

NHS London

2010/11 OPERATING PLAN

PCT / Sector Name: NHS Brent

Version: Draft 1

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NHS
London

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***PCT operating plans should contain all of the sections below, and the annexes.
Sector operating plans should contain the sections indicated only.***

Attachments:

Annex A: Finance Template
 Annex B: Informatics Template
 Annex C: Performance Improvement Plans

SECTION 1: STRATEGIC OVERVIEW (PCTs and Sectors)

Introduction

This draft of the 2010/11 Operating Plan has been developed in conjunction with the PCT's Strategy Plan and is entirely consistent with it.

It follows the structure set out by NHS London with the addition of Annex C which has been added to provide further details of the PCT's Performance Improvement Plans.

Between the production of this draft on 25 January and the final Operating Plan and budgets for 2010/11 to be presented to the Board on 1 April, the finance and activity projections will be subject to revision as a result of:

- a) The outcome of 2010/11 contract negotiations, including the impact of the 2010/11 tariff;
- b) The PCT's budget setting processes;
- c) The further detailed planning work being undertaken on CSP initiatives;
- d) Changes instigated following the external review of the PCT's Medium Term Financial Strategy and CSP, to be undertaken in late January – mid-February;
- e) Other externally driven changes e.g. to resource assumptions.

1.1 Summary

Summarise your organisation's five year strategic plan (1000 words maximum or a diagrammatic summary).

Making a significant improvement to the health and well being of the people of Brent.

People in Brent suffer more ill health than in most locations in England. Our commitment is to work with our partners to reduce that experience and ensure that when they are unwell the services that we commission are responsive to their diverse needs.

To achieve this we have five specific goals:

1. Increasing the life expectancy of our population by 2.8 years amongst males and 2.2 years amongst females by 2013/14;
2. Reducing the projected gap in life expectancy by 6 months amongst males and 4 months amongst females by 2013/14;
3. Promoting good health and preventing ill health, to improve the health and wellbeing of our population with a significant impact on a number of outcomes;
4. By working with partners we will improve the quality and safety of services commissioned to at least the equivalent to the existing Good CQC rating;
5. By 2014 providers commissioned by us will achieve patient experience scores at least as good as the London average.

The core principles which continue to underpin everything we do are set out below:

1. Evidence-based care – the PCT will draw on the available evidence to take good decisions about which health issues should be the highest priority, and which interventions will be most effective in addressing those issues. Where the evidence base does not exist, or is weak, we will contribute to strengthening it;
2. Health outcomes – the PCT will look beyond process targets to focus on achieving health outcomes for our population, ensuring we understand the health benefits of every new initiative;
3. Value for money – the PCT will test the efficiency and effectiveness of all investments, commissioning and decommissioning care services to maximise value for money;
4. Public engagement – the PCT will ensure that all members of our community, including those who often have the poorest health and are hardest to reach, are genuinely involved, helping to shape service changes and not simply consulted on them.

Brent has a compelling case for changing the way we currently commission and provide healthcare to our residents. Brent is a borough which epitomises London's opportunities and its challenges. Its structure, history and demography mean that health and healthcare remain in need of urgent change and improvement. In the current political and financial environment the NHS in Brent stands on a burning platform where the need to change the way health services are commissioned and provided becomes ever more imperative.

In 2007 Healthcare for London's *Framework for Action* highlighted eight reasons why change was needed. For Brent this case for change remains as salient and urgent as ever.

Brent's mortality rate of 570 per 100,000 is lower than the England & Wales average of 628 per 100,000 but this below average mortality rate masks a range of specific health issues where improvement is urgently required. Brent performs well in many overall measures of health but there are stark inequalities in health linked to socio-economic status, gender, ethnicity, and geography. There is an 8.6 year gap in male life expectancy between the most deprived and least deprived 10% of areas in Brent (the slope index of inequality) and a gap of 2 years for females. The gap in male life expectancy is increasing rapidly and is expected to reach 13.2 years by 2014 if the current rate of increase continues. Increased disease prevalence in future also highlights the need for more effective intervention from the NHS in Brent. Many of the deaths in Brent are preventable – cardiovascular diseases and cancers are Brent's biggest killers, accounting for 448 and 330 deaths in 2008 respectively. Healthy lifestyles and early intervention can have a major impact on these deaths.

We do not underestimate the magnitude of the challenge. Activity and expenditure in acute settings are rapidly increasing and whilst we recognise that the changing profile of our population means that health needs will continue to rise, our plans seek to ensure that these interactions will be shifted to more appropriate settings that offer better value for money.

We will deliver improvement through better case management, prevention, decommissioning and productivity gains that will provide sufficient disinvestment and efficiencies to maintain financial stability as well as investment to drive up quality. Commissioning of preventative and people-centred services that are better for patients but also more productive is central to achievement of our plan. Meeting this productivity challenge is critical to success.

Successfully realising these shifts and changes to the required extent can only be delivered through coordinated transformational changes within Brent and sector-wide on an unprecedented scale. Our CSP sets out our strategy for achieving this transformation across each of the eight Healthcare for London pathways and how we are establishing a polysystem model across Brent to support these changes.

We have set tangible objectives for these goals and to monitor our progress against achieving them as described above. These include our selected World Class Commissioning Outcomes.

We have retained 9 of the 10 outcomes agreed with stakeholders last year as they continue to represent the key outcomes we are committed to achieving for our population and we confirmed these with stakeholders at an engagement workshop in October 2009. The tenth outcome last year was a locally defined outcome to better measure health inequalities but this has effectively been duplicated in 2009/10 with the revision of the mandatory Health Inequalities indicator. We have therefore added a further outcome to set and track performance for End of Life care. This addition means that our outcomes now cover 6 of the 8 Healthcare for London outcomes with Maternity & Newborn and Mental Health being the exceptions.

Our rationale for selecting "Proportion of all deaths that occur at home" as our tenth outcome is that this is a key outcome for End of Life Care which is a more emerging priority for us and is not well covered by other performance frameworks at this point. Maternity & Newborn is increasingly being delivered at a sector level and is also well covered by other performance frameworks. There is no single Mental Health outcome that would provide a reasonably comprehensive measure for our Mental Health initiative and this is also an area that is well covered by other performance frameworks.

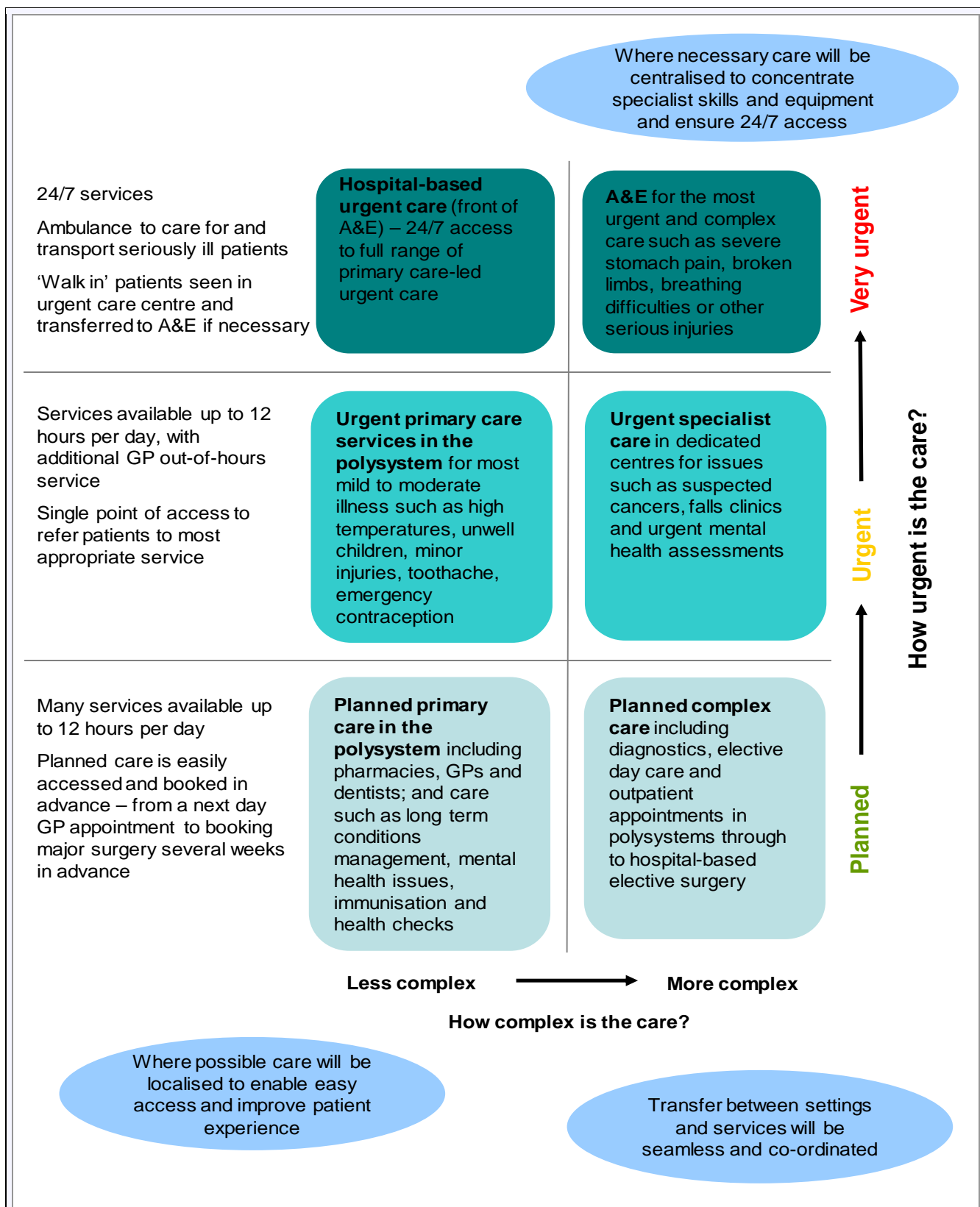
We have set aspirations for all these outcomes as set out in the table below. (1046 words)

Outcome Description	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Health inequalities in years (Males)	9.7	10.39	10.76	11.29	11.87	12.38
Health inequalities in years (Females)	1.9	1.98	1.90	1.90	1.93	1.92

Life expectancy in years (Males)	78.20	78.69	79.04	79.50	79.96	80.96
Life expectancy in years (Females)	83.40	83.92	84.22	84.53	84.83	85.13
Proportion of children completing MMR immunisation (1st & 2nd dose) by 5th Birthday	41.8%	72.7%	90.7%	94.4%	95%	95%
Smoking quitters (per 100,000)	332	911	1,059	1,059	1,059	1,059
Proportion of women aged 53-70 screened for breast cancer within the last three years	44%	49.7%	59%	71%	75%	78%
Self reported experience of patients & users	70.3%	72%	74%	76%	78%	80%
Delayed transfers of care (% of cases per 100,000 over 18)	13.6%	13%	11%	9%	7%	5%
CVD mortality (per 100,000 > 75)	86.65	78.81	75.43	70.84	64.75	58.16
Diabetes controlled blood sugar (at Hba1c 7.5)	56.8%	65%	68%	70%	74.3	75
Proportion of all deaths that occur at home	N/A	19%	20.5%	22%	23.5%	25%

The gap in male life expectancy is increasing rapidly and is expected to reach 13.2 years by 2014 if the current rate of increase continues. We aim to reduce the gap in life expectancy against this baseline by 6 months amongst males and 4 months amongst females by 2014.

If we are to achieve our goals we need to commission differently – changing the models of healthcare delivery and transforming the ways in which care is accessed. Central to delivery is the development of a polysystem model to ensure that care, where appropriate, is delivered in community settings and that we work with other PCTs in our sector to develop our plans for changes to acute care delivery in North West London. The diagram below summarises the changes we will make to transform healthcare and achieve our goals in Brent by 2014.



1.2 Care pathway priorities

List your organisation's priorities in redesigning the Healthcare for London care pathways.

In 2010/11 NHS Brent's priorities in redesigning the Healthcare for London care pathways are:

Maternity and New Born

- By October 2010 we will have introduced polysystem-based care pathways for maternity care Children and Young People
 - By October 2010 we will have introduced a comprehensive Healthy Child Programme, fully integrated with Children's Centres and Extended Schools
 - By the end of October 2010 we will have in place new pathway models of care for children with complex community needs
 - By April 2010 we will have completed our public consultation to reconfigure inpatient paediatric services onto one site thereby centralising the paediatric inpatient service at Northwick Park Hospital - a reduction of 6 beds at CMH which will be supported by the development of Paediatric Assessment Units at both sites as well as Urgent Care Centres that will reduce the need for secondary care.
- Acute care
- By July 2010 all people with acute exacerbations will be cared for in polysystem settings of care if medically appropriate
 - By April 2010 the HfL rehabilitation pathway for stroke will be fully implemented across Brent
 - By the end of Q1 2010/11 we will have an Urgent Care Centre at the 'front end' of CMH
- Planned care
- By March 2011 we will have agreed protocol driven pathways based on Map of Medicine, agreement with clinical commissioners of polysystem improvement plans, introduced integrated teams at polysystem level and specification agreed for community services based in polysystems to complete primary and community transformation of elective care pathways
- Mental Health
- By September 2010 talking therapies (IAPT) will be available across Brent
 - By the end of 2010 new, streamlined pathways mental health care will be in place with more integrated team working utilising settings of care across the polysystem
 - By the end of 2010 we will have improved specialist mental health pathways in place
- Staying Healthy
- In 2010/11 we will commence a phased implementation of the NHS Health Check
 - By September 2010 we will have an agreed strategy and implementation plan for obesity
 - By Q4 in 2010/11 we will have achieved the annual target for smoking cessation as set by the DH
- Long term conditions
- From January 2011 onwards 30 emergency admissions a month will be avoided through improved case management and reablement. We will have developed pathways for LTCs and risk stratification methods. Patients will experience a standardised response, personalised care and consistent standards
- End of Life care
- By April 2010 the End of Life care strategy will be agreed and timelines established for full implementation

1.3 Strategic initiatives

Summarise your organisation's strategic initiatives.

NHS Brent's strategic initiatives have been aligned with the Healthcare for London pathways.

Maternity and New Born: NHS Brent will concentrate on developing two main areas:

- Improved pre-conception care and encouragement of early booking - We will ensure that all GP practices, family planning clinics and sexual health clinics across Brent have access to the appropriate health education materials to support pro-active pre-conception care including tailored information for high-risk women.
- Continuity of care throughout the maternity pathway and in line with the Children's Centres pathways of care - locally we will work with NWLH to implement the care pathway, including introducing joint midwife and consultant services in our Children's Centres. In implementing good practice we will ensure that we have agreed clear expectations of service providers, including GPs continuing to be involved in shared care, and that we have eradicated the current inefficiencies we have due to duplication of commissioning.

Children and Young People: NHS Brent will focus on three main areas:

- The Healthy Child - We will be reviewing the specification and commissioning a care pathway that fully integrates the work of health visitors with children's centres with identified elements of the healthy child programme being commissioned directly from the Children's Centres. . We will also be developing and implementing a new specification and care pathway for school-aged children integrating more fully the

work of school nurses with the extended schools programme.

- The Unwell Child - we will commission a support programme for primary care in relation to self-management; management within community support and management in primary care. We will also develop care pathways for common conditions and commission multi-disciplinary teams including consultants, primary care specialist doctors, nurses and therapists, to work within the polysystems to provide assessment and treatment, avoiding the need for hospital referral. We will centralise paediatric inpatient services at NPH supported by PAUs at both NPH and CMH.
- Children with complex community needs - We will review our existing pathways for children with complex community needs and establish new care pathways to support improved access to specialist care at times of acute exacerbations, both to prevent admissions and to expedite discharge; access to specialist advice in community settings and ongoing support at home and school

Acute care: NHS Brent will focus on three main areas:

- Access to primary care urgent care services - Our polysystem implementation plans outline the establishment of two polyclinics providing 8-8 access to primary care urgent care consultations for both the registered and unregistered population. There will be an Urgent Care Centre at the front end of CMH and we will commission the UCC to provide the out-of-hours service for those GP practices across Brent who have delegated responsibility for out-of-hours cover to NHS Brent.
- Establishment of a short term assessment, rehabilitation and reablement service (STARRs) - The STARRs service comprises a number of key elements; single point of access and brokerage; access to rapid response intensive health and social care response for people at risk of hospital admission; step-up and step-down health and social beds; rehabilitation and reablement in the community. The hub of the service will be based at CMH establishing integrated working with the UCC.
- Implementation of community pathway following stroke - We are planning to use Clinicenta, in collaboration with NWLH, as the main provider of early supported discharge and stroke rehabilitation. We have agreed revised specifications for these services to ensure they meet the needs of our residents and a balanced scorecard to ensure benefits realisation

In addition to the above three priority areas we will seek to drive out significant savings through the Acute Commissioning Vehicle, London Ambulance Service utilisation and other specialist commissioning savings as well as further cost reductions and decommissioning opportunities at A&E.

Planned Care: NHS Brent will focus on three main areas:

- Primary care contractors – Transformational change is required to deliver the improvements required in primary care to deliver the CSP. We will undertake a number of actions to achieve this including list validation, standardised core offer in general practice, review of contractual frameworks, performance management, succession planning, estates rationalisation and improving access to primary care. A similar approach will be taken with other independent contractors
- Care pathways for elective care – phase one of the programme will roll out in 2010/11 with the anticipated shifts in activity to polysystems starting in the second half of 2011/12. We will agree consistent, protocol driven care pathways based on Map of Medicine and agree Polysystem Improvement Plans with clinical commissioners. We will introduce integrated teams at polysystem level to support the polysystem through tailored training and access to specialist advice. We will agree clear measurable outcomes and develop specifications for community service based in polysystems and procure the new service to complete the primary and community transformation of elective care pathways
- Community services – We will require significant productivity gains from our existing community providers and will be rationalising commitments with neighbouring PCTs. Through infrastructure changes we expect a significant reduction in the contract/pricing structure for Brent Community Services (BCS)

Mental Health: NHS Brent will focus on four main areas:

- Raising public awareness, health promotion and improving services in primary care - NHS Brent will support the pan-London social marketing campaigns planned to raise public awareness and promote health with targeted local initiatives. More explicit links will be made with the Staying Healthy Initiative, recognising the role physical activity can play in improving wellbeing and reducing depression and with Children and Young People, in relation to early intervention and mental wellbeing through work such as anti-bullying strategies. Commissioning of a compliant IAPT service is planned for the summer of 2010 and will be supported by awareness raising training for primary care clinicians
- Co-ordinated community specialist input - We will rationalise the number of teams; streamline the care pathways to improve user experience and simplify communication between health and social care

professionals. The new model of coordinated community specialist input will be a central component of our polysystem model of care

- In-patient and specialist pathways - We want to commission high-quality in-patient care which is outward focussed and working towards care outside of hospital wherever possible. We anticipate that the outcome from this work (together with the community work) will be a reduction in the number of people admitted as in-patients and reductions in length of stay for those admitted. In addition, we plan to review our commissioning arrangements for those in need of specialist services to ensure that we are getting the best value for money in the most appropriate location
- Implementation of an integrated pathway for dementia – We will develop and implement an agreed pathway for dementia

Staying Healthy: NHS Brent will focus on six main areas:

- NHS Health Checks - We have undertaken detailed work to ensure successful implementation and will be commencing the phased programme from April 2010. Phasing supports the need to prioritise areas of maximum need and will commence in Harness polysystem (Harlesden) rolling out across other polysystems across a four year period
- Childhood immunisations – We will continue to focus upon establishing the required infrastructure from which to accurately identify the current uptake rates and to ensure improvement both across Brent and within identified communities
- Obesity – We will develop a strategy and implementation plan for adult obesity
- Smoking cessation - We will continue to work to identify new and innovative ways of commissioning the service for target populations, diversifying the range of providers to include workplaces and community groups, and incentivising and performance managing providers to achieve improved outcomes
- Breast, bowel and cervical screening - we have improvement plans to ensure that we achieve trajectories for uptake for all screening programmes and across the whole of Brent
- Communicable diseases - We are currently developing implementation plans to ensure that we meet the requirements for both Tuberculosis and HIV

Long Term Conditions: NHS Brent will focus on four main areas:

- Improved patient education and empowerment - we will commission a range of resources to promote self care including using innovative approaches such as telecoaching as well as revitalising existing schemes such as the Expert Patient Programme. We will link this closely with each polysystem's health and wellbeing strategy and healthy neighbourhoods as well as ensuring access to talking therapies. We anticipate an increasingly focussed use of community pharmacists in relation to self management
- Improved primary care management (Level 1 and 2 – simple and complex care) - we will implement a programme across all practices designed to ensure that all practices offer a high standard of quality care and advice. This will include risk stratification and predictive modelling tools, agreement with clinical commissioners on Polysystem Improvement Plans, development of protocol driven access to diagnostics and review of practice registers, and the introduction of integrated LTC teams at polysystem level
- Improved specialist advice/co-ordination (Level 3 – Multi complex care) - Specialist care and advice will be commissioned predominantly within polysystem settings including polyclinics. Models of commissioning will promote improved integration between GP practices and hospital specialists maximising the use of polyclinics as the appropriate setting of care and avoiding the need for attendance at acute hospitals unless specialist diagnostics or outpatient care is required
- Improved case management (level 3 – multi complex care) - this workstream will mainstream care management and reablement as integral parts of LTC management within each polysystem health and social care system

End of Life Care: NHS Brent will focus on four main areas:

- Choice - We will work with all our partners to promote awareness and understanding of EOL care services and ensure that plans are agreed to reduce the gaps through better integration and coordination of services across all settings to be able to offer choice to patients
- National standards - We will ensure that all practices have registers of palliative care patients. Data will be gathered to evaluate EOLC services to support the commissioning of appropriate services. We will ensure that baseline national standards including the Gold Standard Framework, Liverpool Care Pathway and Preferred Priorities of Care initiatives are implemented
- Access to 24/7 care - We will work to achieve better co-ordinated care on a 24/7 basis across Brent through better integration of current care provision in the first instance including the development of a standardised palliative and end of life care model
- Optimising care across the pathway - We will undertake a comprehensive review of services across

Brent to identify the capacity available, the gaps in services and understand the current constraints in the system. We will introduce the advance care planning tool and ensure that all partners in care provision including the London Ambulance Service, social care and Out of Hours GP services work to deliver care in accordance with the plans.

1.4 Settings of care

What shifts in activity, services and expenditure between the settings of care do you plan to achieve?

Initiative one: Maternity and New Born:

This initiative will see a focus on increasing the numbers of home birth, reducing the proportion of hospital births. It will also drive a reduction in the numbers of caesarean sections supporting shorter hospital stays and reducing expenditure on acute interventions. More midwife activity will be delivered in polysystem settings and women will be encouraged to book directly for ante-natal care reducing inappropriate GP appointments for women with non-complex pregnancies and ensuring that the midwife is the main point of contact.

Initiative two: Children and Young people:

This initiative will lead to significant reductions in paediatric outpatient's appointments in acute settings reducing unnecessary follow up care and ensuring that the majority of paediatric outpatient care in undertaken in polysystem settings. New investment will be required to support this and savings will be realised from 2011/12 onwards.

Initiative three: Acute care

This initiative will deliver significant shifts in activity by ensuring that intermediate care services are delivered in such a way that all unnecessary emergency admissions are avoided. In addition the extension of primary care access and development of urgent care centre at CMH will deliver significant reductions in A&E activity starting in 2010/11. New investment will be required but the activity shifts anticipated will ensure that savings are delivered from 2010/11.

Initiative four: Planned Care

This initiative will deliver significant shifts in outpatient and elective activity from acute settings into polysystems. The changes in activity will start in 2011/12, increasing in the following years. The focus in 2010/11 will be on ensuring that detailed pathways of care are developed to enable us to commission the care in polysystems and to fully review all activity to ensure that only clinically effective interventions that offer excellent value for money are commissioned.

Initiative five: Mental Health

Mental health services will be fully integrated into the polysystem and all pathways streamlined to ensure we can maximise efficiency in the commissioning and delivery of mental health care. Talking therapies will be available in community setting ensuring that people with mental health problems can access appropriate care as early as possible.

Initiative six: Staying Healthy

We will commission the 'NHS Health Checks' on a phased basis starting in 2010/11 which we anticipate will deliver reductions in the numbers of CVD events. New investment will be required for this initiative and it will take some time for the impact on acute activity to result in savings. However the long term benefits and impact on the health outcomes for the population and the subsequent impact on reducing health inequalities support this new investment.

Initiative seven: Long term conditions

Care for people with long term conditions will be predominately provided in primary care with specialist elements for complex needs commissioned via polysystems. Improved case management will reduce acute exacerbations and levels of urgent care activity. Only very specialist or complex care will require support in acute settings. This will be a significant shift of activity out of hospital settings. In 2010/11 these pathways will be developed and commissioned with the changes in activity starting in 2011/12 and increasing year on year thereafter.

Initiative eight: End of Life Care

Implementation of the Gold Standards Framework within primary care and in nursing homes will reduce

emergency admissions and unnecessary admissions at end of life ensuring that people are supported at home by primary care and by specialist palliative teams who will be fully integrated into the polysystem. It is planned to deliver this shift in activity from 2010/11.

1.5 Implications for provider configuration

What changes do you expect to your provider configuration during 2010/11 (acute, mental health, community and primary care)?

Acute provider configuration changes in 2010/11

- Changes in paediatric ambulatory care and inpatient provision pending outcome of consultation
- Development of front end Urgent Care Centre at CMH
- Consultation via the NWLCP on future acute provider landscape recognising the impact of the planned shifts in care setting

Mental Health provider configuration changes in 2010/11

- Working with existing providers to develop how they can be integrated into polysystems
- Existing counselling, psychology and psychotherapy services will be reconfigured to deliver IAPT and new service providers invited to tender for additional IAPT services

Community provider configuration changes during 2010/11

- Integration of community services into polysystems
- Work with partners to merge BCS with similar types of providers in neighbouring boroughs or a vertical integration with an acute or mental health foundation trust

Primary care configuration changes during 2010/11

- Integrate primary, community and social care staff in polysystems
- Consolidation and rationalisation of existing GP practice landscape

SECTION 2: WORLD CLASS COMMISSIONING (PCTs and sectors)

What are your priority delivery areas in 2010/11 for year one implementation of your WCC OD plan?

The NHS Brent OD plan identifies three work programmes to support delivery of our CSP. These are:

- Pathways into polysystems: Supporting the creation of new service and organisational model including design, skills analysis, capability development and models of staffing. Working with our communities and clinicians to build local health care for the future via clinically driven commissioning.
- New ways of working: Developing our skills, culture, organisational systems and processes to become a more organic, adaptable, outward looking and responsive organisation.
- Information and Analytics: Advanced analytical skills and insights to support strategic commissioning decisions and drive performance.

The workplans for these three work programmes are below:

Activity Description	Sponsor	Project Manager	2009		2010			2011			
			Oct - Dec	Jan - Mar	Apr - Jun	July - Sep	Oct - Dec	Jan - Mar	Apr - Jun	July - Sep	Oct - Dec
Pathways into Polysystems											
Programme Initiation											
Establish Programme Management	TS	TBD									
Define and agree governance arrangements	TS	TBD									
Identify and allocate project and programme resources	TS	TBD									
Define benefits management strategy and processes	TS	TBD									
Develop Board and governance arrangements for clinical commissioning groups											
Define membership, terms of reference and establish clinical commissioning Boards	JO	Graham Bostock									
Establish governance arrangements	JO	Graham Bostock									
Define and implement Board development programmes	JO	Graham Bostock									
Develop Primary Care capabilities and capacity											
Develop Health and Social Care Workforce strategy with LBB	CA	TBD									
Undertake training needs analysis for Primary Care	CA	TBD									
Define training solutions	CA	TBD									
Implement training programmes for HCA, Practice Nurse and Nurse Practitioner	CA	TBD									
Design and develop and implement new care pathways											
Long term conditions pathway (MDT)	JO	Helen Poole									
Elective pathways (MDT)	TS	Mary Cleary									
Implement Public and Patient engagement plan											
Implement Polysystem PPI Plan	TS	Marco Inzani									
Implement Patient Experience Improvement programme	TS	Marco Inzani									
Implement voluntary and community strategy (including carers)	TS	Javina Sehgal									
Implement IT infrastructure and systems											
Define IT requirements	JO	TBD									
Implement IT infrastructure	JW	TBD									
Implement EMIS web solution	JW	TBD									
Implement Market Management strategy and procurement of services											

New Ways of Working									
Develop a culture of engagement and communications both within and beyond the organisation	CA	Gemma Davies							
Establish staff engagement group	CA								
Deliver cultural change workshops	CA								
Define and implement Codes of Behaviours	CA								
Run workshops and create materials to embed Codes of Behaviours	CA								
Run whole organisation event for staff setting out priorities ahead	CA								
Establish new arrangements for working with staff side in a commissioning organisation	CA								
Launch new staff magazine	CA								
Implement new style team brief for all commissioning staff	CA								
Procure for suppliers to manage exit interviews	CA								
Establish new arrangements for exit interviews									
Exit interview data analysed and recommendations based on data made	CA								
Develop internet/intranet as a tool for public engagement and consultation	TS	Marco Inzani							
Implement a revised employments package and staff healthy living scheme	CA	Gemma Davies							
Implement revised flexible working arrangements	CA								
Implement revised discounts scheme and bike to work scheme	CA								
Implement Employee Assistance telephone support	CA								
Implement Childcare scheme vouchers	CA								
Implement Active Healthy working scheme with borough	CA								
Deliver joining Healthy living sessions	CA								
Implement Occupational Health annual local health checks	CA								
Implement the single equalities scheme	CA	Nolan Victory							
Develop business case	CA								
Run Equality and Diversity conference	CA								
Deliver learning disability awareness training	CA								
Deliver equality, diversity and human rights training	CA								
Implement the learning and development plan and talent management strategy	CA	Gemma Davies							
Cross check interventions for 2009/10 against new CSP priorities	CA								
Establish training approvals board	CA								
Procure and deliver priority training courses	CA								
Establish cross sector group to skill/resource share	CA								
Undertake skills analysis for new employees	CA								
Set up annual programme of "quick bite" sessions	CA								
Delivery of "quick bite" session	CA								
Build web based knowledge share/development on intranet	CA								
Develop and implement talent management strategy with sector	CA								
Implement "Partnership for Dignity" project	CA	Gemma Davies							
Project mobilisation event	CA								
Focus Groups run	CA								
Mediation training run	CA								
Implementation of new policies and working arrangements	CA								
Evaluation and benefits realisation	CA								
Implement team development and cross boundaries working	CA	Gemma Davies							
Procure for suppliers	CA								
Design away days	CA								
Run series of Team and Directorate integration away days	CA								
Cross directorate senior working network group established	CA								
Deliver 8d's cross directorate programme	CA								
Team temperature check	CA								
Develop and implement high performing teams model	CA								
Collaborative working across the sector and across agencies	CA	Charles Allen							
Set up sector OD forum	CA								
Identify areas for collaborative working	CA								
Identify priorities	CA								
Identify resource leads for each area	CA								
Develop business case for implementation	CA								
Implementation									

Information and Analytics										
Continue to improve the quality of data										
Liaise with CSL/ACV on developing acute contract challenges	JW	Jonathan Phimister								
Improving data quality across primary care	JO	Jonathan Phimister								
Undertake cleansing activity of GP patient lists	JO									
Embedding a culture of advanced analysis and modelling										
Systematic use of benchmarking information to understand relative performance	JW	Jonathan Phimister								
Enable PBC to carry out more sophisticated analysis and modelling	JW	Jonathan Phimister								
Align our activities and processes and become an informed customer of ACV/CSL	JW	Jonathan Phimister								
Development of investment and disinvestment processes										
Develop framework for measuring costs and benefits/outcomes across initiatives	JW	Jenny Greenshields								
Expand investment processes to include disinvestment proposals	ME	Bevis Sydney								
Deliver training and support to enable implementation of framework and processes	JW	Jenny Greenshields								
Ensuring information flows and analysis enables the monitoring and delivery of our key CSP initiatives										
Developing information regarding activity undertaken in Primary Care	JW	Avtar Ubbi								
Providing information analysis and insights to support redesign of pathways	JW	Jonathan Phimister								
Support the development of contract currencies for community services	JW	Jonathan Phimister								
Develop information flows to PBC	JW	Gary Sired								

Impact on workforce:		
The community midwifery team will be working in a new way and will be based in children's centres within polysystems rather than within the Acute provider premises. There will be more movement for staff out and about across the localities and this impact may take time for staff to adjust to new working model.		
Risks:	High/ Medium/ Low risk	Mitigating actions:
PbR tariff for community midwifery may reduce ability to make savings	Likelihood – 3 Impact – 4 Risk rating – 12	Adherence to DH guidance on PbR to support commissioning of care pathways and patient choice.
Community infrastructure may not support the shift	Likelihood – 3 Impact – 3 Risk rating – 9	Prioritise community midwifery teams in local authority children's centres. The development of alternative community settings to house midwifery i.e., one stop shop scheme, local health centres etc.
Recruitment of adequate numbers of midwives	Likelihood – 3 Impact – 4 Risk rating – 12	Alignment to sector wide recruitment campaigns. Support for key providers PR campaigns to promote working at their Trust.
Difficulty in negotiating savings from NWL	Likelihood – 4 Impact – 5 Risk rating – 20	Early engagement with the ACV to ensure activity shifts are recognised in activity plans and performance monitored.

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 2c: Children & Young People

Linked Healthcare for London care pathway(s) and/or care setting(s):

Children and Young People

Linked pledges and targets:

- VSB08 Teenage pregnancy
- VSA06 Patient reported measure of GP access
- VSA07 Supporting Lines: patient reported measure of GP access (to follow)
- VSB09 Childhood Obesity
- VSB10 Individuals who complete immunisation

Linked WCC outcome(s):

- Proportion of children completing MMR immunisation (1st and 2nd dose) by 5th birthday

£ (Reinvestment)	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	300
Activity																				
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R

Impact on workforce:

Ongoing difficulty recruiting health visitors and change to working practices due to integration.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Does not achieve full integration along polysystem lines	Likelihood – 3 Impact – 3 Risk rating – 9	GPs and health visitors well represented on implementation group
Capability of BCS to recruit the required numbers of health visitors	Likelihood – 3 Impact – 3 Risk rating – 9	Full and active mitigation plan in place for health visiting service since Autumn 09

Strategic initiative 3: Acute Care

Linked Healthcare for London care pathway(s) and/or care setting(s):

Acute Care

Linked pledges and targets:

- VSA01 Incidence of MRSA
- VSA02 MRSA Supporting Lines
- VSA03 Incidence of C. Difficile
- VSA08 Breast Symptom Two Week Wait)
- VSA11 31-Day Standard for Subsequent Cancer Treatments (Chemotherapy and Surgery) National requirement (to follow)
- VSA12 31-Day Standard for Subsequent Cancer Treatments (Radiotherapy) National requirement (to follow)
- VSA13 Extended 62-Day Cancer Treatment Targets (National Requirement)(to follow)
- VSA14 Quality stroke care (outcome: Reduction in stroke related mortality and disability)
- VSB01 All-age all cause mortality (AAACM) rate
- VSB15 Self reported experience of patients/users (National priority for local delivery)
- VSB16 Public Confidence in Local NHS

Linked WCC outcome(s):

- Delayed transfers of care (% of case per 100,000 over 18)
- Self reported experience of patients and carers

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

new service		Development of alternative access points Identification of alternative suitable estate
GP and patient behaviour does not change resulting in GPs not referring to Rapid Response Service therefore patients attend A&E and RR service not fully utilised. Patients do not consent to being treated at home	Likelihood – 3 Impact – 5 Risk rating – 15	Suitable communications with GPs and engagement with PBC Rapid Response will attend A&E to prevent admissions. Early communications about service change with all partners and suitable patient communication tools developed. Patients kept informed of their medical status and reassured by the service received
Underestimation of need and costs	Likelihood – 3 Impact – 4 Risk rating - 12	Development of good KPI's and constant monitoring of these Unmet demand and activity growth factored into assumptions about patient demand

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London’s planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 3b: Urgent Care Centre

Linked Healthcare for London care pathway(s) and/or care setting(s):
Acute Care

Linked pledges and targets:

Linked WCC outcome(s):

- Delayed transfers of care (% of case per 100,000 over 18)
- Self reported experience of patients and carers

Actions:

When will the action be completed? (month)

Commence Competitive Procurement process

Jan 10

Complete negotiation with NWLHT re use of space at CMH

Feb 10

Contract award

May 10

Provider mobilisation complete and service starts.

June 10

Benefits realisation and pathway review

March 11

Performance measure(s):

Baseline level of

Target level of performance

organisation without a history of delivery	Risk rating – 15	the JCPCT Senior local commissioning and finance managers will continue to participate in contract meetings until adequate assurance in place re effectiveness of NWLCP
Level of saving required from areas which have been traditionally difficult to manage	Likelihood – 3 Impact – 5 Risk rating – 15	Input from local senior commissioning and finance staff to ensure corporate memory is not lost Ongoing oversight from JCPCT
Ability of Commissioning Support for London (CSL) to undertake claims management effectively	Likelihood – 4 Impact – 4 Risk rating – 16	Close engagement with sector and London wide governance mechanisms led at CEO level

SECTION 3: PERFORMANCE (PCTs and Sectors)		
<p><i>Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.</i></p> <p><i>The impact of each action on commissioned activity and finance <u>must</u> be quantified.</i></p>		
Strategic initiative 3d: LAS Utilisation Savings		
Linked Healthcare for London care pathway(s) and/or care setting(s): Acute Care		
Linked pledges and targets: <ul style="list-style-type: none"> See overarching strategic initiative 3: Acute Care 	Linked WCC outcome(s): <ul style="list-style-type: none"> Delayed transfers of care (% of case per 100,000 over 18) Self reported experience of patients and carers 	
Actions:	When will the action be completed? (month)	
Contracts signed off with LAS	Feb 2010	
Review of Mth 1 performance and activity information. (to be undertaken each month)	May 2010	
Review 1 st Qtr performance and develop action plan if performance not on trajectory	Aug 2010	
Report on performance to date to NHS Brent Board	Sept 2010	
Determine level of further engagement required	Sept 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
<i>Initiative specific measures are</i>		Q1

Review of Mth 1 performance (to be undertaken each month)		May 2010											
Review 1 st Qtr performance and develop action plan if performance not on trajectory		Aug 2010											
Report on performance to date to NHS Brent Board		Sept 2010											
Determine level of further engagement required		Sept 2010											
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:											
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>		Q1											
		Q2											
		Q3											
		Q4											
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(992)
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity													
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce:													
New ways of working across specialist providers to implement more efficient pathways of care													
Risks:	High/ Medium/ Low risk		Mitigating actions:										
Very high level of saving assumed for NICU which may not be realised	Likelihood – 3 Impact – 3 Risk rating – 9		Further interrogation of figures to be undertaken										
Costs in this area have increased year on year to date so lack of evidence of delivery of savings	Likelihood – 3 Impact – 4 Risk rating – 12		Engagement at CEO level and Director with governance structures Validation of costs and activity submitted to date Close monitoring of activity and costs early in 10/11										

Strategic initiative 4: Planned Care

Linked Healthcare for London care pathway(s) and/or care setting(s):
Planned Care

<p>Linked pledges and targets:</p> <ul style="list-style-type: none"> • VSA04 NHS-reported waits for elective care • VSB18 Dental Services • VSA06 Patient reported measure of GP access • VSA07 Supporting Lines: patient reported measure of GP access (to follow) • VSB01 All-age all cause mortality (AAACM) rate • VSB15 Self reported experience of patients/users (National priority for local delivery) <p>VSB16 Public Confidence in Local NHS</p>	<p>Linked WCC outcome(s):</p> <ul style="list-style-type: none"> • Delayed transfers of care (% of case per 100,000 over 18) • Self reported experience of patients and carers • Proportion of all deaths that occur at home • CVD mortality (per 100,000 > 75)
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SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

*The impact of each action on commissioned activity and finance **must** be quantified.*

Strategic initiative 4a: Outpatient shift to lower cost settings

Linked Healthcare for London care pathway(s) and/or care setting(s):
Planned Care

<p>Linked pledges and targets:</p> <ul style="list-style-type: none"> • See overarching strategic initiative 4: Planned Care 	<p>Linked WCC outcome(s):</p> <ul style="list-style-type: none"> • Delayed transfers of care (% of case per 100,000 over 18) • Self reported experience of patients and carers • Proportion of all deaths that occur at home • CVD mortality (per 100,000 > 75)
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Actions:		When will the action be completed? (month)	
• Pathway definition agreed with clinicians		• Sep 2010	
• Business case approved and service specification agreed		• Oct 2010	
• Commence competitive procurement process		• Dec 2010	
• Contract award		• May 2011	
• Provider mobilisation complete		• Jul 2011	
• Activity shifts and benefits commence		• Oct 2011	
• Performance improvement achieved		• Feb 2012	
• Benefits realisation and pathway review		• Mar 2012	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
<i>Initiative specific measures are included in the CSP. For</i>		Q1	
		Q2	

Vital Signs please see Annex C.	Q3
	Q4

Impact on activity and finance (commissioned / decommissioned):

Month (10/11)	1	2	3	4	5	6	7	8	9	10	11	12	Total
Value £000 (Saving)	0	0	0	0	0	0	0	0	0	0	0	0	0
Value £000 (Re-investment)													
Activity	0	0	0	0	0	0	0	0	0	0	0	0	0
Rec (R) or Non-rec (N/R)													

Impact on workforce:

Significant moves anticipated with acute services staff moving to polysystem settings. High potential for TUPE transfer of staff to new providers in polysystems. Skills updating required to ensure staff can deliver the care required in community based settings. Potential need for new roles that encompass health and social care components. Greater multidisciplinary working and staff taking on non- traditional roles.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Speed of implementation of polysystem and the associated significant change in health service delivery	Likelihood – 4 Impact - 4 Risk rating - 16	Use of non recurrent 2% headroom money to address skills and capacity issues in commissioning Close engagement with Practice Based Commissioners Phased implementation over 4 years
Capability of the provider workforce to respond to the pace of change	Likelihood – 4 Impact – 4 Risk rating – 16	Primary care development supported in NHS Brent OD plan Collaborative working with current and potential future providers Detailed understanding of the provider landscape and work with other PCTs in sector to ensure alignment of polysystem development with changes in the provider landscape
Patient behaviour does not change or patients report that delivery of services in new settings is unacceptable	Likelihood – 3 Impact – 4 Risk rating – 12	Effective pathway redesign and decommissioning existing services Use of social marketing and communications linked to sector and pan London
Lack of an integrated IT system across the health economy	Likelihood – 5 Impact – 3 Risk rating – 15	Development of an IT programme within NHS Brent to support delivery of the OP

R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce: Development of workforce with health and social care focus													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Attaining agreement with the Local Authority that they will manage reablement packages for patients who are identified by EARLI etc, but may not be substantial/ critical on FACS				Likelihood – 2 Impact – 5 Risk rating – 10				Engage at an early stage with the LA to ensure buy-in and agree commercial terms.					
Defining a referral pathway that meets the needs of Brent GPs and also captures the full information set required to commence reablement				Likelihood – 3 Impact – 3 Risk rating – 9				Pathway development workshop, considering possible routes including via STARRS SPA, ICCS or direct referral to One-Stop Shop					
Local Authority ability to commission and manage additional reablement hours				Likelihood – 3 Impact – 3 Risk rating – 9				Early engagement with LA and modelling exercise to predict additional demand Development of good KPIs and ongoing joint monitoring					
GPs may not refer to the service, leading to limited benefits realisation				Likelihood – 3 Impact – 4 Risk rating – 12				Ensure any arrangement with LA is based on a tariff, rather than block payment. Engage PBC Management Leads in service design and promotion					

SECTION 3: PERFORMANCE (PCTs and Sectors)	
Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London’s planning guidance, and the DH Operating Framework.	
The impact of each action on commissioned activity and finance <u>must</u> be quantified.	
Strategic initiative 4c: Sexual Health (GUM reprovion)	
Linked Healthcare for London care pathway(s) and/or care setting(s): Planned Care	
Linked pledges and targets: <ul style="list-style-type: none"> See overarching strategic initiative 4: Planned Care 	Linked WCC outcome(s): <ul style="list-style-type: none"> Self reported experience of patients and carers

Actions:												When will the action be completed? (month)	
Pathway definition agreed with clinicians												April 10	
Commence competitive procurement process												July 10	
Contract award												Jan 11	
Activity shifts and benefits commence												Apr 11	
Benefits realisation and pathway review												Mar 12	
Performance measure(s):			Baseline level of performance:									Target level of performance each quarter:	
Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.												Q1	
												Q2	
												Q3	
												Q4	
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	0	0	0	0	0	0	0	0	0	0	0	0	0
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity													
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce: Potential TUPE implications for existing staff and move to community from acute settings.													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Identifying suitable estate offering access to relevant population				Likelihood – 4 Impact – 4 Risk rating – 16				Comprehensive site search, looking at full estate available within the polysystems, converting non-clinical sites for use or rental of high street premises					
Unable to procure new service at projected price and quality				Likelihood – 4 Impact – 4 Risk rating – 16				Early engagement with potential providers Detailed assessment of provider economies					
Pace of change constrained by organisational capability or provider capability				Likelihood – 3 Impact – 4 Risk rating – 12				Upskilling of commissioners in procurement and market management skills Early engagement with current providers to address cost and quality issues					

not successful timetable around starting the procurement will affect the anticipated savings targets.	Impact – 3 Risk rating – 9	need to be set out and impacts fed back into financial planning for 2010/2011
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SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 4e: Review of Enhanced services

Linked Healthcare for London care pathway(s) and/or care setting(s):
Planned Care

Linked pledges and targets:	Linked WCC outcome(s):
<ul style="list-style-type: none"> See overarching strategic initiative 4: Planned Care 	<ul style="list-style-type: none"> Self reported experience of patients and carers

Actions:		When will the action be completed? (month)
Notice to LMC on re-commissioned services and decommissioned services		Jan 2010
Three months notice to Contractors to be given on decommissioned services and re-commissioning of services		Jan 2010
Scoping, business case and project plan developed		Feb 2010
Last day of provision of enhanced services 23 rd April 2010 for decommissioned services		April 2010
New specifications to be commissioned		April 2010
Aim for EMIS Web to be implemented		April 2010
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>		Q1
		Q2
		Q3
		Q4

Impact on activity and finance (commissioned / decommissioned):

2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
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Preferred supplier identified	Mar 10
Business case approved	Mar 10
Contracts signed	Apr 10
Service commencement	May 10
Service completion	Oct 10
Performance measure(s):	Baseline level of performance:
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>	
	Target level of performance each quarter:
	Q1
	Q2
	Q3
	Q4

Impact on activity and finance (commissioned / decommissioned):

2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	0	0	0	0	0	0	0	0	(126)	(94)	(32)	(16)	(268)
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity													
R/NR							R	R	R	R	R	R	R

Impact on workforce:

Risks:	High/ Medium/ Low risk	Mitigating actions:
LMC/LINKS opposition to the validation protocol.	Likelihood – 4 Impact – 4 Risk rating – 16	Discuss and agree protocol with LMC and LINKS.
OJEU Procurement procedure is required	Likelihood – 2 Impact – 4 Risk rating – 8	Review SBS/NHS framework agreement
Patients are re-registered shortly after being removed from list	Likelihood – 3 Impact – 4 Risk rating – 12	Ensure robust annual validation process is in place
Patients are incorrectly removed from GP practice.	Likelihood – 2 Impact – 3 Risk rating – 6	The FP69 process allows practices 6 months to verify patient details.

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance <u>must</u> be quantified.													
Strategic initiative 4g: Primary Care contract management													
Linked Healthcare for London care pathway(s) and/or care setting(s): Planned Care													
Linked pledges and targets: <ul style="list-style-type: none"> See overarching strategic initiative 4: Planned Care 						Linked WCC outcome(s): <ul style="list-style-type: none"> Self reported experience of patients and carers 							
Actions:										When will the action be completed? (month)			
Balanced scorecard completed and signed off by clinical leaders										March 2010			
Develop contract monitoring process that is linked in with balanced scorecard monitoring										March 2010			
Develop specification and appoint consultants for retirement work										March 2010			
Consultants provide NHS Brent with outcomes										May 2010			
Plan prepared										June 2010			
Performance measure(s):			Baseline level of performance:				Target level of performance each quarter:						
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>							Q1						
							Q2						
							Q3						
							Q4						
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	0	0	0	0	0	0	0	0	0	0	0	0	0
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity													
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce:													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Agreeing Performance metrics with				Likelihood – 2 Impact – 4				Balanced scorecard working group to be					

clinical leaders	Risk rating – 8	established
Agreeing more intensive contact monitoring process with LMC	Likelihood – 3 Impact – 5 Risk rating – 15	Link to contract, regs and best practice. Invite to working group above.
Resource (clinical and management) to undertake the monitoring visits	Likelihood – 3 Impact – 5 Risk rating – 15	Business case for additional resource once plan is developed.
Contractors agree to independent consultants having discussion about retirement and providing PCT with outcomes of discussion.	Likelihood – 3 Impact – 5 Risk rating – 15	Gain agreement from LMC. Communicate with Contractors directly. Potentially involve them in appointing consultants and developing spec.

SECTION 3: PERFORMANCE (PCTs and Sectors)		
<i>Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.</i>		
<i>The impact of each action on commissioned activity and finance <u>must</u> be quantified.</i>		
Strategic initiative 4h: Review of GP Prescribing/Incentive Scheme		
Linked Healthcare for London care pathway(s) and/or care setting(s): Planned Care		
Linked pledges and targets:		Linked WCC outcome(s):
<ul style="list-style-type: none"> See overarching strategic initiative 4: Planned Care 		<ul style="list-style-type: none"> Self reported experience of patients and carers
Actions:		When will the action be completed? (month)
Agreement of the CEPIS by Prescribing & Medicines Management Committee & PBC Federation		March 2010
Prepare detailed practice profile and baseline monitoring information		April to October 2010
Practice visits to agree		April to October 2010
GP practices to implement CEPIS and GMS prescribing actions to release savings		October to March 2010-11
Complete prescribing monitoring information for CEPIS and GMS actions		July 2011
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
<i>Initiative specific measures are included in the CSP. For Vital</i>		Q1
		Q2

Signs please see Annex D.									Q3				
									Q4				
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	(101)	(101)	(101)	(101)	(101)	(101)	(101)	(101)	(101)	(101)	(101)	(101)	(1,215)
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity													
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce:													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Will need to recruit an interim Prescribing Adviser if there is a short fall in the number of Prescribing Advisers (<i>due to maternity leave or otherwise</i>) available to visit the GP practices to agree the CEPIS, and GMS saving actions and support practices during the financial year 2010-11.				Likelihood – 3 Impact – 4 Risk rating – 12				Agree to maternity cover – temporary cover will be needed for a year (Daily costs for a replacement is approximately @ £500)					
Hospital prescribing and consultant recommendations to GPs				Likelihood – 4 Impact – 4 Risk rating – 16				Primary care reduction in cost has been negated by increase in hospital expenditure on drugs 1. Careful Commissioning which specifically addresses this feature in the acute trusts SLA 2. Senior representation on NWL Drugs & Therapeutics Committee and Drugs, Devices and Procedures Commissioning Group					
Failure of practices to adopt CEPIS and QoF savings targets, both of which are voluntary				Likelihood – 3 Impact – 4 Risk rating – 12				Joint working based on PCT and PBC ownership					
Unexpected events e.g. Pandemic				Likelihood – 2 Impact – 5 Risk rating – 10				Difficult to predict					

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Lack of capital funding to make site fit for purpose (see above)	Likelihood – 3 Impact – 3 Risk rating – 9	Ascertain availability of capital funding Keep costs to a minimum
There is a risk that service delivery will be adversely affected by an inability on the part of BCS to deliver high quality services to a reduced contract sum	Likelihood – 3 Impact – 4 Risk rating – 12	Commissioners will work closely with BCS to realise the required productivity savings and ensure that the quality and performance metrics support improved productivity
Repatriating patients that use Barnet intermediate care beds may be affected by in year acute pressures such as flu creating peaks of demand	Likelihood – 2 Impact – 3 Risk rating – 6	Ensure BCS have up-to-date winter and emergency action plans in place

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London’s planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 4j: Estates Efficiencies

Linked Healthcare for London care pathway(s) and/or care setting(s):
Planned Care

Linked pledges and targets:

- See overarching strategic initiative 4: Planned Care

Linked WCC outcome(s):

- Self reported experience of patients and carers

Actions:

When will the action be completed? (month)

Facilities contract meetings with all providers

Jan 2010

Leases signed for Hillside and Chalkhill

Jan 2010

Source all data on energy and determine DEC reports

End Feb 2010

Relocate GP at stag lane

End Feb 2010

Determine improvement energy plan

End Mar 2010

Actions:		When will the action be completed? (month)	
These changes are not due to start until 2011/12			
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>		Q1	
		Q2	
		Q3	
		Q4	
Impact on activity and finance (commissioned / decommissioned):			
N/A			
Impact on workforce:			
Risks:	High/ Medium/ Low risk	Mitigating actions:	

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 4I: 21 Building SLA

Linked Healthcare for London care pathway(s) and/or care setting(s):

Planned Care

Linked pledges and targets:

- See overarching strategic initiative 4: Planned Care

Linked WCC outcome(s):

- Self reported experience of patients and carers

Actions:		When will the action be completed? (month)											
Internal benchmarking exercise to be undertaken.		Jan 2010											
Working Group to be established and set up		Jan 2010											
Working group to identify savings from within the SLA		Jan 2010											
SLA to have been re-drafted and agreed by both NHS Brent and NHS Harrow		Mar 2010											
Directors of Finance / CEO to sign off SLA		Mar 2010											
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:											
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>		Q1											
		Q2											
		Q3											
		Q4											
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(125)
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity													
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce:													
Risks:	High/ Medium/ Low risk		Mitigating actions:										
£125k worth of efficiencies can not be found within the SLA	Likelihood – 3 Impact – 4 Risk rating – 12		Benchmark the SLA against other SLAs with Contractor services to ensure getting best value.										
No agreement by NHS Harrow that the savings within the SLA are possible	Likelihood – 4 Impact – 4 Risk rating – 16		Working group to be established. Objective to be clear from outset.										
Timescales very short to achieve re-negotiations	Likelihood – 3 Impact – 3 Risk rating – 9		Resource from finance to undertake benchmarking exercise to be agreed.										

Risks:	High/ Medium/ Low risk	Mitigating actions:
Implement Contract management process	Likelihood – 1 Impact – 3 Risk rating – 4	LDC are aware of need for contract management. Process in line with regulations and contract.
Terminate contracts where possible	Likelihood – 2 Impact – 5 Risk rating – 10	Robust contract monitoring. Following regulations to ensure risk of any challenge is minimal.
Renegotiation of UDA Value with individual Contractors	Likelihood – 5 Impact – 5 Risk rating – 25	Understand and be able to evidence how much they are outliers by. Understand why values so high through look back exercise on how initially calculated.
Relationship with Contractors and LDC becomes difficult	Likelihood – 3 Impact – 3 Risk rating – 9	Steering group established. Clear communication with both.

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 4n: PBC shift recurrent to non-recurrent expenditure

Linked Healthcare for London care pathway(s) and/or care setting(s):

Planned Care

Linked pledges and targets:

- See overarching strategic initiative 4: Planned Care

Linked WCC outcome(s):

Actions:

When will the action be completed? (month)

Performance measure(s):

Baseline level of

Target level of performance

	performance:	each quarter:	
Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.		Q1	
		Q2	
		Q3	
		Q4	
Impact on activity and finance (commissioned / decommissioned):			
Impact on workforce:			
Risks:	High/ Medium/ Low risk	Mitigating actions:	

Strategic initiative 5: Mental Health

Linked Healthcare for London care pathway(s) and/or care setting(s):

Mental Health

Linked pledges and targets:

- VSB01 All-age all cause mortality (AAACM) rate
- VSB15 Self reported experience of patients/users (National priority for local delivery)
- VSB16 Public Confidence in Local NHS

Linked WCC outcome(s):

- Self reported experience of patients and carers

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 5a: CNWL contract rebasing, LD bed reduction and service reconfiguration

Linked Healthcare for London care pathway(s) and/or care setting(s):

Mental Health

Linked pledges and targets:						Linked WCC outcome(s):							
<ul style="list-style-type: none"> See overarching strategic initiative 5: Mental Health 						<ul style="list-style-type: none"> Self reported experience of patients and carers 							
Actions:								When will the action be completed? (month)					
Agree contract rebasing and prices with CNWL and other sector PCTs and sign off new 3 year contract with CNWL								Feb 2010					
Agree pathway and service specification for LD beds and KPIs for ongoing monitoring of bed use								Feb 2010					
Agree workplan with local Modernisation Board for community services reconfiguration								March 2010					
Monthly and quarterly meetings to review progress								June 2010					
Performance measure(s):				Baseline level of performance:				Target level of performance each quarter:					
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>								Q1					
								Q2					
								Q3					
								Q4					
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	(119)	(119)	(119)	(119)	(119)	(119)	(119)	(119)	(119)	(119)	(119)	(119)	(1,423)
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity							(3)	(3)	(3)	(3)	(3)	(3)	(3)
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce:													
Significant reconfiguration of current non acute teams and integration with polysystems. Development of new community based psychological therapy workforce which will impact on existing counselling staff and traditional psychotherapy teams to meet the stepped care model.													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Inability to achieve agreement with main provider and 4 other NWL PCTs on contract rebasing				Likelihood – 3 Impact – 5 Risk rating – 15				Director of Finance working with other sector DoFs to achieve agreement Extra project support resourced by all the PCTs involved to interrogate data and assumptions					
Destabilisation of local MH services due to				Likelihood – 3 Impact – 3				Close working with provider and other sector PCTs to monitor KPIs and recognise system					

N/A		
Risks:	High/ Medium/ Low risk	Mitigating actions:
Transfer of funding for LD social care to LA reduces budget available	Likelihood – 3 Impact – 4 Rating - 12	Good engagement with LA to ensure clarity of responsibilities Good process for CC approval with KPIs for ongoing monitoring
High levels of activity growth in continuing care	Likelihood – 4 Impact – 3 Rating - 12	Good process for CC approval with KPIs for ongoing monitoring Good process for contract monitoring and negotiation to secure best value placements
Activity levels currently exceed budget for MH Cont care increasing the challenge to find savings	Likelihood – 4 Impact 5 Rating 20	Discussions with CNWL started in Dec 2009 to see if activity can be repatriated at lower cost.

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London’s planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 5c: CNWL general target 2%

Linked Healthcare for London care pathway(s) and/or care setting(s):

Mental Health

Linked pledges and targets:

- See overarching strategic initiative 5: Mental Health

Linked WCC outcome(s):

- Self reported experience of patients and carers

Actions:

When will the action be completed? (month)

Agree contract value with CNWL and sign off new 3 year contract reflecting ongoing efficiency savings required

Feb 2010

Agree workplan with local Modernisation Board for community services reconfiguration

March 2010

Monthly and quarterly meetings to review progress

June 2010

Performance measure(s):

Baseline level of performance:

Target level of performance each quarter:

Initiative specific measures are

Q1

(Screening) <ul style="list-style-type: none"> • VSC27 Patients with diabetes • VSB14 Number of Drug Users recorded as being in effective treatment • VSC18 Carers receiving a 'carer's break' or a specific carers' service • VSB01 All-age all cause mortality (AAACM) rate • VSB15 Self reported experience of patients/users (National priority for local delivery) • VSB16 Public Confidence in Local NHS 	
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SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 6a: Health checks

Linked Healthcare for London care pathway(s) and/or care setting(s):
Staying Healthy

Linked pledges and targets:

- See overarching strategic initiative 6: Staying Healthy

Linked WCC outcome(s):

- Health inequalities in years (males and females)
- Life expectancy in years (males and females)
- Smoking quitters (per 100,000)
- Proportion of women ages 53-70 screened for breast cancer within the last three years
- CVD mortality (per 100,000 > 75)

Actions:	When will the action be completed? (month)
Business Case Sign Off by PCT Board	January 2010
Sign off Operating Procedures	March 2010
LES Negotiations and Sign up	May 2010
Implement Information/Performance system	January to June 2010
Engagement Programme	January to May 2010
Commissioned Services 'Go Live'	April/July 2010
Evaluate Progress/Business Case for 2011/12	October 2010

Linked pledges and targets:						Linked WCC outcome(s):							
<ul style="list-style-type: none"> • See overarching strategic initiative 6: Staying Healthy 						<ul style="list-style-type: none"> • Health inequalities in years (males and females) • Life expectancy in years (males and females) • Smoking quitters (per 100,000) • Proportion of women ages 53-70 screened for breast cancer within the last three years • CVD mortality (per 100,000 > 75) 							
Actions:						When will the action be completed? (month)							
Exploration of efficiency savings plan						February /March 2010							
Review targets and stop smoking plan						June/July 2010							
Finalise plan/business case for 2011/12						October 2010							
Review targets and develop business case for 2012/13						October 2011							
Performance measure(s):			Baseline level of performance:			Target level of performance each quarter:							
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>						Q1							
						Q2							
						Q3							
						Q4							
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	0	0	0	0	0	0	0	0	0	0	0	0	0
£ (Reinvestment)	0	0	0	0	0	0	0	0	0	0	0	0	0
Activity	0	0	0	0	0	0	0	0	0	0	0	0	0
R/NR	R	R	R	R	R	R	R	R	R	R	R	R	R
Impact on workforce:													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Reduction in current investment will delay the establishment and subsequently failure to meet targets				Likelihood – 5 Impact – 5 Risk rating – 25				Stop Smoking Performance Board to oversee successful Implementation of initiatives as set out in the stop smoking plan and business case					
Confidence of providers and reputation of senior managers in the PCT				Likelihood – 5 Impact – 5 Risk rating – 25				Public assurance needs to be guaranteed for the service					

Impact on workforce:		
Risks:	High/ Medium/ Low risk	Mitigating actions:
Lack of buy in from GP Practices and secondary care clinicians.	Likelihood – 3 Impact – 5 Risk rating – 15	Stakeholder events and clinically led programme, both by primary and secondary care.
Insufficient resource to manage programme effectively.	Likelihood – 3 Impact – 4 Risk rating – 12	Business Case being prepared for funding to concentrate solely on LTC programme.
Timescales are too tight to mobilise programme and savings.	Likelihood – 3 Impact – 5 Risk rating – 15	Business case prepared for additional resource to move programme forward in time to realise projected savings.

SECTION 3: PERFORMANCE (PCTs and Sectors)	
<i>Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.</i>	
<i>The impact of each action on commissioned activity and finance <u>must</u> be quantified.</i>	
Strategic initiative 8: End of Life Care	
Linked Healthcare for London care pathway(s) and/or care setting(s): End of Life	
Linked pledges and targets: <ul style="list-style-type: none"> • VSC15 The proportion of all deaths that occur at home. • VSB01 All-age all cause mortality (AAACM) rate • VSB15 Self reported experience of patients/users (National priority for local delivery) • VSB16 Public Confidence in Local NHS 	Linked WCC outcome(s): <ul style="list-style-type: none"> • Proportion of all deaths that occur at home • Self reported experience of patients and carers
Actions:	When will the action be completed? (month)
Project Board set up	January 2010
Stakeholder engagement plan agreed	November 2009
Pathway definition agreed with clinicians	January / Feb2010
Outline Business Case approved	March 2010

Service specification signed off		March 2010											
Business case approved		March 2010											
Procurement route decision made		April 2010											
Contract award		May 2010 (If appropriate)											
Investment starts		June 2010 (for training)											
Provider mobilisation complete		July 2010											
Activity shifts and benefits commence		January 2011											
Performance improvement begins		January 2011											
Benefits realisation and pathway review		January 2011											
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:											
<i>Initiative specific measures are included in the CSP. For Vital Signs please see Annex C.</i>		Q1											
		Q2											
		Q3											
		Q4											
Impact on activity and finance (commissioned / decommissioned):													
2010/11	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
£ (Savings)	0	0	0	0	0	0	0	0	0	(65)	(65)	(65)	(194)
£ (Reinvestment)	8	8	10	10	10	10	10	10	10	10	10	10	116
Activity										(22)	(22)	(22)	(65)
R/NR										R	R	R	R
Impact on workforce:													
Risks:				High/ Medium/ Low risk				Mitigating actions:					
Patients do not consent to being treated at home.				Likelihood – 1 Impact – 5 Risk rating – 5				Patients kept informed of their medical status and reassured by the service received.					
Organisations acting independently and not in the required integrated way and in line with the identified pathways				Likelihood – 1 Impact – 3 Risk rating – 3				Joint strategy, jointly owned within each organisation.					

People remaining in Acute hospital and receiving treatment that could be provided in the community (at a higher cost).	Likelihood – 4 Impact – 4 Risk rating – 16	Discharge Support 'in-reach' presence on wards.
GPs not adhering to the identified pathways therefore patients attend A&E and community services not fully utilised	Likelihood – 3 Impact – 5 Risk rating – 15	Suitable communications with GPs and PBC clusters

4.3 Revenue

Please explain the significant changes in revenue.

Under the base case scenario the PCT's recurrent resource limit is subject to a tariff uplift of 5.1% in accordance with published planning guidelines. For 2011/12 no recurrent uplift has been assumed. Non recurrent income comprises the brought forward surplus from the previous financial year as set out in the financial template (Annexe A). The position is summarised in the tables below.

	2010-11		2011-12	
	Net Tariff uplift %	Net Tariff uplift £ 000s	Net Tariff uplift %	Net Tariff uplift £ 000s
Recurrent :-				
Recurrent Allocation	5.1	25,578	0	-
Other Allocation	5.1	717	0	-
Total Recurrent		26,295		-

	2010-11	2011-12
	£ 000s	£ 000s
Non Recurrent:-		
Non Rec Allocation	0	0
Non Rec - B/F surplus/(deficit)	15968	16174
Total Non Recurrent	15968	16174

4.4 Commentary on overall position

Please provide an explanation of your overall financial position including sections on:

Medium Term Financial Strategy (MTFS)

The PCT forecast financial outturn for 2009/10 and plans for 2010/11 and 2011/12 are summarised below. The recurrent planned recurrent surplus for both 2010/11 and 2011/12 is 2.2% of revenue allocation. The contingency for both years represents 1% and 1.5% of revenue allocation respectively. This robust financial plan is underpinned by the savings initiatives summarised in sections 4.1, 4.8 and 4.9 which total £5.8m (1% of allocation) in 2010/11 and £14.9m (2.6% of allocation) in 2011/12.

The PCT's plans have been subject to a rigorous risk assessment and headroom analysis and confirm that NHS Brent will be in a position to achieve financial equilibrium under all financial scenarios.

A full analysis of the PCT financial strategy is set out within the MTFS

Category	2010-11					2011-12				
	Funding (%)	Inflation (%)	Tariff Efficiency (%)	COQUIN (%)	Activity growth (%)	Funding (%)	Inflation (%)	Tariff Efficiency (%)	COQUIN (%)	Activity growth (%)
Allocation	5.1					0.0				
Primary Care		1.0	0.0	0.0	1.0		1.0	0.0	0.0	1.0
Prescribing		4	0.0	0.0	3.0		4.0	0.0	0.0	3.0
Acute		3.5	-3.5	1.0	4.9		3.5	-3.5	0.0	4.5
Specialist Consortia		3.5	-3.5	1.0	4.1		0.0	0.0	0.0	5.1
Mental Health		3.5	-3.5	1.0	1.0		3.5	-3.5	0.0	1.0
Community		3.5	-3.5	1.0	0.9		3.5	-3.5	0.0	0.9
Other		1.0	0.0	0.0	0.0		1.0	0.0	0.0	0.0
Overall Average		3.0	-2.5	0.7	3.1		2.8	-2.3	0.0	2.8

4.6 Key risks included within your financial plan

Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
Risk to delivery of strategic initiatives and associated savings/disinvestment programmes	High	<p>Pursue all available opportunities to support the achievement of the efficiency/disinvestment programme on both a local, sector-wide and pan-London basis.</p> <p>Implement PCT agreed 15 point action plan to ensure delivery of financial plan by monitoring the development and implementation of initiatives</p>
Impact of population growth/mix and other activity drivers in excess of planned levels	Low	<p>The PCT will focus on ensuring that it is able to respond to changes in key assumptions and projections in a flexible and optimum manner by:-</p> <ul style="list-style-type: none"> • The solid foundation and recent track record providing a strong platform on which to build • The strength of the PCT's planning process including base case assumptions, identification and assessment of risks and opportunities, scenario planning, and the levels of contingency and non-recurrent investment • 15 point action plan to ensure that a firm grip is maintained on the financial position and flexibility retained in plans to ensure that under all scenarios the capability exists to manage risk and volatility to be able to maintain a sustainable financial position • Headroom analysis confirms that the PCT has sufficient financial flexibility to remain in financial balance in all scenarios.
Tariff increases greater than forecast	Low	As above
Other unexpected cost pressures	Medium	As above
Opportunities – See MTF5		

4.7 CQUIN

Describe your proposed CQUIN schemes and how CQUIN payments have been treated in contracts. Where relevant, what is the link to your strategic initiatives and WCC outcomes?

NHS Brent will implement the approach to CQUIN developed by the NWL sector acute commissioning unit (SACU) which has agreed a regional (pan-London) set of CQUINs designed to support the Healthcare for London implementation and polysystem development. The three overarching themes for regional CQUINs are:

1. Long Term Conditions Management (LTC)
2. Emergency admissions and re-admissions across all pathways (combined to be more powerful)
3. Effective discharge/LOS/care planning/ transfer of care

CQUINs for 2010/11 will be 1.5% of total contract value. NHS Brent is in discussions with the SACU to agree local CQUINs which account for 0.5%.

4.8 Cost Improvement Programmes (expenditure savings only)

The balance of the PCT savings programme after taking into account productivity savings (section 4.1) and demand management schemes (section 4.9) comprises management cost savings totalling £473k (3.5%) per annum for both 2010/11 and 2011/12.

How will the achievement of these savings be managed in year and what are the risks to achievement?

The risk of non-delivery of this element of the savings programme is low. The PCT will apply the methodology set out in section 4.6 above to maximise the delivery of the planned level of savings.

4.9 Demand management schemes

The analysis of savings arising from demand management schemes are summarised below by patient care setting and total £727k in 2010/11 and £483k in 2011/12:-

CareSettings	Demand Management	
	2010-11	2011-12
	£ 000s	£ 000s
Acute	727	483
Primary Care	0	0
Community	0	0
Mental Health	0	0
Other PCT (Man Costs)		
Total	727	483

An analysis of the demand management initiatives is summarised below by finance and activity. Other schemes (included in productivity) will also have an impact on providers (e.g. Intermediate care, Urgent care centre). :-

Initiative	Demand Management				
	Risk Assessment	2010-11		2011-12	
		£ 000s	Activity	£ 000s	Activity
A&E Reduction - CMH	Low	132	1,648	84	1,052
A&E Reduction - Other	Medium	595	9,000	35	0
Decommissioning - Outpatients	Medium	0	0	249	1,917
Decommissioning - Electives	Medium	0	0	115	148
Total		727	10,648	483	3,117

4.10 Capital investment and disposal (including sources of funding)

The capital requirement is limited as there exists significant spare capacity in existing facilities as outlined in the Strategic Plan. We have included preliminary estimates of the capital required in our plans, as set out below:-

Category	2010-11 £000	2011-12 £000
Maintenance of capital stock	1,000	1,000
Polysystem Refurbishment	1,500	1,000
ICT programme		500
Total Charge against CRL	2,500	2,500

4.11 Key financial risks and opportunities not included in the financial plan (with mitigating actions)

None

4.12 Use of Resources – plans to improve your score (where relevant)

Category	2008-09	2009-10 Plan	2010-11 Plan
Managing Finances	3	3	4
Governing the Business	2	3	3
Managing the Resources	2	3	3

SECTION 5: WORKFORCE (PCTs and sectors)

5.1 Workforce impact of strategic goals

(PCTs) Please provide a description of the anticipated impact for workforce within local provider Trusts and PCT providers as a result of the PCT's strategic initiatives e.g. describing anticipated increases / decreases for your main providers and services that may see significant change.

Commentary

The principal impact on the provider workforce is anticipated to be a shift from acute providers to primary and community providers with a potential change in location and roles for some staff. The

outcome of this movement will be a reduction in the size of the workforce for acute providers and a potential corresponding increase in community provider workforce numbers though this will be offset by the need for greater community provider efficiency. The efficiency savings required from the provider organisations is likely to result in reductions in staff numbers across the board. It is not at present possible to quantify these changes other than through the workforce productivity expectations set out in 5.5.

5.2 Effective communication with providers

(PCTs) Does your organisation have a process in place by which it can assure the workforce strategies of its provider organisations are fully integrated with service and financial plans, and aligned with the PCT's vision as highlighted in its commissioning intentions communicated to its providers?

Y

Commentary

The workforce dimension of commissioning is less well developed than other areas (i.e. activity, targets, finance). Mechanisms are in place for workforce assurance for Brent Community Services which will be further developed as part of the review of their 2010/11 Operating Plan. We will work with the North West London sector and the Director of Workforce Transformation to better define the workforce dimension of commissioning and develop mechanisms for securing workforce assurance in the future. The Operating Plans of providers will be used to inform workforce risk and assurance.

We have shared our CSP and commissioning intentions with providers and in collaboration with the sector we will be asking provider organisations to review their workforce strategies and plans in light of these and forward revised strategies and plans which are fully integrated with service and financial plans to NHS Brent. Review arrangements for these will be incorporated into our performance management processes for 2010/11.

5.3 Quality of Service / Education considerations

(PCTs) Has the PCT made clear to their provider organisations that their education and training funding should be used to transform their workforce to support the delivery of the PCT's service vision, and does the PCT have mechanisms in place to assess whether provider organisations have appropriate plans to support this objective?

Y

Commentary

In collaboration with other PCTs in the sector and the Director of Workforce Transformation we will make clear to providers that their education and training funding and activity needs to be aligned to the workforce transformation priorities arising from our CSP and commissioning intentions. We will require them to submit their plans as part of the process we will establish for performance management for 2010/11.

(PCTs) Does the PCT have processes in place to ensure that provider organisations carry out appropriate workforce risk assessments and address capability or capacity issues ahead of the changes that the PCT's local service vision will require?

Y

Commentary

We will ensure that provider workforce strategies and plans include an assessment of possible

workforce risks arising from the changes to service provision and location that will be a consequence of CSP and commissioning intentions. We will work with providers to identify these risks and develop mitigation strategies.

5.4 Statutory Workforce Obligations

<p><i>(PCTs) Does the organisation have a process in place by which it can assure statutory workforce obligations (e.g. EWTD, mandatory training, % appraisal rates, quality of appraisals, medical revalidation) are delivered within its provider organisations?</i></p>	<p>Y</p>
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Commentary

We will expect provider organisations to provide us with assurance of compliance with their statutory workforce obligations by providing us with evidence of this as part of their workforce strategies and plans. We will triangulate this with evidence from other sources, for example their staff survey findings and SfBH results. We are developing an action plan for medical revalidation which will include provisions for ensuring satisfactory progress on this from providers.

5.5 Productivity & Efficiency

<p><i>(PCTs) What percentage increase in workforce productivity is the PCT expecting from its providers, and does the PCT have mechanisms to monitor the clinical productivity of provider organisations?</i></p>	<p>Y</p>
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Commentary

The PCT expects an increase in workforce productivity at least equal to the efficiencies assumption in the tariff. The PCT monitors clinical productivity through nationally available benchmarking (e.g Better care, Better value indicators) and expects the Acute Commissioning Vehicle to monitor clinical productivity metrics included in contracts

5.6 Leadership

<p><i>(PCTs) Does the PCT have a strategy on developing talent and leadership in line with service delivery and financial management?</i></p>	<p>Y</p>
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Commentary

As part of the implementation of our WCC OD Plan we are undertaking team development and personal coaching for Board, Executive Team and other senior leaders. We have successfully recruited to most of our senior roles and implemented a programme of 'on-boarding' and team integration as part of this process. We have also created and are implementing a learning and development strategy as a commissioning organisation as well as accessing learning offerings from CSL and others as part of our development of leaders. Our recruitment and PDR processes are now based on WCC competencies.

Year 2 of our OD Plan sets out our intention to work with colleagues across the Sector to build on our talent management initiatives collaboratively.

We are also currently undertaking a PBC development programme in partnership with Humana and the NHS Alliance aimed at developing better clinical engagement, a stronger vision for PBC and stronger clinical leadership. Year 2 of our OD Plan sets out a programme for further developing primary care capability and capacity.

SECTION 6: INFORMATICS (PCTs only)

Please complete the informatics template at Annex B.