



NHS County Durham
and NHS Darlington

Annual Operational Plan 2009/2010

Final V.8

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1. PCT Context

This document sets out the 2009/2010 Annual Operational Plan (AOP) for NHS County Durham and NHS Darlington.

NHS County Durham and NHS Darlington aspire to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable strategies, policies and procedures are applied to all organisational transactions, including relationships with patients, their carers, the public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, NHS County Durham and NHS Darlington will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all, in line with the organisation's Diversity and Human Rights Scheme.

1.1 NHS County Durham

NHS County Durham's vision is 'to deliver excellence today for a healthier tomorrow'. This recognises the need to make a step change in the planning and delivery of services to address the poor levels of health and wider health inequalities across County Durham and Darlington.



To deliver this ambition our strategy has been informed by an assessment of the current state of the population of County Durham and Darlington in relation to the four strategic aims agreed by NHS County Durham:

- Improve the health status of our populations.
- Reduce health inequalities.
- Ensuring access to patient centred services: fair, personalised, effective and safe.
- Ensuring value for money in commissioned services.

The strategy is strongly aligned to and will deliver the north east wide approach ('Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)', 'Better Health, Fairer Health (NHS North East - February 2008)' and 'Safer Care North East (NHS North East - August 2008)') to improving health and addressing health inequalities (see Appendix 1).

Our strategy will deliver a future state in which:

- The health of the population is improved.
- Health inequalities are reduced.
- All services are commissioned to detailed specifications which ensure delivery of clinical quality and value for money.

This future state will be delivered within a system that:

- Ensures best value.
- Fully engages patients, carers and the public.
- Fully engages clinicians.

- Promotes and develops choice of providers including NHS, independent and third sectors.
- Shifts the balance from treatment to prevention.
- Achieves and exceeds national targets as milestones towards real service and health improvement.
- Delivers care as close to home as it is appropriate to do so.

This future state will be achieved through the identification of clear objectives and goals, the implementation of initiatives and the monitoring of their delivery through clear metrics (OGIM) underpinned by a robust investment strategy.

1.2 NHS Darlington

The overarching vision of NHS Darlington states that 'NHS Darlington will be an innovative and developing organisation which puts patients and customers at the centre of all it does, and in partnership, works to be the core provider of choice and deliver first class health care services'.



In delivering the vision, it is recognised that the environment is one, subject to considerable change. This includes changes in NHS policy, extended 'out of hospital' provision, structural changes in the delivery of PCT provided services, contestability and world class commissioning.

The strategic direction of NHS Darlington will however, embrace these changes and continue to have patients at the heart of all it does.

1.3 NHS Darlington and NHS County Durham are committed to improving health and wellbeing and making real improvements for local people. While there are many challenges and milestones which are a given and we will always aim to achieve them, our ten key priorities very much focused upon are:

- Reducing health inequalities.
- Increasing life expectancy.
- Reducing under 18 teenage conception rates.
- Increasing breastfeeding rates.
- Reducing smoking further by increasing the number of people quitting (including reducing smoking in pregnancy).
- Reducing deaths due to cancer.
- Improving patient experience.
- Tackling alcohol misuse and reducing related hospital admissions.
- Reducing the prevalence of cardiovascular disease, including stroke and diabetes and improving related health services.
- Improving access to mental health services.

By delivering on these ten priorities we will deliver greatest health gain for local people and hence deliver best value for money for local tax payers.

1.4 Governance Arrangements

NHS County Durham and NHS Darlington are commissioning organisations. Their primary business is to commission healthcare for the populations they serve. Both organisations are required to commission healthcare services for their local areas, and have corporate responsibilities in their own right.

NHS Darlington with its core visions and values can be seen as having two streams to allow it to meet its objectives. These are NHS Darlington with its corporate and overarching functions, including commissioning contracted to NHS County Durham, (including the Annual Operational Plan), and County Durham and Darlington Community Health Services with its provider responsibilities. County Durham and Darlington Community Health Service focuses on delivering high quality services.

1.5 NHS Constitution



The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services will be required by law to take account of this Constitution in their decisions and actions.

There are seven key principles which guide the NHS in all it does:

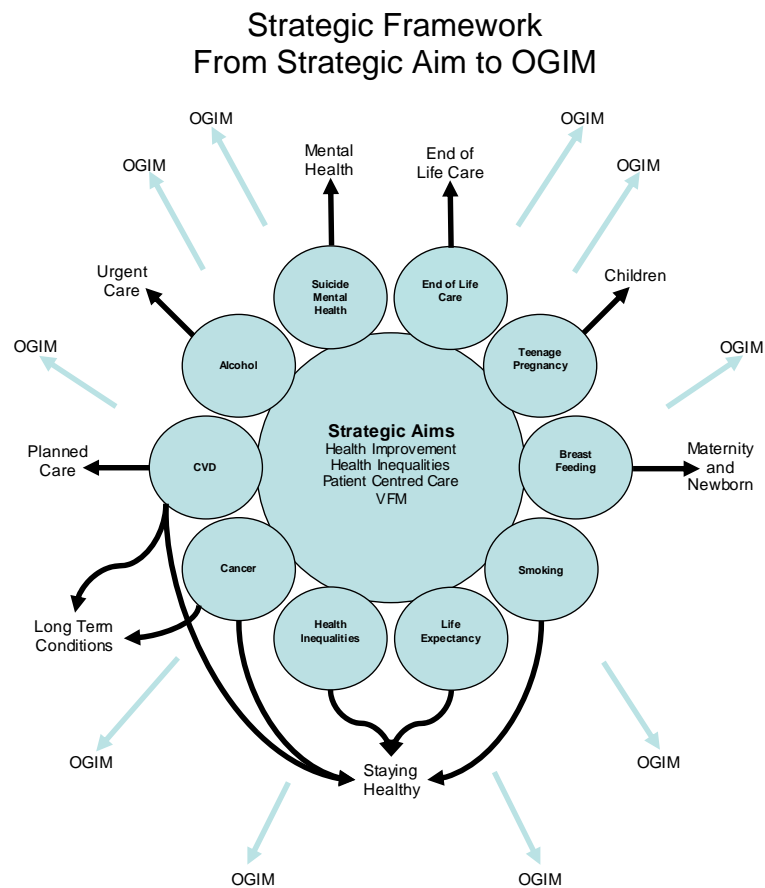
- The NHS provides a comprehensive service, available to all.
- Access to NHS services is based on clinical need, not an individual's ability to pay.
- The NHS aspires to the highest standards of excellence and professionalism.
- NHS services must reflect the needs and preferences of patients, their families and their carers.
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
- The NHS is accountable to the public, communities and patients that it serves.

Driven by the core values of respect and dignity, commitment to quality of care, compassion, improving lives, working together for patients and everyone counts, the constitution aims to address the rights and responsibilities of patients and the public, and staff.

2. PCT Objectives

2.1 Strategic Framework

The AOP will be developed within a strategic framework (Appendix 2) which links the PCT strategic aims, 'Better Health, Fairer Health (NHS North East - February 2008)', 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008) and 'Safer Care North East (NHS North East - August 2008)' to delivery through the AOP approved OGIMs.



2.2 PCT Objectives

2.2.1 Delivering Key Health Outcomes

Ten key outcomes have been identified which will be used to measure success. The delivery of these ten priorities will produce greatest health gain for local people and hence deliver best value for money for local tax payers. In five years time, by delivering the strategic plan, current performance will move to that indicated in the tables below:

County Durham:

Health Outcome	Current Status	Target 2012/13 (2012)	Trajectory				
			Year 1 08/09 (2008)	Year 2 09/10 (2009)	Year 3 10/11 (2010)	Year 4 11/12 (2011)	Year 5 12/13 (2012)
Health Inequalities		Eng Ave					Eng Ave
Life Expectancy							
Male	77.5 (05/07)	Eng Ave	77.8	78.1	78.4	78.8	79.1
Female	81.2 (05/07)	Eng Ave	81.3	81.7	82.0	82.3	82.7
Infants Breastfed	- (1)	Eng Ave (2)	15%	22%	30%	40%	50%
Under 18 Conception Rates	45.5 (1)	Eng Ave (2)	45.0	44.0	42.0	39.5	36.4
Smokers Quitting	1102 (3)	Best in Class Group (4)	1300	1360	1410	1455	1500
Suicide (individuals offered psychological therapy)	8.36 (1)	Eng Ave (2)	8.6	8.4	8.2	7.9	7.4
Alcohol Admissions	1544 (1)	Eng Ave (2)	1654	1703	1747	1700	1564
Cancer Mortality Rate	134 (1)	Eng Ave (2)	123	119	114	108	97
CVD Mortality (stroke deaths within 30 days of admission)	97.0 (1)	Eng Ave (2)	72	64	56	48	39

Darlington:

Health Outcome	Current Status	Target 2012/13 (2012)	Trajectory				
			Year 1 08/09 (2008)	Year 2 09/10 (2009)	Year 3 10/11 (2010)	Year 4 11/12 (2011)	Year 5 12/13 (2012)
Health Inequalities		Eng Ave					Eng Ave
Life Expectancy							
Male	76.3 (05/07)	Eng Ave	76.8	77.4	78.0	78.5	79.1
Female	80.6 (05/07)	Eng Ave	81.2	81.6	81.9	82.3	82.7
Infants Breastfed	- (1)	Eng Ave (2)	15%	22%	30%	40%	50%
Under 18 Conception Rates	48.3 (1)	Eng Ave (2)	45.0	43.3	41.5	39.5	36.4
Smokers Quitting	914 (2)	Top quartile (3)	1277	1335	1390	1455	1500
Suicide (individuals offered psychological therapy)	11.1 (1)	Eng Ave (2)	10.4	10.3	9.8	9.1	7.4
Alcohol Admissions	1717 (1)	Eng Ave (2)	1716	1699	1682	1630	1564
Cancer Mortality Rate	125 (1)	Eng Ave (2)	117	114	110	106	97
CVD Mortality (stroke deaths within 30 days of admission)	93.1 (1)	Eng Ave (2)	71	63	55	47	39

Key	
Below national average (%)	1
At national average	2
Top 25 th percentile	3
Best in class	4

2.2.2 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' Local Delivery

Delivery of these key health outcomes will be within the context of 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' and as such they will be aligned to the eight themes outlined within this approach.

2.2.3 Local Area Agreements

The Local Area Agreements for 2008-2011 for County Durham and Darlington both highlight health inequalities and a range of health improvement indicators as priorities for action for all partner organisations.

2.2.4 'Better Health, Fairer Health'

Mental Health

Across County Durham and Darlington, access to bereavement counselling is normally through GPs to the voluntary sector or to primary care mental health specialists within the local counselling service or through psychology. At present these services are being reviewed as part of the contestability review process with a view to the development of a County Durham and Darlington primary care mental health specification.

Children's Trusts arrangements have Children and Young People's Plans in place that make explicit their respective ambitions for enabling children and young people to enjoy and achieve. Within that context, there are many initiatives and programmes that are designed to improve learning opportunities for children and young people. These include targeted mental health initiatives in schools, a family support strategy that ensures an integrated approach to providing support to vulnerable families; helping families who have a number of complex issues that are impacting upon parenting capacity; working proactively within early years and support to families of disabled children.

To improve perinatal mental health work is underway to produce clear pathways with referral times. This referral process is designed to be easy to understand and access Midwives / Maternity Care Assistants / Health Visitors / other Health professionals. Care is joined up to include midwife / GP / consultant / health visitor / mental health professional (e.g. if a midwife makes a referral she is aware of treatment pathway).

Tobacco

NHS County Durham plans to commission additional stop-smoking services (particularly from pharmacists) across County Durham and Darlington and increase specialist adviser capacity to ensure that we can prioritise key target groups. Quality will be ensured through an improved service specification for commissioned providers. The dangers to babies of smoking during and after pregnancy will be tackled through the development of a local multi-agency action plan reflecting the regional document *Reducing Smoking Pre-conception, During Pregnancy and Postpartum* publication. NHS County Durham and NHS Darlington will continue to support *FRESH*, the regional tobacco control office and will also develop a local communication strategy.

Obesity, Diet & Physical Activity

A service specification has been developed to standardise the delivery of cardiac rehabilitation for patients in County Durham and Darlington. It covers the first three phases of cardiac rehabilitation taking evidence from the National Service Framework for coronary heart disease and the British Association of Cardiac Rehabilitation guidelines. It will ensure that patients are given the most appropriate education and support as part of a menu based programme that includes post myocardial infarction, pre and post cardiac surgery and electrophysiology, newly diagnosed angina, patients who have had an exacerbation of angina and peripheral vascular disease with ischaemia.

The patients will receive Phase II rehabilitation in the community and will have a choice of over 20 venues for Phase III in either the community or in hospital settings. In 2009/10 the AOP submission centres on Phase IV provision, with a number of stakeholder sessions to map the current provision and the gaps in service across the 6 localities in Durham and Darlington. A separate stakeholder group will be set up to discuss Phase IV with the heart support groups who play an increasingly important role in the on-going support for cardiac patients.

Strategies to tackle both childhood and adult obesity are in place across County Durham and Darlington and we will be updating the children's strategy in 2010 to include comprehensive, integrated, community-based prevention, treatment and support services for children. Diet and physical activity are important elements of both strategies.

An evidence-based childhood obesity pathway has been developed to support practitioners with a framework that has agreed entry criteria, promotes equitable access to services and provides group and one to one interventions with children and their families. A specialist service has been developed for obese children with associated diseases or disabilities or who are morbidly obese.

From 2010 a maternal obesity pathway will be developed. This will include the use of social marketing techniques to raise awareness amongst professionals of the serious risks to both mother and baby of obesity in pregnancy. The importance of influencing diet in the pre-conceptual period and during pregnancy will be emphasised.

For adults, a comprehensive five-tier obesity service is under development, ranging from brief advice for those who are overweight at one end to bariatric surgery at the other. Uptake of treatments such as orlistat and sibutramine is likely to exceed the national rate as a significant number of people will meet the access criteria for intermediate service at tiers two and three and specialist community services at tier four.

Services at tiers two and three will be commissioned from providers in the public, private, voluntary and community sectors. The NHS will set an appropriate per patient payment. A formal referral system for current risk individuals to registered, licensed and performance-monitored providers of evidence-based and cost-effective lifestyle alteration packages of care will be established.

The Health Trainer programme will work predominantly with the general population of future risk individuals. We will engage with even the most deprived groups to motivate them to eat more healthily, be more active, improve their lifestyles and appropriately access services.

Alcohol

Comprehensive, integrated, alcohol treatment and support services will be developed. This will be in line with the National Models of Care for Alcohol Misuse across four tiers.

The care pathway will ensure a stepped up and stepped down approach with wrap around services so that the holistic needs of individuals and families are addressed.

We will expand the use of services to deliver brief interventions to reduce alcohol abuse ensuring that by 2010, the North East has the highest per capita availability of brief interventions in the country. This will be embedded within the care pathway with a rolling programme of training to be delivered to frontline practitioners. The professional group identified as a priority for 2009/10 is primary care practitioners, who will be supported through a GP led service to screen, deliver brief interventions and appropriately refer to the community alcohol services across County Durham and Darlington.

Development of a social marketing approach to build the conceptual link between alcohol and domestic or public violence. This will be done by contributing to a research programme in Durham to further understand the relationship between domestic violence and substance misuse. Additionally we will implement the Cardiff Model (a collaborative programme between A&E and the Police to reduce violent crime and inform licensing decisions) to increase intelligence of violent hotspots where alcohol is a factor. The establishment of *Balance* (the regional alcohol office) will be supported financially and through leadership and joint working across the north east.

Prevention, Fair and Early Treatment

By commissioning an additional local enhanced service to provide nursing support within general practice NHS County Durham will enhance the national GP extended hours programme (DES). Services could take the form of nurse led clinics for LTC, contraception and sexual health services etc.

Early Life

The development of the maternal obesity pathway will utilise social marketing approaches to raise awareness of the important links to childhood obesity and promote breastfeeding across County Durham and Darlington.

Maternity service details to be improved in existing PCT literature and on PCT website allowing early access to / and facilitate self referral into the local midwifery service. Information also to be provided on where maternity services exist in the community and the choices available to all pregnant women across NHS County Durham & Darlington. Submitted OGIMs show nine specific initiatives around implementing maternity matters.

We will develop a youth advocacy approach to prevent the uptake of smoking by children and young people. We will implement the Smokefree schools award, invest in *'The Truth'* theatre production and support the March 2009 launch of *'Butt Out'* (a resource pack for schools and youth services). Reducing adult smoking prevalence remains the most effective intervention for preventing the uptake of smoking in young people.

Through the established partnership of the County Durham and Darlington Healthy Schools Programme we will support schools to embed a whole school approach to health and wellbeing.

We will build on this framework by enabling schools to develop new ways of encouraging children and young people to actively embrace healthier behaviour.

The healthy schools programme is a school improvement vehicle and we will promote and deliver the enhanced programme to support the academic curriculum.

We believe that a healthy school is also an inclusive and successful school which provides an environment where each child can effectively learn.

Through positive messages which tackle stigma and misconceptions about mental health we aim to build self esteem and resilience amongst the most vulnerable groups. Population wide programmes of education will enable recognisers of poor mental health (in themselves and others) to act quickly and seek appropriate help. In partnership with children and young people we will identify the most appropriate means of engaging with those groups subject to known risk factors for the development of poor mental health (for example looked after children, young carers and those not in education, training or employment).

Mature & Working Life

We will work with our local authority partners to integrate the commissioning of domestic abuse services. Third sector providers are currently commissioned to deliver outreach and support services to victims of domestic abuse and to contribute to training and development for professionals in conjunction with the MARAC, local authorities and criminal justice partners.

We are committed to pursuing the workplace health agenda by increasing workplace engagement in health improvement activity. There is a particular focus on delivery frameworks including County Durham Working for Health Award, Darlington Investors in Health Award, the Regional Better Health at Work Award and Mindful Employer. We are also seeking to integrate workplace health into wider local partnerships, develop capacity building programmes for workplace settings and improve our data collection systems.

Later Life

NHS County Durham has been instrumental in establishing the County Durham Rights to Warmth Partnership that it currently chairs. This is an interagency partnership with Durham County Council and third sector providers (TAEDA and Rights to Warmth). Key components of the programme include a North East Public Health Observatory (NEPHO) commissioned baseline and follow up study scoping the extent and impact of excess winter deaths, social marketing to investigate the acceptability of a range of communication resources to particular population groups and the commissioning of the Life Channel for Practices in County Durham and Darlington and an annual distribution of the Keep Warm Keep Well material to a range of outlets. The development of a referral mechanism and an emergency fund that enables health and social care professionals to refer clients with a long term condition they suspect could be at risk from badly heated property.

A similar partnership exists in Darlington but chaired by Age Concern Darlington. It has a similar focus although there is currently no emergency fund established.

A Good Death

NHS County Durham has developed a strategy for end of life and palliative care with supporting specification detailing what services will be required to deliver the strategy for our patients. NHS County Durham have committed to invest in these services which will ensure that every person is seen and treated as an individual, with specific individual needs and circumstances. The specification sets out seven key themes that together make up an integrated service which addresses clinical, technological, educational and psychological issues that are vital to ensuring that patients achieve “a good death” in the place of their choosing with those who care around them.

2.2.5 Corporate Objectives

The annual delivery plan will be based on the following corporate objectives:

NHS County Durham

- Ensuring effective partnership working.
- Developing and embedding the skills and competencies associated with world class commissioning.
- Effective resource and financial management in line with the strategic plan.
- Effective performance management of the delivery plan.
- Ensuring safety, quality and risk management.

NHS Darlington

- Improve the health and wellbeing of County Durham and Darlington residents.
- Achieve best value in all commissioned services.
- Ensure patient, carer and public involvement through stakeholder engagement.
- To provide high quality, safe, cost effective health services, that are responsive to patient's needs.
- Provide locally based healthcare services for each care sector where this improves health outcomes, provides value for money and maintains financial balance.
- Achieve and exceed national performance targets to a level of excellence.

3. Strategic Initiatives 2009/10

This section outlines the strategic initiatives that have been phased to take place in 2009/2010. These are framed around the four strategic aims:

- Improve the health status of our populations.
- Reduce health inequalities.
- Ensuring access to patient centred services.
(fair, personalised, effective and safe)
- Ensuring value for money in commissioned services.

To ensure any initiatives that have been developed for inclusion in the AOP are aligned to delivery of our strategic framework, a prioritisation matrix has been developed (Appendix 3). The matrix therefore prioritises against criteria which reflect strategic aims, delivery of 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)', 'Better Health, Fairer Health (NHS North East - February 2008)', and 'Safer Care North East (NHS North East - August 2008)' and also acknowledge the scale of challenge that any individual initiative may present.

To ensure that the agreed initiatives are evidence based and appropriately focussed their impact has been defined at three levels:

Population Level Interventions

This range of initiatives will engage with the public and will range from:

- Awareness raising.
- Education and support.
- Creating opportunities to change lifestyle.

Resources to support these initiatives have been identified based upon an impact assessment which takes into account:

- Universal / segment impact.
- Impact upon behaviour.
- Impact upon health and wellbeing.

Prevention / Early Intervention

A range of initiatives that will highlight and identify those:

- At greatest risk of health deterioration.
- At greatest need of accessing health and social care services.
- Gaining maximum benefit from a specific health initiative.

Quality and Patient Experience

This range of initiatives will ensure patient centred pathways for access and treatment within a given geographical area or aligned to a specific illness or disease process by creating service specifications which may:

- Create a new pathway which transfers activity from a secondary care to a primary care based model of delivery.
- Improve the quality and / or cost effectiveness of a current care pathway.

Plans are being prepared to operationalise commissioning for quality and innovation (CQUIN) with a locally agreed incentive scheme developed (with NHS North East overview) with providers.

4. Measure of Success

The method for delivery of objectives and initiatives is built upon the development of objectives, goals, initiatives and metrics (OGIMS).

Many of the OGIMs build upon initiatives that have been developed as the result of service reviews that have been undertaken in the previous year.

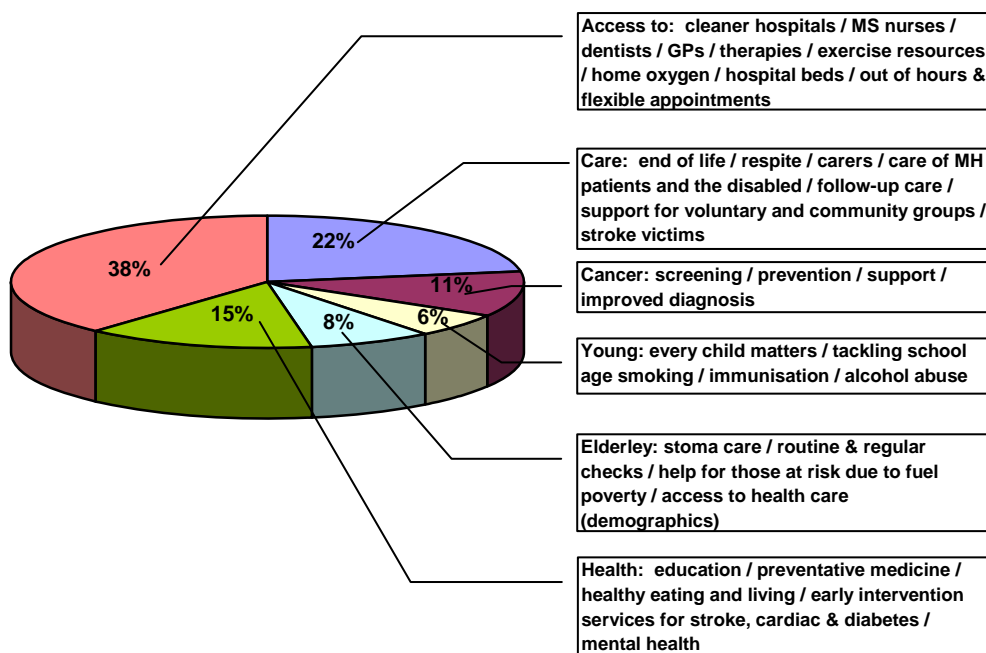
The OGIMs include metrics which will show how well the initiatives are being delivered with key performance measures. NHS County Durham has selected a range of breakthrough OGIMs which have been summarised in Appendix 4. It is intended that the development of OGIMs will be a continuous process with development and prioritisation taking place throughout the year.

5. Work Plans/Delivery Plans for Each Initiative

5.1 Commissioning Intentions 2009/2010 and Stakeholder Involvement

In November 2008, NHS County Durham published a 'Commissioning Intentions' document. The document was sent to over 1,000 people who are members of public, patient and carer networks, provider organisations working with the PCT or key health partner organisations including voluntary and community groups. The Commissioning Intentions document describes the progress in implementing the current AOP and sets out emerging priorities for investment in 2009/2010. The document requested comments on both elements in the form of a short questionnaire which also carried details of two stakeholder events to be held in February 2009 in the North and South of County Durham. Respondents were invited to complete and return the questionnaire to a freepost address and to indicate if they wished to attend either event, over 125 written responses have been received.

The majority of respondents agreed that the key priorities identified for 2009/10 were appropriate. A breakdown of comments received is provided in the chart below.



Meetings have also been held with the Overview and Scrutiny Committees of Darlington and Durham to discuss the commissioning intentions. The meetings provided an opportunity for the committees to exercise their role in scrutinising how well the PCT has met the requirements to involve, consult and respond in its development of the AOP process.

Other meetings are taking place with stakeholder organisations including a meeting with County Durham & Darlington LINKs.



The stakeholder events in Durham and Darlington on the 5th and 12th of February 2009 respectively were well attended with over 100 delegates at each. Delegates included members of public, patient and carer networks, provider organisations working with the PCT and key health partner organisations including voluntary and community groups.

The sessions provided an opportunity to discuss key health challenges and an overview of the AOP process, priorities for inclusion in the plan and the approach to prioritisation. Table discussions focused on a range of key issues including: support for carers; voluntary sector involvement in the provision of services; and inequalities.



5.2 Programme Structure to Deliver the AOP

The PCT has put in place a structure to ensure continued implementation of the 5 year strategic plan and AOP through the establishment of a Strategic Delivery Group (SDG) and Strategic Enablers Group (SEG). These groups oversee the identification and prioritisation of service development proposals using the Objectives, Goals, Initiatives, Metrics and Milestones (OGIM) planning template.

These templates have been developed to assist with the allocation and prioritisation process for resources, aligned to the objectives and goals agreed within the strategic plan. The annual operational plan for 2009/2010 will therefore demonstrate the alignment of resource allocation with delivery over that one year period.

5.3 Progress to Date

The PCT has developed approximately 260 OGIMs for consideration. The Strategic Development Group have utilised a prioritisation matrix (see Appendix 3) and scored individual OGIMs based upon the following criteria:

- Overall health impact.
- Inequalities impact.
- Quality and patient experience.
- Contribution to Our Vision, Our Future.
- Delivers targets/vital signs outlined within Operating Framework.
- Population impact.

Following this process it was agreed to support schemes above an agreed threshold. As described above these schemes are the breakthrough OGIMs which are being presented as part of the AOP and which will be developed and implemented during 2009/10. A number of schemes fell below the agreed threshold but will continue to be developed as part of the ongoing AOP process.

It is essential that all enabling services work together to inform and align their strategies to the five year strategy and the AOP and that in turn the AOP and five year strategy are informed by all the enabling services.

A Strategy Enablers Group (SEG) has been established which comprises all the enabling services within the PCT, including informatics, workforce, estates, communications, finance, market development, governance, knowledge management, intelligence, patient and public involvement and corporate improvement. Breakthrough OGIMs have been assessed by this group.

These assessments include a risk assessment. Further work will continue with the appropriate service leads to understand requirements, develop those initiatives and perform risk assessments.

The SEG will work with all those leading on breakthrough OGIMs to ensure that all enabling services and initiatives are fully involved with and incorporated into all service developments and plans.

From 2009/10 the OGIM process will be adopted for all service initiatives and these will be developed, considered and prioritised throughout the year.

5.4 Primary & Community Health Care

Primary care describes community based health services that are usually the first, and often the only, point of contact that patients make with the health service. It covers services provided by family doctors (GPs), community and practice nurses, community therapists (such as physiotherapists and occupational therapists), community pharmacists, optometrists, dentists and midwives.

NHS County Durham will be developing robust strategies to ensure that primary care and community services play a crucial role in helping to co-ordinate NHS care, particularly for people with long term conditions and in helping patients to access wider or more specialised NHS services. We will ensure that patients get access to the most appropriate care in the most appropriate settings. Our strategy is based around four key areas:

- shaping services around people's needs and views
- promoting healthy lives and tackling health inequalities
- continuously improving quality
- ensuring that change is led locally

NHS County Durham and NHS Darlington are already maintaining at least 50% of GP practices offering extended opening hours and plans are in place to ensure this continues.

6. Business as Usual

The progress toward and achievements of key performance standards in 2008/09 will be consolidated in 2009/10. The scope is broad (Appendix 5) however of particular note are:

No waits - both PCTs have achieved the promise of an 18 week referral to treatment pathway for our patients. This success will be built upon in 2009/10 by ensuring all acute specialties meet the standard, with orthopaedics being a particular challenge. Contractual mechanisms will be deployed to reduce waiting times in all regardless of the setting. Patients with suspected cancer already have speedy access to care; these waiting times will be further reduced in 2009/10.

Healthcare acquired infection - There has been progress in 2008/09 but there is more to do in 2009/10. Reduction in meticillin-resistant staphylococcus aureus (MRSA) and clostridium difficile will continue to receive director level focus between NHS County Durham and our partners. A particular focus will be on partnership working between community and acute providers

Patient Experience - Feedback from patients and the public is used to define our commissioning priorities. Our commissioned providers will continue to be required to actively seek feedback on and improve patient satisfaction and clinical outcomes. A particular importance will be placed on ensuring our providers afford patients the dignity of single-sex accommodation. We will work with local providers to deliver improvements in patient views on mixed sex accommodation as set out in the Operating Framework:

- Using the new standard contract to apply the requirement of a mixed sex accommodation action plan.
- Working with County Durham & Darlington Foundation Trust in particular to address existing issues.
- Monitoring progress against implementation through monthly contract management meetings.
- A commitment is in place to provide financial assistance where required in order to implement the action plan.
- Under lead commissioning, Tees, Esk & Wear Valley NHS Trust reporting fully compliant and Northumberland Tyne & Wear NHS Trust have agreed action plan and funding requirements.
- 'Inpatient's View' element of mixed sex accommodation is covered in the mandatory section of the quality framework for the MH Trusts. A baseline is being sought prior to establishing a trajectory for improvement. The Trusts have action plans in place covering the eradication of mixed sex accommodation areas.

Patient Choice - Commissioning strategies centre on offering patients a choice of provider and/or therapy to meet their need. To facilitate an informed and efficient experience of choice, the performance of commissioned services will be made more widely available to the public and the Choose and Book process will migrate to a paperless system. NHS County Durham and NHS Darlington are working closely with providers and GP's, to ensure that information is available regarding choice of services. An Expert Patient Programme is in place across both NHS County Durham

and NHS Darlington. Mechanisms are being developed to ensure NHS choices information updated as required

Military Personnel – All of this will include ensuring existing arrangements for priority treatment and access to NHS dentistry services for war pensioners are extended to all military personnel, war veterans and their families to take account of their special circumstances

Cancer Services - A network group is carrying out a piece of work on the radiotherapy strategy which will feed into PCTs. County Durham & Darlington Foundation Trust are already assessing how they could operate as a satellite service to ensure capacity to deliver the 31 day target.

To fully implement the Supportive and Palliative Care Cancer Improving Outcomes Guidance (IOG) by Dec 09 key objectives have been included in the Terms of Reference for cancer locality management group. Currently PCTs are working towards implementation in the areas of head & neck, palliative & supportive care and skin – monitored on a monthly basis.

Plans have been put in place to ensure full roll out of the bowel cancer screening programme for men and women aged 60-69 by December 2009, this was agreed by NHS County Durham, February 2009.

Clinical Champions - NHS County Durham (as a commissioning organisation) has made progress in developing a framework and mechanism for the delivery of actions from the eight clinical pathway groups in 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' (OVOF). All of our clinical champions appointed to date (13) are individually aligned to specific OVOF work streams. Additionally the PBC chairs now each have a portfolio lead on behalf of the local PBC groups, for one of the OVOF work streams. This alignment is to ensure full clinical engagement across a range of settings and clinical professions which is key to the commissioning of high quality, safe and effective services locally. These clinicians will connect and feed into and out of the SHA OVOF work streams and will be influential in setting up the local clinical pathway groups in the Durham and Darlington cluster.

Long Term Conditions – To ensure that anyone living with a Long Term Condition is offered a personalised care plan by March 2011, the long term conditions commissioning group are currently reviewing an implementation plan to work closely with PBC colleagues, community providers and other key stakeholders.

Carers - Work is ongoing with local authority partners in developing the support for carers in a personalised way:

- A Joint Commissioning Strategy with Durham County Council is being developed and covers Carers across County Durham (the Strategy is currently out for consultation to all Carer groups). Following the consultation a Joint Strategy will be launched in April.
- Meetings with Managers from all Carer's organisations are regularly held which ensures feedback from Carer's on their needs and wishes.
- Working closely with Durham County Council around how best to utilise the new government money to support Carer breaks.

- Linking with Patient and Carer Public Engagement around Joint Consultation events with Carers locally.
- Joint strategy for Darlington will be developed this year.
- Carer service tender has been jointly formulated and is currently out to expressions of interest.
- Plans for an emergency carer service being developed for Durham have now been extended to cover Darlington.
- Durham County Council and NHS County Durham have submitted an application for Department of Health demonstrator site status and this will also if successful extend to Darlington - we have applied for funding for carer breaks, carer health checks and NHS support.
- Links now made with Darlington Borough Council carer lead and plans for joint working/commissioning in place.
- Commitment to further develop the range of carer support options in Darlington over the coming years with additional government funding for carer breaks - linked to personal budgets to ensure a more flexible and individual provision of carer breaks/respite in future.
- Developing carer forums to ensure that the voices of Darlington carer's are heard and that their needs are incorporated into any new service developments, to this end dialogue with Darlington Carer's Centre has begun.

Stroke Services - Across County Durham and Darlington, the stroke clinical action team oversees the delivery of the stroke care review. The review is underpinned by the quality markers outlined in the national stroke strategy and work is underway to:-

- Maximise opportunities for preventing stroke.
- Improve diagnostics and screening.
- Provide multi-disciplinary rehabilitation and psychological support within the hospital sector and in the community.

Recent investments have resulted in the commissioning of family and carer support and communication support services, through the Stroke Association and both Darlington Borough Council and Durham County Council will be allocating funding to stroke care through their respective stroke care grant allocations. This model has been agreed via the stroke clinical action team and the joint commissioning group for older people, physical disabilities and chronic care.

Mental Health - The expectation that by April 2010 no 16-17 year olds will be treated on adult psychiatric wards unless such an admission is in accordance with their needs is included in the mandatory section of the standard contract's quality and performance frameworks. Both mental health trusts have agreed to report the information and we are examining how to measure the 'accordance with their needs element'. As from next year under 18's on adult wards should generate a serious untoward incident (SUI).

Early intervention targets have been highlighted in the mandatory elements of the quality and performance frameworks. Systems are already collating the information and trusts report on a monthly basis. Within the performance frameworks there are developmental sections which cover average length of stay. Following national guidance and ensuring that continuity of care post discharge from EIP will be monitored for effectiveness and need.

Major Incidents - The PCT has a key role in planning for and responding to major incidents. This involves explicit multi agency cooperation. In specific situations, primary care and community health services may be required to:

- deliver mass immunisation or drug treatment/prophylaxis,
- manage large numbers of sick patients in the community,
- provide minor injuries care,
- provide staff for reception or evacuation centres,
- continue to provide services in spite of reduced staffing.

Detailed plans are in place for a number of scenarios which will undergo systematic exercise and review. Emergency planning is a statutory duty of the PCT (*Civil Contingencies Act 2004*).

Abortion Services - Around 98% of our abortions are performed by local & regional acute trusts and we are working with our gynaecological contacts at our primary providers to ensure sufficient steps are taken to meet the new mandatory requirements. Around 2% of abortions are carried out beyond 20-weeks and as such are done through private providers BPAS and MSI with service provisions for Durham & Darlington patients at Doncaster and London. Although these providers will not be on the new mandatory community contract for April 1st they are under contract and service specifications and relevant adjustments are being made as an interim measure before they move to the new mandatory contract. Providers have been part of a Department of Health led group seeking to address this new requirement and have taken steps inline with Depart of Health guidance so as to meet the new standard. NHS County Durham is part of that group and are assured that necessary steps have been taken.

18 weeks Referral to Treatment - 18 weeks performance is a standing agenda item on each Foundation/NHS Trust contract management meeting. NHS County Durham is the host commissioner for County Durham and Darlington Foundation Trust (CDDFT) and has developed a set of performance indicators in agreement with the FT for the monitoring of national targets and standards including 18 weeks:

- Orthopaedics is monitored separately as a specific local pressure posing a risk to the achievement and sustainment of 18 weeks.
- Fortnightly orthopaedic focused 18 weeks meetings between NHS County Durham and CDDFT at operational level working to an agreed action plan (available on request).
- Contract for 2009/10 have penalties for non-delivery of 18 weeks at specialty level. Monthly contract management meetings pick up 18 week performance as standing agenda item.
- Quarterly CEO/Director level performance review meetings between NHS County Durham and CDDFT are in place.
- Monthly 18 week position sign-off between NHS County Durham and CDDFT.
- NHS County Durham actively engages in market development work in order to identify and secure alternative capacity.
- NHS County Durham is engaged in discussions on a Market Analysis pilot tool developed by Price Waterhouse Coopers for the Department of Health.

Active dialogue is being held with provider services with the aim of rolling out reporting of waiting times for their services and will be required through specifications and contracts. When available this information will be presented in the public domain.

Offender Health – Across the four prisons in County Durham there is a clear focus to commission services which establish an equivalence of care to improve health and support justice. NHS County Durham have a dedicated commissioning team committed to the development of patient centred services, improving life expectancy and reducing health inequalities through the development of a comprehensive offender pathway, co-commissioning proactively with National Offender Management Services (NOMS) to optimise our respective investments.

7. Monitoring

The strategic health outcomes and the vital signs performance framework are key deliverables. A baseline for health outcomes has been established using annual data with predictive modelling overlaid. The outcomes have been further analysed down to individual practice level to facilitate delivery improvement. Dashboards are being created to allow staff instantaneous access to up to date performance.

Existing performance systems and reports are fit for purpose to monitor the vital signs (Appendix 5). Organisation-wide risk management and quality improvement techniques will also be exploited.

8. Delivery Requirements

NHS County Durham have adopted an integrated delivery framework for achieving our strategic aims through which practice based commissioning and the eight clinical pathways of 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' are supported by a series of enablers which will deliver our organisational development to become World Class Commissioners.

Ten key outcome priorities will lead the development of a range of initiatives across the eight clinical delivery pathways; these will be benchmarked against the aims of 'Better Health, Fairer Health (NHS North East - February 2008)', 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' and 'Safer Care North East (NHS North East - August 2008)'.

At delivery level, we will identify clear objectives and goals to achieve the outcome priorities. We will establish delivery and implementation of initiatives for these and monitor this through clear metrics. These will be underpinned by a robust investment strategy.

This delivery framework will enable us to develop our commissioning strategy, which will in turn inform the local NHS organisations' own strategic plans. This is particularly relevant to local foundation trusts who are currently developing and implementing their own strategic direction (for example 'Seizing the Future' in County Durham and Darlington and 'Momentum – Pathways to Healthcare' in Hartlepool and Stockton).

Practice based commissioning also has an overarching role to play within the delivery framework by contributing to system-wide delivery and ensuring local delivery of our collective ambitions.

We have developed a new and innovative approach to practice based commissioning which will ensure that PBC is at the forefront of the commissioning agenda and that front line clinicians are afforded the opportunity to lead and influence the commissioning of services. There are several strands to this new approach, which include; a new mechanism for rewarding practice involvement, clarification of the role of PBC in the commissioning cycle and the strengthening of clinical engagement.

The new reward scheme rewards practices for undertaking commissioning-related activities to improve health and reduce health inequalities, informed by local and county wide health profiling and strategic planning. It will have a significant impact on the quality of patient care focusing on areas that have been identified as key health outcome measures, in strategic plans, both on a county wide and locality level. It will also enable us to make immediate and significant strides towards addressing health inequalities for a specific range of patient groups focusing on obesity management as well as diabetes and COPD screening.

9. Finance and Activity Plan

NHS County Durham and NHS Darlington have received confirmation of growth levels in their allocations for 2009/10 and 2010/11. Modelling work has been undertaken to estimate the funding required for inflation, and identify the resources available for investment, both on a recurring and non-recurring basis.

The recurring funding available for NHS County Durham and NHS Darlington are shown in table 1 below:

	NHS County Durham		NHS Darlington	
	2009/10	2010/11	2009/10	2010/11
Growth	£46.2m (5.5%)	£48.8m (5.5%)	£8.2m (5.3%)	£8.6m (5.2%)

Table 1: Growth allocations and inflation estimates – CDPCT & NHS Darlington

Distance from Target Allocation

Following the substantial investment shown above, NHS County Durham will still be under the allocation target by 5.4%, in contrast, NHS Darlington will be 0.9% over the allocation target.

Financial assumptions for 2011/12 & 2012/13

It is anticipated that levels of growth will be significantly reduced for these later years, and at present a headline growth figure of 3% per annum has been assumed. This is consistent with other NHS organisations in the North East.

Activity Planning Assumptions

Comprehensive demand planning modelling has been carried out for NHS County Durham and NHS Darlington. This modelling has used a variety of information, including actual activity in previous years, impacts from service changes, implications of coding and counting changes notified by provider organisations, demographic changes and both national and local guidance. This modelling has resulted in a robust plan for activity requirements for 2009/10, with the factors stated above helping to form the plan for activity requirements in 2010/11 and beyond.

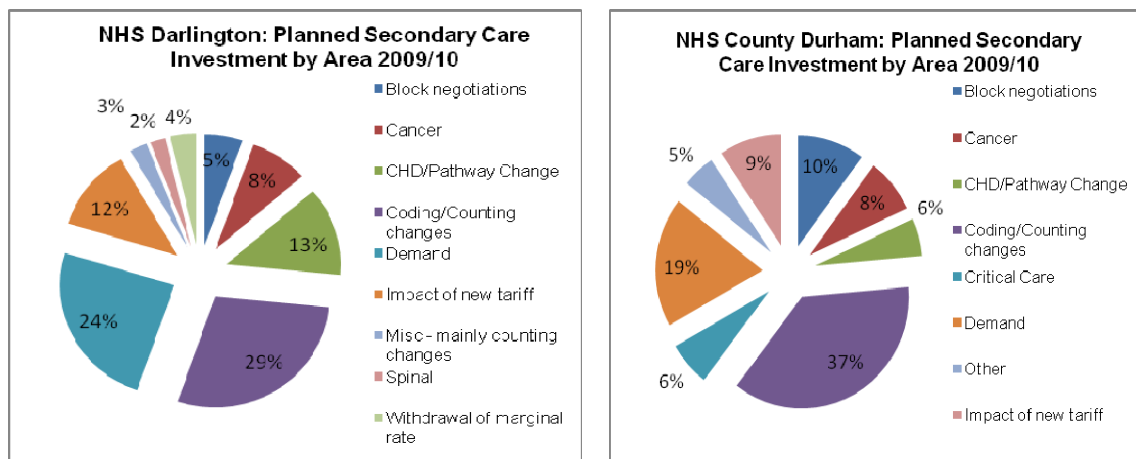
Whilst the starting point for this modelling has been existing activity levels in 2007/08 and 2008/09, the sophisticated projections have needed to include the following factors impacting upon those levels of activity experienced in previous years, for example:

- Additional activity undertaken to achieve waiting times targets.
- Step changes associated with changes in counting and coding at provider trusts.
- Reclassification of activity between categories arising from changes in payment regulations under the Payment by Results (PbR) system.

As a result of this modelling work, significant recurrent investment in increased activity is not planned, although it is anticipated that some non-recurring investment in activity will be required in 2009/10 and 2010/11. This non-recurring investment will fund secondary care activity in the short term, whilst community and primary care developments come to full capacity enabling that activity to be delivered in a different setting.

However recurring investment, at a lower level than previous years, will be required in order to allow for the implementation of coding and counting changes from provider organisations. In addition, provision will need to be made for the recurring financial risk arising from the implementation of new tariffs based upon the latest version of Healthcare Resource Groups (HRG4).

The charts shown below show the planned investment in secondary care, which demonstrates the limited investment in both NHS Darlington and NHS County Durham arising from increased demand. In NHS Darlington this amounts to only 24% of the total investment, and in NHS County Durham this amounts to only 19%.



One element of the planning for this period has been to review existing commitments and reserves. This has identified opportunities for disinvestments in a number of areas, which will enable the organisation to move forward with a number of its key priorities in 2009/10. An ongoing target of disinvestment has been built into the financial planning above, to facilitate further investments to be made in future years.

Revenue & Expenditure Forecasts 09/10 and 10/11 - NHS Darlington

	09/10 Recurring £m	09/10 Non-Rec £m	09/10 Total £m	10/11 Recurring £m	10/11 Non-Rec £m	10/11 Total £m
FUNDING AVAILABLE						
Resource available before funding increase	157.9		157.9	166.1		166.1
Annual funding increase	8.2		8.2	8.6		8.6
Return of SHA Lodgements		0.8	0.8		0.8	0.8
Other Anticipated Allocations		4.8	4.8		4.8	4.8
Total Resources Available	166.1	5.6	171.7	174.7	5.6	180.3
PLANNED EXPENDITURE						
Baseline Spend	157.9		157.9	166.1		166.1
Inflation / CQUIN / Generic Pressures	10.2		10.2	10.9		10.9
3% Efficiency Gain	-5.0		-5.0	-5.2		-5.2
Disinvestment of Resources (target)	-2.0		-2.0	-1.0		-1.0
Deployment of Existing Resources	-2.3		-2.3	-3.3		-3.3
Deployment of Specific Allocations		4.7	4.7		4.8	4.8
Prioritised Investments	4.0	4.2	8.2	3.7	4.3	8.0
Total Expenditure	162.8	8.9	171.7	171.2	9.1	180.3
Target Surplus / (Deficit)	3.3	-3.3	0.0	3.5	-3.5	0.0

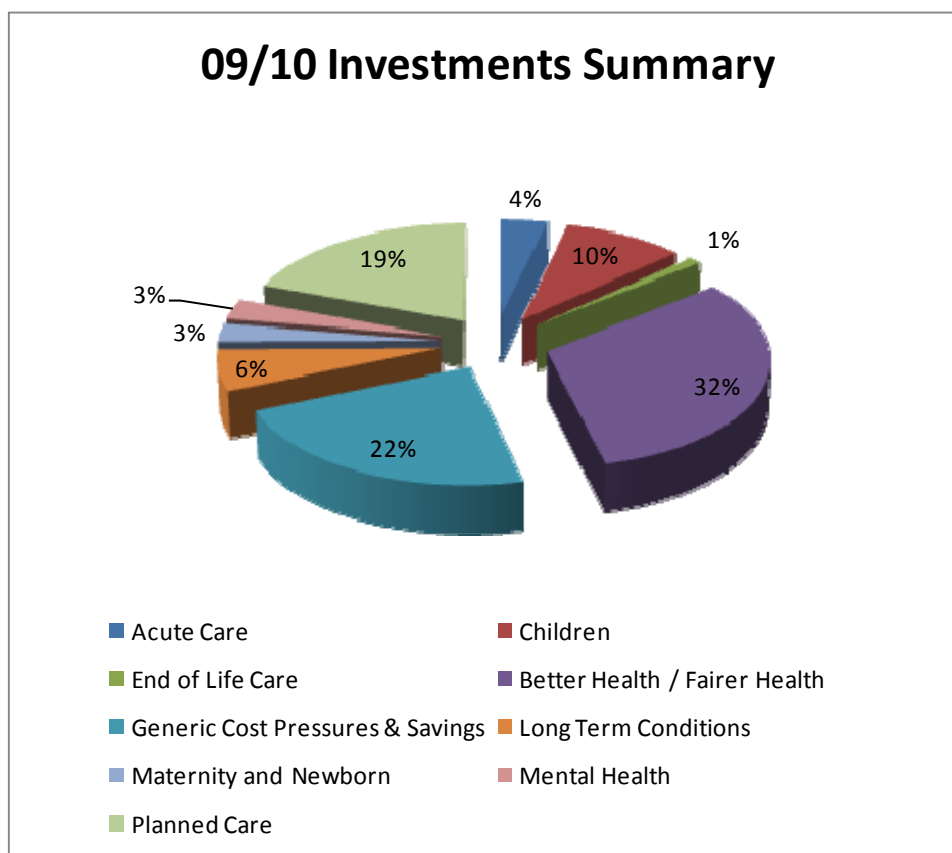
Revenue & Expenditure Forecasts 09/10 and 10/11 - NHS County Durham

	09/10 Recurring £m	09/10 Non-Rec £m	09/10 Total £m	10/11 Recurring £m	10/11 Non-Rec £m	10/11 Total £m
FUNDING AVAILABLE						
Resource available before funding increase	840.6		840.6	886.8		886.8
Annual funding increase	46.2		46.2	48.8		48.8
Return of SHA Lodgements		9.2	9.2		9.2	9.2
Other Anticipated Allocations		18.3	18.3		17.8	17.8
Total Resources Available	886.8	27.5	914.3	935.6	27.0	962.6
PLANNED EXPENDITURE						
Baseline Spend	840.6		840.6	886.8		886.8
Inflation / CQUIN / Generic Pressures	47.9		47.9	47.6		47.6
3% Efficiency Gain	-27.3		-27.3	-27.5		-27.5
Disinvestment of Resources (target)	-11.7		-11.7	-8.9		-8.9
Deployment of Existing Resources	-6.6		-6.6	-7.2		-7.2
Deployment of Specific Allocations		14.5	14.5		14.9	14.9
Prioritised Investments	26.2	30.7	56.9	26.0	30.9	56.9
Total Expenditure	869.1	45.2	914.3	916.8	45.8	962.6
Target Surplus / (Deficit)	17.7	-17.7	0.0	18.8	-18.8	0.0

Recurrent commissioning and contingency reserves amounting to approximately 2% of recurring funding are built into the plans above. In addition, non-recurring funding is available to provide cover for a further 1% if required. The expectation is that these contingency sums will be used in the main to deal with non-recurrent risks in activity levels and cost pressures. As each financial year progresses, uncommitted contingency funds may be deployed on a non-recurring basis to accelerate the implementation of planned investments.

The planning of these investments has incorporated a comprehensive evaluation of local and national priorities, and has also taken into account the output from the 'Resources for Health' health economics project. At present, both PCT's analyse their expenditure across 23 'programmes' of expenditure, and this project enabled further analysis and benchmarking of these programmes.

A financial summary of the 2009/10 and 2010/11 Annual Operational Plan for NHS County Durham and NHS Darlington can be found in Appendix 6, the chart below shows expenditure (expressed as a percentage) across the 8 key pathway groups:



Further details of financial planning over this period, including capital and cash implications may be found in the Medium Term Financial Strategy for NHS County Durham and NHS Darlington.

10. Workforce Plan 2009 / 2011

It is essential that workforce planning is aligned to the Annual Operating Plan (AOP) in order to enable plans to be successfully implemented. In the commissioner role NHS County Durham is adopting the approach described in the NHS Operating Framework 2008-09, and the workforce section of the AOP details a workforce risk assessment plan (WRAP), which highlights risks, as opposed to a traditional style workforce plan, highlighting numbers needed to provide services.

A strategic workforce direction has been produced outlining our vision for the workforce and the framework to support our vision which is the "5 rights". This is about having the workforce in the right place, at the right time, in the right number, with the right skills and providing the right quality of care. The aim of the workforce risk assessment plan is to support the achievement of our vision of the 5 rights for the workforce. The assessment of risks will be used to assess the capacity and capability of the workforce to deliver services.

The plan achieves this by using the following step by step approach:

- Step 1** Workforce implications for each of the schemes in the AOP are identified.
- Step 2** Workforce information from providers is matched against the AOP to highlight risks in capacity and capability to deliver the schemes.
- Step 3** Information about the local labour market and national workforce is reviewed in relation to the risks identified.
- Step 4** Solutions to overcome and minimise risks are identified and detailed as specific actions to be taken forward by various key stakeholders.
- Step 5** Workforce implications and risks continuously monitored through the contracting process.

A detailed workforce risk assessment plan will be used to understand the workforce capacity risks across provider organisations. The risk assessment will examine issues such as retirements, sole practitioners and Working Time Directive (WTD). The current assessment of our Foundation Trust providers is indicating compliance of the WTD by August 2009. Ongoing risk assessment information will be requested from all providers for the duration of contracts to monitor risks on an ongoing basis.

The information gathered from the workforce risk assessment will be used to inform cross cluster work such as the development of new roles and the recommendations of commissioning of additional capacity. It will also be used to make recommendations to reconsider commissioning plans where it is clear the workforce capacity is not present within the required timescales. The information requirements will be included in contracts for providers and service specifications.

The County Durham and Darlington Strategic Workforce Cluster Group (SWCG) will provide the opportunity for ongoing strategic dialogue with key stakeholders such as education providers, local health and social care providers and skills for health. As part of locally leading the NHS we will provide the overall vision and strategic direction in workforce terms to support the emerging commissioning intentions and support the 5 year strategic plan.

From 2009/10 the objectives, goals, initiatives & measures (OGIM) process will be adopted for all new service initiatives and these will be developed, considered and prioritised throughout the year with an ongoing assessment of workforce implications and monitoring workforce risks through the contracting process.

A workforce team is in place within the County Durham structure, in the Directorate of Strategy, Planning and Involvement. The team has the capacity and capability to deliver the workforce risk assessment activity and the workforce team will work with the other enabler functions through the Strategy Enabler Group.

The table below shows the high level risks that are emerging from the main 10 objectives:

Our vision our future theme	Workforce high level risk and implication	Impact on other areas?
Maternity and new born	<ul style="list-style-type: none"> High number of support workers needed to deliver OGIMs, training implications as specialised skills required. Limited existing pool of health care assistants (HCAs) along with an ageing profile may affect ability to deliver plans. Additional consultant capacity from a limited supply pool. 	YES: Mental Health, Better Health Fairer Health, Planned Care and Acute Care OGIMs all plan to increase use of HCAs.
Children	<ul style="list-style-type: none"> Lack of information about capacity/capability of school nurses and health visitors. Psychology services (see MH) 	YES: Better Health Fairer Health OGIMs also intend to utilise school nursing staff.
Better health / fairer health - staying healthy - improving health - reducing health inequalities	<ul style="list-style-type: none"> Use of band 4 staff – limited capacity. Shortage of dietitians will affect delivery of plans. Lack of information about capacity/capability of school nurses and health visitors. A number of OGIMs involve the Public Health workforce to deliver services. Limited capacity may affect delivery. 	YES: Maternity and New Born, Planned Care, Acute Care and Mental Health OGIMs also intend to utilise band 4 staff e.g. Pharmacy technicians, health advisors, dementia support workers. Planned Care OGIMs require dietitians and Public health workforce.
Mental Health (MH)	<ul style="list-style-type: none"> Lack of psychology workforce availability due to Increasing Access to Psychological Therapies (IAPT) programme and a number of AOP bids requiring psychological services, able to deliver quality of care needed. Existing psychiatry medical and the AHP workforces make up a small percentage of the overall workforce resulting in any changes having a high impact on supply. The increased usage of band four workforce will effect workforce availability to provide the quality of care required. Lack of maintenance crafts apprentices. Increasing use of pharmacists to deliver services. Concerns regarding increase in capacity to deliver demand. 	YES: Children and Better Health Fairer Health OGIMs intend to increase use of psychology staff.
Planned Care	<ul style="list-style-type: none"> Pharmacists as above. Lack of senior physiotherapists to deliver plans. A number of OGIMs involve the Public Health workforce to deliver services. Limited capacity may affect delivery. 	YES: Better Health Fairer Health and acute care OGIMs plan to increase the use of pharmacists. Acute care OGIMs rely on physiotherapy to deliver plans.
Acute Care	<ul style="list-style-type: none"> Physiotherapy (as above). Pharmacists (as above). 	YES: Planned Care and Better Health Fairer Health.
Long Term Conditions (LTC)	<ul style="list-style-type: none"> Increase in use of telemedicine will have training implications. Age profile of nursing staff. 	NO.
End of Life Care	<ul style="list-style-type: none"> No high level risk identified. 	
Fair, personalised, effective, safe services	<ul style="list-style-type: none"> No high level risk identified. 	
Value for Money	<ul style="list-style-type: none"> No high level risk identified. 	

Common themes emerging across the 10 Objectives:

- Insufficient numbers and age profile of HCAs is a concern as 39% are aged over 50. A number of the OGIMs require this workforce to deliver services.
- Lack of fully integrated planning across whole health and social care workforce.
- Increasing reliance on band 4 workforce for a number of pathways.
- Impact of IAPT programme and the reliance of psychology skills across a number of pathways.
- Increasing use of pharmacists across a number of pathways, workforce capacity unknown but, according to NHS Information Centre data, vacancy rate is high for the North East.

Emerging Solutions:

- Co-ordinated patch-wide approach to the recruitment and deployment of HCAs.
- Joint working across health and social care boundaries.
- Understand impact of IAPT programme and demand for psychology staff across the cluster in order to develop opportunities for skill mix.
- Workforce risk assessments to be undertaken for all pathways to identify workforce capacity issues with feedback and involvement of SWCG to consider issues and options for action e.g. school nurses, IAPT, pharmacy.
- Workforce team to sense check against all pathways using band 4's staffing pool in order to get strategic picture and co ordinate action planning.
- Discuss with SWCG the option to develop a patch wide, co-ordinated approach to the recruitment and training of HCA staff group.
- Feedback to Strategic Health Authority (SHA) any evidence / issues that the numbers of education commissions need to be amended.
- Current project underway to map whole Public Health workforce across all sectors and this important piece of work will help us to understand capacity and training gaps in order to shape future services.
- Marketing of North East region.
- Option to look at developing generic worker across a number of pathways and new ways of working.

Each of the above themes has been looked at in detail to extract further the detailed workforce implications and risks in our WRAP, an example is shown below. The WRAP will be completed by 20 March 2009 and will be used as the vehicle for driving through assurance and enable schemes to be delivered through the effective management and deployment of the workforce.

Key theme	Workforce implication	National workforce info from WRT info	Local workforce info	Risks	Solutions	Who will be responsible
Long Term Conditions e.g. Diabetes: Slow down the rise in prevalence of diabetes in Co Durham & Darlington to match the England average by 2013	The capacity and capability of the workforce to implement the CVD risk assessment programme	The general move towards community-based care is likely to be implemented by the integration of diabetic specialists in primary care, rather than GPs simply taking over the role	Endocrinologist specialists capacity is in balance at present Primary Care capacity in general is currently rated at amber locally	Implementing the CVD risk assessment programme has the potential to increase demand on all associated services e.g. retinal screeners	Monitor service demands through ongoing workforce capacity risk assessment Work with providers on service improvement /introduction of new roles	Commissioning leads with providers Workforce team

Workforce risks will be used to inform timescales of OGIMs and support delivery by working with key stakeholders on solutions through the cluster group. Providers will produce their own workforce plans based on the delivery of services now and in the future. These plans will be used by NHS County Durham in the commissioning role to highlight workforce risks and implications in delivering OGIMs

The workforce implications of commissioning intentions will be discussed and shared with providers NHS and non-NHS. This will be done through 1:1 meetings and through the workforce cluster group. A risk assessment will be completed by providers to supply information about their own workforce. This information will be used alongside workforce demands of commissioning intentions to highlight risks. Workforce risks will be considered in the procurement process and will influence commissioning decisions, for example workforce risk too high to deliver the service.

Using this approach, workforce is aligned to the commissioning cycle and is integral to enabling strategy development, delivery of the AOP and OGIMs developing provider markets, contestability process and contract monitoring. Workforce risks will be managed throughout the procurement and contracting process, in service specifications, evaluation panels and service contracts. Documentation has been produced and is being used to ensure workforce risks are included in the commissioning process.

In line with the Regional Strategy *Better Health Fairer Health*, the public health lead for workforce is encouraging the Public Health strategic leads to ensure the vision for "every contact is a public health contact" is included within the AOP. Part of this process includes building capacity and capability within the PCT cluster and raising the profile of the vision at every opportunity including within the public health directorates own workforce plan.

Future success will see not only every contact is a public health contact, but every contract is a public health contract within service contracts and specifications, and linking with all public sectors and Local Authorities to ensure health and well being is part of their delivery.

11. Informatics

It is essential that informatics planning and service delivery are driven by business strategy and service plans to ensure that information and technology are appropriately focused. Those links have been firmly established in the PCTs as part of the AOP and other processes.

The post of Assistant Director of Informatics has been created to concentrate on commissioning aspects rather than service delivery. The role is largely strategic and will create an important link to enable delivery of PCT commissioning plans.

The Assistant Director of Informatics chairs the Strategy Enablers Group (SEG) (previously described) which has been formed to ensure the delivery of the five year strategy and the AOP.

Informatics is therefore considered an essential part of the AOP process in the PCTs. Informatics planning will be driven by service needs and will therefore be information led and will support patient pathways across health and social care settings.

Strong informatics governance arrangements are in place across the Local Health Community (LHC). The following boards are well established:

- County Durham and Darlington (CDD) Local Health Community NPfIT Programme Board.
- County Durham and Darlington Commissioning and Primary Care Informatics Board.
- Provider Boards for County Durham and Darlington Community Health Services, County Durham and Darlington Foundation Trust and Tees, Esk, and Wear Valley Trust.

These boards all include appropriate clinical representation and, where appropriate, representation from local authorities. County Durham PCT is the lead commissioner within the LHC. The SRO with local responsibility for the LHC informatics programme is the County Durham PCT Director of Planning, Strategy and Involvement.

The 2008/09 Informatics Plan for the County Durham and Darlington LHC has been refreshed in line with the 2009/10 CfH Informatics Planning Guidance, the PCT 5 year strategy and the AOP. It therefore fits with the local strategic commissioning agenda. This process involved all major service providers within the LHC, including local authorities and has resulted in a finalised plan approved by the LHC Programme Board by 20 March 2009. This plan provides the detail required to fully respond to all the requirements of the Informatics Planning Guidance.

The Informatics Plan is reviewed and maintained throughout the year by the LHC Programme Board. This includes rigorous identification and management of risk. Implementation of the plan is supported by a recurring LHC wide National Programme for IT (NPfIT) budget of £1.2 million which is available to those organisations who have agreed to operate within the financial management arrangements. Capital budgets to support this are secured each year in line with the capital planning process. The budget is managed by the CDD Commissioning and Primary Care Informatics Board. Trusts also have access to their own local sources of funding which will be used to fund many of the initiatives outlined in Appendix 8, particularly where they do not form part of NPfIT.

A summary of the key informatics initiatives which are included in the refreshed plan, linked to *Our Vision Our Future*, are outlined in Appendix 8. As described in sections 2.1 of this document, the AOP has been developed within a strategic framework (Appendix 2) which links the PCT strategic aims, 'Better Health, Fairer Health (NHS North East - February 2008)' and 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' to delivery through the AOP approved OGIMs. Those informatics initiatives described in Appendix 7 are therefore very clearly linked to and enable the achievement of the PCT strategic objectives.

It should be noted that some of these initiatives are necessarily longer term due to the availability of national systems, such as Lorenzo. In the meantime, existing informatics systems will be utilised where possible to enable AOP and other local initiatives.

The Summary Care Record is recognised as a potential key enabler in the commissioning intentions for urgent care. A detailed review of the Summary Care Record (SCR) will take place in March/April 2009. This will investigate the potential of the SCR to support the urgent care strategy for NHS County Durham, with a view to the SCR being used in various LHC settings in 2009/10. The SCR will potentially provide key clinical information across any care setting irrespective of clinical system. It will also overcome the limitation that the 'TPP' system is used by a minority of GP practices (30 out of 86) and therefore the capability to share information is currently limited to this sub-set of overall patient information.

While undertaking the review other potential applications of the SCR will be considered, such as supporting information flows across social care and health, long term conditions and end of life care.

A number of gaps have been identified in the availability of nationally contracted systems to meet local requirements either within the timescales required or with the necessary functionality. Local procurements will be undertaken to provide some of these systems where they are needed to meet AOP requirements and local timescales. These include:

- Sexual health.
- Child protection.
- Drug and alcohol treatment and prevention.
- Cardiovascular disease risk registers.
- Dentistry.
- Optometry.
- Health integration with social care.
- Acute and mental health pharmacy.

All LHC initiatives at programme and project level follow MSP and PRINCE2 methodologies and principles including the definition of envisaged financial and non financial benefits in initial business cases, with the production of 'benefits profiles' and management through to realisation. Post implementation benefits reviews are undertaken, with financial benefits tracked post project and reported into the National Benefits Programme for nationally supported projects. The current approach will be strengthened across the LHC using informatics as an enabler to achieve the benefits articulated by organisations, staff, the public and patients. The LHC is also increasingly adopting the CfH standards around benefits management, including the production and updating of benefits registers to track both quantitative and qualitative benefits.

Informatics capacity and capability are regularly reviewed as part of programme and project planning, to ensure that the informatics developments and solutions required to underpin service plans can be delivered.

Information governance requirements in line with the NHS Information Governance Assurance Framework are included in all specifications issued for service provision and in all contracts subsequently issued. This will ensure that all organisations from which care is commissioned are brought within this framework. Informatics is fully involved in all stages of the contestability process to ensure information governance and all other informatics requirements, including the pseudonymisation of data where required, are addressed by potential providers.

12. Estates

NHS County Durham outlines an approach to estate that looks to develop networks of care utilising existing community hospitals and developing new primary care centres and other integrated community facilities. The ethos behind these developments is a strong focus upon 'services drive infrastructure' to ensure the need for estate development is based upon service requirements.

The organisation aims to provide fully accessible and as much care as is safe and affordable at home or in the community using community hospitals, existing primary care centres and developing others in strategic locations to ensure even coverage of service.

There is a strong focus upon improvements to the patient environment, value for money for taxpayers and safe environments. NHS County Durham is in the process of currently updating the estate strategy to reflect the direction of the Department of Health guidance document 'Transforming Community Services (2009)'. This is to ensure the development of an effective strategic partnership model to allow the effective utilisation and development of the community estate and to meet the needs of the organisation as a world class commissioner.

There is strong focus to align the use of estate with the commissioning process. To deliver this, estates is a key partner in the Strategy Enablers Group (SEG) which supports the five year plan and the annual operational plan. This ensures that the patient environment is considered in all areas of service planning at the earliest stages through to the delivery points.

The organisation is ambitious in its goals to provide fit for purpose estate to support the annual operational plan (AOP) and five year strategy. Therefore the following goals have been developed to ensure continuous improvement in facilities across NHS County Durham:

Objective	Goal	Initiatives	Milestones & Metrics
Maximise the use of our estate to deliver care closer to home	Maximise the use of community hospitals to form integrated networks with acute hospitals	Complete the purchase of Shotley Bridge and Peterlee Community Hospitals Further develop other community hospitals	Both hospitals transferred by end of March 2009 Plan for community hospital infrastructure developed by April 2009
	Develop two new primary care centres	Build and develop strategically placed primary care centres in Seaham and Stanley	Seaham open for business in 2011 Stanley PCC open in 2009
	Develop a series of community facilities to provide a one-stop-shop for patients in more rural areas	Develop centres in Wheatley Hill, The Dales, etc	Business cases developed with local input Co-location/integration with other agencies
	Deliver a programme of upgrading of estates to ensure all facilities remain in suitable condition for clinical use	Estates investment plan	Delivery of plan
	Develop a strategic approach to estates and facilities management which supports plurality	Develop and deliver strategy Link into Growth Point developments with the LAs	Strategy complete June 2009 Delivery of strategic model

Investment and governance is carefully monitored through the development of the Strategic Estates and Facilities Management Group which oversees capital and revenue investment in the form of approval of estate business cases, the annual

capital programme, use of resources and healthcare commission standards, sustainability targets, estate risk management and backlog maintenance.

13. Change Management and Organisational Development

The PCT will be implementing the action plans drawn up to fill the priority organisational development gaps identified through the world class commissioning assurance process. The main challenges facing the PCT in 2009/10 are the establishment of a robust and effective investment planning process, securing and developing high quality procurement skills and further extending the organisations ability to stimulate the provider market. A series of options to address the underlying gaps in these areas have been appraised and a range of solutions have been selected that enable the PCT to progress further, by either learning from, sharing with or buying in new skills, systems and expertise from leading consultancies and academic bodies.

In addition to this the range of priority project work supported by the corporate improvement team is currently being reviewed by the chief executive and director of innovation to ensure that alignment of improvement resource will give maximum return towards delivery on the PCTs strategic aims. These priority areas include increasing support and expertise to priority pathway reviews and service developments and implementing key enablers that will improve the PCTs operational performance. Leadership development will also remain a priority in 2009/10 with the continuation of the Leaders as Coaches programme run in conjunction with Newcastle Business School.

In line with SHA requirements, we are working to produce an action plan by the of April 2009 which will deliver level 4 for all competencies by the end of 2012.

14. Management of Risk

There is an agreed risk management strategy and process for the identification, assessment escalation and management of risk across all areas of business activity. Risks associated with the annual operational plan are integrated into this process and included in the corporate risk register. The corporate risk register is reviewed by the senior management team on a two-weekly basis and formally reviewed and updated monthly. Significant risk of failure to meet an objective is escalated to board.

Each project lead will act as 'risk owner' for the management and escalation of risks related to their area of responsibility for delivery of the plan. The protocol for informing relevant parties will include the following steps:

- Significant risk of failure, rated as red in the risk analysis matrix, will be communicated to relevant parties in advance to make them aware of the potential failure.
- When a risk of failure to achieve an aspect of the plan has been realised, this will be formally reported to the relevant party and a 'stop the line' rapid review undertaken with relevant parties. A recovery plan or the implementation of the contingency will be introduced and monitored.

- All such cases would be reported to management group by the relevant directors for formal monitoring until the risk has been reduced to an acceptable level.

Procurement

NHS County Durham aims to address issues of health inequality, variations in access and to improve the health outcomes of the populations of County Durham and Darlington. To support this, investment will be delivered via robust procurement and investment planning. Through its contestability framework, NHS County Durham will determine which changes will occur to service delivery of existing services and where there will be benefit to patients in terms of access, choice and patient experience by identifying new providers into the market. The latter might be through 'any willing provider' or through open competitive tendering. To achieve this it is essential that there are well developed, transparent processes that are accessible and effective.

NHS County Durham will ensure that all procurements are transparent, evidence based; deliver key business objectives; services are innovative, affordable and viable; clinically safe and effective; set stretched targets to improve health outcomes and the quality of patient experience.

All procurements will be underpinned by a number of core principles that NHS County Durham will observe. This will clearly demonstrate to all stakeholders including providers of service that NHS County Durham is adopting a principled approach to the procurement of healthcare.

NHS County Durham procurement policy identifies its principles when procuring clinical health services as:

Transparency - NHS County Durham will advertise all its commissioning intentions, service reviews and service specifications on its website and advertise service specifications via the NHS procurement portal 'NHS Supply2Health'.

Assurance, objectivity, proportionality - NHS County Durham will carry out the relevant financial & quality assurance checks for all potential providers by undertaking a core assessment of each provider.

Competition, non-discrimination - All providers will be assessed under the same criteria for that service and no provider will be given preference over another.

Contracts - Standard NHS contracts will be used. Where no NHS contract is available a locally developed contract will be used until such times as a national template becomes available.

Conflicts - All conflicts of interest will be declared and managed appropriately as highlighted in the dispute resolution process.

Diversity - NHS County Durham will promote diversity of provision and acceptable choices for local service users.

Procurement competencies - Recognise the contribution of all functions in NHS County Durham in delivering best procurement outcomes and support competency and development in the commissioning and procurement process.

Auditors Local Evaluation (ALE) requirements - NHS County Durham will comply with internal governance and legal requirements for procurement procedures.

A key factor which has emerged in recent months is the national and regional economic downturn or 'credit crunch'. As we take forward the implementation of the AOP we will ensure that we maximise:

- Opportunities to increase local employment.
- Support for those falling out of employment.
- Support for those with increasing levels of mental health problems.
- Proactively seek to maximise the opportunity to address equality and diversity issues.

15. Governance, Service Safety and Quality

NHS County Durham has an approved and documented governance and assurance framework, which is applied to the annual operational plan. This framework is designed to ensure the focused delivery of corporate objectives and statutory duties of the PCT. The delivery of the annual operational plan is a corporate objective which is agreed and monitored by the board. Accountability for the delivery of the annual operational plan is overseen by the chief executive and responsible executive director.

NHS County Durham is implementing Leadership for Safety through the National Patient Safety First Campaign and has Board commitment to patient safety to address the following:

- Develop explicit strategic priorities and goals for commissioning safety into services through development of explicit service specifications, safety key performance indicators (KPIs) within performance monitoring.
- Provide demonstrable leadership in patient safety across the organisation reflected in the chief executive officer, chair and each director's objectives.
- Ensure executive accountability for patient safety and quality through at least 30% of Board agenda focused on safety and quality issues.
- Establish and monitor explicit system level measures in line with the 'Safer Care North East (NHS North East - August 2008)' Strategic Framework using clinical safety themes relevant to the different NHS care sectors commissioned, including those for people with special needs.
- Employ key enablers to support patient safety, relating to culture, systems and process, skills and knowledge, IM&T and other significant levers.
- Utilise the North east dashboard of high level patient safety indicators to measure patient safety improvement using North East Transformational System (NETS) programme.
- Utilise the supporting role of the Patient Safety Action Team.
- Monitor progress and drive execution of plans for patient safety through meaningful data for the Board to consider on key providers.
- Build patient safety and improvement knowledge and capability through Board accountability and their knowledge of the current state of providers and decide on leverage for improvement.

To these ends NHS County Durham will ensure that it commissions from providers who develop a more proactive, transformational and systematic approach to patient safety aligned to the national developments arising from *Safety First*, whilst supporting concerted action on key local safety issues relating to the North East Transformation System the Patient Safety Strategic Framework. The framework of strategic priorities for patient safety has been developed across NHS organisations in the North east region and is focused on local implementation of national safety policy and collective action on locally identified patient safety issues aligned to the vision for health care in the North East with the aim of achieving 'No avoidable deaths, injury or illness'.

High level indicators have been selected to provide an overall view of patient safety across County Durham and Darlington. These indicators will be monitored within each provider organisation. They will be used to inform further enquiry and prioritisation of developmental activity. These indicators will be a starting point drawn from currently available information and representing a combination of target-related issues and broad surveillance. Further work will be needed during the coming year to increase understanding of the implications of each indicator and more locally focused indicators will be developed, from emerging clinical themes arising from patient experience data such as patient surveys, complaints and untoward incidents.

A Quality Review group is to be established with County Durham and Darlington Foundation Trust (CDDFT) and County Durham and Darlington Community Services to ensure delivery of NHS County Durham strategic plan *Your Health, Your Choice, Your Care, Our Commitment*: the NE Strategy (Our Vision, Our Future) and the Never Events initiative by working closely with all partner organisations across the County to fulfil this ambition to be world class commissioners with a focus on safety, quality and patient experience.

The review group will implement Measuring for Quality Improvement and collate, monitor, review year on year the quality of services commissioned by NHS County Durham and provided by CDD Foundation Trust.

Commissioning for Quality and Innovation (CQUIN) payment framework is to be utilised to focus specifically on supporting measurement for improvement, and to make even more effective use of the quality measures emerging locally. Local CQUIN Indicators have been developed for discussion with both CDDFT and with community providers. A potential CQUIN for independent contractors is being considered.

NHS Darlington - Patient safety and excellent patient experiences are vitally important to NHS Darlington. To ensure the safe delivery of high quality care there is a team of senior clinicians who in addition to providing clinical and professional leadership also manage the complaints, PALS and patient safety services ensuring the organisation learns lessons.

To ensure the best possible outcomes for all patients who use local health services, the North East Transformation System is being encouraged to promote excellence in care. This will maximise opportunities for NHS staff to transform health services providing a clear focus for health improvement which will drive efficiency and effectiveness over the coming years.

NHS Darlington is determined to make the delivery of high quality health care its priority and it is expected that in the future, the community health services directorate will further develop into an autonomous body e.g. possibly a social enterprise trust or a community foundation trust, but of course, will remain a part of the NHS with sound governance arrangements. Residents of County Durham and Darlington can be reassured these changes will come about with patients at the heart of decision making and dedicated professionals will be the people who will be leading this process.

16. Conclusion

This AOP clearly demonstrates a sound use of growth funding which pays particular attention to the pathway areas identified within 'Better Health, Fairer Health (NHS North East - February 2008)', 'Our Vision, Our Future, Our North East NHS (NHS North East - February 2008)', 'Safer Care North East (NHS North East - August 2008)' and 'The NHS in England: The Operating Framework for 2009/10'.

This Plan and its accompanying appendices provide a detailed response regarding the utilisation of resources for NHS County Durham and NHS Darlington. It clearly demonstrates proposals which deliver a balanced financial position for 2009/10.

Overall, NHS County Durham and NHS Darlington believe that the AOP for 2009/10 takes an innovative approach to the delivery of its objectives and goals, meeting national performance targets and achieving financial balance. This is underpinned by sound supporting strategies from enabling teams across the organisation including informatics, workforce, estates, patient & public involvement, communications, market development, finance and takes into account equality & diversity issues. The plan will not be achieved without NHS County Durham and NHS Darlington continuing to maintain a challenging programme of development, involving high levels of productivity and efficiency with close monitoring of performance against planned targets and key goals and objectives.

‘Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)’	PCT Strategic Aims			
	Health Status	Health Inequalities	Patient Centred Services	Value for Money
Maternity and Newborn	X	X	X	X
Children	X	X	X	X
Staying Healthy	X	X		X
Mental Health	X	X	X	X
Planned Care			X	X
Acute Care			X	X
Long Term Conditions	X			X
End of Life Care			X	X

X = key alignment

Implementing High Quality Care for All Annual Operating Plan 2009/2010

Strategic Framework:

Strategic Aims	Health Outcomes	Our Vision Our Future
<ol style="list-style-type: none"> 1. Improve the health status of our populations 2. Reduce health inequalities 3. Access to patient centre centred services (fair, personalised, effective and safe) 4. Ensuring value for money in commissioned services 	<ol style="list-style-type: none"> 1. Health inequalities 2. Life expectancy 3. Infants breastfed 4. Under 18 conception rates 5. Smokers quitting 6. Suicide 7. Alcohol admissions 8. Cancer mortality rate 9. CVD mortality 10. Experience of end of life care 	<ol style="list-style-type: none"> 1. Maternity & newborn 2. Children 3. Better health/fairer health: staying healthy/improving health/reducing health inequalities 4. Mental Health 5. Planned care 6. Acute care 7. Long term conditions 8. End of life care

Delivery Framework:

1. High Quality Care for Patients and the Public	Alignment of Strategy			Lead Director
	Strategic Aims	Health Outcomes	Our Vision, our Future	
Setting priorities for 2009/2010				
• Cleanliness and HCAI	3			
• Improving access	3		5, 6	
18 weeks				
Primary Care	2, 3		5, 6	
• Keeping adults and children well				
Reducing smoking	1	5	3	
Tackling obesity	1	2	3	
Improving sexual health	1	4	3	
Improving mental health	1	6	4	
Treating drug addiction	1	6	4	
Reducing alcohol harm	1	7	3, 4	
Prevention package for older people	1	1	3	
Abortion and contraception services	1	1	3	
LTC	1	2	7	
Carers Strategy	3	1	7, 3	
Cancer	1	8	3, 5, 6	
Stroke	1	2, 8	3, 6	
Maternity and neonatal	1	3, 4	1	
Children	1	3	2	
• Experience, satisfaction and engagement	3			
• Emergency preparedness	3			
• Priorities determined and set locally				
Alcohol	1	7	3, 4	
Dementia	1, 3	1	7	
End of life care	1, 3	10	8	
Mental health	1, 3	6	4	
Military personnel	3			
Mixed sex accommodation	3			
People living in vulnerable circumstances	2, 3	1	3	
People with learning disabilities	1, 2	1, 6	3	

3. Investing in Quality	Alignment of Strategy			Lead Director
	Strategic Aims	Health Outcomes	Our Vision, our Future	
Financial Framework for 2009/2010 <ul style="list-style-type: none"> PCT allocations <ul style="list-style-type: none"> Revenue Capital Accounting regime PBR NHS North East flexibilities Efficiency NHS North East bundle Central budgets 	4 4 4 4 4 4 4 4	Across All Outcomes	Across All Outcomes	

Prioritisation Matrix

Prioritisation: first stage review

Overall health impact *	Large impact, significant numbers	5	
	Modest impact, significant numbers	4	
	Modest impact, moderate numbers	3	
	Modest impact, small numbers	2	
	Limited impact, small numbers	1	
Inequalities impact *	High intrinsic impact	5	-5
	Significant impact	4	-4
	Modest impact	3	-3
	Minimal impact	2	-2
	No impact	1	-1
Quality and patient experience *	Significant positive impact on quality and patient experience	5	
	Substantial positive impact on quality and patient experience	4	
	Medium impact on quality and patient experience	3	
	Some impact on quality and patient experience	2	
	No impact on quality and patient experience	1	
Contribution to 'Our Vision, Our Future, Our North East NHS (NHS North East - June 2008)' *	Hits all key priorities	5	
	Hits most key priorities	4	
	Hits some key priorities	3	
	Little contribution to key priorities	2	
	No contribution to existing priorities	1	
Delivers targets/vital signs outlined within Operating Framework	Significant impact upon delivery	5	
	Substantial impact upon delivery	4	
	Moderate impact upon delivery	3	
	Some impact upon delivery	2	
	No impact upon delivery	1	
Population Impact	Practice Level up to 20,000	1	
	Cluster Level 20,000 to 150,000	2	
	150,000 plus	3	

Prioritisation: second stage review

Risk	Significant and difficult risk	5
	Substantial risk	4
	Medium level of risk	3
	Some risk	2
	Minimal risk	1
Value for money	Significant increase in quality/productivity	5
	Substantial increase in quality/productivity	4
	Medium increase in quality/productivity	3
	Some increase in quality/productivity	2
	No increase in quality/productivity	1

* PCT strategic aims

List of Breakthrough OGIMs

Staying Healthy

1. Support of Domiciliary Care Workers by Preparation of a Medication administration Record (MAR) sheet, when a prescription is presented for a patient assessed as requiring the service.
2. Reducing Cancer Deaths.
3. CVD Risk Assessment and Management Pathway.
4. Developing Alcohol Services.
5. Childhood and Maternal Obesity.

Planned Care

6. Intermediate Care.
7. Telehealth.

End of Life Care

8. Bereavement Services.

Long Term Conditions

9. Telemedicine.

Child Health

10. Targeted Mental Health in Schools.
11. Complex and Continuing Health Care for Children with Disabilities, including palliative care.
12. Family Support.
13. Services for School Age Children (including services for children not in school).

Maternity & Newborn Care

14. Maternity Matters.
15. Sexual Health.

Acute Care

16. Urgent Care Communication Centre.
17. Urgent Care 24/7 Clinical Service.

Mental Health

18. Dementia Assessment and Support Services for Adults with Learning Disabilities.
19. Dementia Home Care Support.

Improving Health

20. Delivery of Quality & Outcomes Framework

Reducing Health Inequalities

21. Healthy Schools Plus
22. Health Trainer Programme
23. Increasing Access to NHS Dental Services

Fair Personalise Effective & Safe

24. Coordinated Integrated Transport Scheme

	County Durham PCT				Darlington PCT				Period	Source	Latest Reported Performance			
	Target	Previous	Latest	Movement	Target	Previous	Latest	Movement			SHA	Period	National	Period

Vital Signs Tier 1

Cleanliness and healthcare associated infections

VSA1	Incidence of MRSA (Provider - CDDFT)	19	36	38	↑	19	36	38	↑	Mar-09 YTD	MESS	188	Mar-09 YTD	2993	Mar-09 YTD
VSA3	Incidence of Clostridium difficile (Provider - CDDFT)	195	221	247	↑	195	221	247	↑	Mar-09 YTD	MESS	1443	Feb-09 YTD	18453	Feb-09 YTD
VSA3	Incidence of Clostridium difficile (Commissioner)	444	482	525	↑	55	102	111	↑	Mar-09 YTD	MESS	2426	Feb-09 YTD	33435	Feb-09 YTD

Access to personalised and effective care

VSA4a	18 weeks admitted, adjusted	90.0%	93.6%	93.3%	↓	90.0%	94.6%	97.0%	↑	Feb-09	Unify2	93.5%	Jan-09	92.9%	Jan-09
VSA4b	18 weeks non admitted	95.0%	97.0%	97.4%	↑	95.0%	97.7%	98.9%	↑	Feb-09	Unify2	97.4%	Jan-09	97.3%	Jan-09
VSA4c	18 weeks Direct Access Audiology	95.0%	99.7%	100.0%	↑	95.0%	100.0%	100.0%	→	Feb-09	Unify2	92.8%	Oct-08	93.90%	Oct-08
VSA4d	>6 weeks 15 key diagnostic tests	0	23	37	↑	0	0	0	→	Mar-09	Unify2	37	Nov-08	4839	Nov-08
VSA7	Practices offering extended opening	50.7%	87.5%	93.0%	↑	54.5%	100.0%	100.0%	→	Mar-09	Unify2	79.6%	Dec-08	69.2%	Dec-08

Vital Signs Tier 2

Health Improvement & Reducing Health Inequalities

























VSB1a	All age all cause mortality (AAACM) rate for males	785	807.4	742.5		846	832.0	737.4		2007	ONS	774.12	2007	688.76	2007
VSB1b	All age all cause mortality (AAACM) rate for females	563	568.6	557.3		566	562.3	561.6		2007	ONS	552.36	2007	488.71	2007
VSB2	Reduction in CVD mortality	95.1	90.4	83.4		108.3	87.0	88.1		2007	NCHOD	87.63	2007	74.4	2007
VSB3	Reduction in Cancer mortality	127.9	134.3	131.4		119.5	125.0	113.3		2007	NCHOD	133.29	2007	114.07	2007
VSB4	Reduction in mortality from suicide & injury of undetermined intent	0	6.9	8.3		0	8.9	4.6		2007	NCHOD	8.08	2007	7.47	2007
VSB5	Smoking Quitters	2918 YTD	2038	3084		488 YTD	396	555		Qtr 3 2008/09	LDPr Practice Systems	2025	Qtr 1 2008/09	30706	Qtr 1 2008/09
VSB6	Early access to Maternity Services	67%	78.8%	79.1%		67%	80.5%	83.8%		Qtr 4 2008/09	Acute VSMr	N/A	N/A	N/A	N/A
VSB8	Under 18 conception rate	35.8	46.1	49.9		39.6	51.2	55.2		2007	PH/ONS	52.9	2007	41.7	2007
VSB9a	Children in Reception with height and weight recorded who are obese	12.0%	9.7%	9.6%		13.0%	10.7%	10.0%		2007/08	NCMP	10.7%	2007/08	9.6%	2007/08
VSB9b	Children in Reception with height and weight recorded	100.0%	100%	90.0%		97.0%	97%	99.0%		2007/08	NCMP	93%	2007/08	89%	2007/08
VSB9c	Children in Year 6 with height and weight recorded who are obese	22.0%	19.7%	20.9%		21%	21%	20%		2007/08	NCMP	20.8%	2007/08	18.3%	2007/08
VSB9d	Children in Year 6 with height and weight recorded	90.0%	84%	92.0%		97.0%	97%	98.0%		2007/08	NCMP	90%	2007/08	87%	2007/08

















VSB10a	Immunisation rate for children aged 1 for Dtap/IPV/Hib	95.0%	96.6%	96.4%		95.0%	93.2%	96.3%		Qtr 3 2008/09	HPA	95.0%	Qtr 3 2008/09	91.6%	Qtr 3 2008/09
VSB10b	Immunisation rate for children aged 2 for PCV	95.0%	85.8%	81.9%		95.0%	84.4%	84.3%		Qtr 3 2008/09	HPA	86%	Qtr 3 2008/09	82.8%	Qtr 3 2008/09
VSB10c	Immunisation rate for children aged 2 for HibMenC	95.0%	94.9%	93.5%		95.0%	89.9%	91.4%		Qtr 3 2008/09	HPA	91.7%	Qtr 3 2008/09	85.8%	Qtr 3 2008/09
VSB10d	Immunisation rate for children aged 2 for MMR	95.0%	91.2%	90.5%		95.0%	91.4%	90.1%		Qtr 3 2008/09	HPA	88.2%	Qtr 3 2008/09	85%	Qtr 3 2008/09
VSB10e	Immunisation rate for children aged 5 for DTaP/IPV	95.0%	90.9%	89.8%		95.0%	93.0%	91%		Qtr 3 2008/09	HPA	87.6%	Qtr 3 2008/09	79.2%	Qtr 3 2008/09
VSB10f	Immunisation rate for children aged 5 for MMR	95.0%	88.3%	87.7%		95.0%	87.9%	87.9%		Qtr 3 2008/09	HPA	85.0%	Qtr 3 2008/09	77.4%	Qtr 3 2008/09
VSB11a	Prevalence of Breastfeeding at 6-8 weeks	34.1%	26.6%	25.3%		37.2%	32.9%	33.6%		Qtr 4 2008/09	VSMr				
VSB11b	Coverage - Breastfeeding status (6-8 wk) recorded as % of all due 6-8 wk check	85.3%	97.5%	93.5%		85.1%	99.7%	99.1%		Qtr 4 2008/09	VSMr				
VSB12a	Has a full range of CAMHs for LD been commissioned for the council area?	3	3	3		3	3	3		Qtr 4 2008/09	VSMr	NA		NA	
VSB12b	Do 16 and 17 year olds who require MH services have age appropriate access?	4	4	4		4	4	4		Qtr 4 2008/09	VSMr	NA		NA	
VSB12c	24hr cover for urgent MH needs of CYP and a MH Assess. to be undertaken within 24 hours?	3	3	3		3	3	3		Qtr 4 2008/09	VSMr	NA		NA	
VSB12d	Is a full range of EI services for children experiencing MH problems	4	4	4		4	4	4		Qtr 4 2008/09	VSMr	NA		NA	
VSB13	Chlamydia Screening	12% YTD	3.2%	10.4%		12% YTD	3.2%	12.2%		Qtr 3 2008/09	HPA	11.0%	Qtr 3 2008/09	9.5%	Qtr 3 2008/09

Improving Access

VSB18	Dental Services	273000	271881	274812		69784	65399	65312		Qtr 4 2008/09	IC				
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HCC Indicators

HCC1	Access to GUM clinics	100%	100%	99.9%		100%	100%	100%		Mar-09	GUMAMM / HPA	99.8%	Nov-08	99.70%	Nov-08
HCC2	Category A calls meeting 19 minute standard	95.0%	98.6%	98.6%		95.0%	99.0%	99.0%		Mar-09 (YTD)	NEAS	99.0%	Mar-09 YTD	N/A	N/A
HCC3	Category A calls meeting 8 minute standard	75.0%	64.6%	64.9%		75.0%	83.5%	83.8%		Mar-09 (YTD)	NEAS	75.7%	Mar-09 YTD	N/A	N/A
HCC4	Category B calls meeting 19 minute standard	95.0%	93.0%	93.1%		95.0%	94.6%	94.7%		Mar-09 (YTD)	NEAS	95.6%	Mar-09 YTD	N/A	N/A
HCC5	Commissioning of crisis resolution/ home treatment services	1189	1177	1359		209	193	243		Mar-09 (YTD)	VSMr/ MH Trusts	7452	Feb-09 (YTD)	73491	Dec-07
HCC6	Commissioning of early intervention in psychosis services	92	107	123		16	21	26		Mar-09 (YTD)	VSMr/ MH Trusts	500	Feb-09 (YTD)	5887	Dec-07
HCC7	Data Quality on Ethnic Group	80%	-	88.49%		80%	-	82.34%		2007/08	MHMDS and SUS			87.30%	2007/08
HCC8	Delayed transfers of care	<=3.5%	0.18%	1.0%		<=3.5%	0%	0.0%		Jun-08	VSMR				
HCC9	Diabetic Retinopathy Screening	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		Q4 2008/09	Screening service	94.40%	Sep-08	90.30%	Sep-08
HCC10	Inpatients waiting longer than the 26 week standard	0	2	2		0	2	2		Mar-09 (YTD)	Online Reports				
HCC11	Outpatients waiting longer than the 13 week standard	0	0	0		0	0	1		Mar-09 (YTD)	Online Reports				
HCC12	Patients waiting longer than 3 months for revascularisation	0	0	0		0	0	0		Mar-09 (YTD)	Online Reports				
HCC13	Time to reperfusion for patients who have had a heart attack	Data will only be available at Y/E 08-09				Not applicable - numbers are too low to be statistically valid and assessed					MINAP	Data will only be available at Y/E 08-09			

HCC14	Total time in A & E - CDDFT only	98.0%	97.4%	97.5%		98.0%	97.4%	97.5%		Y/E 08/09	Online Reports	99.2%	Mar-09	98.6%	Mar-09
HCC15	Access to a GP	100%	100%	100%		100%	100%	100%		Q4 2008/09	PCAS	99.8%	Q3 2008/09	99.4%	Q3 2008/09
HCC16	Access to a primary care professional	100%	100%	100%		100%	100%	100%		Q4 2008/09	PCAS	100.0%	Q3 2008/09	98.9%	Q3 2008/09
HCC17	Percentage of women eligible for breast screening 53-64 who have been screened	65%	78.4%	79.1%		65%	77.8%	78.1%		2007/08	KC63	79.4%	2006/07	76.0%	2006/07
HCC18	Percentage of women eligible for breast screening 65-70 who have been screened	N/A	57.8%	75.2%		N/A	74.6%	76.6%		2007/08	KC63				
HCC19	All Cancer 2 Week Waits	100%	100.0%	100.0%		100%	100.0%	100.0%		Dec-08	CWT	99.9%	Nov-08	99.9%	Nov-08
HCC20	All Cancers: 31 day wait - diagnosis to 1st treatment	98%	99.5%	99.6%		98%	100.0%	100.0%		Dec-08	CWT	99.6%	Nov-08	99.4%	Nov-08
HCC21	All Cancers: 62 day wait - urgent GP referral to 1st treatment	95%	95.3%	98.9%		95%	100.0%	100.0%		Dec-08	CWT	97.6%	Nov-08	96.9%	Nov-08

Appendix 6

NHS County Durham Annual Operating Plan - Financial Summary 09/10 & 10/11	Recurrent 2009-2010 Full Year Plan £000s	Non-Recurrent 2009-2010 Full Year Plan £000s	TOTAL 2009-2010 Full Year Plan £000s	Recurrent 2010-2011 Full Year Plan £000s	Non-Recurrent 2010-2011 Full Year Plan £000s	TOTAL 2010-2011 Full Year Plan £000s
Opening Recurrent Baseline Allocation	840,592		840,592	886,826		886,826
New Resources Available :						
Increase to recurrent baseline allocation	46,233		46,233	48,775		48,775
Confirmed non-recurrent allocations		14,453	14,453		14,886	14,886
Other non-recurrent allocations - Local assumptions		3,829	3,829		2,939	2,939
Return of top-sliced funding		9,214	9,214		9,214	9,214
Deployment of existing recurring resources	18,228		18,228	16,068		16,068
TOTAL RESOURCES AVAILABLE IN YEAR	64,461	27,496	91,957	64,843	27,039	91,882
APPLICATIONS - Generic Cost (+) Pressures and Savings (-)						
Tariff and Inflationary uplifts on Baseline	37,118		37,118	39,698		39,698
Tariff and Inflationary uplifts on Investments from Growth monies	3,130		3,130	1,463		1,463
Prescribing Uplift	5,598		5,598	5,765		5,765
IFRS Impact	773		773	702		702
Accounting for MFF/HRG4	1,304		1,304	0		0
Efficiency Savings on Baseline	(24,257)		(24,257)	(26,018)		(26,018)
Efficiency Savings on Growth monies	(3,131)		(3,131)	(1,463)		(1,463)
INVESTMENT / (DISINVESTMENT) (-)						
Adjustment for dental & specialised services non-recurring allocations		14,453	14,453		14,886	14,886
Stroke	425	77	502	438	79	517
Childrens Health	4,175	1,646	5,821	4,300	1,695	5,995
Maternity Services	1,612	325	1,937	1,660	335	1,995
Smoking Cessation	117	0	117	121	0	121
Obesity	519	1,700	2,219	535	1,600	2,135
Sexual Health	273	22	295	281	23	304
Long term conditions / self care management	425	30	455	438	31	469
Drugs/Alcohol	977	263	1,240	1,006	353	1,359
Lifestyle services	337	2,000	2,337	347	2,060	2,407
Other public health and health inequalities	120	62	182	124	64	188
Elective Access - maintaining 18 Weeks	1,250	9,213	10,463	363	9,489	9,852
Elective Access - other	588	0	588	606	0	606
Change in acute healthcare not due to inflation, efficiency or volume	2,500		2,500	2,500		2,500
Non Elective/Emergency Access	1,615	0	1,615	1,663	0	1,663
CHD	0	213	213	0	219	219
Cancer	366	48	414	377	49	426
Other Patient safety and clinical governance	12	0	12	12	0	12
Improving patient experience	115	0	115	118	0	118
Mixed Sex Accommodation		974	974	0	1,003	1,003
Ambulance Services	320	0	320	330	0	330
Improving access to psychological therapies	309	0	309	318	0	318
Other Mental Health	1,133	358	1,491	1,167	369	1,536
People living in vulnerable circumstances	425	0	425	438	0	438
Learning Disabilities	462	298	760	476	307	783
Continuing Care	4,753	3,500	8,253	4,896	3,605	8,501
Older People's Dementia Care	268	0	268	276	0	276
End of Life Care	228	732	960	235	754	989
Diabetic Retinopathy		1,000	1,000	0	1,030	1,030
Primary Care - pharmacy	0	14	14	0	14	14
GP access	638	4,880	5,518	657	5,026	5,683
Dental services	213	184	397	219	190	409
Community Services - Existing	531	0	531	547	0	547
Community Services - New	1,089	673	1,762	1,122	693	1,815
Management/HQ Costs	189	543	732	195	559	754
Contingency	0	498	498	9	200	209
Other policy	204	1,528	1,732	210	1,118	1,328
TOTAL CHANGES TO APPLICATIONS IN YEAR	46,723	45,234	91,957	46,131	45,751	91,882
Resources Less Applications:	17,738	(17,738)	0	18,712	(18,712)	0
Total Recurrent Baseline	886,825			935,601		
Recurrent Surplus as % of Recurrent Baseline	2.00%			2.00%		
Total Investments excluding tariff/inflation/generic pressures	26,188	30,781	56,969			
Less deployment of existing resources	(18,228)	0	(18,228)			
Net Additional Investment excluding tariff/inflation/pressures	7,960	30,781	38,741			

NHS Darlington	Recurrent	Non-Recurrent	TOTAL	Recurrent	Non-Recurrent	TOTAL
Annual Operating Plan - Financial Summary 09/10 & 10/11	2009-2010	2009-2010	2009-2010	2010-2011	2010-2011	2010-2011
	Full Year Plan	Full Year Plan	Full Year Plan	Full Year Plan	Full Year Plan	Full Year Plan
	£000s	£000s	£000s	£000s	£000s	£000s
Opening Recurrent Baseline Allocation	157,792		157,792	166,081		166,081
New Resources Available :						
Increase to recurrent baseline allocation	8,289		8,289	8,624		8,624
Confirmed non-recurrent allocations		4,698	4,698		4,839	4,839
Other non-recurrent allocations - Local assumptions		193	193		0	0
Return of top-sliced funding		751	751		751	751
Deployment of existing recurring resources	4,320		4,320	4,267		4,267
TOTAL RESOURCES AVAILABLE IN YEAR	12,609	5,642	18,251	12,891	5,590	18,481
APPLICATIONS - Generic Cost (+) Pressures and Savings (-)						
Tariff and Inflationary uplifts on Baseline	7,063		7,063	7,681		7,681
Tariff and Inflationary uplifts on Investments from Growth monies	549		549	259		259
Prescribing Uplift	1,035		1,035	1,066		1,066
Accounting for MFF/HRG4	577		577	928		928
Efficiency Savings on Baseline	(4,476)		(4,476)	(4,983)		(4,983)
Efficiency Savings on Growth monies	(550)		(550)	(259)		(259)
Change in acute healthcare expenditure not due to inflation, efficiency or volume	1,000	0	1,000	1,000		1,000
INVESTMENT / (DISINVESTMENT) (-)						
Adjustment for dental & specialised services non-rec allocations		4,698	4,698		4,839	4,839
Stroke	75	14	89	77	14	91
Childrens Health	388	268	656	400	276	676
Maternity services	284	57	341	293	59	352
Smoking Cessation	21	0	21	22	0	22
Obesity	92	0	92	95	0	95
Sexual Health	48	0	48	49	0	49
Long term conditions / self care management	45	5	50	46	5	51
Drugs/Alcohol	172	0	172	177	0	177
Elective Access - maintaining 18 Weeks	567	683	1,250	172	482	654
Elective Access - other	413	496	909	425	511	936
Non Elective/Emergency Access	285	0	285	294	0	294
Cancer	65	0	65	67	0	67
Other Patient safety and clinical governance	2	0	2	2	0	2
Mixed Sex Accommodation	0	161	161	0	166	166
Improving access to psychological therapies	75	0	75	77	0	77
Other Mental Health	359	200	559	370	206	576
Continuing Care	668	400	1,068	635	412	1,047
Older People's Dementia Care	58	0	58	60	0	60
End of Life Care	23	0	23	24	0	24
Diabetic Retinopathy	0	200	200	0	206	206
GP access	0	1,279	1,279	0	1,317	1,317
Dental services	38	22	60	39	23	62
Community Services - Existing	34	0	34	35	0	35
Community Services - New	50	30	80	52	31	83
Management/HQ Costs	25	102	127	26	105	131
Contingency	0	100	100	0	103	103
Other policy	301	250	551	268	329	597
TOTAL CHANGES TO APPLICATIONS IN YEAR	9,286	8,965	18,251	9,397	9,084	18,481
Resources Less Applications:	3,323	(3,323)	0	3,494	(3,494)	0
Total Recurrent Baseline	166,081			174,705		
Recurrent Surplus as % of Recurrent Baseline	2.00%			2.00%		

Our Vision Our Future Theme	Informatics Initiatives	Delivery timescale, Dependency/Risk
Maternity & Newborn	<ul style="list-style-type: none"> • Lorenzo (CDDFT) • TPP (CDDCHS and GPs) • Summary Care Record • Detailed Care Record • Choose and Book • COIN • EPS release 2 • NHSmail (GP practices) • NHS number • Order communications and diagnostics reporting • Electronic discharge summaries • Expansion of the existing PCT data warehouse to include additional data flows • Delivery of PCT commissioning dashboards • Map of Medicine • Document 	<p>Lorenzo deployment dependant on national contract development and care management functionality being proven in practice. CDDFT plan to deploy once resolved. CDDCHS TPP deployments to complete for all service areas in 2009/10, including prisons. R3.01 to be deployed for all TPP users in 09/10, including RBAC</p> <p>Review of existing child health systems in north Durham and Easington in 09/10 towards potential TPP implementation – timescale to be agreed</p> <p>TPP implemented in all GP practices who have shown an interest – remaining practices keen to stay with existing GPSoC systems</p> <p>SCR timescales to be agreed across LHC – significant LHC wide project with significant dependencies on national systems availability</p> <p>Choose and Book currently deployed with expansion to further services in 2009/10. TPP system users dependant on R4.01 to allow receipt of electronic bookings. For all community services developments TPP will be continually monitored and implemented accordingly. Version 4.01 will be implemented as soon as possible within CDDCHS to enable direct booking of patients through Choose & Book (due June 2009)</p> <p>COIN technical deployment to complete May 2009, followed by further benefits exploitation</p> <p>EPS release 2 – a clinical lead will be identified and local planning will commence as soon as the outcomes of the national pilots for release 2 are published (national timescales currently not known). This will include plans for the issue of smartcards to pharmacists</p> <p>Following successful deployment of NHSmail in the PCTs in 08/09 this will be extended to GP practices in 09/10 (some already in place)</p> <p>Complete adoption of the NHS number by all providers by end 09/10 – this is the aspiration and will be achieved where possible</p> <p>Order comms and diagnostics reporting to be delivered by CDDFT to all GP practices and TEWV in 09/10 – dependant on local CDDFT radiology and pathology projects</p> <p>Completion of a pilot in Q1 09/10 for sending discharge summaries electronically from CDDFT to all GPs in CDD using NHSmail – possible extension to other areas</p> <p>PCT Data Warehouse, commissioning dashboards, map of medicine (for potential LHC wide use) and a document management system currently being expanded/implemented/considered as part of the wider PCT Knowledge project</p> <p>Local solutions may also be required in some areas where there is lack of functionality/availability of national</p>

Our Vision Our Future Theme	Informatics Initiatives	Delivery timescale, Dependency/Risk
	management <ul style="list-style-type: none"> • Local initiatives 	systems. Informatics programme plans, including dependencies, timescales and resource requirements required to support AOP initiatives will be completed in Q1 09/10.
Children	<ul style="list-style-type: none"> • As above • TPP (child health and school nurses) • ContactPoint • eCAF • Child protection system • Drug and alcohol system • System integration and information sharing • Sexual health system 	As above Current timescales for ContactPoint are for 18 months implementation from mid 2009/10. Risk that national timescales further delayed. National eCAF timescales are for 2010/11, an interim local deployment in County Durham is being considered for 2009/10. A local child protection system specification has been developed for implementation during 2009/10 – national systems are not regarded as meeting the requirements. OJEU Procurement of a drug and alcohol system was completed in 2008/9 for implementation in Q1 2009/10. Further work will be done to explore and where possible implement integration and information sharing to meet the requirements of all health and social care providers – lack of a cohesive national strategy and suitable systems makes this difficult in some areas Procurement of sexual health system in line with national requirements – for trial by end of 09/10
Staying Healthy	<ul style="list-style-type: none"> • As above • NHS Choices Website • HealthSpace • CVD risk register expansion into other settings • Community pharmacy systems 	As above All organisations are actively planning to use NHS Choices. CDDFT have contact monitoring and management processes in place, TEWV are actively engaged to ensure their earliest possible involvement, CDDCHS are actively planning. Adoption of HealthSpace is dependent upon national delivery timelines and the SCR scoping exercise. CVD risk register in place in GP practices - to be deployed in other pilot settings during 09/10 Development of computerized medical administration records in community pharmacies – plans to be developed
Mental Health	<ul style="list-style-type: none"> • As above • Utilise completed Paris deployment • TEWV data warehouse enhancement • TEWV pharmacy system • Pathology/radiology orders and results links to mental health • Summary Care Record 	As above Paris to be deployed for new initiatives in TEWV TEWV data warehouse and pharmacy system timescales to be confirmed As above from CDDFT SCR timescales to be agreed across LHC – significant LHC wide project with significant dependencies on national systems availability
Planned Care	<ul style="list-style-type: none"> • As above • Telehealth 	As above Telehealth Q2 09/10

Our Vision Our Future Theme	Informatics Initiatives	Delivery timescale, Dependency/Risk
	<ul style="list-style-type: none"> • Telemedicine (prisons) 	Project underway to implement telemedicine by 09/10 in all prisons
Acute Care	<ul style="list-style-type: none"> • As above • Urgent Care Review • CDDFT Bed management – also to support infection control • CDDFT e-prescribing for take out medications • Benefits realisation of new CDDFT radiology systems • CDDFT pathology system • CDDFT stock management robotic pharmacy system and ward based medicines management • CDDFT consideration of future areas for investments for 09/10 and 10/11: email, file storage, backup facilities, local area network, PACS, telephones, order communications and results reporting, potential new service developments being explored by the Trust 	<p>As above</p> <p>Delivery of systems to support the urgent care review will be enabled by the Summary Care Record - timescales to be agreed across LHC – significant LHC wide project with significant dependencies on national systems availability Specification for bed management developed – local solutions to be sought in 09/10</p> <p>E-prescribing – planned part of CDDFT Care Records Project in 09/10</p> <p>Radiology systems installed March 2008 – ongoing benefits realisation including exploration of voice recognition technologies</p> <p>Pathology implementation underway</p> <p>Stock management system by end 09/10</p> <p>Risk assessments completed, outline proposals in preparation for the Board</p>
Long Term Conditions	<ul style="list-style-type: none"> • As above • GPSoC • GP to GP Record Transfer • Summary Care Record 	<p>As above</p> <p>GPSoC practice agreements all signed off and in place in 08/09. All practices using GPSoC systems by end 08/09. Practice agreements also extended to TPP practices. Full implementation including development/agreement of practice plans in 09/10</p> <p>GP to GP record transfer deployment dependant on supplier availability</p> <p>National templates for the SCR for long term conditions will be considered for local application</p>
End of Life Care	<ul style="list-style-type: none"> • As above • Hospices • Summary Care Record 	<p>As above</p> <p>Requirements for hospices to be considered in 09/10</p> <p>National templates for the SCR for end of life care will be considered for local application</p>

Appendix 8 – Acronym Buster

Acronym	Explanation
AC	Audit Commission
A&E	Accident & Emergency
AHP	Allied Health Profession
ALE	Auditors Local Evaluation
ALE	Audit Local Evaluation assessment
AOP	Annual Operational Plan
BMA	British Medical Association
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CASH	Contraception and Sexual Health
CDO	Chief Dental Officer
CFH	Connecting for Health (NHS)
CHD	Coronary Heart Disease
CHIQ	Centre for Health Information Quality
CHRE	Council for Healthcare Regulatory Excellence
CIO	Chief Information Officer
CIP	Cost Improvement Programme
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CPPIH	Commission for Patient and Public Involvement in Health
CPR	Child Protection Register
CQUIN	Commissioning for Quality and Innovation
CRS	Care Records Service (NHS)
CVD	Cardio Vascular Disease
DAT	Drug Action Team
DGH	District General Hospital
DH or DoH	Department of Health
DIODIR	Do It Once, Do It Right
DPR	Data Protection Registrar
DSU	Day Surgery Unit
EBH	Evidence-Based Healthcare
EBM	Evidence-Based Medicine
ECHR	European Convention on Human Rights
ECJ	European Court of Justice
EHR	Electronic Health Record
ENT	Ear, Nose, Throat
EPP	Expert Patient Programme
EPR	Electronic Patient Record
EPS	Electronic Prescription Service
ESR	Electronic Staff Record
FESC	Framework for securing External Support for Commissioners
FESC	Framework for procuring External Support for Commissioners
FISCH	Family Initiative Supporting Children's Health
FISH	Family Initiative Supporting Health
FT	Foundation Trust
GDC	General Dental Council
GMC	General Medical Council
GPwSI	General Practitioner with Special Interest
HB	Health Board
HCAI	Healthcare Associated Infection
HCC	Healthcare Commission
HCSU	Healthcare Standards Unit
HIA	Health Impact Assessment
HIC	Health Innovation Council
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSC	Health Select Committee

ICAS	Independent Complaints Advocacy Service
ICP	Integrated Care Pathway
ICU	Intensive Care Unit
ISB	Information Standards Board (NHS)
IWL	Improving Working Lives
JIP	Joint Investment Plan
JSNA	Joint Strategic Needs Assessment
KSF	Knowledge and Skills Framework
LDP	Local Delivery Plan
LHE	Local Health Economy
LINK	Local Involvement Network
LPC	Local Pharmaceutical Committee
LSP	Local Strategic Partnership
LTA	Long-term Agreement
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
NAO	National Audit Office
NCAS	National Clinical Assessment Service
NCG	National Commissioning Group
NED	Non-Executive Directors
NESCG	North East Specialised Commissioning Group
NHSI	NHS Institute for Innovation and Improvement
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NPfIT	National programme for IT (NHS)
NPSA	National Patient Safety Agency
NSF	National Service Framework
NTO	National Training Organisation
OAT	Out of Area Treatment
OGIM	Objectives, Goals, Initiatives and Measures
OSC	Overview and Scrutiny Committee
PAF	Performance Assessment Framework
PALs	Patient Advice and Liaison Service
PBC	Practice Based Commissioning
PBMA	Programme Budgeting Marginal Analysis
PBR	Payment By Results
PCPI	Patient Carer Public Involvement
PCT	Primary Care Trust
PEC	Professional Executive Committee
PFI	Private Finance Initiative
PRB	Pay Review Body
PRCC	Principles and Rules for Cooperation and Competition
PROMS	Patient Reported Outcome Measures
PRONE	Procurement North East
PSA	Public Service Agreement
QA	Quality Assurance
QOF	Quality and Outcomes Framework
SCG	Specialist Commissioning Group
SDG	Strategy Delivery Group
SHA	Strategic Health Authority
SLA	Service Level Agreement
WCC	World Class Commissioning
WHO	World Health Organisation