.

7.2 Financial Schedules

7.2.1 **Appendix H** contains the financial plan for 2007-8 to 2009-10 which comprises a budget for 2007-8 and an estimated plan for 2008-9 and 2000-10 the latter two years being refreshed annually as a three year rolling plan. **The summary below provides the budget for 2007-8 which the Board is required to endorse.**

Operating cost statement

7.2.2 The table below summarises the roll-over baseline budgets, amounts set aside to fund inflationary uplifts in 2007/08 (in line with NWSHA guidance) and level of new investments in 2007/08 which can be funded within our total notified allocation for 2007/08 together planned savings released from our Efficiency Savings programme of £6.9m

Figure 13 Operating Cost Statement 07-8

				Memorandum	
Summary Operating Cost Statement 07/08	**Recurrent Budget 2007/08**	**Non Recurrent Budget 2007/08**	**Total In-Year Budget 2007/08**	**Total In-Year Budget 2008/09**	**Total In-Year Budget 2009/10**
Purchase of Healthcare					
NHS Providers	224,597,622	0	224,597,622	230,619,034	234,949,393
Non NHS Providers	14,901,434	0	14,901,434	16,550,371	18,214,100
CATs & Diagnostics	0	0	0	5,964,000	6,113,100
Primary Care					
GP Prescribing	50,157,000	0	50,157,000	53,521,130	56,360,118
Pharmacy Services/Products	1,567,431	0	1,567,431	1,606,617	1,646,782
New Pharmacy Contract	2,172,000	0	2,172,000	2,226,300	2,281,958
nGMS Contracts	28,619,378	0	28,619,378	31,093,770	31,871,114
New Dental Contract	950,000	0	950,000	973,750	998,094
Primary Care Developments	719,910	0	719,910	737,908	756,355
Provided Services	22,803,843	0	22,803,843	23,715,939	24,368,838
Headquarters Costs	6,547,338	0	6,547,338	7,317,021	8,499,977
Choosing Health	0	0	0	1,103,000	1,380,575
Hosted Monies - NPfIT	1,707,000	0	1,707,000	2,409,675	3,129,917
Reserves c/fwd 06/07	3,644,044	5,957,000	9,601,044	5,407,485	5,506,679
Roll over Baseline Budgets	**358,387,000**	**5,957,000**	**364,344,000**	**383,246,000**	**396,077,000**
Inflation Reserve (07/08)	12,877,000	0	12,877,000	12,263,000	12,770,000
Investments	17,207,000	(1,757,600)	15,449,400	6,425,000	3,595,000
Turn Around Target saving (as per 07/8 LDP)	(6,891,000)	0	(6,891,000)	(5,856,000)	(1,500,000)
Planned Surplus / (Deficit c/fwd)				5,354,000	10,308,000
TOTAL BUDGET 07-08	**381,580,000**	**4,199,400**	**385,779,400**	**401,247,000**	**421,250,000**

The detailed budget analysis for 2007-08 is attached at Appendix H

Capital Programme

7.2.3 The table below summarises the draft Capital plan for 2007/08. This shows that the PCT is anticipating a total source of funds of £836k to deliver its capital programme requirements in 2007/08. The majority is the capital programme is targeted at improving the infrastructure of our estate.

Figure 14 Capital programme 07-8

Draft Capital Programme 2007 - 2008

	Budget 2007-08 £'000
1) SOURCE OF FUNDS	
Allocations	422
Sale of Assets	414
TOTAL SOURCE OF FUNDS	**836**
2) APPLICATION OF FUNDS	
Total Spend on Non Estates capital	163
Total Spend on Estates capital	673
TOTAL APPLICATION OF FUNDS	**836**
Total Uncommitted/(overcommitted)	0

Appendix H provides a more detailed analysis of the capital programme showing planned spend by individual scheme.

Balance sheet

7.2.4 A summary of the balance sheet for 2007/08 is shown below. This reflects both revenue and capital spending at the budgeted level in 2007/08 and anticipated movements in the balance sheet arising from technical adjustments eg capital charges, indexation on fixed assets.

Figure 15 Balance Sheet

Forecast Balance Sheet 2007-08	Balance at 1.4.07 £'000s	Balance at 31.3.08 £'000s	Movement £'000s	31.3.09 £000s	31.3.10 £000s
FIXED ASSETS					
Total Fixed Assets	**24,045**	**24,369**	**324**	**24,688**	**25,125**
CURRENT ASSETS					
Stocks	86	86	0	86	86
Total Debtors	4,117	4,017	(100)	3,950	3,950
Total Cash at Bank and in hand	21	21	0	15	15
TOTAL CURRENT ASSETS	**4,224**	**4,124**	**(100)**	**4,051**	**4,051**
CREDITORS (< 1 YEAR)					
Total amounts falling due in 1 year	**(22,984)**	**(23,339)**	**(355)**	**(23,300)**	**(24,000)**
NET CURRENT ASSETS/(LIABILITIES)	**(18,760)**	**(19,215)**	**(455)**	**(19,249)**	**(19,949)**
TOTAL ASSETS LESS CURRENT LIABS	**5,285**	**5,154**	**(131)**	**5,439**	**5,177**
CREDITORS (> 1 YEAR)					
Total amounts falling due more than 1 year	**0**	**0**	**0**	**0**	**0**
Provisions for Liabilities & Charges	(1,847)	(1,496)	351	(1,600)	(1,750)
Total Assets Employed	**3,438**	**3,658**	**220**	**3,839**	**3,427**
TAXPAYERS EQUITY					
General Fund	(7,208)	(8,498)	(1,290)	(9,882)	(11,903)
Revaluation Reserve	10,646	12,156	1,510	13,721	15,330
Other Reserves	0	0	0		
Total	**3,438**	**3,658**	**220**	**3,839**	**3,427**

A more detailed analysis if the balance sheet can be seen at Appendix H

Source and application

7.2.5 The table below summarises the Source & Application of Funds statement for 2007/08.

Figure 16 Source and Application of Funds (add in yr 2/3)

Summary Source & Application of Funds	2007/08			2008/09			2009/10		
	Rec £'000s	Non Rec £'000s	Total £'000s	Rec £'000s	Non Rec £'000s	Total £'000s	Rec £'000s	Non Rec £'000s	Total £'000s
(i) Source of Funds									
Funding Available (incl Growth)	379,537	6,242	**385,779**	396,592	4,655	**401,247**	414,431	6,819	**421,250**
Planned Efficiency Programme	6,891	0	**6,891**	5,856		**5,856**	1,500		**1,500**
TOTAL SOURCE OF FUNDS	**386,428**	**6,242**	**392,670**	**402,448**	**4,655**	**407,103**	**415,931**	**6,819**	**422,750**
(ii) Application of Funds									
Baseline Budgets (incl Pre-Commitments)	358,387	5,957	364,344	381,581	1,665	383,246	394,412	1,665	396,077
Inflation Uplifts on baseline budgets	12,877	0	12,877	12,263	0	12,263	12,770	0	12,770
New Investments in 07/08	17,207	(1,758)	15,449	6,425	(185)	6,240	2,995	600	3,595
TOTAL APPLICATION OF FUNDS	**388,471**	**4,199**	**392,670**	**400,269**	**1,480**	**401,749**	**410,177**	**2,265**	**412,442**
Bottom Line Surplus / (Deficit)	**(2,043)**	**2,043**	**0**	**2,179**	**3,175**	**5,354**	**5,754**	**4,554**	**10,308**

The above table shows that the PCT has a recurrent deficit at c£2m and has achieved an in-year balanced budget with an offsetting c£2m surplus on non recurrent budgets.

Efficiency plan

7.2.6 This plan has been set out in outline detail, this has been converted into an activity plan reduction on those key areas in the programme which require demand management. This activity plan reduction has been shared with all main providers of health services and agreement on planning for this reduction and risk management strategies surrounding this.

Risk Management

7.2.7 This plan also includes a 'scenario' assessment on potential risks to the assumptions underpinning this financial plan. These scenarios are not unmanaged. A detailed performance management process is to be delivered within the PCT to reduce risk and manage delivery.

Figure 17 Risk Management

Scenario	Risk	Benefit
Productivity savings not realised by 50% - loss of £3.5m	£3.5m (low)	
Cost estimates on required investments exceed by £1m in particular in relation to 18 wks and specialist services	£1m (high)	
Unforeseen pressures. E.g continuing care £2m	£2m (medium)	
PCT provider does not achieve CRES and statutory risk lies with PCT risk £1m	£1m (low)	
Uplifts on GMS/pay are less than assumed £2m benefit		£1m (medium)
Prescribing uplifts higher than required benefit £2m		£1m (high)
In year slippage on investments and change programmes, further scrutiny on investment provisions benefit £2m		£2m (medium)
Productivity release higher than minimum level		£1m (medium)

7.3 Workforce Planning

7.3.1 The Local Development Plan 2007/08 (LDP) contains a number of programmes which require additional or changed workforce resource in the future.

7.3.2 A key component of the success of any of the LDP's will be ensuring we have the right staff, with the right skills in the right place, doing what we need them to do. A number of the programmes require an increased emphasis on Training and Development to ensure we have new skills to support developments, along with ensuring robust succession plans are in place to support services where we place heavy reliance on specialist skills. Work will also continue around the commissioning of newly qualified staff and the development of new roles e.g. Advanced / Assistant Practitioners in partnership with the University's.

7.3.3 The training and development of staff is already underway to support programmes such as 18 weeks, Older People, Practice Based Commissioning and Children's Reconfiguration etc, with skills such as business management, advanced clinical skills and increased IT skills.

7.3.4 In addition to training a number of the programmes also require new staff, an example of which are the new Health Trainers role which has specific skills and will play a key role in the health inequalities agenda. Where new staff are required, these have been factored into our LDP workforce return and local workforce planning. However, in the coming months we need to be aware of the potential impact of the nationally procured Independent Sector CATS, on established local CATS and the local workforce.

7.3.5 A number of the programmes also include plans for staff to be utilised in different ways due to services being modernised, in order to gain efficiencies and improve the quality of the service provided, therefore where services may need less staff, it is envisaged that they will be re-skilled and where possible fill new roles or gaps in services.

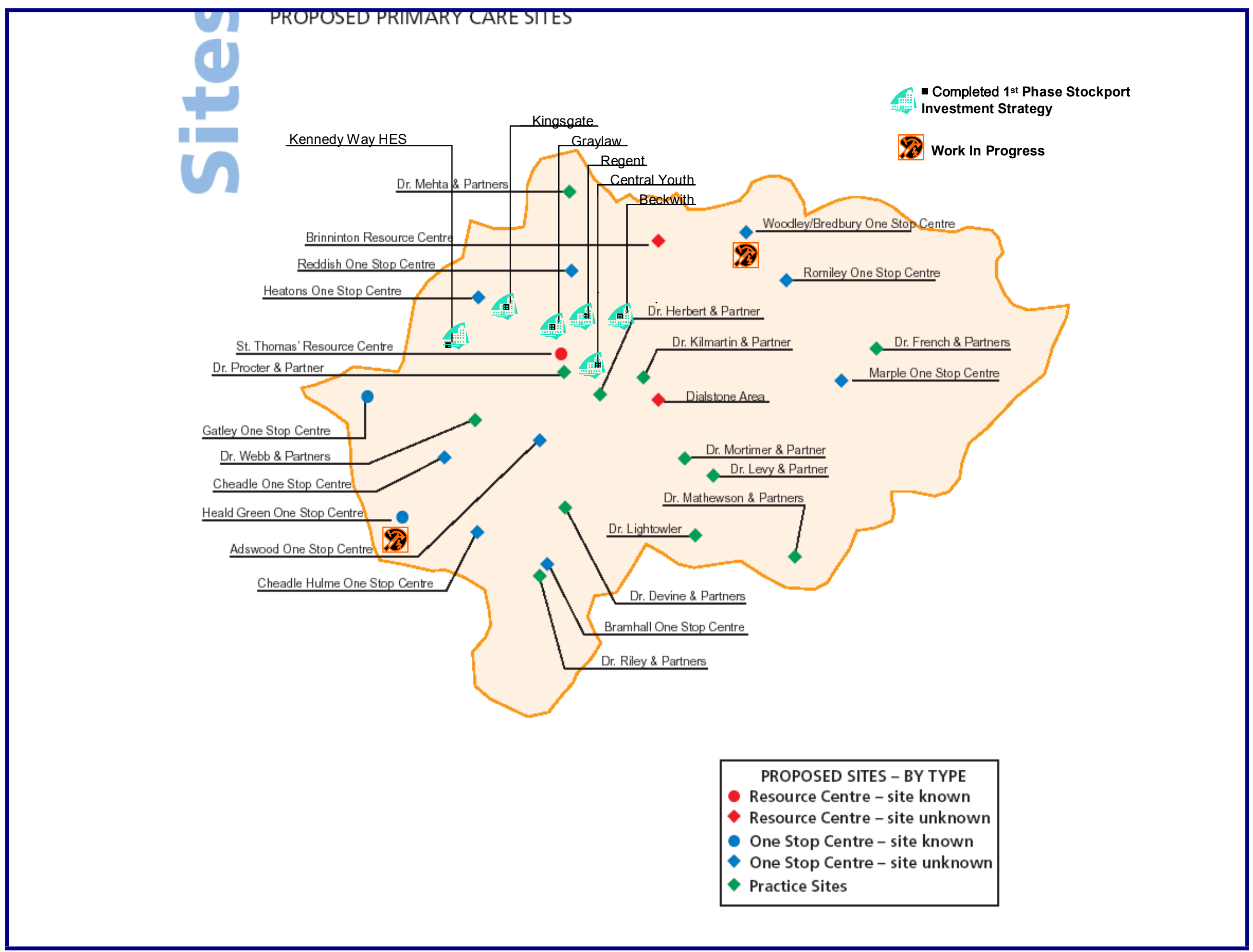
7.3.6 The Agenda for Change pay structure and the Knowledge and Skills Framework will support the development of skills to support modernisation and will enable the development of a more flexible workforce to take us into the future, whilst being mindful of succession planning and sustainability. Following the recent Fitness for Purpose exercise which highlighted the need for increased capacity and identified gaps in capability in some areas, the PCT is undertaking a full training/skills needs analysis for the organisation in 2007 and a Workforce Strategy will be produced to support the organisation in meeting its challenging targets including financial balance.

7.4 Estates

7.4.1 The PCT and PBC recognise the importance of a strategic plan for investment in the estate. Back log maintenance and major repair work for the PCT community sites totals in excess of £10m, against a book value of just under £20m (Land and Buildings)

7.4.2 The Strategic Estates plan identified a strategy which consolidated and reduced the number of sites for delivery of health services across the Borough. This plan is set out below in map form together with annotation on recent investments and delivery, and current work in progress.

Figure 18 Estates Strategy



7.4.3 The revised strategic programme for the next three years is set out below which confirms the investment priorities in the Stategic Estates plan. This investment plan will not be reflected in the Capital Programme of the PCT as this is to be delivered largely through the new community interest company established for renewal of community estates for community, intermediate tier and primary care services 'Stockport Health Enterprise'.

Figure 19 Estates three year Investment Plan

	2007-8	2008-9	2009-10
Heald Green and Woodley	Build phase operational April 2008 partnership Ist Health	*Fully operational*	
Central Youth	Relocation to new integrated youth centre subject to business case and lease	*Fully operational*	
Hazel Grove extension	Improvement grant for enhancements to health centre in hazel grove	*New Build and fully operational*	
Sale /disposal of Cherry Tree	*Site development and* preparatory work in conjunction with implementation of closure on the site. Legal measures in place	*Receipt of disposal* proceeds	*Continued distribution of site sale proceeds in the form of grants for new builds and improvements*
Romiley	*Minor works funded out of PCT capita*l Enabling work subject to business case and confirmation of Cherry Tree sale	New build partnership with stockport health enterprise CIC	Operational
Dialstone	Enabling work subject to business case	New build partnership with Stockport Health Enterprise and SMBC	Operational
St Thomas's community hospital for managed care	Site clearance of St thomas's and enabling work	New build using anticipated grant from community hospital fund and in partnership with Stockport Health enterprise /PBC	Build and operation

8 PBC ACCOUNTABILITY

8.1 Stockport Managed Care Commissioning

8.1.1 Stockport Practices have agreed to form a 'Society for the Benefit of the Community' this is a membership organisation which is called Stockport Managed Care Commissioning and is an Industrial Provident Society. This new company will have a Board of Directors which includes 6 GP, 1 Local Authority, 2 PCT and 1 lay member. Members will vote to elect board members. The PCT governs its relationship with this new body through an Annual Accountability Agreement, a second Management Services agreement also sets out the support provided to practices

8.2 Accountability Agreement

8.2.1 This agreement sets out the following

- Targets for improvement in services
- Budget delegated
- Scheme of delegation and financial governance arrangements
- Expected efficiency savings and investments sponsored across practices

8.3 Incentive Scheme

8.3.1 Resources are identified for the delivery of targets which rely upon practices changing patient management processes, engaging in new referral management policies, switching to more cost effective drugs. It is recognised that change management requires incentive to firstly target attention on the area of change needed and secondly pull practices forward to adopt best practice much faster than would otherwise occur.

8.4 Budgets

8.4.1 The PBC budget is £351m and is constructed as follows

- Total Resource Limit for 2007-8 £ 385m

- Not Devolved : Primary Care £ 34m- conflict of interest as a Provider.
- **Total PBC Budget £351m**
- Devolved and blocked back for management £7M, a separate management agreement is in place for support provided to the IPS and associated resources
- Devolved to Practice level : Elective Prescribing Outpatients: £103m
- Devolved to IPS Corporate level : £201m
- Devolved to IPS Corporate Level with PCT/Collaborative Commissioning £40m

8.5 Management Services Agreement

8.5.1 This agreement sets out the services and resources made available to practices with key performance indicators on each area. This agreement is managed through SMC board and management under this agreement who are providing significant resources to the new society will be deemed to operate on behalf of this body and under its guidance. Terms are included in this agreement relating to notice period and associated management of change.

Appendix J provides the details of these agreements. The individual budgets relating to practices are not disclosed here.

9 PROVIDER MANAGEMENT

9.1 Market Management Issues

9.1.1 The following outlines the key areas envisaged in commissioning for change in existing provider services and in bringing in new providers for a service not previously commissioned.

Area	Issue	Approach
Specialist	A new northwest wide specialist collaborative team will be responsible for commissioning almost £900m of services	PCT will collaborate with this team in terms of market management approaches
Acute	Additional capacity commissioned in NHS, FT and IS providers to meet 18 weeks. This in patient capacity will include in house diagnostics and associated aligned services.	Any willing provider approach taken to this requirement, however capacity review highlighted that to meet 18 weeks on orthopaedics required both ISTC contract and FT contract to be fully efficient. Additional capacity in the IS will also be sourced for orthopaedics based on this evaluation.
Mental Health	Additional capacity will be offered to Pennine care for primary care and crisis resolution teams	No market exists currently for either core acute mental health or primary care. Further work is planned to explore a more diverse market for primary care.
Intermediate Tier	Additional community based diagnostics capacity required to meet planned coverage and access levels and facilitate 18 week pathway New clinical assessment and treatment capacity required to meet 18 weeks pathways	PCT to approach local NHS Trusts for 'local diagnostic' capacity and benchmark this. Major diagnostics in relation to MR, CT and US provided through nationally tendered service along with other GM/NW PCT's, and local NHS capacity. Choice will be ensured through Choose and book for this capacity PCT to commission from in house community services in partnership with GP's and local FT and also to tender with

Area	Issue	Approach
		other NW PCT's for CAT's services to compete with the locally sponsored Choice will be ensured through choose and book for this capacity
	New 48 hour community based GUM service to be established	Specification and benchmarking comparators established prior to award of this investment to in house provider. Pilot is planned.
	Audiology – modernised reassessment pathway service	Following pilot in 2006 contract will be awarded to IS contractor able to meet specification for this modernised service and based in accessible community premises
	Long Term conditions call centre	Specification and evaluation of pilot will inform competitive tendering approach for this service in 2008-9, depending on results of pilot
	Community intermediate care and rehabilitation services	Specifications and competitive process for 'lead development partner' selected from local providers and meeting specification and value /performance targets established by PCT.
Community	Service review planned for district nursing services	Benchmarking approach and improvement plan with in house provider, in exceptional circumstances tendering approach notified for 2008-9.
Primary Care	Strategy for long term conditions will require review of performance of primary care contractors and evaluation of new enhanced service opportunities for delivery	Enhanced service strategy linked to long term conditions Unscheduled care Older peoples services Award of Enhanced Service contracts subject to meeting

Area	Issue	Approach
	Unscheduled care review of out of hours providers will result in specification for re-tendering services 2008	standards Tender approach will be followed in these services
Partnerships	The domiciliary support service to the disabilities tenancies are being are being tendered out.	Formal tendering of service to Independent sector, voluntary sector, social enterprise or NHS
Voluntary	A more targeted approach to commissioning these services	Cost and benefit review of all existing contracts and clarity on added value to deliver key priorities
Other		

9.2 Provider Contracts and Plans

9.2.1 The table below sets out the summary of planned investment, service changes and efficiency in each of the PCT's top 10 contracts.

Figure 20 Providers

Provider	Baseline contract value including inflation uplifts £000	Investment - £000	Disinvestment - £000
Stockport NHS FT	115,573	3,212	(2,237)
Stockport PCT clinical service provider	25,202	1,069	(847)
Pennine Care NHS Trust	20,284	515	0
South Manchester NHS FT	16,655	535	(813)
Central Manchester NHS Trust	11,505	122	0
East Cheshire NHS Trust	2,435	172	0
Salford NHS FT	1,317	263	0

9.3 Provider contract management and engagement

9.3.1 The PCT's approach to provider management provides for a monthly performance and contract meeting, quality review processes, clinical redesign work and an overarching review mechanism with senior executives on the providers performance which embraces these three equally important focused areas.

9.3.2 A Monthly report on each provider is provided to the PBC/PCT and Strategic Commissioning Board, together with an end of year report on provider delivery.

10 PERFORMANCE MANAGEMENT

10.1 Approach

10.1.1 The approach taken for ensuring delivery of this overall plan can be found in detail in four main performance plans

- Delivery Plan
- PBC Accountability Agreement
- Provider Performance Management Plans and Contracts
- Development Plan

10.2 Delivery plan Management

10.2.1 The PCT Board, Strategic Commissioning Board and PBC Board will all receive a summary integrated report on performance against the delivery plan. This report will be provided monthly however some targets are not expected to be profiled for delivery on this basis.

10.2.2 This report will be formatted to show the trajectory (signed off by the Accountable body /committee, executive and senior responsible officer). This trajectory will be monitored and where outcomes/outputs are not on track with this plan an alert report is provided to the Executive, escalation processes will be established and a root cause analysis.

10.2.3 The planned Trajectories for delivery cannot be amended or adjusted through this process and can only be re-set with Board Approval.

10.3 PBC Accountability Agreement

10.3.1 The PBC Accountability Agreement puts the productivity savings plan firmly in the remit of the new body ‘Stockport Managed Care Commissioning’ using the management resources and capacity under the management services agreement to drive this productivity saving through service and practice reforms.

10.3.2 The monthly reporting under this agreement will set out the following a) pathways and protocols agreed b) productivity enablers in place c) productivity savings realised. This report will be provided to the Strategic Commissioning Board and PCT Board.

10.4 Provider Management reports

10.4.1 The PCT Board, Strategic Commissioning Board and PBC Board will be provided with a monthly report on all contracts and key performance issues under each contract, quality markers achieved or not, modernisation and pathways improvements negotiated.

10.4.2 The report will set out the expected delivery under contract for each of these three dimensions and that achieved. Where this performance is not on plan, the performance report will set out escalation arrangements initiated.

10.5 Development Plan management

10.5.1 A report will be provided on the work streams undertaken for developing the capacity and capability of commissioners locally. This report will be provided quarterly to PCT Board, Strategic Commissioning Board and PBC Board.

10.5.2 Variations from planned and agreed targets will be addressed in a similar approach to that outlined for the delivery plan management