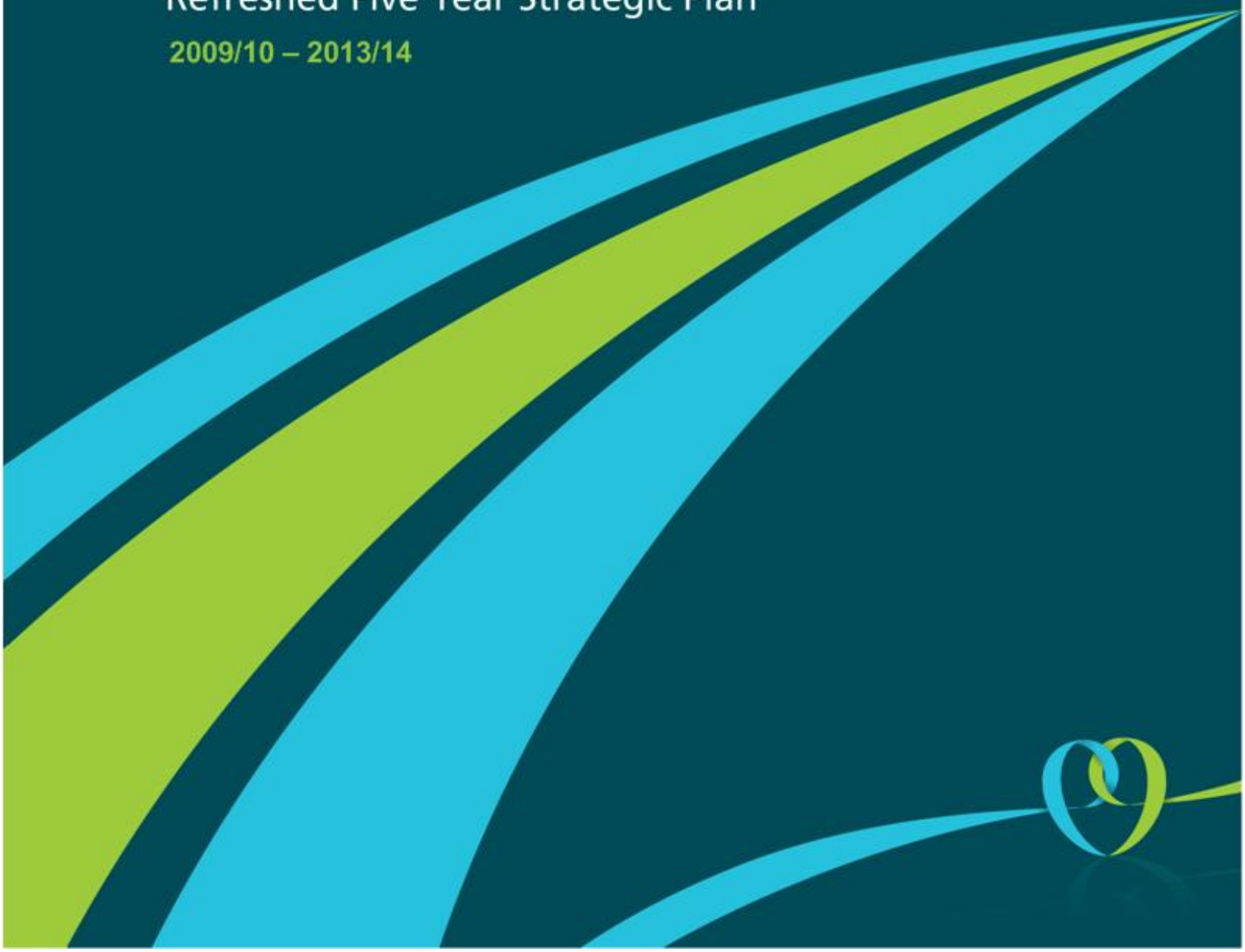
NHS
County Durham and Darlington

Refreshed Five Year Strategic Plan

2009/10 – 2013/14



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Section 1. Chief Executives introduction

NHS County Durham and Darlington have some of the best services in the county and some of the worst levels of health in the country. Therefore, we need to plan how we best use our resources to improve the levels of health for our populations. This strategic plan will demonstrate how we intend to do just that.

Our mission is to improve the health status of our population

> ***For example, we will increase the life expectancy of men in Darlington by two years by 2013 and we will reduce the life expectancy gap for women in County Durham by two years by 2013***

NHS County Durham and Darlington's role is to commission healthcare that will improve health outcomes, reduce health inequalities and ensure fair and equitable access to high quality, safe, patient-centred services. As we do this we will strive to ensure value for money for every pound of tax-payers money that we spend.

This strategic plan also explains how we will implement national policy from the Department of Health and regional strategies from NHS North East and Government Office North East on their behalf, and in partnership.

In particular we have a significant role to play in commissioning inclusive services that will implement the national Next Stage Review, which will be delivered via the regional vision for health and healthcare services 'Our Vision Our Future', and that meet the principles and values outlined in the NHS Constitution.

Our first strategic plan for health and healthcare was launched one year ago. A lot has changed since then. We have improved services in many areas, for example sexual health, diabetes, cancer diagnosis, offender health, chronic obstructive pulmonary disease (COPD) and improvements in GP practice systems.

We have delivered waiting times to 18 weeks in many specialties. This includes treatment in the community which has significantly benefited patients using musculo-skeletal, dermatology and audiology services and especially patients needing digital hearing aid, oral surgery or orthodontic treatment.

We have invested in our estate in both new health care facilities and in making existing buildings more modern, accessible and user-friendly. A new £13 million primary care centre opened its doors in Stanley town centre in autumn 2009 and provides community, children and young people's services, outpatient and diagnostic clinics and voluntary services.

Whilst we are very proud of these achievements, we know we need to do much more. We are presently in a major economic downturn which affects the NHS. This downturn has meant that we have had to review our plans and re-focus our priorities for the coming years.

In this strategic plan we outline our approach to continue tackling the biggest challenges we face in poor health and wellbeing, from birth until late in life. We demonstrate how we intend to deliver a responsive, excellent healthcare system that will provide our public with help they need, when needed and delivered where needed.

Whilst we are not expecting significant changes to our level of funding, we need to anticipate the impact of cost increases linked to inflation, new technology, an expanding drugs bill and new pressures on services – especially linked to people living longer.

This is a huge commissioning challenge for the NHS over the coming years this challenge means that we will have to think differently if we are to achieve our objectives.

Our providers of healthcare services, such as hospitals, community services and general practitioners, will see within this plan how we intend to move care closer to home, and how they can work with us to respond to the challenges we face.

Our strategic plan has been developed over the last two years by listening to and working with patients, carers, the public, clinicians, practice based commissioners and other key local stakeholders and partners through a wide ranging programme of engagement.

It is very important that we seek views to determine our vision for the people of County Durham and Darlington; by doing this together we understand what we need to do to deliver the improvements we need.

We have started our journey in developing a world class local health economy. We have a clear picture of where we began, our ambitions and aspirations remain unchanged and we have the energy and determination to deliver our vision and working together to create a healthier future.

Our Vision

This section outlines:

- Our vision for health and healthcare over the next five years.
- Our goals and aspirations for health improvement

Section 2. Our Vision

Currently, in County Durham, men living in the most deprived areas will die 11.8 years earlier then those in the most affluent areas. For women, this difference is 16.1 years. In Darlington this is 15.5 years for men and nearly 12.5 years for women in the most deprived areas compared with the least deprived areas.

In response to this and to ensure that the populations of County Durham and Darlington have the levels of health and healthcare that they deserve, we will deliver:

"Excellence today for a healthier tomorrow"

This means that our population will receive excellent local healthcare that meets individual needs and as a citizen you will live in an environment where, over time, people are healthier, more independent and less reliant on health services.

To turn this vision into reality, we will concentrate our efforts on four strategic objectives:

- giving children a better start in life
- helping to keep our public healthy
- ensuring high quality care at the most appropriate time and place
- helping people get the most out of later life

By tackling these objectives, we can deliver the greatest return on investment in terms of health gain for every pound of tax-payers money we spend.

In some instances we will tackle these objectives by using broad initiatives that benefit patients and members of our public county-wide (the improvement of the urgent care system) while in other instances we will target areas or groups of patients (annual health checks for 40 – 74 year olds). Sometimes the initiatives will reflect conditions associated with living in rural or urban areas (tackling COPD in Easington) while on other occasions it will reflect a small number of people based on specific conditions (improving access to services for those with early on-set dementia).

The result of the key programmes of work and initiatives that will deliver our objectives will be a healthcare system that looks very different from today. A move from treatment to prevention and the increased burden of long term conditions that comes with an ageing population means that the focus of our system will move away from the acute hospital to care closer to home.

More care will be provided in primary care and community settings by a diverse range of organisations. Pathways of care will be centred on the needs of the patient and designed to support them in managing their conditions as independently as possible.

2.1 Our vision, goals and aspirations

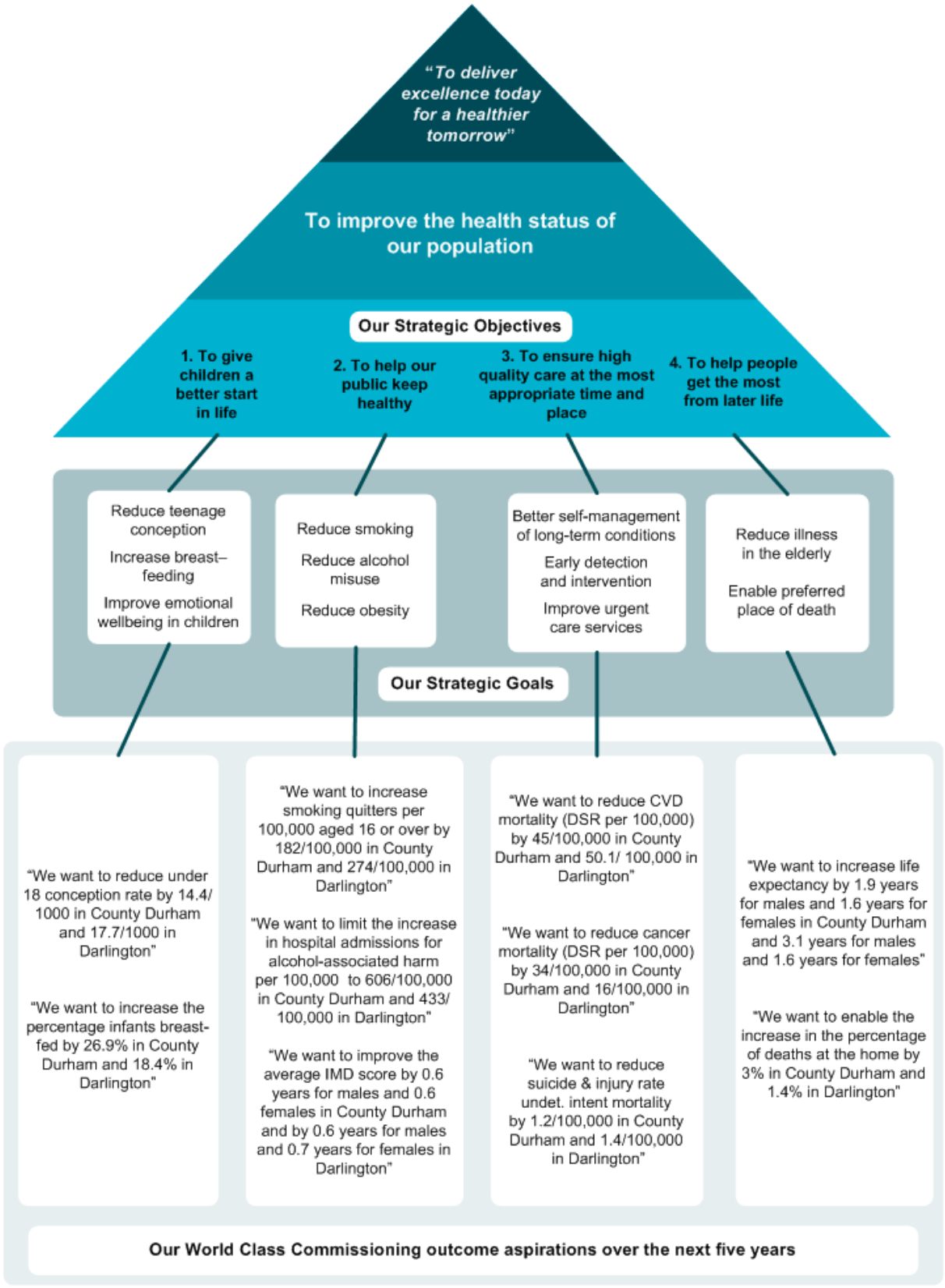


Figure 1: Relationship between our vision, mission objectives, goals and world class commissioning aspirations

2.2 Our objectives

Giving children a better start in life

In County Durham and Darlington, children have poorer levels of health than in other parts of the country. By investing in our children now, we sow the seeds for a healthier population in the future.

Breastfeeding rates in County Durham and Darlington are very low compared to both regional and national averages and the teenage conception rate is significantly higher then the national average in England.

> ***Five of the eight local councils in County Durham and Darlington have teenage conception rates far exceeding the national average. By 2014 we aim to have closed this gap by 180 teenage conceptions a year.***

Our long term vision is that mothers will be helped to maintain a healthy lifestyle before their baby is born. They will then have a choice of where they would like to give birth and then encouraged to make healthy post-natal choices that will benefit their child in a wider supportive environment. These children will grow up to enjoy good health and wellbeing. They will be protected from preventable diseases and should expect to lead healthy, active lives whilst growing. When they reach teenage years they will be supported to make the best lifestyle choices. They will also have aspirations and feel that attainment is possible.

Over the next five years we plan to invest in peer support programmes to encourage the initiation and maintenance of breastfeeding, to redesign the way contraception and sexual health services are delivered to teenagers and to commission a new model of care to support children with poor emotional wellbeing (including those with learning difficulties).

Helping our public keep healthy

We will help our population to keep healthy by directing our efforts at reducing the underlying risk factors that can lead to more severe health problems.

Smoking is one of the principal avoidable causes of premature death and ill-health in County Durham and Darlington and rates of obesity, that are already higher than the England average, are rising in children and adults. Admissions to hospital for alcohol-specific harm are higher in nearly all areas of County Durham and Darlington than the national average.

> ***The population of County Durham and Darlington will lose 815,000 years of life due to smoking every year. By 2014 we aim to have increased the number of smoking quitters by over 1,000 people a year to significantly reduce this figure.***

Our long term vision is that people of County Durham and Darlington will be able to make informed choices about how to live a healthy lifestyle. Services and organisations will work together effectively to tackle socio-economic factors that contribute to poor health and wellbeing. We will have significantly closed the gap in health inequalities across the county.

Over the next five years we plan to redesign the way stop-smoking services are delivered, commission physical exercise programmes that can be accessed by children and adults and develop a wider range of support services to help people reduce their risk of alcohol related harm.

Ensuring high quality care at the most appropriate time and place

Where people do fall ill and need diagnosis, treatment and support from healthcare services, we will ensure that our providers offer high quality services in the most appropriate place and at the most appropriate time.

There is significant variation in cancer mortality across County Durham and Darlington whilst a significant gap remains in coronary heart disease mortality between County Durham and Darlington and the rate for England. The prevalence of the major diseases that are associated with long term conditions (such as diabetes) is increasing due to an ageing population and obesity levels. Suicides continue to occur at a higher than expected rate.

> ***In Durham, people with cancer are 29% more likely to die of the disease in the most deprived ward than in the least deprived ward. In Darlington this figure rises to 60%. By 2014 we aim to stop 230 more patients a year dying from cancer.***

Our long term vision is that earlier identification of symptoms and risks linked to the major causes of premature death will lead to quicker and more effective treatment. People with chronic illnesses will be able and supported to manage their condition in the environment they choose. Overall, more healthcare will be delivered outside of the hospital setting, as close to local communities as possible and where appropriate.

Over the next five years we plan to provide annual health checks for more of our population so that illnesses are identified before they become life threatening, particularly for cancer and coronary heart disease, and increase access to psychological therapies to support those with mental health problems.

Helping people get the most out of later life

As people live longer and our population overall ages, we will support the people of County Durham and Darlington to get the most from later life.

We will target a reduction in the burden of illness that afflicts many older people, working with our partners to ensure that both health and social care needs are met. When the time comes we will ensure that death is pain free, dignified and within the environment of choice. It is forecasted that the age profile of the population in County Durham and Darlington will change significantly, with a greater proportion being over the age of 65, which is more than the increase nationally.

> ***Between 2007 and 2026 the number of older people over 65, 75 and 85 years old will increase by 49.9%, 71.4% and 115.2% respectively in County Durham. In Darlington*** **it is projected that by 2015 over 19% of the population will be aged 65 years or older.**

Our long term vision is that people are active, engaged and listened to members of the population. They will be able to live independently longer and will be treated with dignity at all times when coming into contact with health. At the end of life, people will be able to have a good experience in their preferred place of death, be that hospital, hospice or home.

Over the next five years we plan to introduce services to reduce the effects of dementia and improve the co-ordination of end of life care services

2.3 Aligning to deliver the vision

Whilst our ambition for the improvement of health and high quality services remains, we have had to reflect on how we will deliver our strategic goals within an extremely challenging financial environment.

Delivering these goals will mean our health economy will need to look significantly different in five years time. The prevention of ill-health becomes even more important as we look to reduce the reliance of our public on healthcare providers in line with the regional public health strategy Better Health, Fairer Health.

Primary care and community services will have to take on a bigger role in delivering health advice and services as described in national policy for Transforming Community Services. There will be more clinically led innovation and a strong evidence base behind the development of our services in order to meet the needs of the patient as outlined in Our Vision, Our Future.

The regional Clinical Innovation Teams (groups of clinicians representing different health care organisations and specialist care areas) are providing this innovation from a regional perspective around eight key health themes – maternity and newborn, child health, staying healthy, acute care, planned care, mental health, long term conditions and end of life.

Internally we have aligned our planning processes to ‘Our Vision Our Future’ workstreams by creating Clinical Programme Groups (CPGs). These clinically led groups, representing the views of practice based commissioners, clinical champions and our policy, planning and public health leads, will interpret the output of this regional work and combine it with our specific local need.

By tackling our priority areas, delivering our vision, strategic objectives for health in NHS County Durham and Darlington, we will have played a significant role in delivering the NHS North East vision *“Passionate about health”*:

- No barriers to health and well being
- No avoidable deaths, injury or illness
- No avoidable suffering or pain
- No helplessness
- No unnecessary waiting or delays
- No waste
- No inequality

2.4 Funding the delivery of the vision

The scale of the financial challenge we face in the future is great. Over the last seven years we have received unprecedented levels of new money that have enabled us to fund growth in our health services to respond to local health need. This level of new money into the system will not continue into the future.

Every year we face additional pressure on the funding we receive due to inflation associated with demographic changes of an aging and growing population and the cost of innovative new technologies and drug advancements recommended by the National Institute for Clinical Excellence. This means that we need to drive high levels of efficiency out of the current system in order to maintain a stable and high performing health service that can meet the growing needs of the population.

To understand if we can deliver our strategic plan, we have modelled our programmes against potential future scenarios.

By using these financial scenarios we can determine to what the extent we will need to drive efficiencies from the current system, disinvest from services we no longer need and where to deliver services differently over the next five years.

2.5 Core values

The following core values were developed as part of the engagement process with the public, clinicians, partners and staff. These core values will underpin the delivery of our strategy:

- The safety of the patient will always come first. Patient safety and clinical quality are everyday responsibilities of commissioners and priorities from the services we commission
- The full engagement of patients, carers and the public. The services we commission must be in line with what the public values.
- The full engagement of clinicians. Clinical leadership and direction must steer the shaping of the health economy
- The promotion and development of choice for patients. Services need to be designed around the needs of the patient.
- The shift in the balance from treatment to prevention. The improvement of health outcomes and the reduction of health inequalities can only be delivered through more preventative measures.

This strategic plan has also undergone an equality and diversity impact assessment as part of the NHS County Durham and Darlington Single Equality Scheme. This can be found in appendix B.

Context

This section outlines the need for change based on:

- Demographic and health need analysis taken from both the County Durham and Darlington joint strategic needs assessment and other statistical sources such as the Office for National Statistics, the NHS Information Centre and the National Clinical Health Outcomes Database.

- Clinical quality and performance information taken from our performance and quality monitoring tools such as clinical audit and the evidence base for pathways development using the Map of Medicine.

- Health economic analysis taken from the NHS County Durham and Darlington Annual Population Value Review.

- Analysis on our provider's economics from the NHS County Durham and Darlington Health Market Analysis review.

- Patients, carers and public insights into our services.

- Clinical and stakeholder experience and insights into our service.

Section 3. Context

3.1 Demographics

NHS County Durham and Darlington commissions services on behalf of nearly 600,000 people.

County Durham is characterised by:

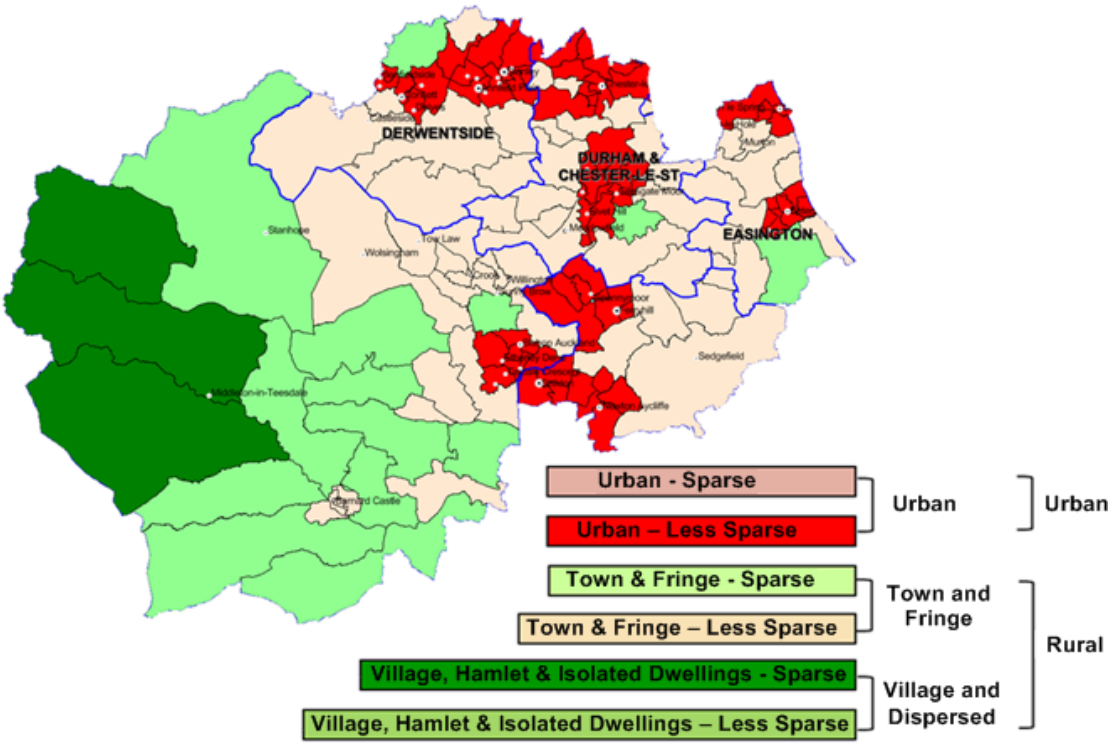
- A population of around 500,700 living in a large area of 862 square miles.
- 56.8% of the population live in urban areas, 33.9% in the rural/urban fringe and 9.3% in strictly rural areas.
- A smaller proportion of black and minority ethnic populations (1%) than in England and Wales (8.7%).

Darlington is characterised by:

- A population of around 98,600 living in a compact area of 76.2 square miles.
- 88% of the population live in urban areas and 12% live in urban/rural fringe or rural areas.
- A smaller proportion of black and minority ethnic populations (2.1%) than in England and Wales (8.7%).

Health inequalities are affected by the socio-economic conditions that exist across County Durham and Darlington such as lower household income levels, lower educational attainment levels and higher levels of unemployment which lead to higher rates of benefits claimants suffering from mental or behavioural disorders.

In addition County Durham and Darlington also has significant challenges relating to geography and rurality with issues ranging from transportation and accessibility of services to the use of local facilities. There are also significant pockets of deprivation and disadvantage in our rural areas which are often hidden as inequalities but which manifest themselves very differently to those in the more urban areas.



After two decades of population decline, the population of the County has begun to increase again. Birth rates in County Durham and Darlington have climbed steadily since 2001 and are currently at a level last seen in the late 1960s. The Government Actuary now views this as a significant change in trend.

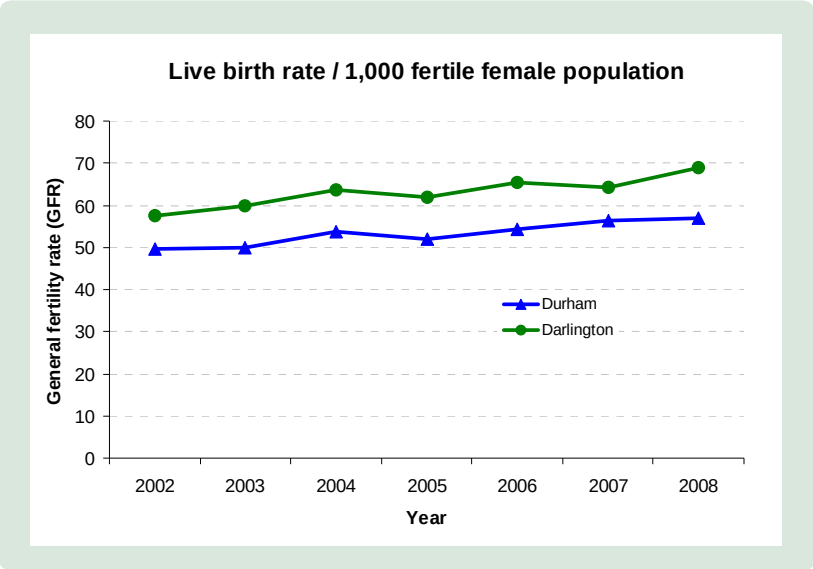


Figure 2: Increase in birth rate in recent years

In common with the rest of the country, County Durham and Darlington's age distribution is becoming older. The numbers of people in the retirement age group are predicted to peak in the year 2037, and the numbers of those aged 85+ will peak in 2056. Within the five year lifetime of the strategy the population will have grown by nearly 18,000 people and the proportion of people over 65 will have risen by over two percent.

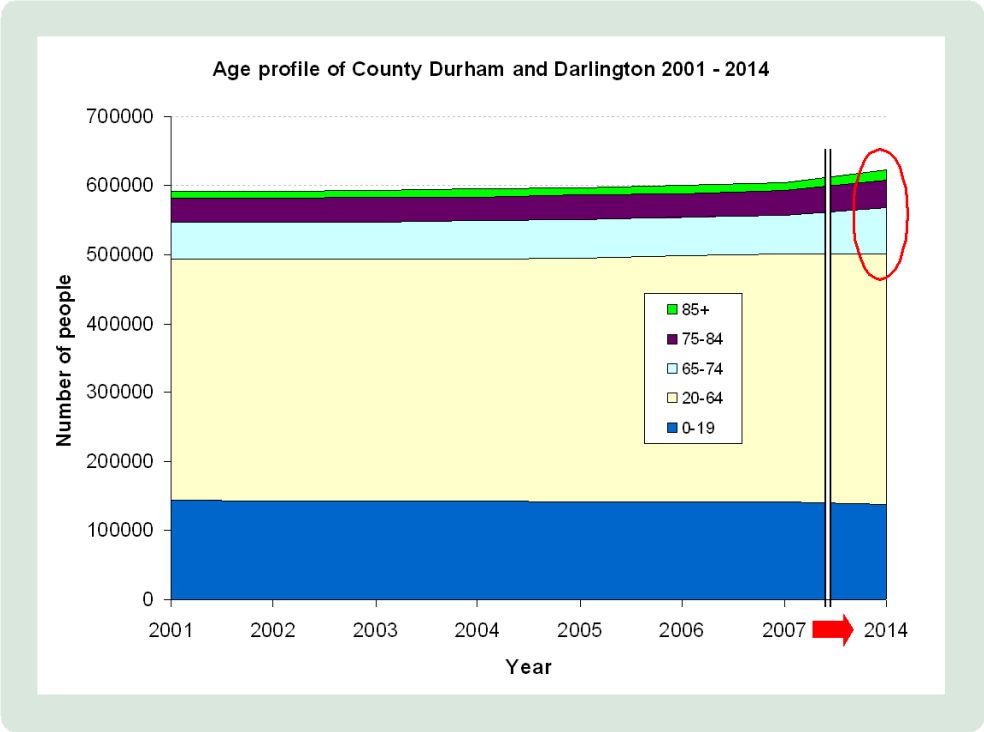


Figure 3: Growing and ageing population

A measure of the impact of the ageing population is the older person demographic dependency ratio. This is the measure of people of retirement age compared to the number of people of working age and demonstrates the increasing demands on health and social care this will have. The older person dependency ratio for County Durham and Darlington will increase significantly over the next five years and will remain well above the ratio for both the north east and England.

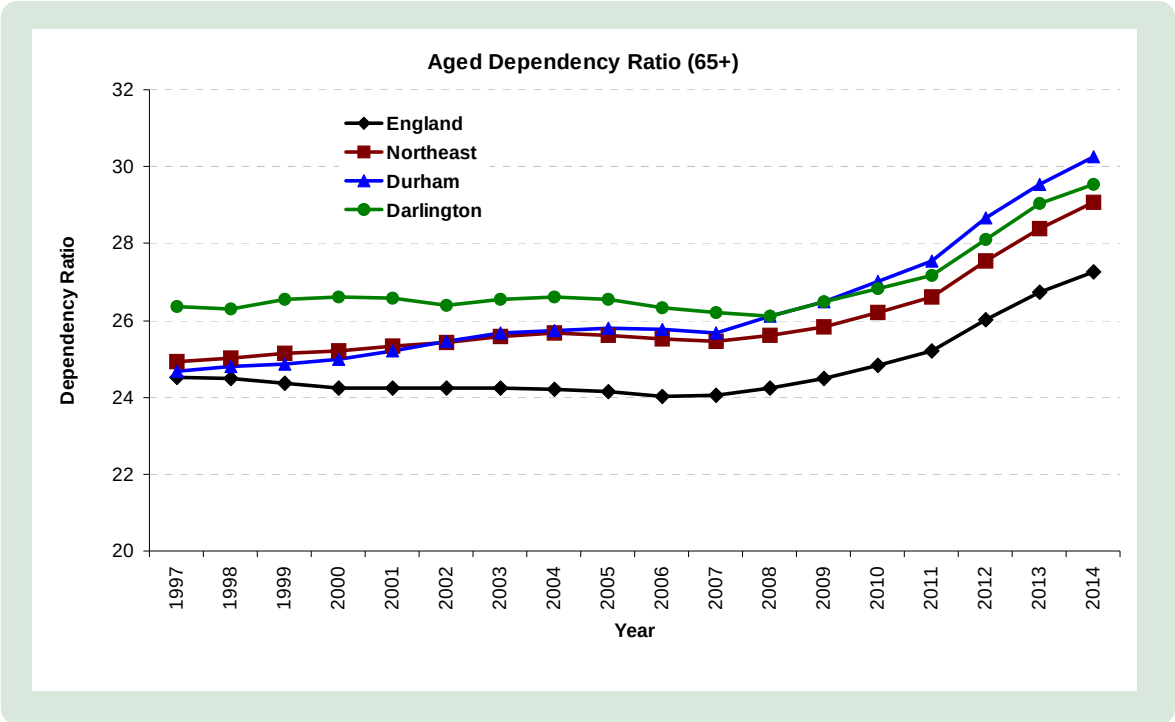


Figure 4: Older person dependency ratio (65+)

3.2 Health need

Life expectancy at birth is a summary measure of all cause mortality that quantifies the differences between areas in unit years of life. It is the average number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life. In using this measure, male and female life expectancy in Durham and Darlington are significantly lower than the national figure.

	Male	Female
County Durham	76.70	80.50
Darlington	76.30	80.50
England	77.93	82.02

Figure 5: Life expectancy within County Durham and Darlington and the national average

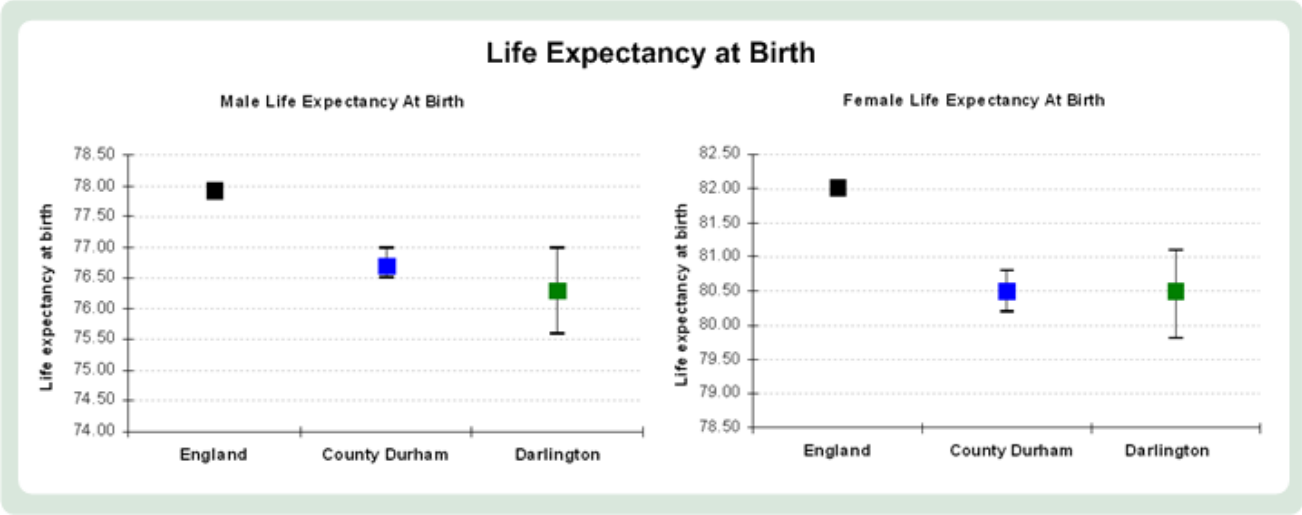


Figure 6: Life expectancy within County Durham and Darlington and gap from the national average

Life expectancy is considered a valid method of measuring health inequalities at a national level. However, a review by the Department of Health (2006) concluded that as a measure, life expectancy is not well understood and many actions undertaken by local partnerships would not reduce the gap between the fifth worst areas and the national average. In addition to this, there are many complex factors involved in determining how long people live and the long time frames involved in measuring life expectancy.

Following the Department of Health review, all age all cause mortality (AAACM) was introduced to make the process of narrowing the life expectancy gap and performance management more relevant at local levels. AAACM correlates break down mortality rates into the ages and causes of death at local authority level and allows planners of services to understand the main health issues.

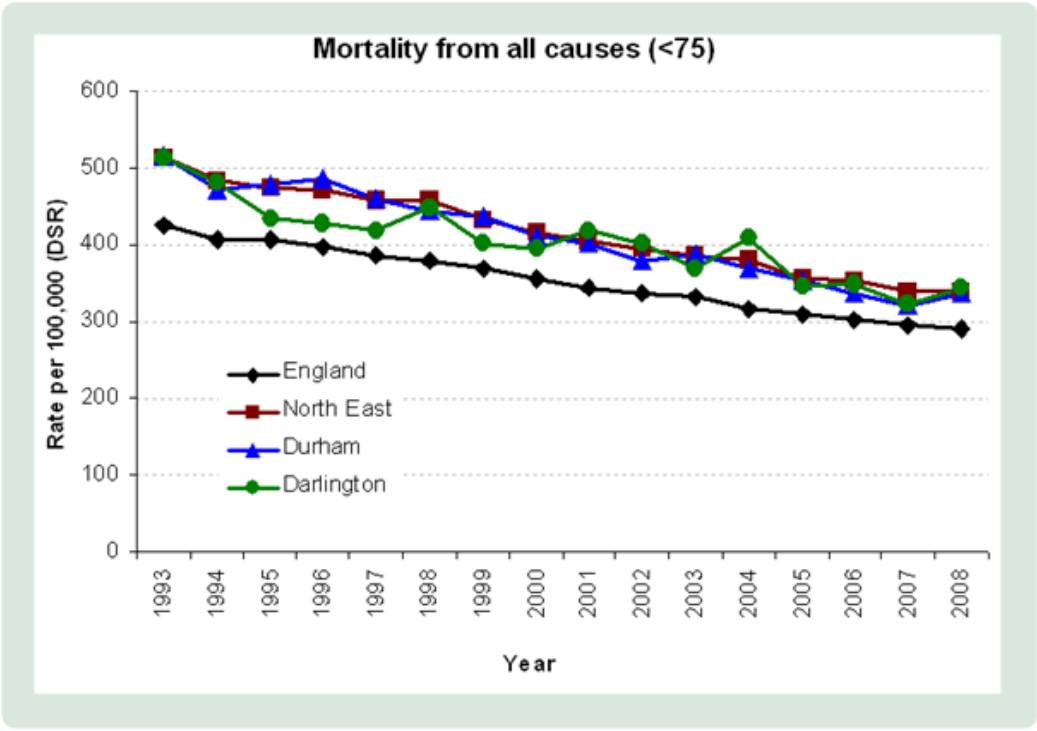


Figure 7: All age all cause mortality within County Durham and Darlington and gap from the national average

The following charts are taken from the national 2009 Community Health Profiles for County Durham and Darlington. They show how the population's health compares to the rest of England. The local result for each indicator is shown as a circle against a range of results for England which is shown as a bar.

Health summary for County Durham

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator Set 2009

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	154158	31.0	19.9	89.2		0.0
	2 Children in poverty *	21451	23.7	22.4	66.5		6.0
	3 Statutory homelessness	615	2.7	2.8	8.9		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths) *	2791	44.5	48.3	26.5		73.3
	5 Violent crime *	6981	14.0	17.6	38.4		4.8
	6 Carbon emissions *	3482	7.0	7.2	15.7		4.6
Children's and young people's health	7 Smoking in pregnancy	1250	22.5	14.7	37.8		3.7
	8 Breast feeding initiation *	2930	52.9	71.0	32.5		92.2
	9 Physically active children *	54929	90.8	90.0	77.5		100.0
	10 Obese children *	460	9.6	9.6	16.2		3.9
	11 Children's tooth decay (at age 5)	n/a		1.5	3.2		0.0
	12 Teenage pregnancy (under 18) *	456	48.6	41.2	79.1		15.0
Adults' health and lifestyle	13 Adults who smoke *	n/a	24.5	24.1	40.9		13.7
	14 Binge drinking adults	n/a	23.8	18.0	28.9		9.7
	15 Healthy eating adults	n/a	21.0	26.3	15.8		45.8
	16 Physically active adults	n/a	11.1	10.8	4.4		17.1
	17 Obese adults	n/a	25.3	23.6	31.2		11.9
Disease and poor health	18 Over 65s 'not in good health'	23629	29.8	21.5	32.5		13.5
	19 Incapacity benefits for mental illness *	13360	42.6	27.7	59.4		8.7
	20 Hospital stays for alcohol related harm *	10635	1789.2	1472.5	2615.1		639.9
	21 Drug misuse	2114	6.4	9.8	27.5		1.3
	22 People diagnosed with diabetes	20120	4.0	4.1	6.3		2.6
	23 New cases of tuberculosis	18	3.6	15.0	102.1		0.0
	24 Hip fracture in over-65s	560	544.3	479.8	699.8		219.0
Life expectancy and causes of death	25 Excess winter deaths	345	20.5	17.0	30.3		4.0
	26 Life expectancy - male *	n/a	76.5	77.7	73.2		83.7
	27 Life expectancy - female *	n/a	80.2	81.8	78.1		87.8
	28 Infant deaths	29	5.4	4.9	9.6		1.3
	29 Deaths from smoking	1072	274.6	210.2	330.2		134.4
	30 Early deaths: heart disease & stroke *	554	92.5	79.1	130.5		39.6
	31 Early deaths: cancer *	774	131.6	115.5	164.3		75.7
	32 Road injuries and deaths *	227	45.5	54.3	188.3		18.4

Figure 8: Community Health Profile 2009 for County Durham

Health summary for Darlington

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator Set 2009

England Worst | Regional average | England Average | England Best | 25th Percentile | 75th Percentile

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	23679	24.0	19.9	89.2		0.0
	2 Children in poverty *	4612	23.7	22.4	66.5		6.0
	3 Statutory homelessness	11	0.2	2.8	8.9		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths) *	588	47.7	48.3	26.5		73.3
	5 Violent crime *	1644	16.6	17.6	38.4		4.8
	6 Carbon emissions *	773	7.8	7.2	15.7		4.6
Children's and young people's health	7 Smoking in pregnancy	274	21.3	14.7	37.8		3.7
	8 Breast feeding initiation *	746	57.9	71.0	32.5		92.2
	9 Physically active children *	11335	88.6	90.0	77.5		100.0
	10 Obese children *	111	10.0	9.6	16.2		3.9
	11 Children's tooth decay (at age 5)	n/a		1.5	3.2		0.0
	12 Teenage pregnancy (under 18) *	103	53.0	41.2	79.1		15.0
Adults' health and lifestyle	13 Adults who smoke *	n/a	27.9	24.1	40.9		13.7
	14 Binge drinking adults	n/a	25.3	18.0	28.9		9.7
	15 Healthy eating adults	n/a	20.5	26.3	15.8		45.8
	16 Physically active adults	n/a	11.2	10.8	4.4		17.1
	17 Obese adults	n/a	22.9	23.6	31.2		11.9
Disease and poor health	18 Over 65s 'not in good health'	3669	22.6	21.5	32.5		13.5
	19 Incapacity benefits for mental illness *	2330	38.4	27.7	59.4		8.7
	20 Hospital stays for alcohol related harm *	2155	1886.2	1472.5	2615.1		639.9
	21 Drug misuse	754	11.7	9.8	27.5		1.3
	22 People diagnosed with diabetes	4240	4.2	4.1	6.3		2.6
	23 New cases of tuberculosis	n/a	n/a	15.0	102.1		0.0
	24 Hip fracture in over-65s	115	546.2	479.8	699.8		219.0
Life expectancy and causes of death	25 Excess winter deaths	53	15.3	17.0	30.3		4.0
	26 Life expectancy - male *	n/a	76.3	77.7	73.2		83.7
	27 Life expectancy - female *	n/a	80.4	81.8	78.1		87.8
	28 Infant deaths	9	6.9	4.9	9.6		1.3
	29 Deaths from smoking	177	229.3	210.2	330.2		134.4
	30 Early deaths: heart disease & stroke *	95	84.6	79.1	130.5		39.6
	31 Early deaths: cancer *	133	120.1	115.5	164.3		75.7
	32 Road injuries and deaths *	46	46.6	54.3	188.3		18.4

Figure 9: Community Health Profile 2009 for Darlington

3.3 Health inequalities

The Index of Multiple Deprivation combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation. The domains within this index include:

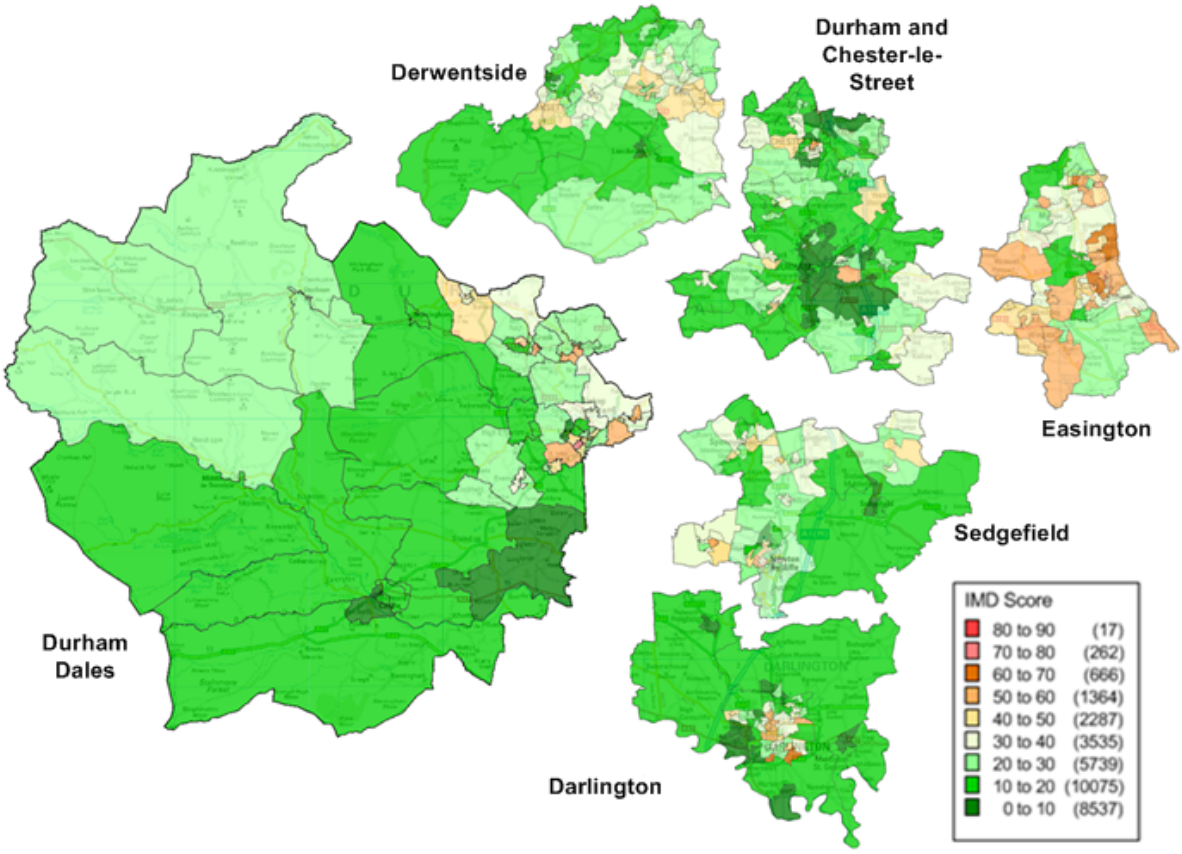
- Income
- Employment
- Health and disability
- Education, skills and training
- Barriers to housing and services
- Crime
- Living environment

The Health and disability domain is calculated from the Years of Potential Life Lost 2001 to 2005), the comparative Illness and Disability Ratio and measures of acute morbidity, derived from Hospital Episode Statistics (2004 – 2005).

Health inequalities exist between the populations of County Durham and Darlington and the rest of England. The analysis shows health inequalities across County Durham and Darlington are persistent and pervasive.

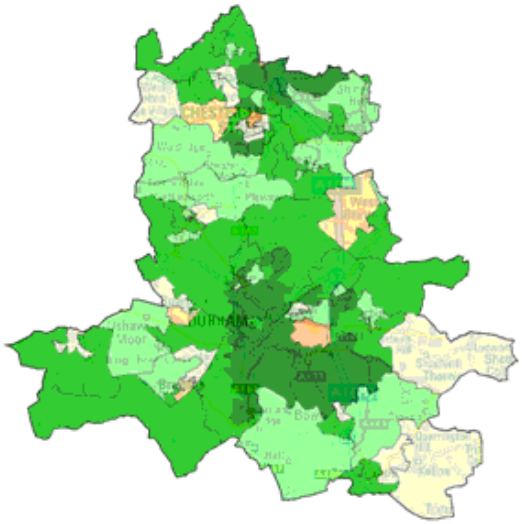
The higher the index is, the higher the level of deprivation in that area. The highest ranked index in the country is 48.26. In 2007 County Durham had an index of 27.13 and was ranked 52 out of 152; Darlington had an index of 24.16 and was ranked 72.

The analysis also shows that there are significant health inequalities between communities in County Durham and Darlington. The map below shows the areas of highest health inequalities within each of the districts of County Durham and Darlington.



These variations are often driven by underlying risk factors such as smoking, obesity and alcohol misuse. Each district has its own set of priorities and needs as described in the following charts (based on the 2008 Community Health Profiles). A green status on an indicator shows better or the same performance than the national average, orange worse than the national average but better than the county average whilst red means worse than both the national and county average.

Durham and Chester-le-Street Locality



Locality information

Risk factors:

Outcome	Dur	CLS	Co. D	Eng
Alcohol related admissions	262.9	295.3	316.3	260.3
Adults who smoke	23.2	23.9	24.5	24.1
Obesity (Childhood)	9.0	8.4	9.7	9.9
Obesity (Adult)	23.8	24.5	25.3	23.6

Health outcomes:

Outcome	Dur	CLS	Co	Eng
Life expectancy (Male)	77.2	75.9	75.9	77.3
Life expectancy (Female)	80.4	80.4	79.9	81.6
Early Deaths: Cancer	120.9	136.6	133.1	117.1
Early Deaths: Heart disease	91.5	86.5	101.2	84.2

Derwentside Locality

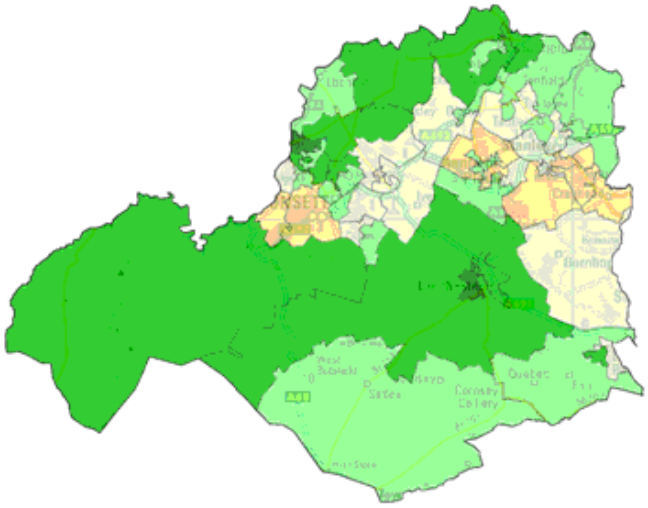
Locality information

Risk factors:

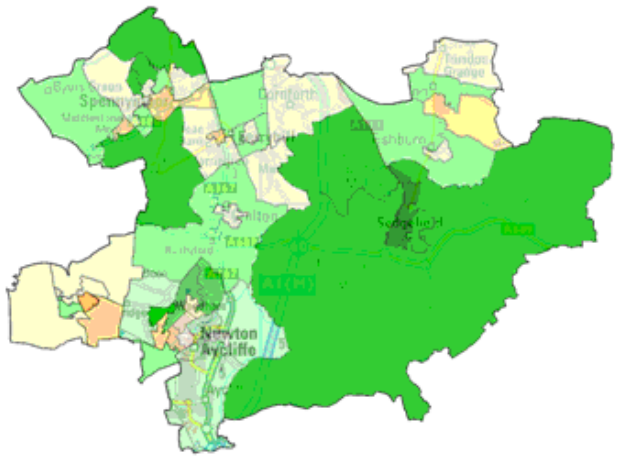
Outcome	Der	Co. D	Eng
Alcohol related admissions	317.8	316.3	260.3
Adults who smoke	25.5	24.5	24.1
Obesity (Childhood)	10.6	9.7	9.9
Obesity (Adult)	25.9	25.3	23.6

Health outcomes:

Outcome	Der	Co. D	Eng
Life expectancy (Male)	75.4	75.9	77.3
Life expectancy (Female)	80.1	79.9	81.6
Early Deaths: Cancer	131.0	133.1	117.1
Early Deaths: Heart disease	113.5	101.2	84.2



Sedgefield Locality



Locality information

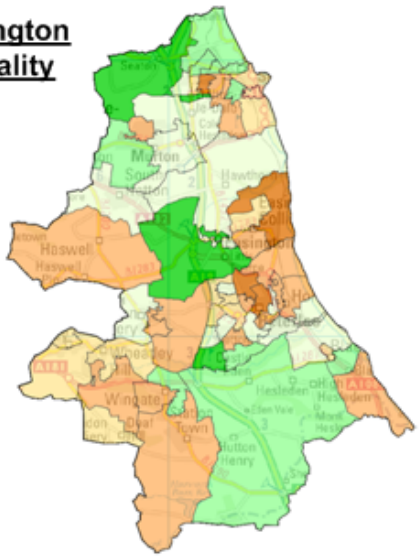
Risk factors:

Outcome	Sed	Co. D	Eng
Alcohol related admissions	353.7	316.3	260.3
Adults who smoke	27.3	24.5	24.1
Obesity (Childhood)	11.8	9.7	9.9
Obesity (Adult)	27.2	25.3	23.6

Health outcomes:

Outcome	Sed	Co. D	Eng
Life expectancy (Male)	76.2	75.9	77.3
Life expectancy (Female)	79.6	79.9	81.6
Early Deaths: Cancer	150.6	133.1	117.1
Early Deaths: Heart disease	100.3	101.2	84.2

Easington Locality



Locality information

Risk factors:

Outcome	Eas	Co. D	Eng
Alcohol related admissions	366.9	316.3	260.3
Adults who smoke	24.1	24.5	24.1
Obesity (Childhood)	9.1	9.7	9.9
Obesity (Adult)	28.9	25.3	23.6

Health outcomes:

Outcome	Eas	Co. D	Eng
Life expectancy (Male)	74.9	75.9	77.3
Life expectancy (Female)	79.2	79.9	81.6
Early Deaths: Cancer	136.6	133.1	117.1
Early Deaths: Heart disease	111.6	101.2	84.2

Locality information

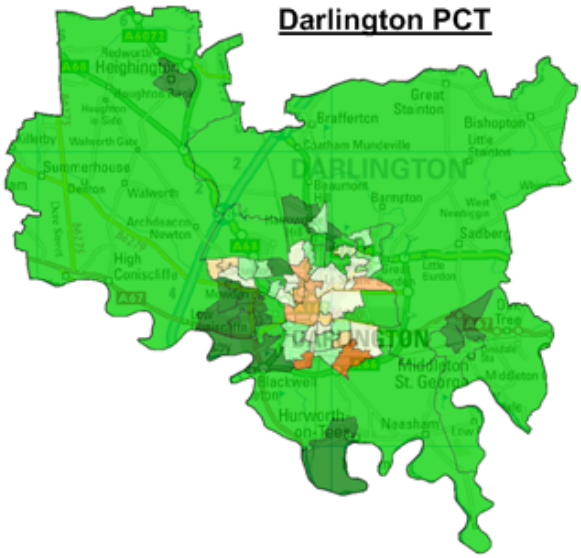
Risk factors:

Outcome	Dar	Co. D	Eng
Alcohol related admissions	432.0	316.3	260.3
Adults who smoke	27.9	24.5	24.1
Obesity (Childhood)	10.7	9.7	9.9
Obesity (Adult)	22.9	25.3	23.6

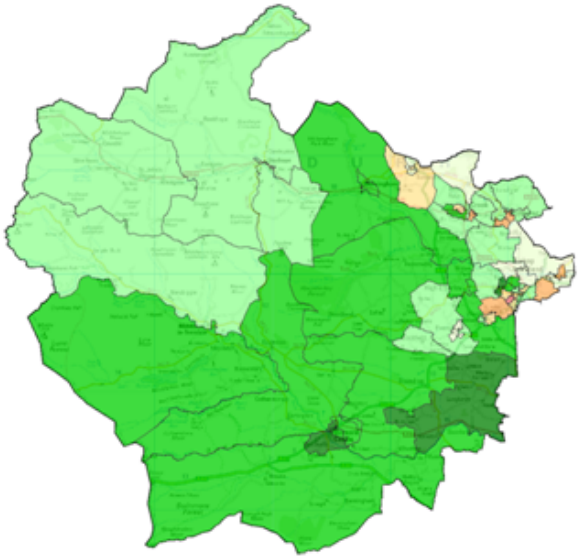
Health outcomes:

Outcome	Dar	Co. D	Eng
Life expectancy (Male)	75.2	75.9	77.3
Life expectancy (Female)	80.0	79.9	81.6
Early Deaths: Cancer	126.6	133.1	117.1
Early Deaths: Heart disease	93.1	101.2	84.2

Darlington PCT



Durham Dales Locality



Locality information

Risk factors:

Outcome	Wear	Tees	Co. D	Eng
Alcohol related admissions	343.2	241.9	316.3	260.3
Adults who smoke	27.9	21.1	24.5	24.1
Obesity (Childhood)	10.6	4.9	9.7	9.9
Obesity (Adult)	26.1	26.3	25.3	23.6

Health outcomes:

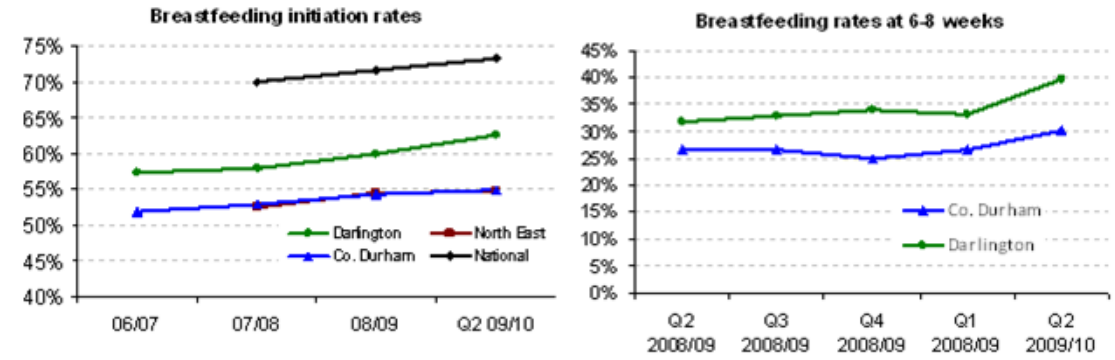
Outcome	Wear	Tees	Co. D	Eng
Life expectancy (Male)	75.7	76.7	75.9	77.3
Life expectancy (Female)	79.1	82.1	79.9	81.6
Early Deaths: Cancer	128.4	119.6	133.1	117.1
Early Deaths: Heart disease	113.1	62.0	101.2	84.2

3.4 Specific health issues

Breastfeeding rates have been identified as a priority area for County Durham and Darlington.

Breastfeeding rates

What health needs analysis tells us



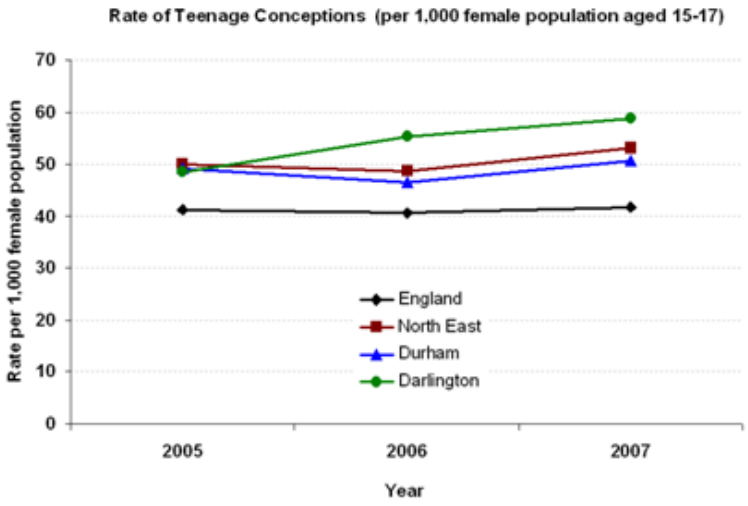
The health needs analysis shows:

- There is overwhelming evidence to demonstrate that children who are breastfed have better long term and short term health outcomes compared with children who are not breast fed or who are only breastfed for a short period of time.
- Children who are breastfed are also less likely to become obese in childhood.
- County Durham and Darlington have significantly lower initiation and maintenance breastfeeding rates than the England average.

Teenage conceptions rates have been identified as a priority area for County Durham and Darlington.

Teenage conception rates

What health needs analysis tells us



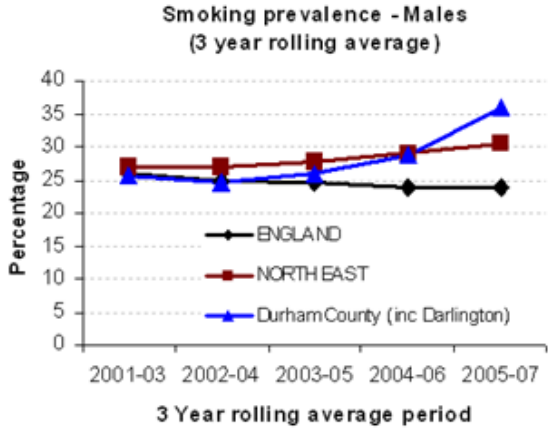
The health needs analysis shows:

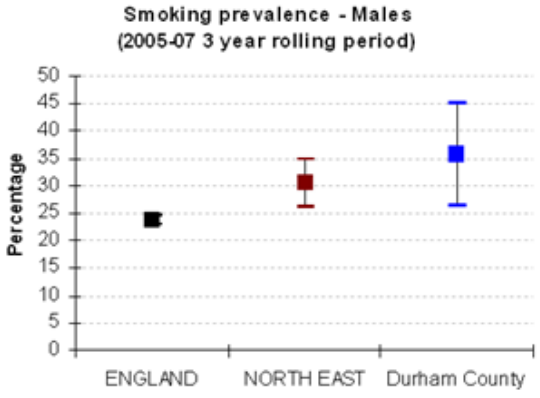
- Compared to the England average Co Durham and Darlington has significantly higher rates of under 18 conceptions.
- 15-17 year old rates in County Durham and Darlington are 50.7 and 58.8 per 1000 population respectively compared to a national average of just 41.7

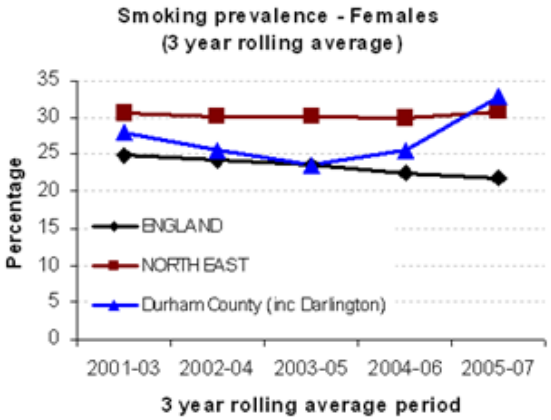
Smoking accounts for between a quarter and a half of the gap in mortality between social classes and can lead to significantly increased risk of coronary heart disease and cancer.

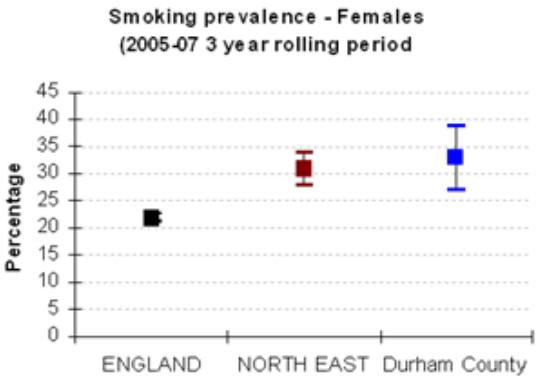
Smoking prevalence

What health needs analysis tells us









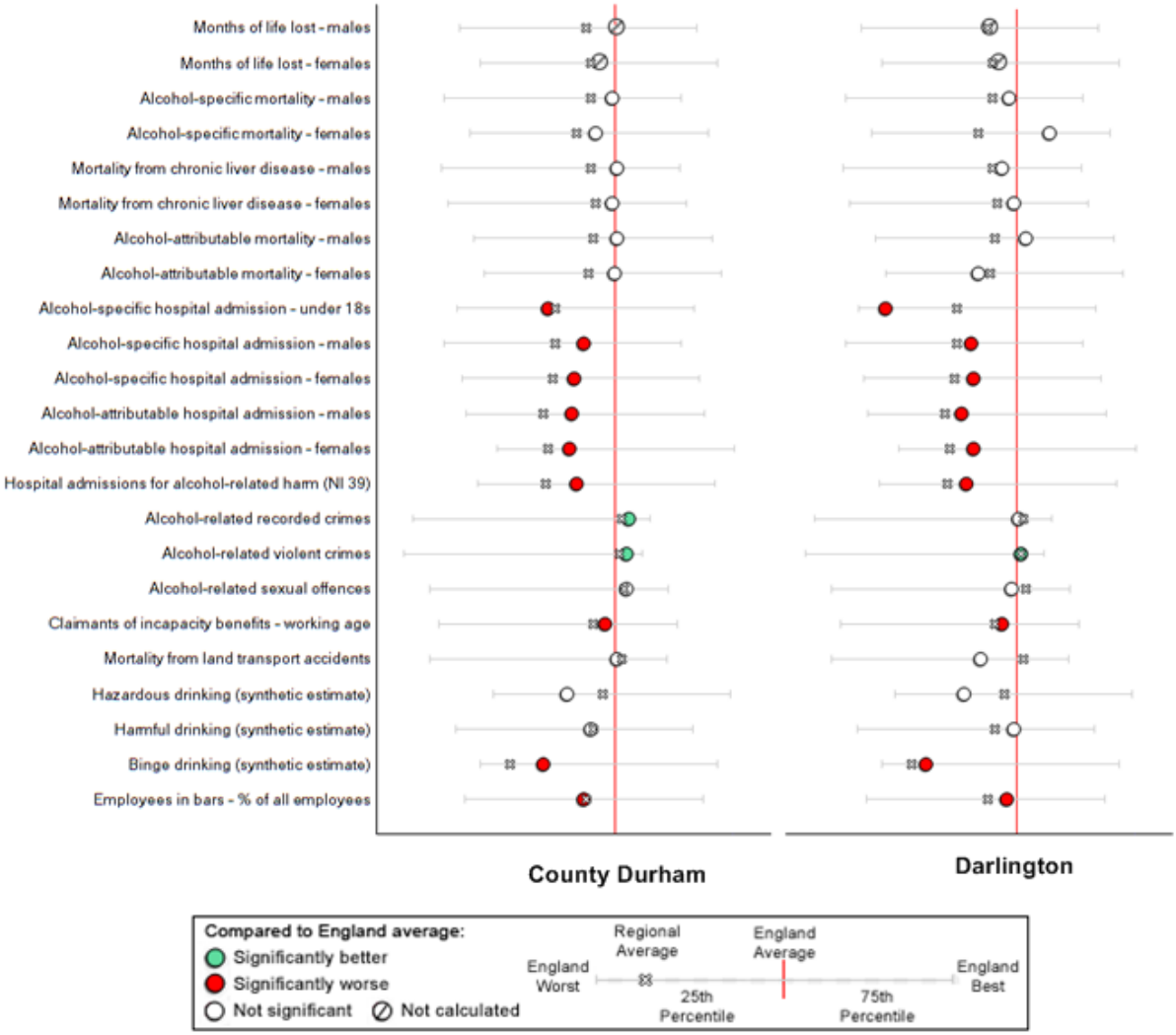
The health needs analysis shows:

- Smoking is the single biggest contributor to the shorter life expectancy experienced locally.
- Smoking accounts for more than 50% of the gap in life expectancy in County Durham and Darlington and is the premature and principal cause of avoidable cause of illness and disability.
- These prevalence figures are based on the results of the General Household Survey and show the percentage of current smokers aged 16 years and over. The graphs show the rolling 3-year average from 2001 to 2007. For both males and females there has been a marked increase in smoking prevalence since 2003-05. Both males and females in county Durham and Darlington have significantly higher smoking prevalence rates than the national average. At a district/county level the prevalence figures from these national surveys may become less accurate. Using data from GP practices we estimate that the smoking prevalence in County Durham in 2007/08 is 25%.

The misuse of alcohol is one of the key risk factors driving ill health in later life.

Alcohol misuse

What health needs analysis tells us



The health needs analysis shows:

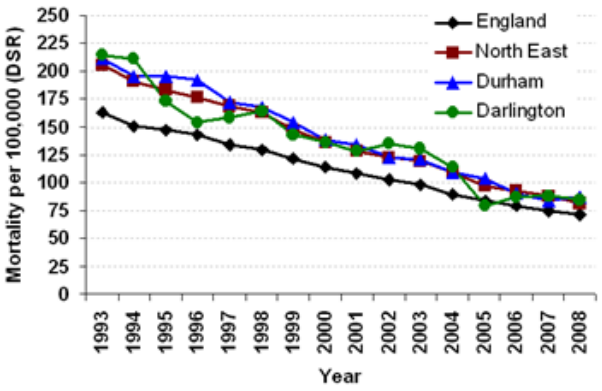
- The prevalence of binge drinking is significantly worse than the England average.
- The national indicator for monitoring alcohol misuse is the rate of admissions for alcohol-related harm per 100,000 population. The rate for Darlington and County Durham in 2006/7 was significantly higher than the national rate, and rates in Sedgefield and Easington are significantly higher than the national rates.
- Alcohol related admissions for under 18s in Wear Valley and Darlington are amongst the highest admission rates in England.

Cardiovascular disease (include coronary heart disease and strokes) is one of the biggest killers in County Durham and Darlington.

Cardiovascular disease mortality

What health needs analysis tells us

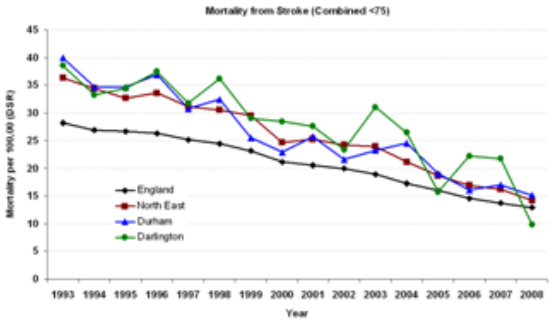
Mortality from all Circulatory Diseases (Combined <75)



The health needs analysis shows:

- CVD mortality is the biggest single contributor to the gap in life expectancy between Co Durham and Darlington and England
- The SMR from all circulatory diseases in County Durham is 116 and for Darlington 113 (significantly worse than England)

Stroke



The health needs analysis shows:

- There are approximately 1,300 strokes in County Durham and Darlington each year of which 20-30% die within one month.

Coronary Heart Disease

The health needs analysis shows:

- Coronary heart disease (CHD) kills more than 110,000 people in England every year.

More than 1.5million people suffer from angina and 275,000 people have a heart attack annually.

- A significant gap remains in CHD mortality between County Durham and Darlington and England
- A health equity audit (Mending Hearts, 2005) identified that across County Durham there was a significant relationship between deprivation and mortality rates.

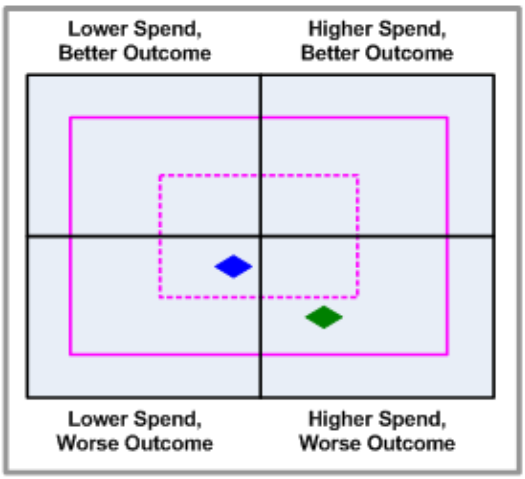
What our healthcare market analysis tells us

Providers:

- The provider landscape for CVD is dominated by County Durham and Darlington NHS Foundation Trust accountable for 70.6% of total market expenditure
- The remaining market share is divided between the community setting and other North East NHS Foundation Trusts, causing this market to heavily dominated by the general hospital setting

- County Durham and Darlington Foundation Trust
- South Tees NHS Foundation Trust
- Community care and overheads
- Others
- North Tees & Hartlepool NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Newcastle upon Tyne NHS Foundation Trust

What our economic analysis tells us



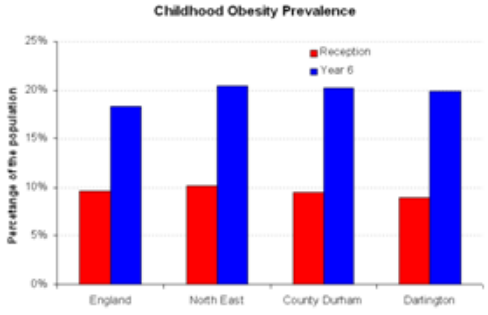
County Durham PCT's expenditure in this category is high in comparison with cluster, SHA and national averages
- National quadrant analysis shows lower spend (this refers to all circulatory disease) and worse outcomes (in terms of mortality from stroke) (not statistically significant with z score of below -1)
- There may be potential to improve outcomes within existing resource.

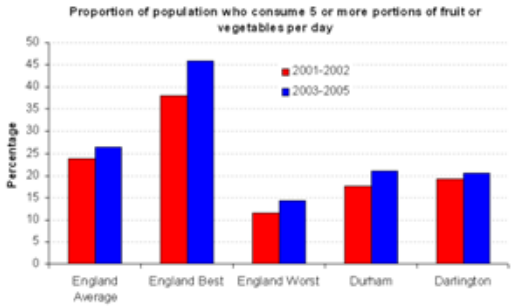
Darlington PCT's expenditure in this category is high in comparison with cluster, SHA and national averages
- National quadrant analysis shows higher spend (this refers to all circulatory disease) and worse outcomes (in terms of mortality from stroke) (z score of over -1)
- There may be potential to improve outcomes within existing resource.

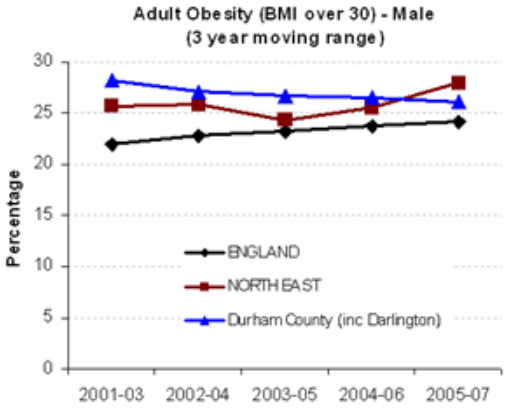
Obesity in children and adults is a major health risk in County Durham and Darlington.

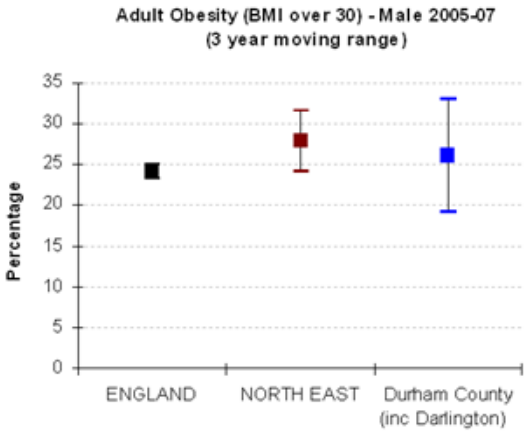
Obesity

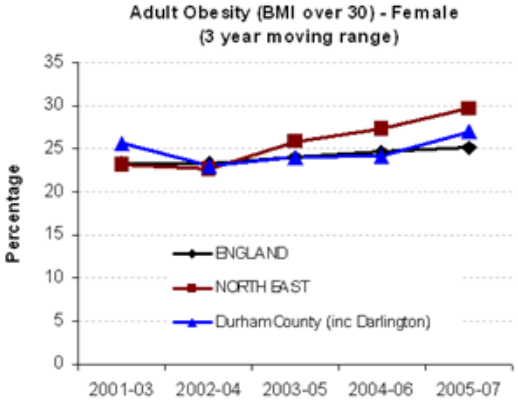
What health needs analysis tells us

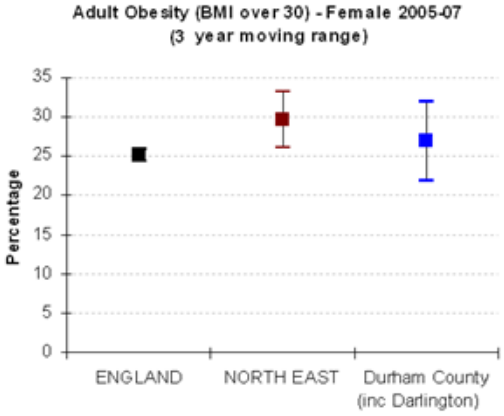






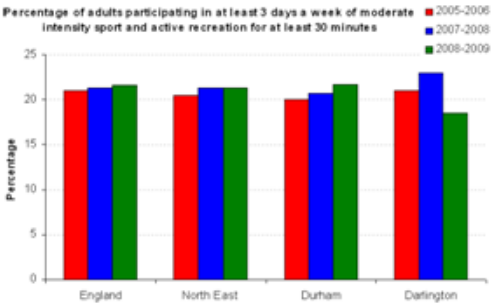






The health needs analysis shows:

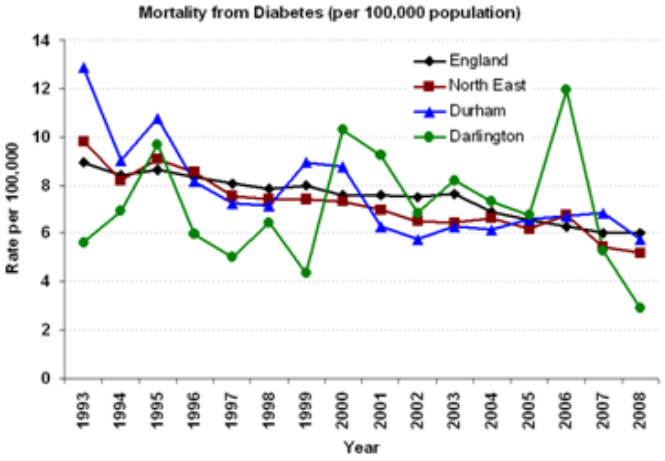
- The prevalence of obesity is increasing rapidly and it is now viewed in almost epidemic terms. Over half the UK population is overweight or obese.
- Rates of obesity in County Durham and Darlington are rising in children and adults
- For adult males there has been a steady fall in obesity and for the period 2005-07 the male prevalence of obesity is closing on the national average. For adult females there has been a slight increase in prevalence since 2002-04.
- The proportion of the population who consume 5 or more portions of fruit or vegetables per day in County Durham and Darlington is lower than the England average.



Rising levels of obesity have seen an increase in the prevalence of diabetes.

Diabetes

What health needs analysis tells us



The health needs analysis shows:

- Current prevalence across County Durham and Darlington 5.2% (SHA prevalence 5%, England Average 4.8%)
- Rising faster than, SHA and national average (QOF data)
- CVD screening and annual health checks programme are finding more undiagnosed patients
- Type 2 Diabetes prevalence linked to obesity

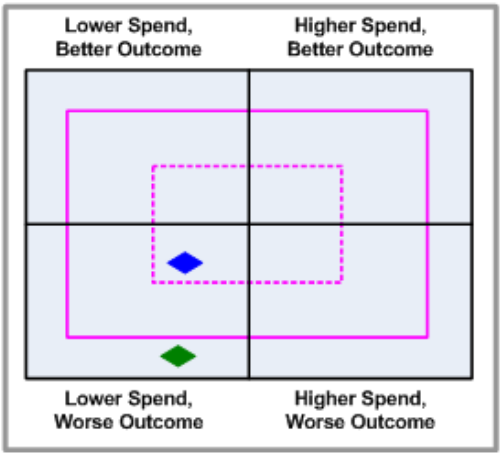
What our healthcare market analysis tells us

Providers:

- Diabetes is a fragmented market. County Durham and Darlington NHS Foundation Trust is the largest single provider and dominates the general hospital setting, but still only accounts for 7.11% of total market expenditure

County Durham and Darlington Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Newcastle upon Tyne NHS Foundation Trust
Community care and overheads
North East Ambulance Service
South Tees NHS Foundation Trust
Continuing care
Others

What our economic analysis tells us



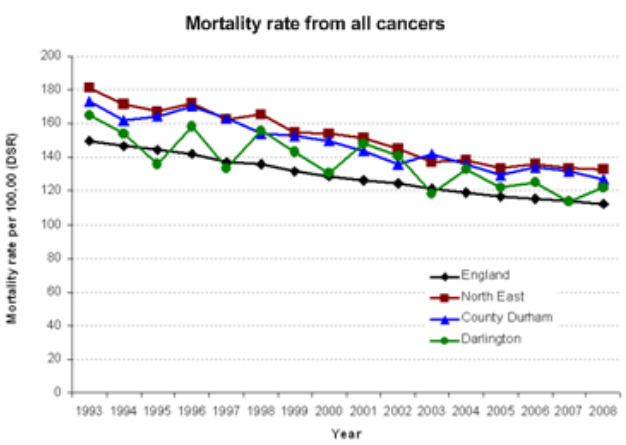
County Durham PCT's expenditure in this category is low in comparison with cluster, SHA and national averages
- National quadrant analysis (relates to all of endocrinology diseases) shows lower spend and worse outcomes (not statistically significant z score of below -1)
- There may be some potential to improve outcomes within existing resource, but it is likely that achievement of better outcomes would require additional investment in this category.

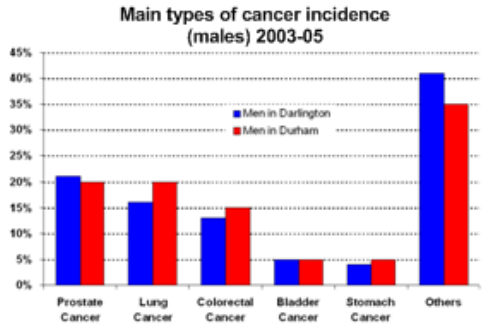
Darlington PCT's expenditure in this category is low in comparison with cluster, SHA and national averages
- National quadrant analysis (relates to all of relates to all of endocrinology diseases) shows lower spend and worse outcomes (statistically significant z score of over -2)
- Four PCTs in the industrial hinterlands A cluster achieve better outcomes for less expenditure
- There is the potential to improve outcomes within existing resource, but it is likely that achievement of better outcomes would require additional investment in this category.

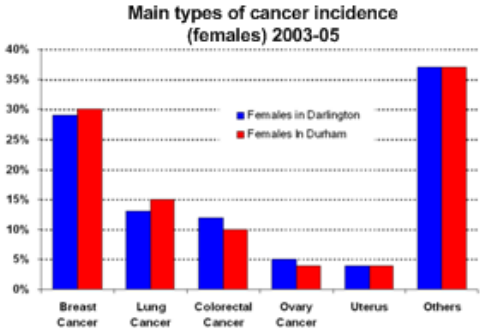
Cancer is one of the biggest killers in County Durham and Darlington.

Cancer mortality rates

What health needs analysis tells us



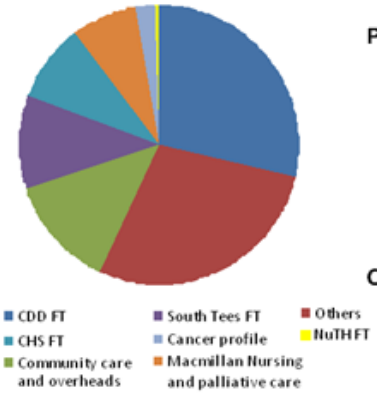




The health needs analysis shows:

- Higher mortality rates than nationally
- Relative indices of inequality of 28-60% in mortality rates between the most and least deprived wards
- Variation in survival rates
- 48% of early cancer deaths accounted for by breast, bowel and lung cancers

What our healthcare market analysis tells us



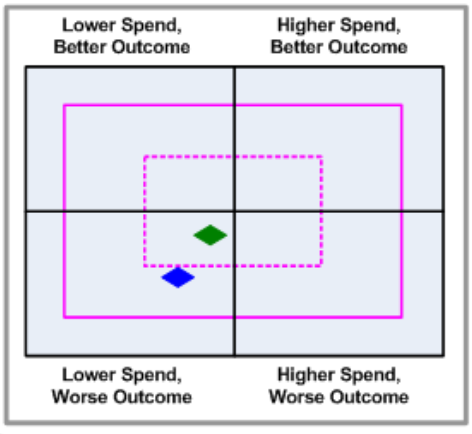
Providers:

- The provider landscape for cancer is dominated by County Durham and Darlington NHS Foundation Trust (accountable for 28.69% of total market expenditure)
- The community setting also plays an important role. One main provider, Macmillan Nursing and palliative care, accounts for 7.59% of total expenditure and is the dominant provider in the community/home setting

Opportunities:

- There are opportunities to expand the community setting and to open up the GP setting to support the need for front line early diagnosis of cancer. The HMA projects support this initiative.

What our economic analysis tells us



County Durham PCT's expenditure in this category is low in comparison with cluster, SHA and national averages

- National quadrant analysis shows lower spend and worse outcomes (z score of over -1)
- County Durham PCT may be able to achieve better outcomes but this would require additional investment in this category

Darlington PCT's expenditure in this category is slightly low in comparison with cluster and national averages

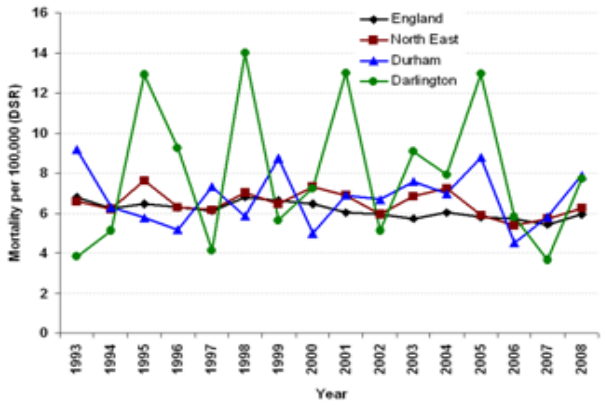
- National quadrant analysis shows lower spend and worse outcomes (not statistically significant with z score of below -1)
- Darlington PCT appears to achieve good outcomes (in terms of mortality from all cancers) for expenditure in comparison with the industrial hinterlands PCTs

Suicide rates in County Durham and Darlington exceed the national average.

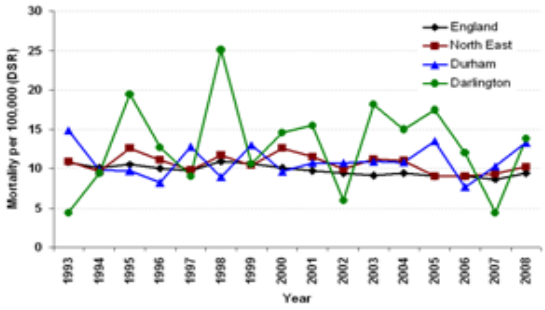
Suicide rates

What health needs analysis tells us

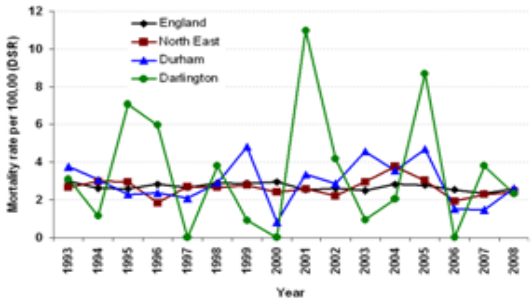
Mortality from Suicide (combined all ages)



Mortality from Suicide (Male all ages)



Mortality from Suicide (Female all ages)



The health needs analysis shows:

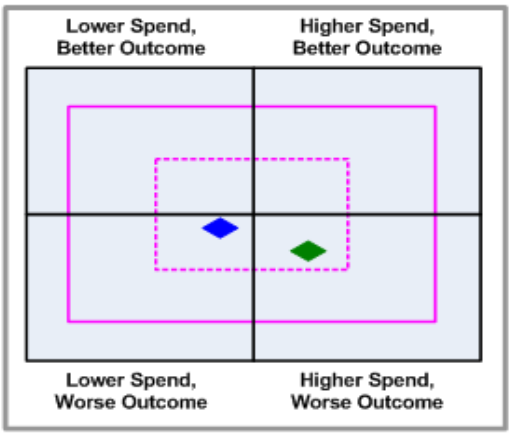
- Durham rates are consistently lower than the North East but exceed national rates
- Darlington rates fluctuate but frequently exceed national and North East rates
- Of the deaths 05-07, 80% were male and 20% female
- Rates peak for the 35-44 age group in males

What our healthcare market analysis tells us

Providers:

- The provider landscape for mental health is dominated by Tees, Esk and Wear Valleys NHS Trust accountable for 52.65% of total market expenditure
- The remaining market shares is split between a large number of small providers holding no more than 3.21% of total expenditure

What our economic analysis tells us

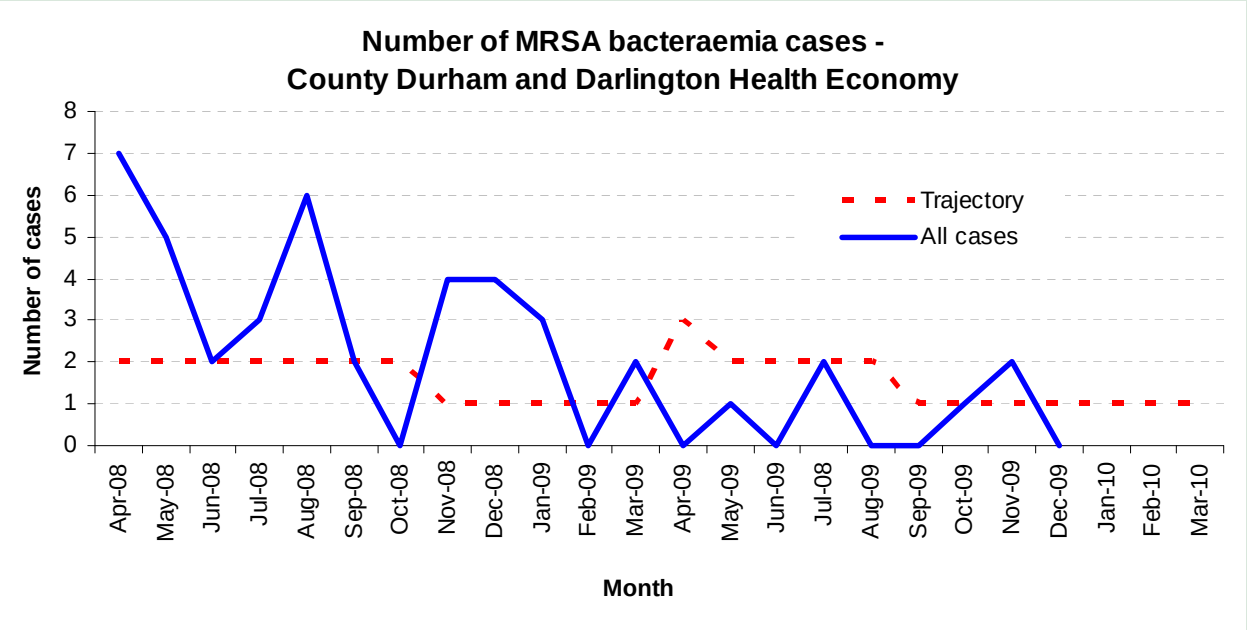


County Durham PCT's expenditure in this category is low in comparison with cluster, SHA and national averages
- National quadrant analysis shows lower spend and worse outcomes (in terms of mortality from suicide and injury undetermined) (not statistically significant with z score of below -1)
- Potential to improve outcomes (in terms of mortality and injury undetermined), but this would require increased investment in this category

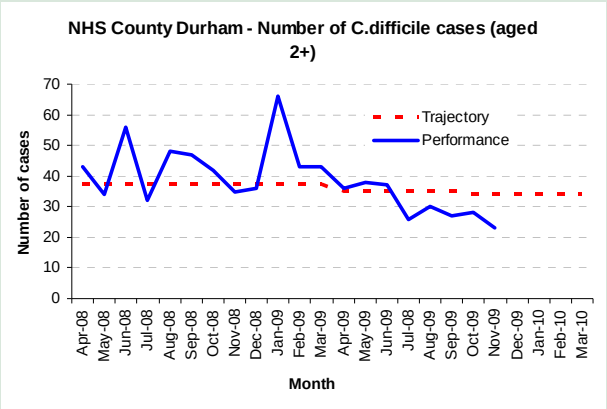
Darlington PCT's expenditure in this category is high in comparison with cluster and national averages
- National quadrant analysis shows higher spend and worse outcomes (in terms of mortality from suicide and injury undetermined) (not statistically significant with z score of below -1)
- Potential to improve outcomes (in terms of mortality for suicide and injury undetermined) and reduce investment

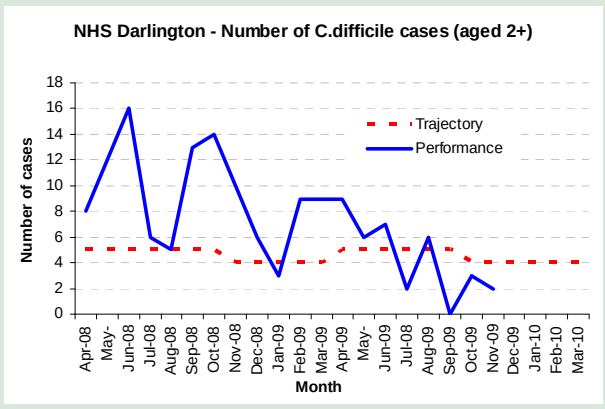
3.5 Clinical quality and performance against existing local and national targets

Following a review of the high incidence of MRSA across the County Durham and Darlington health economy, several measures have been put in place to tackle this issue over the last 18 months. Since then, significant improvements have been made and are being sustained.



A range of initiatives have also been put in place over the last twelve months across the County Durham and Darlington health economy to reduce the number of clostridium difficile cases being reported. Significant improvements have been made and are being sustained.





Whilst developing this strategy we also considered our current performance against national and local targets and priorities in order to understand the impact our commissioning has in health and healthcare.

National targets

Strong performance:
- VSA03: incidence of C.difficile
- VSA04: 18 weeks
- VSB05: smoking quitters
- VSB06: early access to maternity services

Disappointing performance and risks:
- VSA14: stroke
- VSB08: under 18 conception rate
- VSB10: immunisation rates
- VSB14: chlamydia screening
- VSB18: dental access

Mitigating actions:
- VSA14: working with providers to improve data quality
- VSB08: implementation of teenage pregnancy toolkit
- VSB10: one clinical system used by all; work with GPs to further improve rates; run catch-up programme
- VSB14: new laboratory tender to commence April 2010; continue social marketing approaches
- VSB18: strict performance management of contracts

Local targets and priorities

Strong performance:
- MRSA screening of non-elective admissions
- Number of delayed transfers of care per 100,000 population
- Timeliness of social care assessment

Disappointing performance and risks:
- Choose & book utilisation
- Slot availability
- Ambulance response times at PCT level

Mitigating actions:
- Work with PBC groups and providers to improve.
- Close performance management of providers regarding slot polling.
- Detailed data at PCT level to be routinely received and performance managed.

World Class Commissioning

Strong performance:
- Breastfeeding at 6-8 weeks
- Proportion of deaths that occur at home

Disappointing performance and risks:
1) Cancer / CVD mortality
2) Suicide and injury undetermined mortality
3) Smoking quitters
4) Under 18 conception rate
5) All age all cause mortality

Mitigating actions general:
- Secure sufficient funding to allow challenging targets to be achieved.
- Benchmark and learn from strongly performing / most improved organisations to ensure most value for money.
- Develop detailed analysis of the components of the indicators to allow more targeted interventions.

Mitigating actions specific:
1) Cancer awareness training programme / continue roll out of health checks programme.
2) Suicide prevention training and workforce development with providers.
3) Develop additional pharmacy based service and continue joint working with FRESH North East.
4) Improve access to contraception and sexual health services.
5) Complete analysis of data to ensure targeted interventions in appropriate areas.

3.6 Insights from patients, public, clinicians and local partners

In NHS County Durham and Darlington we place real value on the insights provided by our public and other stakeholders. We actively use these insights to shape our strategic direction and inform the commissioning of services. Below is a summary of the various methods used to gain these insights:

Public engagement

- A programme of public stakeholder events have taken place to discuss, challenge and comment on strategy, commissioning intentions. In addition, the concept of commissioning for public value and the development of stakeholder criteria were introduced and explored as a national pilot site for the NHS Institute of Innovation and Improvement
- A commissioning intentions document was sent to over a 1,000 people from our database including members of the public, voluntary and community sector partners, providers and patient/carer network
- A web-based consultation site was established ("have your say")
- Focus groups with a range of seldom heard groups have taken place including children and young people, mental health service users and carers, deaf and deafened people, people with a learning disability, older people and those from rural areas
- The work of our Local Involvement Networks has been supported
- Social marketing techniques are being used

Patients and Carers

- Hard and soft data relating to patient and carer experience, such as SUIs, complaints, PALS, NHS Choices, national and local patient surveys, is explored and discussed at our Quality Review Groups
- The results of patient surveys are scrutinised and action plans produced
- All service specifications have clear reference to the responsibility of providers to collect, analyse and action plan in respect of patient/carer experience
- Focus groups and interviews and surveys have been undertaken in relation to a number of service developments including:
  - stroke services
  - diabetes
  - living with dementia
  - intermediate care
  - offender health services
  - sexual health services

Clinicians

- Clinical programme groups were established to bring together a range of clinicians and clinical champions
- The Durham Dales Integrated Care pilot provided a further opportunity for clinicians to be integrated into the process of identifying and agreeing future direction
- The relationship with our PBC clusters has strengthened and is also a key element of engaging with clinicians
- Separate stakeholder events for clinicians were organised in relation to commissioning for public value and stakeholder criteria

Partners

- A number of joint posts with our local authorities e.g. in relation to joint commissioning and scrutiny have facilitated early discussion and joint consultation and engagement activities. These joint posts have joint accountability and governance arrangements in place.
- Work on implementing "Seizing the Future" proposals with County Durham and Darlington Foundation Trust has continued and there is multi-stakeholder
- membership of the oversight group monitoring this work
- The Durham Dales Integrated Care Pilot has work streams linked to the priority areas and these all have multi-stakeholder membership

PCT staff

- A regular internal staff bulletin is produced
- Board meetings including programmed public board seminars
- Directorate meetings
- Annual conference
- Leadership Group Meetings

Our engagement activities have identified issues of concern in the following areas and these are reflected in our strategic goals and key delivery programmes.

What our patients said to us

Maternity and Newborn services

"There is not as much support for individuals wishing to breastfeed as is needed – this is often done on the ward in front of other patients."

"There aren't as many regular visits from midwives and health visitors as there used to be - are young parents ready to go home after 24 hours if there isn't sufficient support?"

Planned and Acute

"Clear information is needed for patients so that people know exactly what is and isn't possible in relation to care and aftercare – discharge information is particularly important."

"The personal touch is missing from care – small things can make a big difference to the quality of patient experience"

Long Term Conditions

"A greater focus is needed in diabetes care in relation to prevention, early diagnosis and intervention."

"More information is needed for patients and carers so that they understand their condition – this should be clear and consistent"

"Care should be more patient-centred/led rather than "we know best" attitude"

Child Health

"More support in schools would be beneficial."

"More emphasis on prevention is needed."

Mental Health Services

"Improved joint working is needed and preventing mental health problems should also be a priority. Mental health is a particular issue and is likely to get worse in the current economic climate."

"Relationships with the voluntary and community sector are needed, as they are a support mechanism for those with mental health problems"

End of Life Care

"As a population (in County Durham) we need to start talking about death and how we'd like to die. Until we do that we'll never get the service we need at the end of our life"

"Support networks are not always developed for conditions other than cancer"

Staying Healthy

"Use a variety of means to get healthy messages across e.g. youth clubs, WI, employers, education."

"Introduce annual health checks and "Wellness" clinics"

What else we heard

Access

- Concerns with access to transport and information. To address this, a multi agency, "Transport to Health Group" has been working to initiate improvements. For example, a health bus link service has been introduced to improve access for those living in some of our more outlying areas. The work of this group will continue to monitor transport concerns and seek improvements.
- Concerns with information. Our communications and engagement strategy recognises the need for increased information and an on-line survey has produced valuable information to help us with this. In addition, we will be carrying out further work in engaging with our local communities to establish local perceptions on what, how and when information is best disseminated.

Inequalities in healthcare

- Concerns from seldom heard groups. These groups often experience the worst inequalities and we will be carrying out further social marketing exercises to explore how best to support these communities to stay health and to access services in an equitable manner.
- Concerns with levels of engagement with partners. We will work with our local strategic partnerships and our voluntary and community sector to ensure that we take a more proactive approach to addressing inequalities.

3.7 Current provider landscape

NHS County Durham and Darlington commissions services from a wide range of providers, delivered in a diverse range of healthcare settings. Providers include large specialist and district general hospitals, general practices, dentists, optometrists and pharmacists, community services like health visitors and district nurses and private sector providers.

Figure 10 identifies by setting our investment in 2007/08 into each setting.

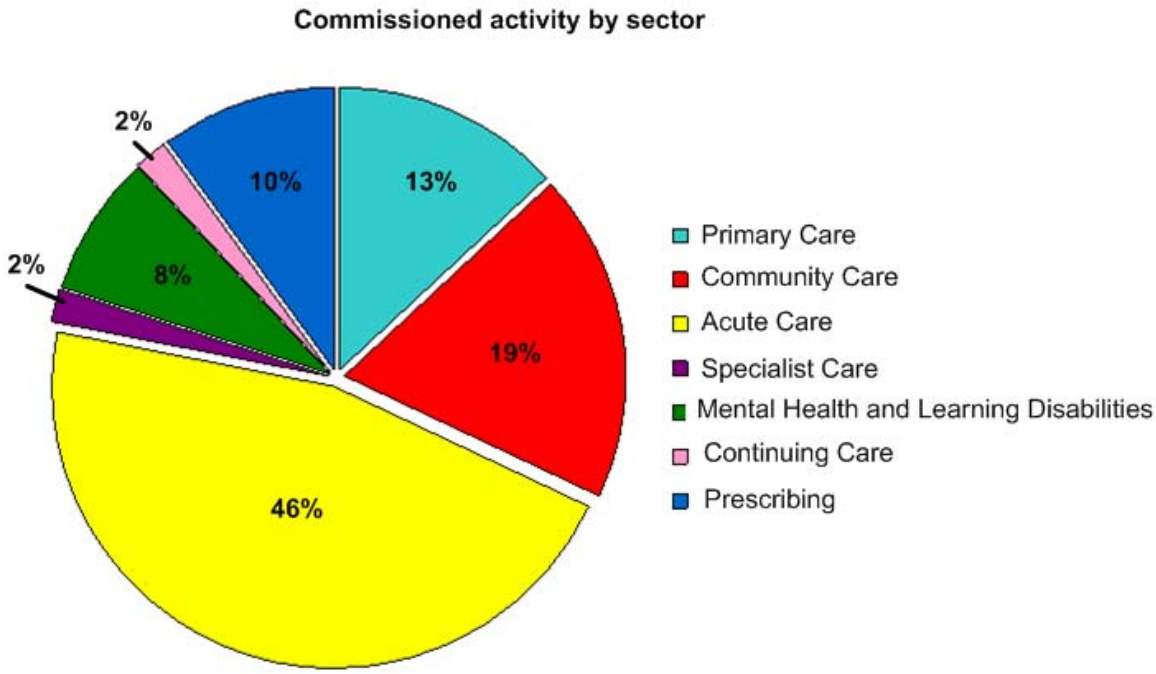


Figure 10: Commissioned activity by sector (source: 2007/08 Programme Budget Data)

Acute services

County Durham and Darlington NHS Foundation Trust is the main provider within the acute setting with 56% of our total acute commissioning investment in 2007/08 (as described in figure 11). Due to its geography people from parts of County Durham and Darlington will access hospital services from North Tees and Hartlepool NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust.

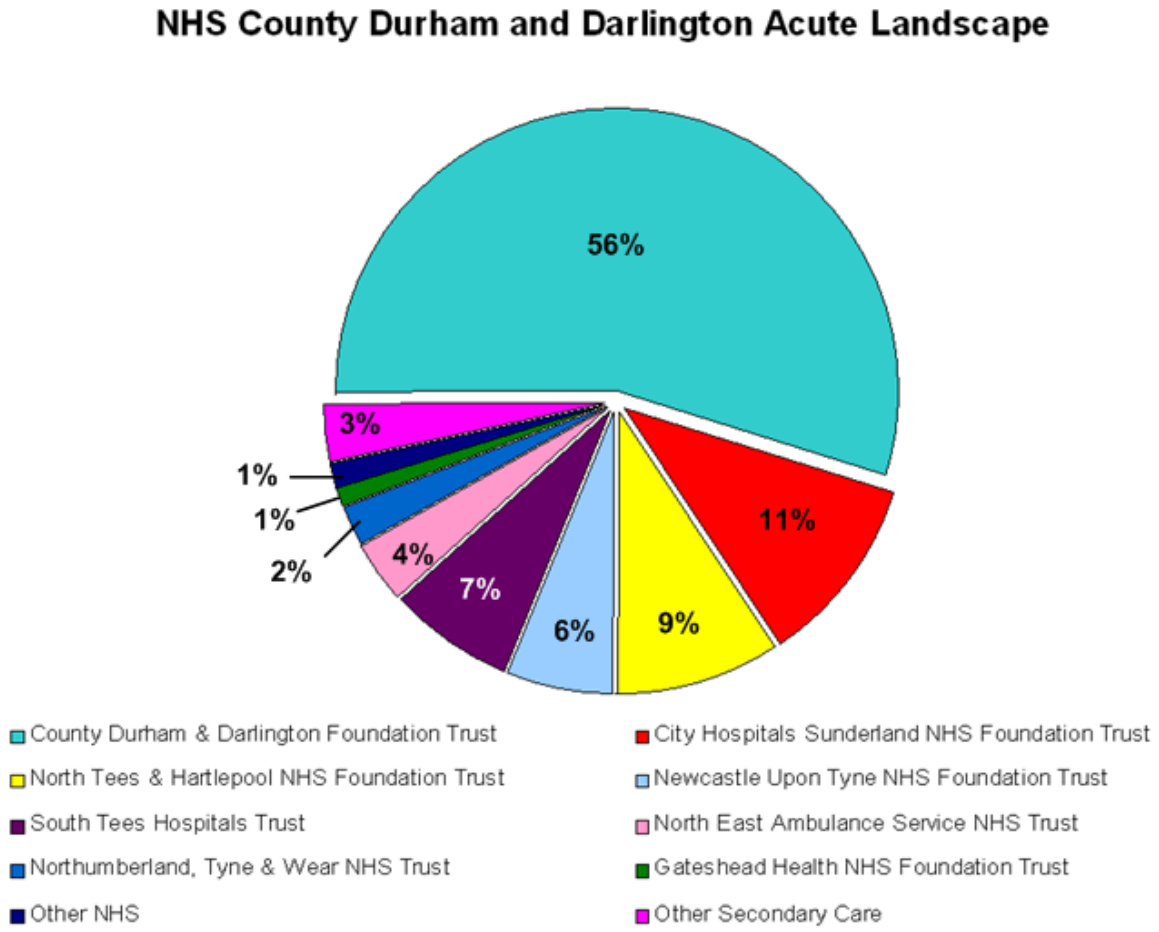


Figure 11: Acute activity (including NEAS urgent care service) by sector (source: 2007/08 Programme Budget Data)

Primary care services

We commission independent contractors such as general practitioners, optometrists, dentists and pharmacists to provide primary care services to the people of County Durham and Darlington.

	Durham	Darlington	Service provided
GP Practices	75	11	Primary medical services
Darzi Health Centres	1	1	Primary medical care for registered and un-registered patients 8am-8pm, 365 days a year.
Optometry (mandatory)	46	7	Mandatory optometry services
Optometry (additional)	43	15	Sight tests in residential and nursing homes
Community Pharmacies	105	17	General pharmacy services
Dental Surgeries	74	23	General dental services

Community services (e.g. community nursing, chiropody, musculo-skeletal services) are predominately commissioned from NHS Darlington through an arms length provider board. Community services are also provided by North Tees and Hartlepool NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust to the parts of population of Easington. County Durham and Darlington NHS Foundation Trust have also been commissioned to provide some community services (musculo-skeletal services).

The process to fully separate the provider arm from the commissioning PCT is well underway. A range of realistic options for implementation (while taking into account Transforming Community Services requirements and deadlines) have been identified for further appraisal. In brief these options include:

- Social enterprise
- Integrated care pilots
- Vertical integration
- Horizontal integration
- Community foundation trust

NHS County Durham and Darlington will decide on the directions for Community Health Services within the timetable set out in the 2010/11 NHS Operating Framework.

Mental health and Learning Disabilities services

A regional Mental Health and Learning Disabilities Commissioning Unit is hosted NHS County Durham with a regional Director of Commissioning who leads the commissioning of mental health and learning disabilities services across the North East. In County Durham and Darlington the majority of acute mental health and learning disabilities services are commissioned from Tees, Esk and Wear Valley NHS Foundation Trust and community mental health services predominately from NHS Darlington Community Services.

Joint commissioning

We also commission several services jointly with our local authorities, especially where there is significant interface between health and social care. For example we work in partnership with our Local Authorities to improve children's health as part of the Children's Trust arrangements. Joint commissioning processes are in place to ensure the delivery of the priorities contained in the Durham Children and Young People's Plan and the Darlington Children and Young People's Plan. Within that context, both Children's Trusts in partnership with ourselves have in place programmes for commissioning integrated services with a focus on pregnancy, early years, school aged children, young people and services for children with acute or additional health needs.

Offender Healthcare

An Offender Health Commissioning Unit is hosted by NHS County Durham, working to the North East Offender Commissioning Board through a regional Director of Commissioning who leads the commissioning of offender health services across the North East.

3.8 Health market analysis

In order to achieve our strategic aims and to deliver our outcome priorities, we must be able to shape and manage the local healthcare market by encouraging plurality of provision. This will enable us to move care closer to patients homes and improve health and quality outcomes and patient experience.

A full healthcare market analysis was undertaken in October 2009. This analysis looked at current and future market structures by reviewing relevant market sizes, minimum economic and clinical scales of sustainability within market segments and barriers of entry and exit.

Current market structure

There are three market types;

- **Monopoly:** a single or dominant provider with all or the majority of market share.

- **Oligopoly:** a small number of providers (2-3) with significant market shares.

- **Competition:** many providers (4+) with market shares that indicate no dominant provider(s).

The health market analysis reviewed a wide range of currently commissioned services. These services were then mapped against ‘Our Vision Our Future’ programme areas and subsequently against the setting of care from which they were delivered.

The analysis of the current market landscape found the following:

- **Specialised hospital setting**
  In comparison to other North East PCTs County Durham and Darlington see an oligopolistic market structure in this setting. This is due to the geography and population proximity to providers.

- **General Practice (GP) / Health Centre (HC) setting**
  Despite the entrepreneurial, competitive nature of this market, the GP/HC setting has created local monopolies.

- **Community/home setting**
  The varying levels of market structure reflect the growing importance of this sector. The closer we work with the community sector the higher the levels of competition.

The full analysis of the current market structure has been summarised in figure 12.

Darzi Theme	SubTheme	Specialised	Gen. Hospital	GP/HC	Community/Home
Staying Healthy	Alcohol			M	O
	Drug			M	O
	Obesity	M	O	M	O
	Other				
	Sexual Health	M	M	M	C
	Smoking			M	M
Maternity	Fertility	O	O		
	Labour & Birth	O	M	M	M
Long Term Condition	CHD/CVD	O	O	M	M
	COPD	O	M	M	M
	Diabetes	O	O	M	M
	Other				
Children	Prevention			M	M
	Treatment	O	O	M	M
Planned Care	Diagnostics	O	O	M	O
	Elective/Day	O	C		O
	GP Treatment			M	M
	Outpatients	O	C	O	M
	Cancer	O	O	M	M
	Other				
Acute Care	Non-Elective	O	O		
	Urgent Care	O	O	O	O
	Other				
Mental Health	CAMHS	O	M		O
	Prevention			M	O
	Treatment	O	M	M	O
	Learning Disabilities	O	M	M	O
End of Life	Continuing Care	M			O
	Palliative		O		O

Figure 12: Current market structure

M Monopoly
O Oligopoly
C Competition

Future market structure

Having established our current market, the analysis has defined the ideal future structure for the healthcare market. The main areas for attention are:

- **GP setting**
  An ideal market structure for most segments in this setting of care is competition. Ideally patients will be able to switch freely between providers to achieve the best outcomes. Competition will increase quality and innovation and increase provider's motivation to tailor services to meet their patients needs. This approach will underpin the future development of primary care services.

- **Community setting**
  The ideal market structure within the community setting is competition. Creating a competitive market structure within this setting will benefit patients greatly by providing care closer to home and reaching hard to reach populations. Closer working with Local Authorities and better use of our community hospital and primary care centre estate will enable this change and will help to deliver the transformation of community services.

- **District General Hospital /local hospital setting**
  In this setting of care the ideal market structure will be oligopolistic and competitive where appropriate. Ideally patients should be exercising choice especially due to the large number of providers within a realistic proximity of our population. We will also focus upon strong performance management and levers for improving quality within the contracting process.

- **Decommission palliative care DGH/local setting**
  A palliative care service in a DGH/local hospital setting may be inappropriate.

Figure 13 maps the current and ideal market structure for each segment next to each other, displaying the intended change in market structure.

Darzi Theme	SubTheme	Specialised		Gen. Hospital		GP/HC		Community/Home	
		Current	Ideal	Current	Ideal	Current	Ideal	Current	Ideal
Staying Healthy	Alcohol					M	C	O	C
	Drug					M	O	O	O
	Obesity	M	O	O	O	M	C	O	C
	Other								
	Sexual Health	M	M	M	M	M	M	C	M
	Smoking					M	C	M	C
Maternity	Fertility	O	O	O	C				
	Labour & Birth	O	O	M	O	M	C	M	C
Long Term Condition	CHD/CVD	O	O	O	O	M	C	M	C
	COPD	O	O	M	O	M	C	M	C
	Diabetes	O	O	O	O	M	C	M	C
	Other								
Children	Prevention					M	C	M	C
	Treatment	O	O	O	O	M	C	M	C
Planned Care	Diagnostics	O	O	O	C	M	C	O	C
	Elective/Day	O	O	C	C			O	C
	GP Treatment					M	C	M	C
	Outpatients	O	O	C	C	O	C	M	O
	Cancer	O	O	O	O	M	O	M	O
	Other								
Acute Care	Non-Elective	O	O	O	O				
	Urgent Care	O	O	O	O	O	C	O	C
	Other								
Mental Health	CAMHS	O	O	M	C		C	O	O
	Prevention					M	C	O	C
	Treatment	O	O	M	C	M	C	O	C
	Learning Disabilities	O	O	M	O	M	O	O	O
End of Life	Continuing Care	M	M				C	O	C
	Palliative			O	D		C	O	C

Figure 13: Current market structure

The differences between current and future market structure can be summarised by setting of care as follows:

- **General Practice / Health Centre setting**
  There is a big difference between the current and target market in this setting from local monopolies to competition.

- **Community/home setting**
  The next biggest difference is in the community setting. The varied gaps illustrate our growing interest and collaboration with this setting of care.

- **Specialist setting**
  This setting, in terms of market structure, is good with only one gap between current and target market structure present (in obesity services due to the increasing demand on this segment).

- **General hospital setting**
  There is little planned change in the market structure of the general hospital setting. It is envisaged that the overall market share of this setting will decrease due to services being commissioned closer to patients homes.

Any development of the appropriate market structure will be carefully managed to ensure that our current service providers are not destabilised by changes to the current pattern of supply.

3.9 Current financial situation

Since the formation of County Durham and Darlington PCTs, we have established a sound track record of financial stability, delivery of statutory duties and achievement of key financial targets.

Both organisations entered 2009/10 with a history of good financial performance which has enabled us to continue to forecast delivery of financial balance and to remain within revenue, capital and cash limits. Financial pressures have emerged in-year, namely acute healthcare, continuing healthcare and prescribing. Continued strong financial and contract management will be required to ensure that these pressures are managed within revenue, capital and cash limits without adverse impact on operational performance targets.

Financial trends

NHS County Durham and NHS Darlington have received confirmation of growth levels in their allocations for 2009/10 and 2010/11. Two assumptions have been made on the possible levels of growth in funding allocations for the financial years 2011/12 – 2013/14. These two assumptions are included in the scenario planning exercise and will be used to determine investment decisions over the life of the strategy.

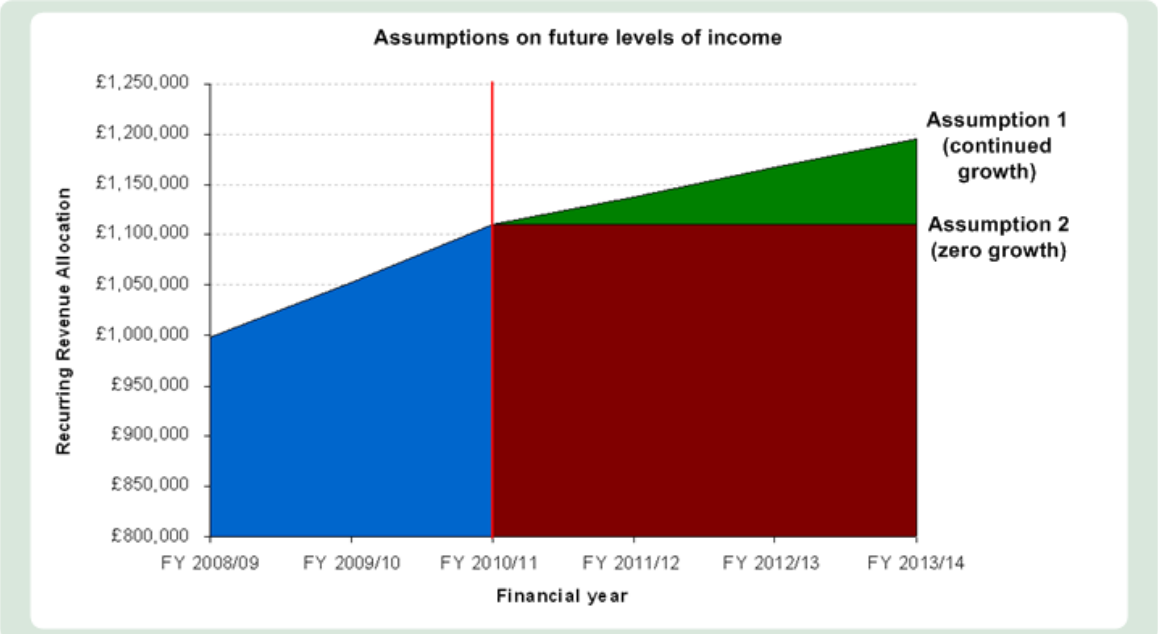


Figure 14: Forecast funding allocations to be used in scenario planning

Strategy

This section outlines how we deliver our vision for health and healthcare based on the evidence described in the context section including:

- How we selected our goals and aspirations for health improvement.
- Our strategic approach.
- An overview of our delivery programmes.
- The implications of different financial funding scenarios.

Section 4. Strategy

4.1 Our strategic goals

To deliver our vision for health and healthcare we have set ourselves a series of goals against our objectives. Each of these goals, supported by delivery programmes, describes where we will gain most benefit from focusing our time and resource.

To give children a better start in life we aim to:
- Reduce teenage conception rates
- Increase breastfeeding rates
- Improve children's emotional wellbeing

To help the public live healthier lives we aim to:
- Reduce smoking rates
- Reduce levels of alcohol misuse
- Reduce levels of obesity

To ensure high quality care at the most appropriate time and place we aim to:
- Improve self-management of long-term conditions
- Detect illness and intervene earlier
- Improve urgent care services

To help people get the most from later life we aim to:
- Reduce illness in the elderly
- Enable preferred place of death

In some cases more than one of our strategic objectives will benefit from our key delivery programmes. For example our initiatives to reduce smoking rates and reduce levels of obesity impact upon both children and adults, something that will help the public stay healthy and help give our children a better start in life. Our key delivery programmes and initiatives to help people stay healthy will enable individuals to better self-manage their care and also reduce illness in the elderly over time.

4.2 Selecting our goals

Many factors were considered when selecting the goals to deliver our strategic objectives. The main set of criteria for the selection of these goals came from our evidence-based assessment of health need.

A significant part of our evidence on health need and levels of inequalities is gained from our local joint strategic needs assessments (JSNA). We have a JSNA for both County Durham and Darlington that highlights areas where we need to do more to improve people's health and wellbeing. The JSNA is produced in partnership with our Local Authorities and it is used to set out priorities in the Local Area Agreements.

While the JSNA does not specifically say what the commissioning priorities are for health, it does provide us with the information we need in order to effectively set priorities. The evidence in the JSNAs showed us our priority goals should be to improve breastfeeding rates, reduce teenage pregnancies and enable earlier diagnosis and intervention of conditions to improve mortality rates in cardio-vascular disease and cancer, reduce suicides and reduce the impact of dementia.

These goals were also considered alongside the evidence for effectiveness of intervention so that we can tackle the causes and not just the symptoms of ill health. A key issue for us was the identification of those lifestyle factors (smoking, obesity, alcohol) which have the greatest direct impact on risk of heart disease, stroke, cancer and chronic obstructive airways disease. The relative inequalities gap for each of these goals was measured in 2009 using our health inequalities monitoring tool. This tool will be used annually to assess whether delivery is reducing the gap in inequalities.

The regional public health strategy Better Health, Fairer Health provided us with further evidence-based information. This strategy reinforced our selection of goals aimed at reducing levels of smoking, alcohol misuse and levels of obesity outlined in the JSNAs but also outlined the need for a ‘good death’. This is something that we highlighted as a priority for our public as this message was constantly articulated during our regular engagement events.

We have also incorporated the output of ‘Our Vision Our Future’ Clinical Innovation Teams into our goals. For example the Acute Care Clinical Innovation Team highlighted many standards and principles that our new urgent care system will benefit from adopting.

In order to define and measure success we have selected a serious of outcome metrics that best describes the aim of each goal. Eight of these outcome measures are reviewed nationally as part of the assurance system that assesses our ability to commission. Other local outcome measures have been agreed and aligned to our goals which are not covered by the national assurance process.

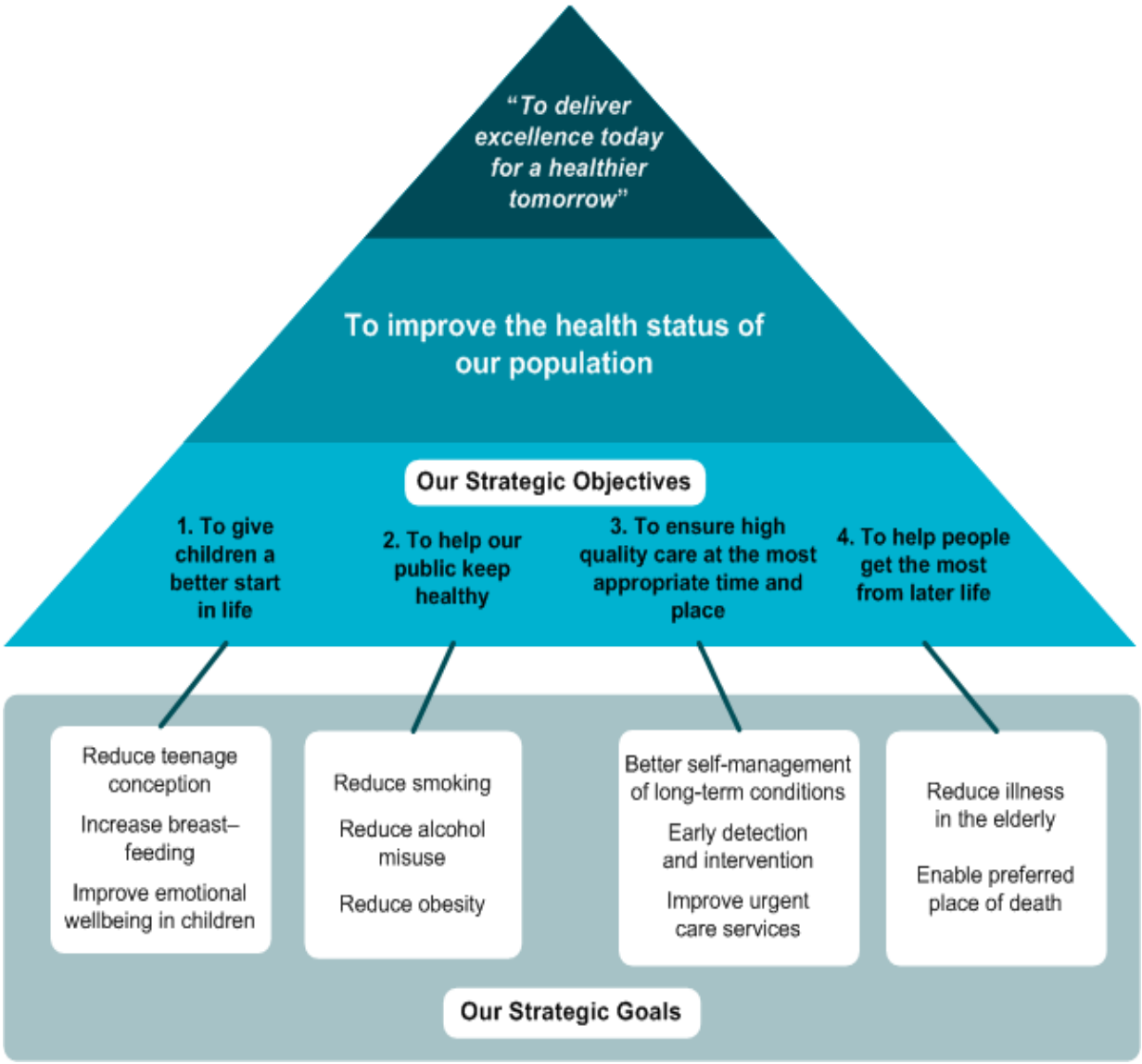


Figure 15: Alignment of strategic goals to objectives

Figure 15 provides an overview of the strategic goals and the strategic objective they align to and figure 16 provides a brief rationale behind the selection of each of these goals.

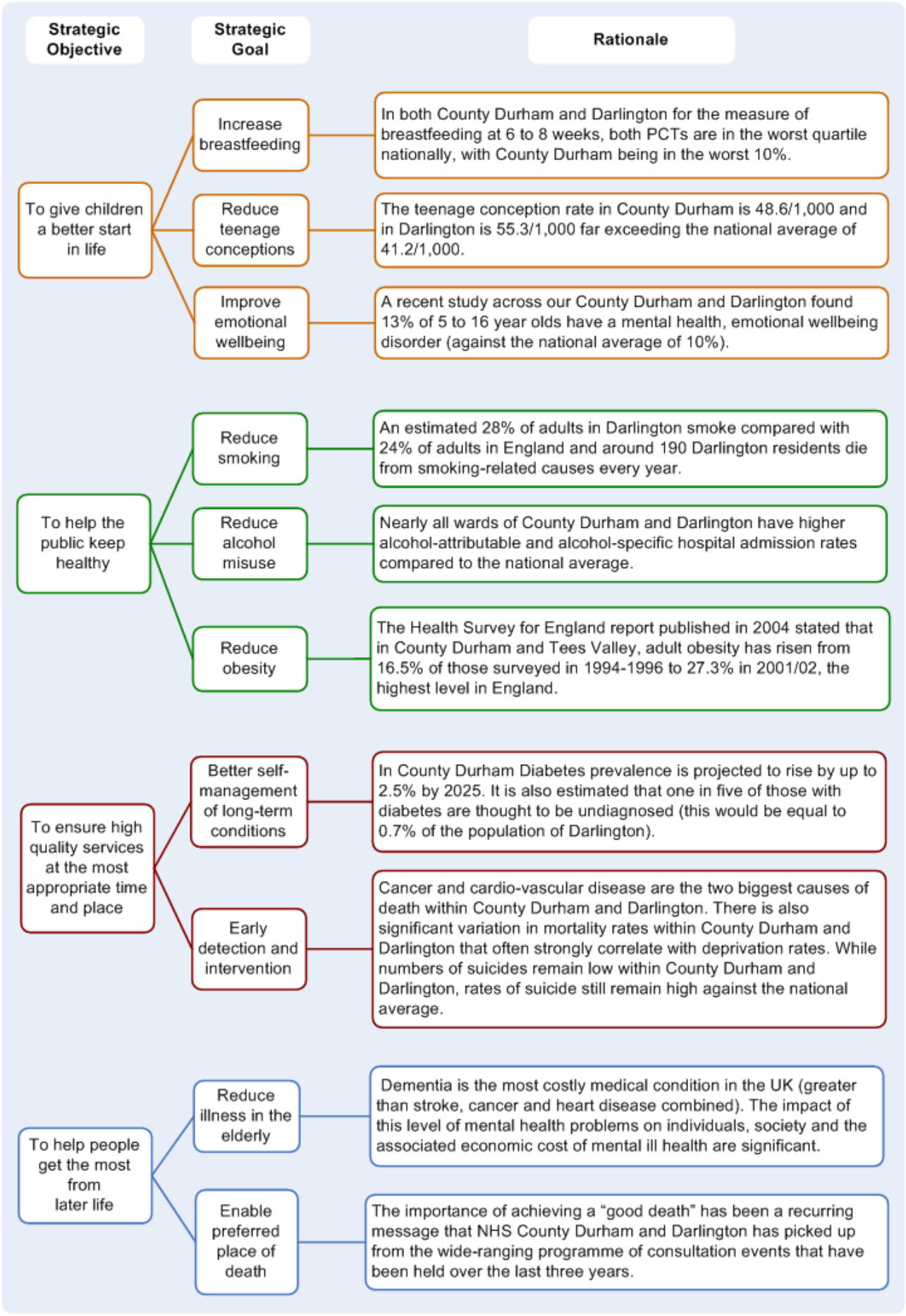


Figure 16: Brief overview of the rationale behind the selection of strategic goals

4.3 Our strategy for delivery

NHS County Durham and Darlington will focus on three approaches to enable it to achieve the strategic objectives of giving children a better start in life, helping our public keep healthy, ensuring high quality care at the appropriate time and place and helping people get the most from later life.

These approaches are:

1) Investing in improvement and innovation

2) Using contracting levers to drive quality and productivity improvements

3) Re-commissioning service models at higher quality specifications (including de-commissioning poorly performing services).

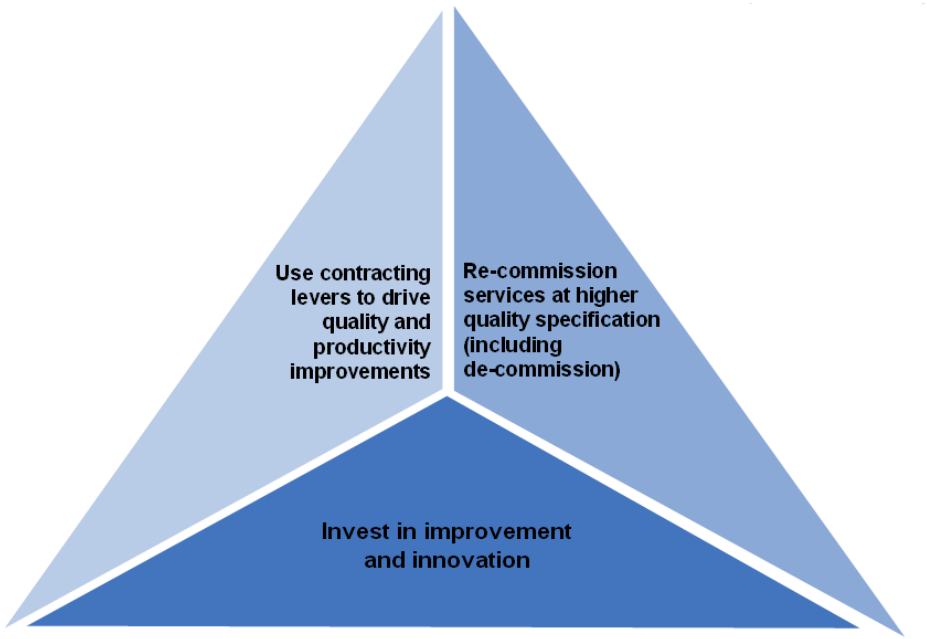


Figure 17: NHS County Durham and Darlington strategic approach

Investing in improvement and innovation

NHS County Durham and Darlington aims to be at the forefront of innovation and improvement when commissioning new service models. Sometimes this new investment will come about due to advancements in drugs or healthcare technologies but the main reason for innovation and improvement will be driven by the need to commission services or programmes that detect the risk of ill health and disease at an earlier stage to improve health outcomes for our population and ensure efficient use of our resources.

Through increased levels of screening, awareness raising and health checks for both physical and mental health we will improve both health outcomes and quality of life for patients whilst getting best value from every pound of tax-payers money that we spend. In most cases we will be commissioning models of care based on national and international evidence and best practice. In some cases however we will go further and faster by leading the way with pilot programmes (such as early cancer awareness programme or social prescription for patients with mental health problems) that are aimed at delivering the step change in health improvement we want for our population.

Where we are leading the way, our work will be rigorously and thoroughly evaluated so that we can be sure we are investing our public's money in the most effective way possible. Where we cannot evidence effectiveness, we will de-commission them and re-allocate the money into other initiatives and priorities.

Using contracting levers to drive quality and productivity improvements

Whilst we will continue to invest in new services and initiatives that will deliver improvements in health outcomes, we will also use contracting levers, both incentives and penalties to continue to push for improvements in quality and productivity.

We will do this by:

- Making best use of Commissioning for Quality and Innovation (CQUIN) payment framework. CQUIN is the contracting lever that allows us to align quality to payment from our acute, community and mental health providers and we will use CQUIN to set stretch targets for quality measures for the benefits of patients.
- Reviewing services to create detailed specifications that outline best practice, outcome measures and the level of quality and patient safety we expect for our patients (in line with the regional patient safety strategy Safer Care North East).
- Setting key performance indicators to improve levels of patient experience.
- Making better use of patient experience measurement such as patient reported outcome measures in our contract monitoring frameworks that will allow us to hold providers to account for the levels of satisfaction and safety their services provide, not just the waiting times and costs.
- Not paying twice for elements of services that we expect to be delivered as part of core contracts.
- Measuring clinical quality through clinical audit and use of clinical effectiveness key performance indicators linked to National Service Frameworks, NICE guidance and best practice standards.

Re-commissioning service models at higher quality specifications

Sometimes we will need to modernise a current service model by redesigning parts of, or whole, pathways of care within their current funding envelope rather than invest new money into them. We will re-commission current service models in different ways that allow us to improve the levels of quality and experience that patients will receive when using them.

This re-commissioning of services will always be done with the full engagement of patients, carers, our public, clinicians and other stakeholders.

In some instances we will look to integrate services to the benefit of patients rather than set up specialist services that are less clinically and cost effective. An example of this would be for patients with a learning disability. We want our providers to adapt the mainstream services we commission from them to make them accessible to patients with a learning disability rather than establish separate stand alone services other than those for a highly specialist need.

We will be looking to integrate services where necessary and to get the most from partnership working, again to improve health outcomes for patients. For example we recognise the link between physical and mental health so will look to develop integrated service models that cross traditional organisational boundaries to provide services that meet both needs.

4.4 Continuing to invest whilst in a “zero growth” scenario

The NHS has not been left unaffected by the recent worldwide economic downturn and subsequent recession. We anticipate that over the lifetime of our strategic plan this will have a significant impact on the way we will achieve our strategic goals. For our health economy to deliver the levels of service quality (in terms of safety, experience and satisfaction) and improvements in health outcomes we need to ensure that we get the best return on investment from our finite resource.

When investing in new services, funding can only come from three areas; growth money, savings and efficiencies released from other services. In two of our three likely future funding scenarios we are not expecting to receive new growth money and as a PCT we do not have the freedom to bank savings other than a 2% contingency that we will hold year on year to deal with in-year pressures. This means that if we want to continue to invest in new service innovations as we do, we must drive improvements in quality and productivity in order to release efficiencies that can be re-invested into services.

To enable us to do this, running alongside programmes of work that are targeted to directly improve specific health outcomes, NHS County Durham and Darlington has established a Quality and Productivity delivery programme. This programme will improve the quality of our current services to make them more cost effective and to make them as productive as possible to give us the biggest return on investment.

The Quality and Productivity delivery programme consists of large scale initiatives that will redesign models of care by moving activity out of acute hospitals and into community care settings closer to patients' homes, developmental programmes that will increase primary care capacity without additional investment and cost improvement programmes that will make the most of our assets. Examples include:

- Care closer to home; creating community based services for planned treatments and diagnostic tests (such as musculo-skeletal services, dermatology and endoscopies) where care can be provided more cost effectively.
- Reforming the urgent care service to ensure that people use the most appropriate access point for emergency care (as directed by the Single Point of Access national pilot).
- Our GP Pathfinder programme which is working with GP practices to introduce Lean methodology in the way they work, removing waste and releasing time for primary care clinicians to spend time with their patients.
- Making best use of our assets through consolidation of our estate portfolio and making best use of the spare capacity in our community hospitals and primary care centres.
- Reviewing services over the five year period to identify opportunities for improved quality, clinical effectiveness, productivity, patient satisfaction and cost efficiency (as described in figure 17)

If a service fails to meet the levels of quality, experience, safety and outcome that we expect for our patients, we will de-commission them and replace them with a higher quality service. We will be relentless in the way we manage our contracts, seeking to get best value and quality improvements at all times.

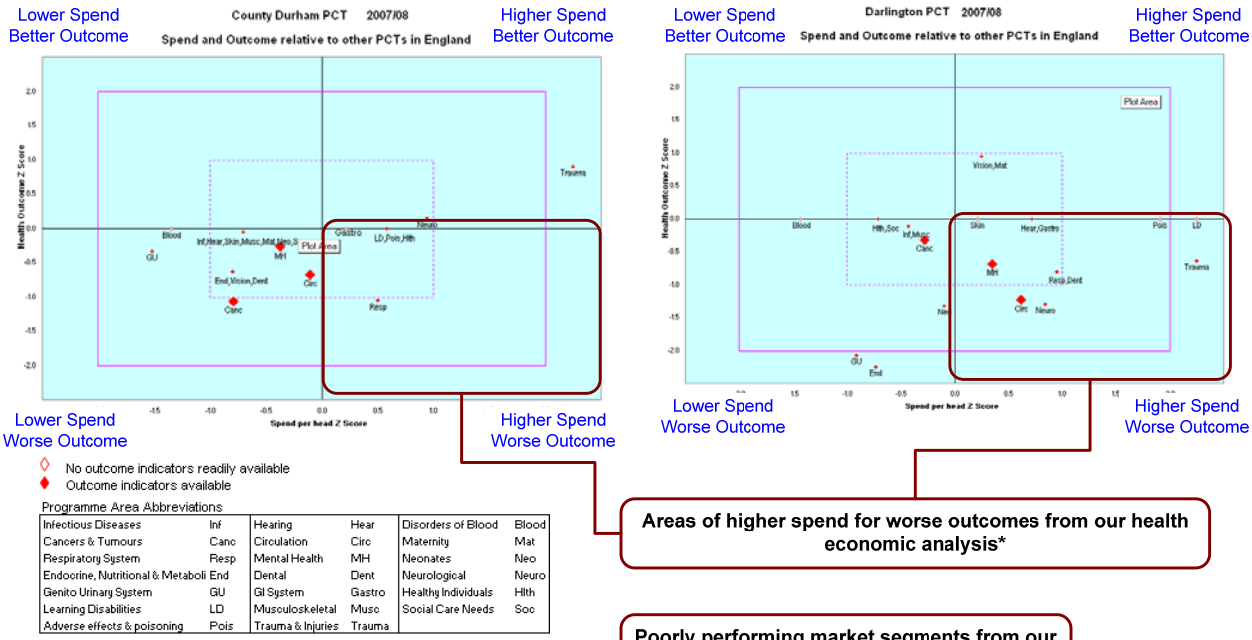
4.5 Aligning our delivery programmes to our goals

All our delivery programmes and development capacity have been aligned to the delivery of our strategic goals and to release efficiencies that will allow for continued investment. Figure 18 shows the mapping from our vision for health and healthcare, through our strategic objectives, goals and into the delivery programmes and initiatives that underpin them. It also shows the metrics we will use to judge how implementation is progressing and how successful we have been.

Our strategy map gives a summary of our key delivery programmes that describes the initiatives we intend to focus on, the investment we will put behind them, the risks that the initiatives might encounter, like resource required to carry them out and their likely impact on health outcomes and on the provider landscape. These initiatives make up the delivery plan that operationalises our strategic plan.

Informing the programme of service reviews

Health Economic Analysis



◊ No outcome indicators readily available
♦ Outcome indicators available

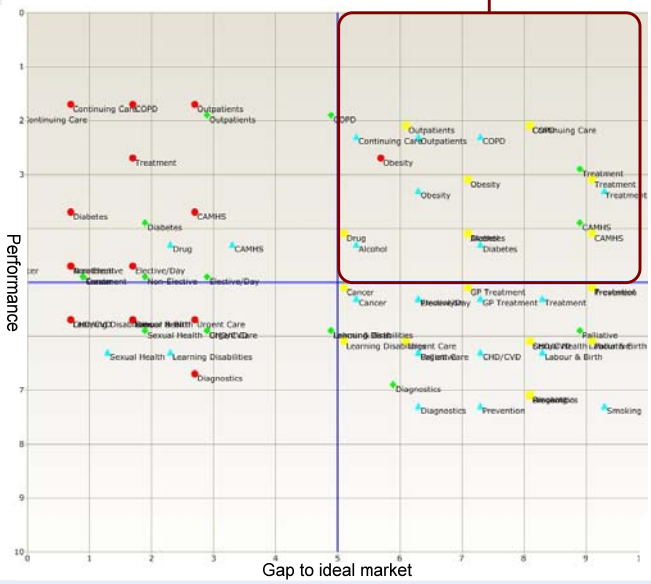
Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metaboli	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Areas of higher spend for worse outcomes from our health economic analysis*

Poorly performing market segments from our health market analysis**

Health Market Analysis



Quality and Productivity – Service Review Programme

As part of the Quality and Productivity delivery programme the PCT will review all services over a five year period to assess opportunities for improvements in quality, clinical effectiveness, productivity, patient satisfaction and cost efficiency. This review programme will prioritise services using benchmarking data from our health economic and market analysis. Services with higher levels of spend for worse outcomes when benchmarked against other PCTs or perform poorly on quality, economic cost, access or outcome metrics when benchmarked against national indicators will be reviewed first.

* NHS County Durham and Darlington Annual Population Value Review
** NHS County Durham and Darlington Health Market Analysis

Figure 17: Our approach to reviewing services

Map of vision, strategic goals, programme and initiatives for Durham and Darlington

Selected WCC health outcomes
Locally selected health outcomes
Productivity goal and outcome

Vision	Strategic objectives	Strategic goals	Outcomes	CPG	Key delivery programmes	Prioritised Initiatives	Key performance indicators
"To deliver excellence today for a healthier tomorrow"	To give children a better start in life	1. Increase breast – feeding	% Infants breastfed at 6-8 weeks	MN	Breast feeding delivery programme	1. UNICEF accreditation for hospital and community based services 2. Commission peer support service 3. Increase access to health professional support	▪ Breastfeeding initiation rates ▪ Breastfeeding maintenance rates
		2. Reduce teenage conception	Under 18 conception rate	CH	Reducing Teenage Conceptions delivery programme	1. Re-commission higher specification CASH 2. Use contracts to increase uptake of LARC 3. Commission targeted health services based in 18 schools	▪ LARC uptake rates ▪ EOHC Pharmacy access ▪ Avoidable ante & post natal admissions
		3. Improve emotional wellbeing in children	Reduction of referral into specialist CAMHS		Improving Emotional Wellbeing in Children delivery programme	1. Develop Tier 4 CAMHS service 2. Commission training on emotional well-being for children for staff of all agencies 3. Targeted Mental Health programme in schools	▪ % of universal and targeted staff trained ▪ Reduced Nos. of occupied bed days
	To help our public keep healthy	4. Reduce smoking	Smoking quitters per 100,000 aged 16+	SH	Tobacco control and smoking reduction delivery programme	1. Develop and extend current stop smoking services 2. Develop a major programme of tobacco control in collaboration with the LAs and FRESH NE	▪ Nicotine Replacement Therapy rates ▪ Smoking prevalence
		5. Reduce alcohol misuse	Hospital admissions for alcohol-specific harm per 100,000		Alcohol harm reduction delivery programme	1. Mainstream Tier 1 services 2. Identify options for delivery of Tier 2 services 3. Develop community-based Tier 3 detox service 4. Commission Tier 4 inpatient detox service	▪ No.s of new referrals to Tier 3 ▪ No.s completing treatment in Tier 3 ▪ %of 16-39 year olds identified, screened and receiving brief advice in primary care
		6. Reduce obesity	Obesity rate		Preventing obesity delivery programme	1. Commission physical activity and healthy eating programmes for children 2. Commission Tiers 2,3 and 4 adult obesity services 3. Changing the Physical Landscape (CPAL) implementation	▪ Childhood obesity rates at reception and year 6 ▪ Prevalence of adult obesity ▪ % compliance and retention to CPAL
	To ensure high quality care at the most appropriate time and place	7. Better self-manage-ment of long-term conditions	% of patients managing their HbA1c levels	LTC	Prevention and Intermediate care strategy	1. Commission system-wide intermediate care service 2. Develop current community estate to support new preventative and intermediate care services	▪ Elective Long Term Conditions activity shift from secondary care to intermediate care
		8. Early detection and intervention	CVD mortality (DSR per 100,000)	PL	CVD mortality reduction delivery programme	1. Introduce NHS health checks programme 2. Commission 24hr Community arrhythmia service 3. Increase implantable device rates 4. Review services for stroke services covering assessment, management and rehabilitation	▪ Referrals from annual health check ▪ Implantable device rate ▪ Revascularisation rate ▪ Number of stroke patients spending 90% of their time on a stroke unit
			Cancer mortality (DSR per 100,000)		Cancer mortality reduction delivery programme	1. Continue local cancer awareness and early diagnosis programme inc. social marketing 2. Extend breast screening programme 3. Increase diagnostic capacity in secondary care	▪ Cancer awareness rates ▪ Cancer screening uptake rate
			Suicide & injury rate undet. Intent mortality	MH	Improving Mental Health delivery programme	1. Extend IAPT programme beyond national funding 2. Expand targeted social prescriptions	▪ No of new people seen in IAPT programme ▪ No of new referrals under social prescription
		Quality and productivity programme	Improved quality and patient experience £ efficiency released to be re-invested	AC	Urgent care strategy	1. Re-commission urgent care service 2. Pilot single point of access 3. Introduce Rapid medical assessment centre	▪ A&E 4 hour waits ▪ Reduction of A&E attendances ▪ Urgent care centre utilisation
				PL	Care Closer To Home	1. Service reviews of dermatology, MSK and orthopaedics (including diagnostics and pain management), ophthalmology and endoscopy	▪ Outpatient and day case activity from secondary to community care settings
	To help people get the most from later life	9. Reduce illness in the elderly	Dementia patients under managed care	MH	Older People with Mental Health Needs delivery programme	1. Increase access to early diagnostic and specialist support services 2. Commission acute liaison service	▪ No. of people with a diagnosis of dementia on GP register ▪ No. of people prescribed anti-cholinesterase
		10. Enable preferred place of death	% Deaths at home	EoL	End of Life Strategy	1. Create end-of-life care register 2. Run public consultation on a "good death" 3. Create 24/7 end of life service	▪ Deaths in preferred location ▪ Hospital bed days for episodes of care ending in patients death

Figure 18: Strategy map

Breastfeeding Delivery Programme

Overview

To improve maternal and child health through increasing rates of breastfeeding initiation and maintenance.

To deliver a multi faceted programme of interventions based on best practice:

- Achieving Unicef Baby Friendly Initiative. Accreditation across hospital based and community based maternity services.
- A peer support programme.
- Increasing accessibility to health professional ante natal and post natal support.

To explore and exploit the use of informatics enabling services including map of medicine for pathway design and assurance.

Rationale

County Durham and Darlington breastfeeding initiation rates are lower than England estimates (77%) at 52.8% and 57.9% respectively.

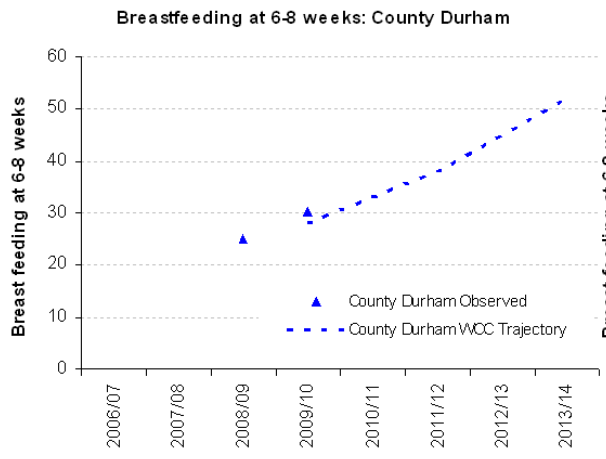
Benefits to mothers include; reduced risk of breast cancer and pre and post menopausal ovarian cancer, positive neurological bonding, utilisation of extra calories and impacting on obesity, late onset diabetes and prevention of rheumatoid arthritis.

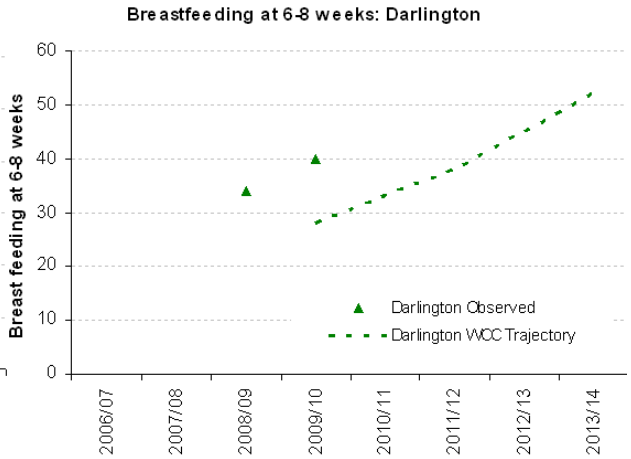
Improving breastfeeding will impact upon realising reductions in primary and secondary care consultations for infants and children.

Children who are breastfed have a reduced risk of illness including: gastro-intestinal infection, wheeze, increased body fat and weight, obesity, urinary tract infection, sudden death syndrome, respiratory illness, asthma, coronary heart disease, ear infections, allergies such as eczema, diabetes and dental caries.

There is significant evidence produced to demonstrate that breastfeeding is a major contributor to Public Health and has an important role to play in reducing health inequalities.

Impact

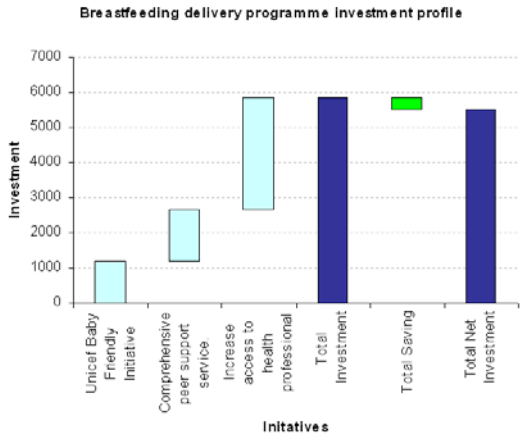




Key Performance Indicators

		2010/11	2011/12	2012/13
Breastfeeding initiation rates	County Durham	59.8%	64.8%	69.8%
	Darlington	67.6%	72.6%	77.6%

Investment



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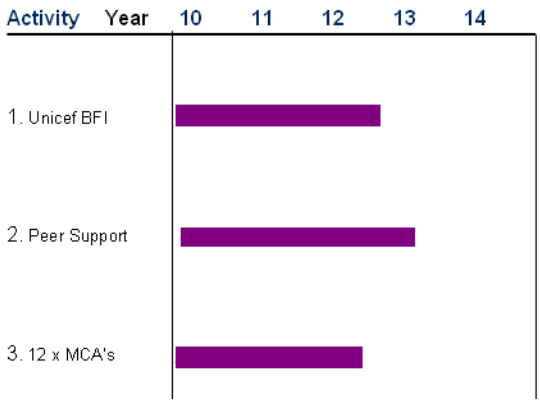


Risk

Impact risk
Societal factors outside of health and healthcare can affect breastfeeding rates.

Financial risk
Moving to 75% or 65% financial scenario would risk delivery of the health outcome trajectory.

Delivery risk
The appointment of a project manager to support the overall development of the project plan for the Unicef Accreditation Initiative will ensure a dedicated focus for this area.

Existing and proposed clinical systems need to be reviewed to ensure they can meet national requirements for integration, data collection and reporting.

The lack of integrated IM&T systems between health and social care systems is a risk to co-ordinated delivery.

Resource

Additional capacity

Project manager required to lead achievement of Unicef Accreditation.
Increasing maternity care assistant capacity across communities is required.
Informatics and IM&T skills/resource.

Skills and capabilities

Achieving Unicef Accreditation is dependent upon integrated working and training and a whole family/ mother/baby support approach to implementing best practice for maternity across all maternity services.
Expertise in the use and application of map of medicine and the use of digital technology for social marketing.

PCT resource to drive initiative

NHS County Durham and Darlington has a dedicated Maternity Matters Policy Lead, supported by a whole health and social care system approach to ensuring improved breastfeeding rates.
During 2010/11 and beyond, additional resources are required to improve breastfeeding rates linked to the initiatives described above.

Likely impact on the provider landscape

The Breastfeeding delivery programme should see a reduction in non-elective and outpatient activity in the the acute sector through the reduced risk of illness in children who are breastfed.

Reducing Teenage Conceptions Delivery Programme

Overview

Initiative 1

To provide a refreshed integrated, focused, multi-faceted and targeted approach to reducing under 18 conception rates in County Durham and Darlington as evidenced by regional, national and international research, against the 63 national indicators.

Initiative 2

Provide a full, on-site CASH to 18 schools with the largest intakes from “hot spot” wards in County Durham and Darlington.

Rationale

PCT’s who have had the most success at reducing the rate of teenage conceptions are able to evidence their practice against 63 indicators, with a focus on early identification, better and earlier access to Sex and Relationships Education linked to younger persons focused Contraception and Sexual Health provision.

Research evidences good Sex and Relationships Education is crucial in delaying early sexual activity and increased use of contraception at first sex.

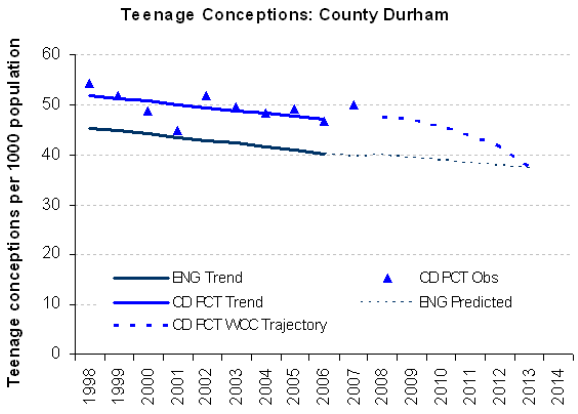
Holland starts teaching Sex and Relationships Education at 5 years olds and has the lowest teenage conception rates in Western Europe. US research evidences that 86% of decline in teenage conception rates is attributed to improved contraception use.

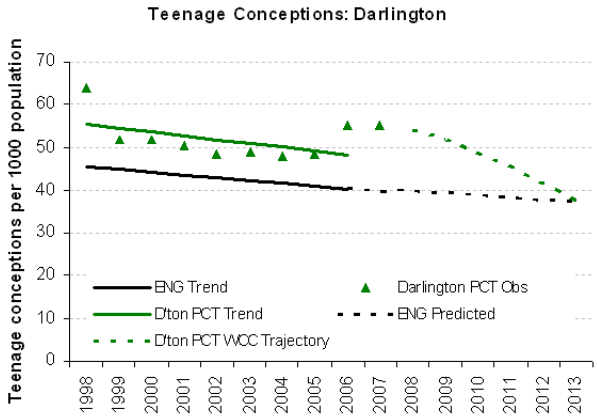
Young people in County Durham and Darlington have voiced that services need to be more accessible and young person friendly reducing stigma.

Integrated school based health services are evidenced as an effective means of ensuring young people get access to contraception.

Local evidence suggests that the reduction in teenage pregnancy rates in Easington by 15% 05/07 rate 56.1 from baseline of 66.1 98/00 is directly attributed to the targeted school health provision.

Impact



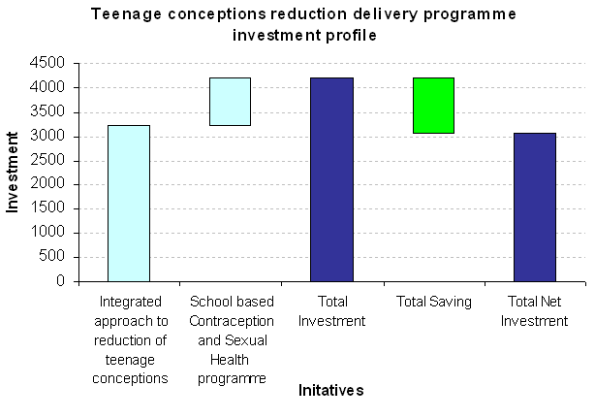


Key Performance Indicators

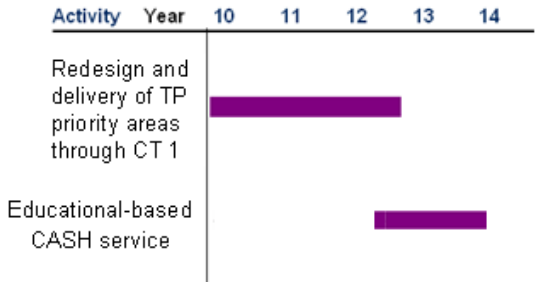
	2010	2011	2012	2013	2014
EOHC Pharmacy Access	2000	1700	1564	1486	1426
LARC Co. Durham	669	669	669	669	669
LARC Darlington	136	136	136	136	136
Co. Durham Avoidable anti & post natal Adm	455	386	355	338	324
Darlington Avoidable anti & post natal Adm	126	107	99	94	90

	2010	2011	2012	2013	2014
Co. Durham Alcohol Admissions 15-17	63	54	49	47	45
Darlington Alcohol Admissions 15 - 17	11	9	9	8	8
Co. Durham Under 2 A&E where mother is U18	174	148	136	129	124
Darlington Under 2 A&E where mother is U18	18	15	14	13	13

Investment



Timeline



Risk

Impact risk
Current needs and demand for services are unknown therefore outcomes are projected against research and evidence based best practice. We have adopted a conservative approach with a 3% year on year reduction.

Financial risk
If investment is not realised achievement of projected reductions in teenage conceptions will be considerably reduced or the current trend which is increasing teenage pregnancy rates may continue.

Potential investment needed for IM&T infrastructure for the proposed sites.

Delivery risk

These programmes rely on full participation of the Children's Trust and integration between all partners.

Workforce Capacity.

Need to ensure that national requirements for integration, data collection and reporting can be met through existing and proposed clinical IM&T systems.

Resource

Additional capacity
Risks with regards to workforce capacity.

Skills and capabilities
Training capacity required to train the whole children and young people economy (Local Authorities, NHS, Community and Third Sector) on early identification and support of at risk children and young people.

PCT resource to drive initiative
Existing funding of approx 550k (Children's Trust) and 400k (PCT) to be realigned to develop and provide focused and targeted initiative 1 & 2.

IM&T support.

Likely impact on the provider landscape

The Teenage Conception Reduction delivery programme should see a reduction in non-elective activity in the acute sector through a reduction in births and terminations.

Improving Emotional Wellbeing in Children Delivery Programme

Overview

Prevention and Early Intervention

To tackle associated stigma.

To target Mental Health in Schools.

To increase Primary Mental Health Workers.

To develop Tier 4 Community Provision.

To train and develop workforce in emotional wellbeing and mental health issues.

To appoint Child and Adolescent Mental Health Service (CAMHS) case manager post.

CAMHS and Learning Disabilities
We will increase staffing and skills of staff across universal and targeted provision (e.g. Primary Mental Health Workers/Therapists).

To deliver services for children and young people with high-level autism and severe challenging behaviour.

Rationale

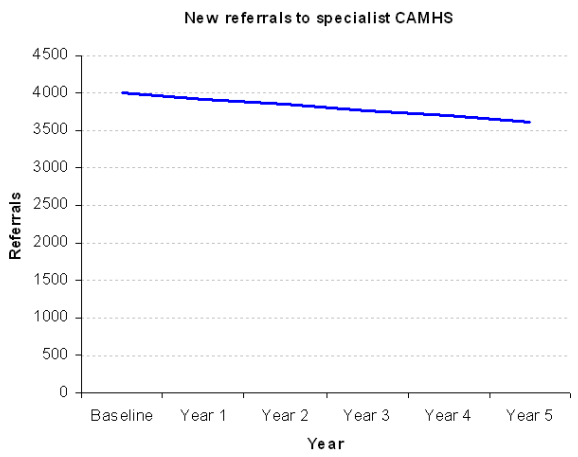
Emotional wellbeing and mental health is nationally an issue, evidenced by ONS data demonstrating 10% of children and young people aged between 5 and 16 have a mental health disorder associated with considerable distress and substantial interference with personal functions such as family and social relationships, their capacity to cope at school and generally life challenges.

It is a priority for County Durham and Darlington as a recent study across our area showed that 13% of our 5 to 16 year old children and young people have a mental health, emotional wellbeing disorder, which is higher than the national average and impacts on education attainment, absences from school, school exclusions, friendships, physical health and offending behaviours.

The children and young person population of County Durham & Darlington is approximately 60,000 of which 7,800 have a diagnosed mental health disorder.

The incidence of children with severe learning disability alone is expected to rise by 1% year on year for the next 15 years.

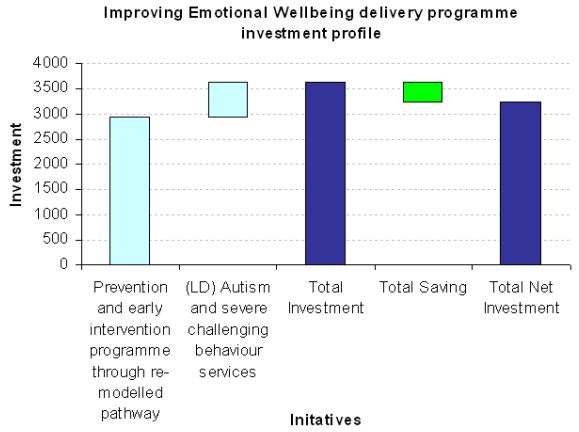
Impact



Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Reduction in number of new referrals to specialist CAMHS (target reduction of 375 over 5 years)	-75	-75	-75	-75	-75
Percentage of universal and targeted staff trained (target 100% over 5	20	20	20	20	20
Reduction in number of Occupied Bed Days on previous year	-75	-75	-75	-75	-75
Percentage of young people with an LD and a MH problem accessing	100	100	100	100	100
Percentage of young people not placed out of area	80	90	100	100	100

Investment



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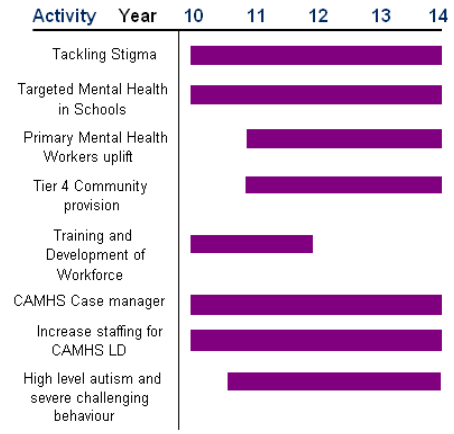


Risk

Impact risk
Measurement of the metrics for these initiatives through health and social care partnership working may require additional system configuration.
Being able to retain children and young people who are at the high end of the Autistic Spectrum and severe Challenging Behaviour within County Durham & Darlington, as there are no facilities of this kind available currently.

Financial risk
When all these initiatives are delivered, there may be an initial knock-on effect to specialist CAMHS due to more appropriate referrals. Until these initiatives are embedded into pathways, this may exceed planned budgets.
The introduction of the national mental health tariff could have a financial impact – reference costs are currently being worked through with providers.
When these initiatives are delivered there will be an impact on our main mental health provider both at Tier 3 and 4 at a total disinvestment at 5 years of £1.5M, including £500-£750k p.a. out of area inpatient care.

Delivery risk
Audits, review of services and performance monitoring are often under-managed as are senior management time to ensure delivery.

Resource

Additional capacity
75% investment will be at universal and targeted services and only 25% or less at specialist services tiers. Partnership working is crucial to support all the elements of emotional wellbeing and mental health.

Skills and capabilities
There are limited skills and capabilities across universal and targeted staff to be able to prevent/identify earlier emotional wellbeing and mental health problems and offer a first intervention.

Workforce capacity
8 Primary Mental Health Workers – Year 1

PCT resource to drive initiative
1 CAMHS Case Manager – Year 1
Roll-out of the national Targeted Mental Health in Schools project to approx 5 school clusters per year (5 year programme)

Likely impact on the provider landscape

The Improving Emotional Wellbeing in Children delivery programme will see a reduction in referrals to specialist CAMHS services.

Tobacco Control and Smoking Reduction Delivery Programme

Overview

Initiative 1 - Stop Smoking Services

Develop existing stop smoking specialist services in secondary care to ensure that services target heavily nicotine dependent smokers, with emphasis on pregnancy, prison health, mental health and manual workers.

Develop additional pharmacy based service.

Develop further level 2 services in primary settings to maximise the role of primary care professionals e.g. health visitors GPs and practice nurses.

Develop an Acute/Elective service.

Initiative 2 - Tobacco Control

An integrated programme of tobacco control work based on elements 2-4 above in collaboration with FRESH North East and Durham County Council.

Rationale

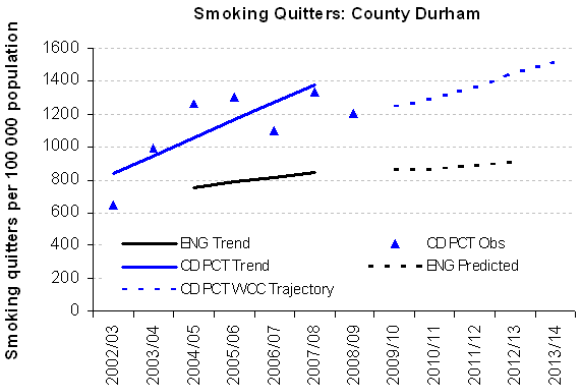
Smoking is one of the most significant contributing factors to low life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease.

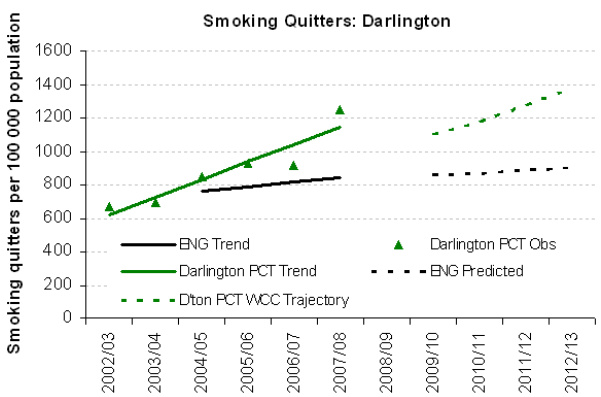
Stop smoking services are a key part of tobacco control and health inequalities policies at local and national levels. Smokers are four more times likely to quit if they use stop smoking services.

International evidence from California and recent data from Ireland demonstrates that tobacco control is key in sustaining a downward trend in smoking prevalence and that although vital, stop smoking services alone are not sufficient in making changes in smoking prevalence.

NICE guidance on acute/elective service indicates hospital length of stay was 11 days for intervention group versus 13 days versus non intervention. All complications (18% intervention group) versus 52% for non-intervention group.

Impact

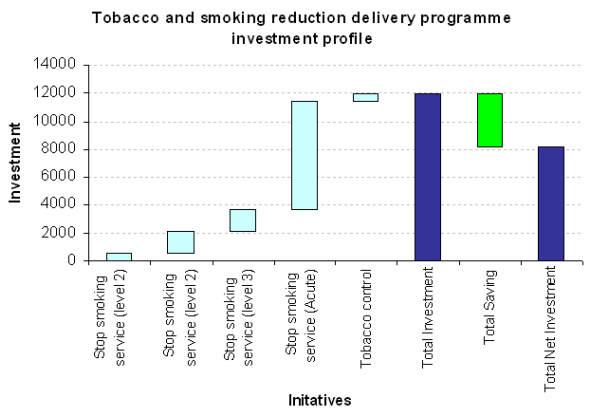




Key Performance Indicators

		Y1	Y2	Y3	Y4	Y5
Carbon monoxide (CO) validation rate	County Durham	87%	87%	87%	87%	87%
	Darlington	82%	85%	87%	87%	87%

Investment



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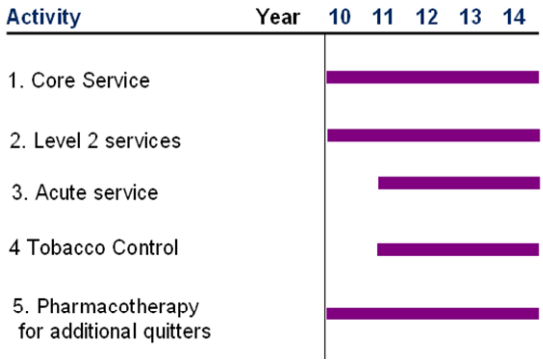


Risk

Impact risk

If specialist services do not adequately target their services at the priority groups, the programme will not deliver the forecast impact.

Financial risk

Increase in demand could overspend on service budgets especially in pharmacies.

Reduced budgets could lead to no new investment in acute and level 2 services, thus presenting a risk to achieve ambitious new targets

Delivery risk

Tobacco control must be kept high on partner's agenda through joint strategic planning and delivery at a time of financial pressure.

Increase in level 2 service providers may require greater market development.

Further work is needed to develop hospital based services.

Resource

Additional service capacity

New service capacity is required for acute stop smoking services

Skills and capabilities

Increase the skills and capacity of providers and partners to be able to deliver tobacco control and stop smoking agenda. Workforce planning needed.

Need more front line staff trained in brief intervention e.g. maternity services, children's services, health visitors, district nurses, dental staff, optometrist, secondary care, mental health services. This process will take time and could lead to delays in the system.

PCT resource to drive initiative

0.6 co-coordinator to drive forward County Durham and Darlington tobacco control and Alliance work.

Likely impact on the provider landscape

The Tobacco Control and Smoking Reduction delivery programme will see an increase in primary care and community pharmacy attendances and an increase in prescribing rates.

Alcohol Harm Reduction Delivery Programme

Overview

Develop the full pathway for Alcohol Treatment Services in line with the national Models of Care for Alcohol Misusers across four tiers.

We will significantly increase the number of people delivering alcohol brief interventions within a range of settings (primary care, acute care, criminal justice and youth providers), expand the provision of outpatient and inpatient detox to reduce alcohol related hospital admissions and prevent relapse.

To support the work we will recruit alcohol clinical champions to ensure our referral pathways for adults and children are seamless; work with the regional alcohol office (BALANCE) to undertake social marketing and campaign work using the national drinker profiles; and undertake detailed analysis of alcohol-specific and alcohol-attributable admissions, identifying high intensity users and demand based on age, gender and geography.

The alcohol services will be available for lower risk, increasing risk (hazardous) and high risk drinkers (harmful) though specific work will be undertaken with targeted groups e.g. young people, offenders, older drinkers and women.

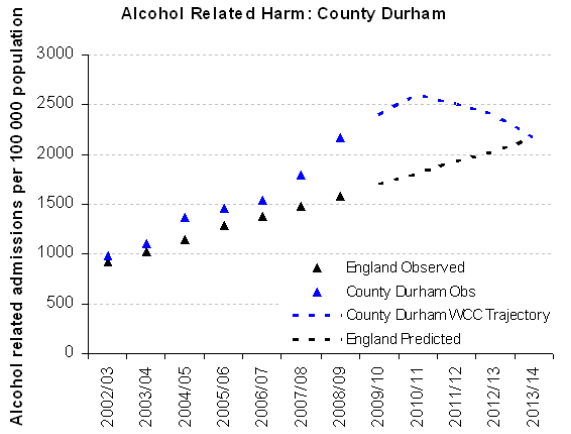
Rationale

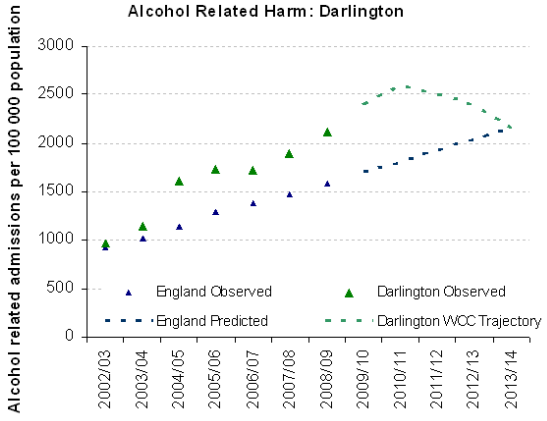
Compared to the England average County Durham and Darlington has:

- significantly higher rates of hospital admissions for alcohol related harm for both men and women (standardised rate per 100,000 population (2008/9)- 2,168 County Durham, 2,113 Darlington compared to 1,583 England);
- significantly worse rates of alcohol admissions for young people under 18 years (crude rate per 100,000 population (205/6-7/8)- 133 County Durham, 192 Darlington and 72.3 England. Darlington ranks 152 and County Durham 138 out of 152 PCTs
- a higher proportion of adults that binge drink (26% County Durham and 25% Darlington compared to 18% England)
- higher levels of claimants on incapacity benefit as a result of alcohol (crude rate per 100,000 working age population (2007) - 151.3 County Durham, 162.9 Darlington compared to 130.63 England).

Hospital admissions directly related and attributable to alcohol are rising nationally by around 80,000 every year, comprising 6% of all NHS hospital admissions.

Impact



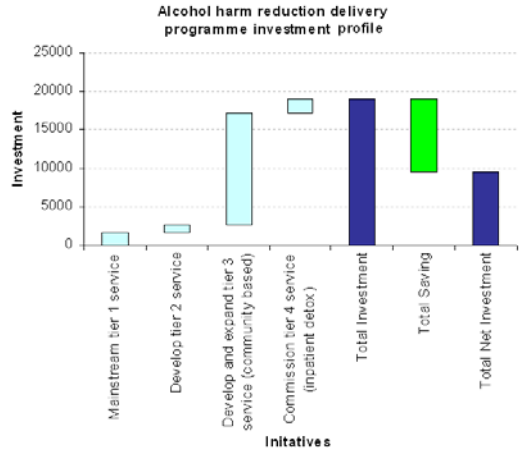


Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Number of new referrals to the Community Alcohol Services	2000	3000	3000	3500	3500
Numbers completing treatment in the Community Alcohol Services	600	900	900	1050	1050
Numbers of young people referred to alcohol treatment services	50	100	200	300	350

	Y1	Y2	Y3	Y4	Y5
Number of families accessing the Early Intervention Team	45	80	80	100	100
Percentage of 16-39 year olds identified, screened and receiving brief advice in primary care	20	45	80	85	90
Percentage of patients referred to a Tier 2 Counsellor	0	5	20	21	22

Investment



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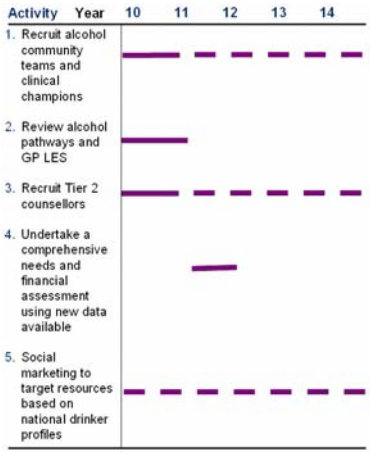


Risk

Impact risk
Current needs and demand for services are unknown due to poor existing data collection on alcohol and use of synthetic estimates.

It is unclear whether the new services, including the proactive CVD risk assessment programme, will have a positive or negative impact on hospital admissions data due to the complex way the target is calculated on alcohol-specific and alcohol-attributable admissions.

To date only 75% of GPs have signed up to the LES.

Increased access and affordability of alcohol makes it difficult to create cultural shift on alcohol.

Financial risk
Financial investment is required across all four tiers of the pathway; otherwise a high burden on tier 3 services will be created.
Financial pressure on public sector agencies may prevent a coordinated approach.

Delivery risk
Having two different alcohol services across County Durham and Darlington (due to two DAATs and two LAs) may lead to an inequitable service and confusion amongst agencies covering both areas.
The POPPIE system is not a national IT system and therefore is not spine connected, which could prevent/ delay transfer of data

Resource

Additional capacity
Additional counsellors need to be recruited for Tier 2 services. Alcohol clinical champions need to be identified to support pathway development.

Skills and Capabilities
Workforce
Training to deliver screening and brief advice needs to be rolled out; it is a requirement in specifications for providers. Three trainers have already been recruited to deliver this.
6 additional counsellors will need to be recruited; Tier 1 service within primary care and Tier 3 service fully recruited .
1 additional IT support officer needs to be recruited to the IM&T team to support the delivery of the service from the additional sites.
Public Health
We will undertake a comprehensive needs and financial assessment using the new data available.
IM&T
A new data system – POPPIE was procured by the DAAT last year and is already fully funded
Estates
The integrated alcohol services are now co-located in County Durham and Darlington, though also utilise other clinical and community settings are also used to see clients.

Likely impact on the provider landscape

The Alcohol Harm Reduction delivery programme should result in fewer A&E attendances and emergency admissions than is currently predicted.

Preventing Obesity Delivery Programme

Overview

Childhood obesity initiatives

Complete the Preventing Obesity, promoting Physical Activity strategies with Children's Trusts.
Utilise childhood surveillance data to measure levels of childhood obesity.
Phased development and Implementation of three age appropriate childhood intervention programmes.
Analyse training needs via workforce competencies review.
Establish weaning forums.

Adult obesity initiatives

Commissioning new care pathway for level 2,3 and 4 services.

Physical activity initiatives

Changing the Physical Activity Landscape (CPAL).
Exercise on referral programme.

Rationale

Levels of obesity in County Durham and Darlington are among the worst in England. The England average is 21.8% whereas the County Durham and Darlington average as a whole is 27.6%.

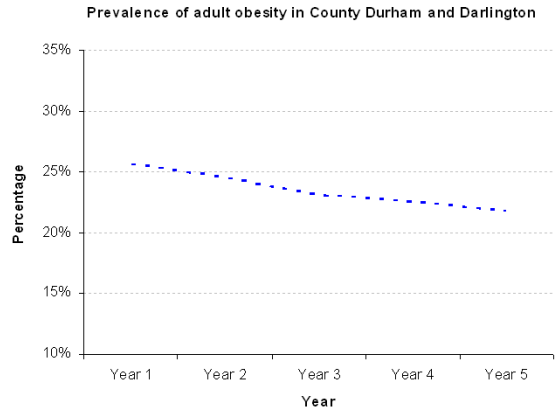
County Durham and Darlington Joint Strategic Needs Assessment clearly stipulates that rising obesity and the prevalence of type 2 diabetes are likely to have a substantial future impact on the demand for health care services.

To reduce health inequalities a reduction must be made in inequalities in lifestyle choices around physical activity and food.

Estimated current cost of obesity and overweight is between £6.6 and £7.4 billion annually in the UK, but more than double by 2050. Wider economy costs (sickness/ reduced productivity) will rise to £50 billion by 2050 (The Foresight Report, 2007).

An Oxford University study analysing the primary and secondary health care costs attributable to physical inactivity for PCTs found that the costs associated with physical inactivity based on 06/07 data to NHS County Durham and Darlington combined are estimated to be around £9.7m per annum.

Impact



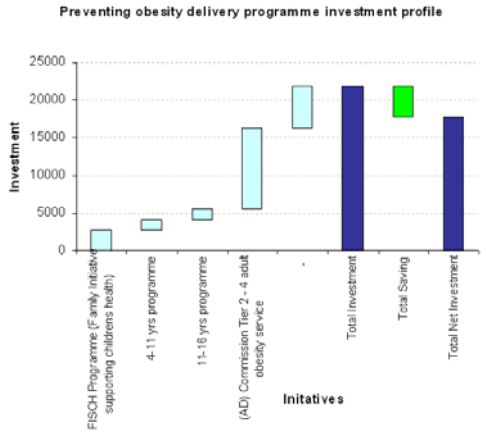
Likely impact on the provider landscape

The Preventing Obesity delivery programme will see a reduction in obesity related admissions into the acute sector.

Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Percentage of children in reception recorded as obese	11.0%	10.4%	10.4%	10.4%	10.4%
Percentage of children in Year 6 recorded as obese	21.0%	20.3%	20.3%	20.3%	20.3%
Percentage reduction in maternal obesity	26%	25%	24%	23%	22%
Percentage of clients in Level 2 and 3 services maintaining 5 x 30 minutes of physical activity per week at three month follow up	50%	50%	50%	50%	50%
Percentage of 16+ year olds participating in physical activity 5 x per week in C-PAL programme	21%	24%	27%	30%	32%
Percentage compliance and retention to Exercise on Referral programme	35%	45%	60%	70%	80%

Investment



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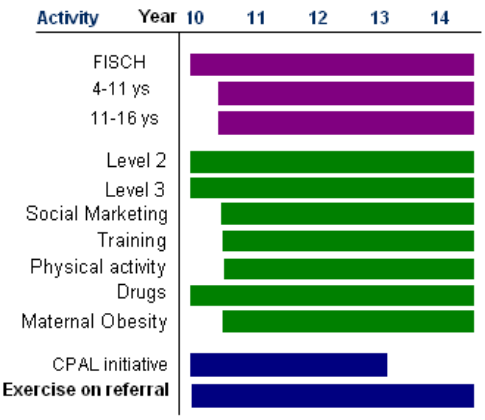


Risk

Impact risk

DH tools used to predict obesity in other children / young people age group suggest obesity levels over 20% in teenage groups. There are currently no intervention programmes available and the teenage programme may not reach some high risk groups.
Capacity of funded initiatives may exceed the service needs.

Financial risk

County Durham and Darlington have higher than average numbers of children who are obese and so programmes may exceed budget due to demand.
Increase in referral to exercise schemes resulting from increased demand associated with NHS Health Checks and brief intervention.

Delivery risk

Reduction of obesity levels will require behaviour change within families.
Measurement of impact can be difficult to measure immediately.
Risk of participation in physical activity not being sustained.
Threat to Exercise on Referral programme due to unequatable services and increased demand via NHS Health Checks and brief interventions.

Resource

Additional capacity

Partnership working is crucial to support all the elements of tackling obesity.
Impact upon specialist services (bariatric surgery) cost to be identified.

Skills and capabilities

Need to consider impact on an aging, community based workforce – potential gap in the future around knowledge, skills and competencies. Optimum skill mix will increase productivity by making better use of staff time whilst enabling them to work smarter using the highest level the skills and knowledge required of their role.
Training to deliver obesity awareness and standardised messages needs to be across both children Trusts integrated workforce.
Increased demand for community support services associated with pregnancy e.g. community midwives, health visitors, whilst recognising that this workforce is a recognised “hotspot”.

PCT resource to drive initiative

Public Health specialist / Consultant / commissioner Contracting/Performance/ Investment Planning/ Business Analysts.

Long Term Conditions Delivery Plan

Overview

Initiative 1
Diabetes service review.
This will cover a full pathway review and look to strengthen skills and knowledge of primary care teams managing diabetes.

Initiative 2
Home Oxygen Assessment Service and Pulmonary Rehabilitation.

Initiative 3
Community based Epilepsy Service and Community Neurological Rehabilitation. The community epilepsy service will provide specialist support clinics supporting patients in the management of epilepsy to achieve optimum seizure control with minimum adverse drug reaction. The service will support both epilepsy specialist and generalist, to ensure access to community and multi-agency service and to provide information and training. The community neurology service will provide ongoing access to a comprehensive range of rehabilitation in the community and support independent living.

Rationale

Current prevalence across County Durham and Darlington 5.2% (SHA prevalence 5%, England Average 4.8%) and is rising faster than, SHA and national average (QOF data).

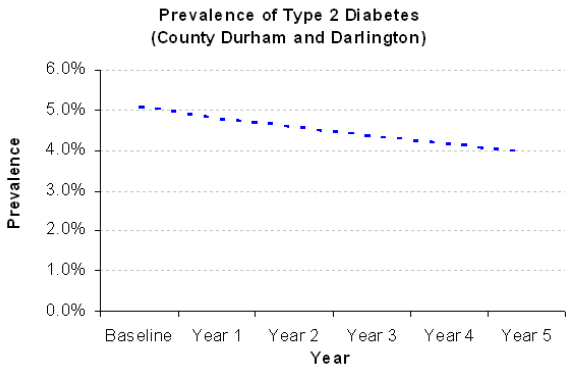
CVD screening and annual health checks are finding undiagnosed patients with diabetes and the demand on current services is already increasing.

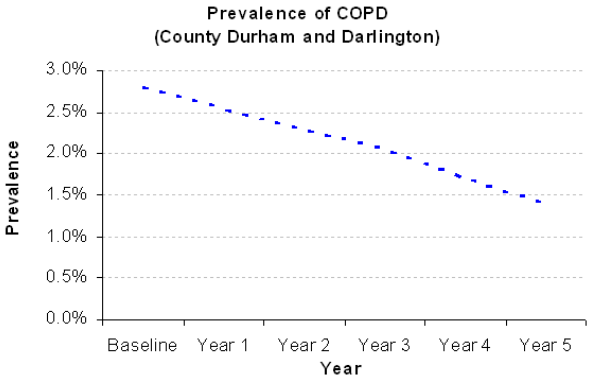
Current prevalence across County Durham and Darlington for COPD is 2.8% (England Average 1.4%) with predicted prevalence across County Durham and Darlington nearer to 4.8%.

Nationally County Durham is 7th in the COPD “hotspots” in the UK and people in County Durham and Darlington are 37% more likely to be admitted to hospital with COPD than the UK average.

Active Local County Durham and Darlington Neurological Forum (Clinical Advisory Group) who have worked in partnership to set localised priorities linked to regional and national strategy for neurological conditions.

Impact

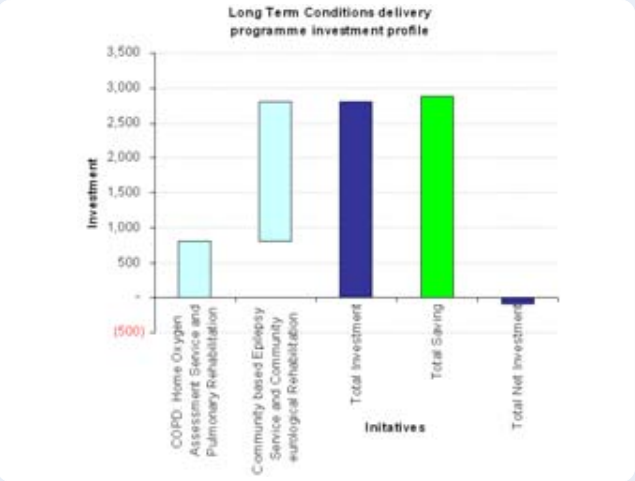




Key Performance Indicators

		Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Neurology	The % of people age 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months from accessing the service	71.4	73.3	75.2	77.0	78.9
Diabetes	The % of patient with diabetes in whom the last HbA1c is 7 or less in the last 15 months	69.3	69.7	70.2	70.6	71.1
	The % of patients with diabetes who have a record of retinal screening in the previous 15 months	93.8	94.2	94.7	95.1	95.6
Home Oxygen Assessment Service	Total number of patients requiring emergency oxygen supply and source of referral	132	107.3	82.5	57.8	33

Investment



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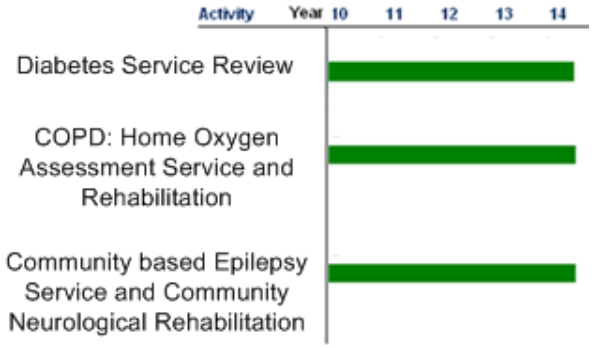


Risk

Impact risk
Failure to ensure that smokers are given appropriate advice and support around smoking cessation will result in poor health and expenditure on COPD.
Failure to reduce diabetes prevalence will lead to an increase in demand for services. Currently this already an issue across County Durham and Darlington where demand is outstripping capacity and will worsen should obesity levels not be tackled.

Financial risk
Increased prescribing associated with the diseases. Currently the prescribing spend is £7.4million (County Durham £6.3M Darlington £1.4M). This is based upon current population size. Utilising the predicted prevalence model there is an assumption that this will increase by around 1.7% over the next 5 years.
Increase in FT activity and costs associated with payment by results tariff.

Delivery risk
Lack of funding will prevent delivery.
Lack of capacity to meet demand due to increased prevalence and active case finding associated with PBC incentive scheme and CVD screening.
Delivery of services could be affected if the providers workforce does not have the necessary capacity or contingency plans in place.

Resource

Additional capacity
Suitable community estates/premises would need to be identified including access to a range of support services for e.g. diagnostics, path labs, plaster rooms, oxygen.

Skills and capabilities
There is a limited number of providers who will be able to offer the required level of services.

There is a need to consider the impact on an aging, community based workforce – potential gap in the future around knowledge skills and competencies.

Appropriate skill mix will need to be considered to support professionally qualified staff which may provide additional capacity over time.

Optimum skill mix will increase productivity by making better use of staff time by enabling staff to work smarter, playing to the highest level of skills and knowledge pertinent to their role.

PCT Resource to drive the initiative
Due to the size and complexities associated with the project, a team approach would need to be associated with implementation. This will include a dedicated project manager and additional support around investment planning, business analysis and public health.

Likely impact on the provider landscape

The Long Term Conditions delivery plan overall see a shift in elective and non-elective activity away from the acute sector into the community sector. There should also be a reduction in A&E attendances related to long term conditions.

Cancer Mortality Reduction Delivery Programme

Overview

The focus of this initiative is in line with the Cancer Reform Strategy which states that the biggest gain in cancer mortality rates will be achieved through the earlier detection of cancers.

Across County Durham and Darlington we have a nationally recognised local initiative in line with the national model comprising:

- Cancer Awareness and Early Diagnosis Service
- Cancer awareness measure to evaluate changes from baseline
- Cancer Screening social marketing programmes
- Primary Care Audit and Intervention to reduce delays in diagnosis
- Primary and community care cancer awareness training programme

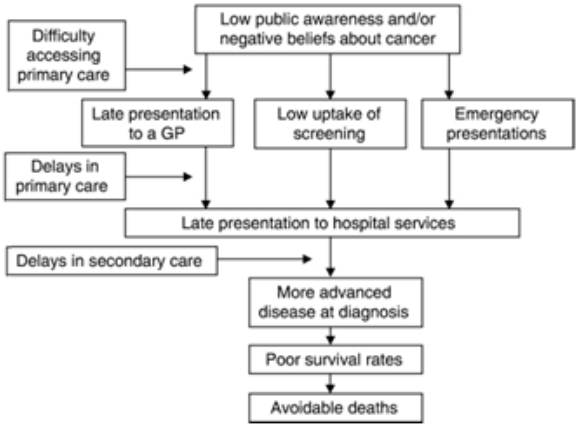
This initiative will focus on those cancers that make up half of our early cancer deaths locally – Breast, Bowel and Lung.

Rationale

Low awareness of cancer combined with negative beliefs about cancer leads to late presentation to primary care and screening services.

Delays in primary care can lead to late diagnosis.

Delays lead to patients being diagnosed with more advanced disease and thus experience poorer survival rates resulting in deaths that could be avoided.



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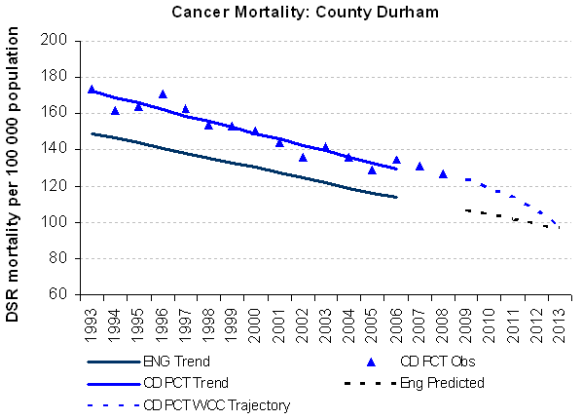
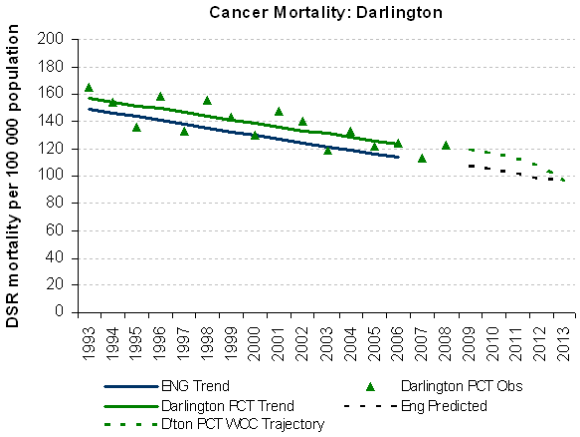




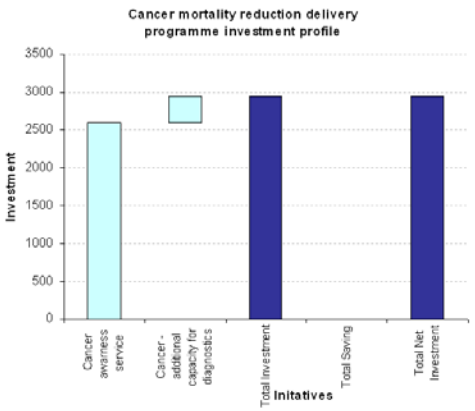
Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Increase in cancer awareness in targeted communities from baseline	5%	5%	5%	5%	5%
Increase in cancer screening uptake - Breast Cancer	600	650	650	400	400
Increase in cancer screening uptake - Bowel Cancer	750	1000	1150	1000	750
Increase in cancer screening uptake - Cervical Cancer	2000	2500	3200	1000	1000
Conversion rate for 2 week diagnostic referrals	15%	16%	17%	18%	19%

Likely impact on the provider landscape

The Cancer Mortality Reduction delivery programme will see an increase in diagnostic tests (breast cancer screening, colonoscopy and chest x-rays) in the acute sector.

Investment



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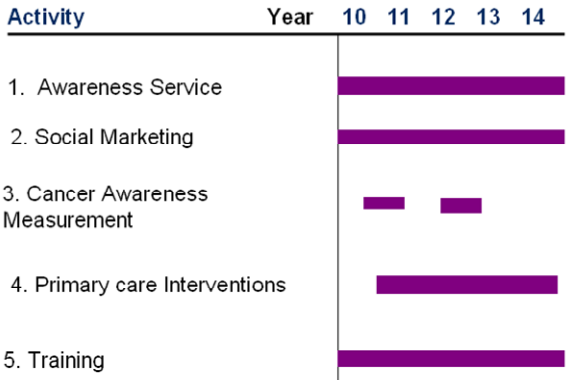


Risk

Impact risk
Engagement of community and primary care staff.

Financial risk
There are additional costs associated with this initiative in terms of diagnostic capacity. However, It is hoped that these costs will be offset through the cost benefits of earlier diagnosis.

Delivery risk
Failure to realise the extra diagnostic capacity has the potential to undermine delivery of the initiative.

Resource

Additional capacity
Diagnostic services will need additional capacity to meet demands of this initiative. From work carried out nationally by Healthy Communities Collaborative in targeted practices we expect to see a 10% increase in diagnostic demand. Across County Durham and Darlington we intend to target 12 practices in the first year, 15 in the second and 20 in the third.

We will calculate this extra capacity needed on this basis and use it to also model additional colonoscopies and mammograms from current based rates.

Skills and capabilities
There is a skilled capable diagnostic workforce in place however there needs to be careful consideration as to where the additional diagnostic capacity will come from. Training and CPD for this specialised field may need to be increased to support demand locally and regionally.

PCT resource to drive initiative
We have no additional resources to support and commission this initiative. Key staff include consultant in public health and social marketing manager.

CVD Mortality Reduction Delivery Programme

Overview

Initiative 1 – Annual Health Checks
The NHS Health Check programme is a CVD primary prevention programme currently implemented in general practice.

The scheme targets the apparently healthy population aged 40-74 without a pre-existing cardiovascular condition, on a five year rolling programme. The aim would be to target those at high risk.

Initiative 2 – Secondary Prevention
Through the early detection of arrhythmias through the use of holter tapes and localising elective PCI.

Initiative 3 – Review of stroke services
Assessment and management of transient ischaemic attacks (TIAs) with carotid endarterectomy.

Assessment and management of acute strokes with thrombolysis in hyper acute setting.

To provide Early Supported Discharge and specialist community rehabilitation for all patients discharged from hospital with a stroke.

Management of acute stokes within specialised stroke units.

Rationale

CVD mortality is the biggest single contributor to the gap in life expectancy between Co Durham and Darlington and England.

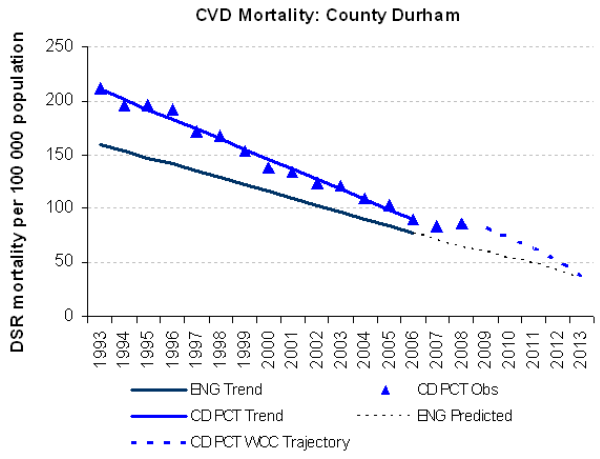
Stroke is the third largest cause of death in the UK responsible for 11% of deaths in England.

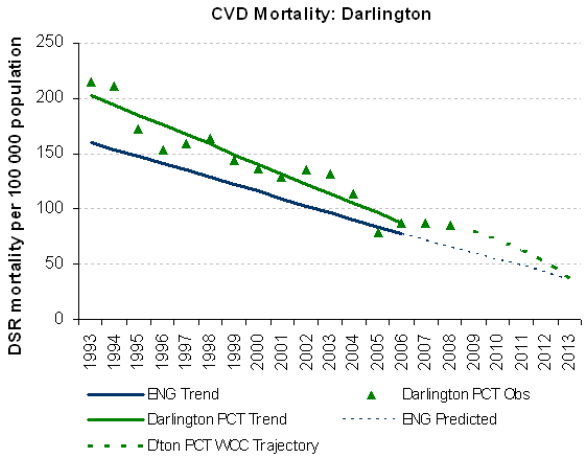
There are approximately 1,300 strokes in County Durham and Darlington each year of which 20-30% die within one month.

It will contribute to a reduction in CVD mortality from 86.6 (Durham) and 84.5 (Darlington) to under 40 per 100,000 population.

Targeting the high risk population aged 40-74 has been shown to be cost effective.

Impact



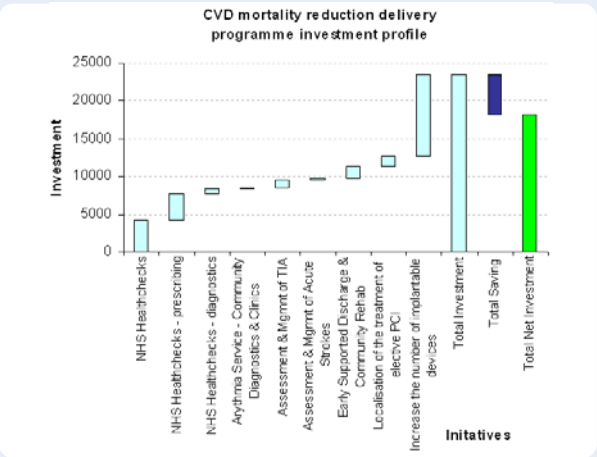


Key Performance Indicators

		Y1	Y2	Y3	Y4	Y5
Deficit in patients receiving pacemakers	County Durham	28	27	20	10	0
	Darlington	7	7	5	3	0
Deficit in patients receiving implantable devices (ICD)	County Durham	60	55	40	20	0
	Darlington	90	85	65	30	0

	Y1	Y2	Y3	Y4	Y5
Number of stroke patients spending 90% of their time on a stroke unit	70%	80%	85%	90%	95%
Number of high risk TIA cases scanned within 24-hours	45%	60%	70%	80%	90%
Number of stroke patients seen by ESD/Specialist Community Stroke Team	40	100	160	200	200

Investment



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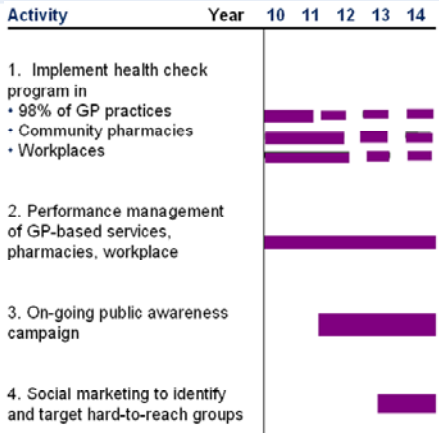


Risk

Impact risk
Maximum impact will be achieved by targeting those at greatest CVD risk. Social marketing work will be necessary to identify those hard to reach groups and devise strategies to improve uptake in these groups.

Health checks and referrals may not lead to a sufficient level of lifestyle change. Compliance with interventions will need to be high and sustained to deliver health outcome benefits.

Financial risk
Unforeseen impact on acute care activity.
Increased uptake of lifestyle pathways.
Mobile technology.
The drug costs of £4.1m have not previously been accounted for. The pathology costs of £0.53m have not previously been itemised.
Financial scenarios would risk failing to deliver health outcome trajectory.

Delivery risk
Hard to reach groups may not access health checks in the settings provided.
Insufficient capacity in primary care.
Insufficient capacity in lifestyle pathways.
The impact of an aging community based workforce.

Resource

Additional capacity
Providers (GPs, pharmacists) need to increase activity to provide up to 44,660 Health Checks p.a.
Lifestyle pathways need to increase capacity.

Skills and capabilities
More staff will need to be trained to deliver the required number of Health Checks.
Not all pharmacies will have capacity or facilities to offer NHS Health Checks.
Potential to open to any willing provider to deliver NHS Health Checks to required service specification.

PCT Resource to drive the initiative
Project management and evaluation
Data quality and intelligence support
Internal informatics support

Likely impact on the provider landscape

The CVD Mortality Reduction delivery programme will initially see an increase in prescribing rates and diagnostic tests (such as blood and cholesterol tests). As a result of these increases there will be a reduction in non-elective activity in the acute sector. There will be an increase in elective activity in the acute sector through secondary prevention measures. Earlier discharges will result in increased community activity.

Improving Mental Health Delivery Programme

Overview

Initiative 1

Invest in access to psychological therapies to ensure that the initially identified population need is fully catered for. This provides the gap in funding which resulted from a reduction in national funding available post initial needs assessment.

Initiative 2

Expansion and coordination of targeted social prescriptions for those subject to risk factors for poor mental health.

Social prescribing involves addressing some of the root causes of poor mental health including loneliness, Isolation, low self esteem and poor resilience/coping skills.

These factors are more present in specific communities as a result of risk factors for poor mental health that they have been exposed to. Social prescribing provides coordinated and free or subsidised access to non-medical interventions which are evidenced to improve mental health and wellbeing.

There are many social prescribing models, two of which are currently being piloted in County Durham and Darlington.

Rationale

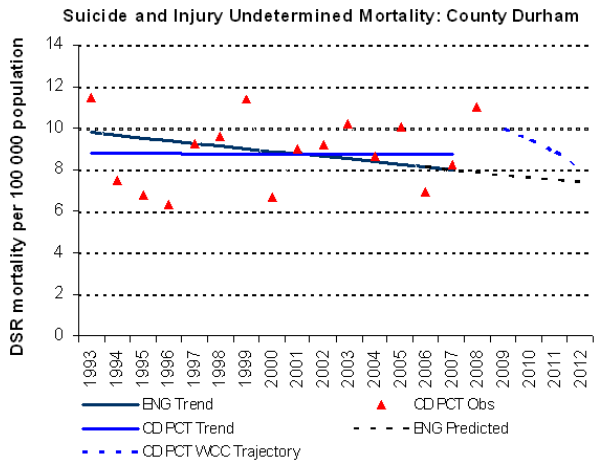
Half of all women and a quarter of men will be affected by depression at some time in their life and 15% experience a disabling depression.

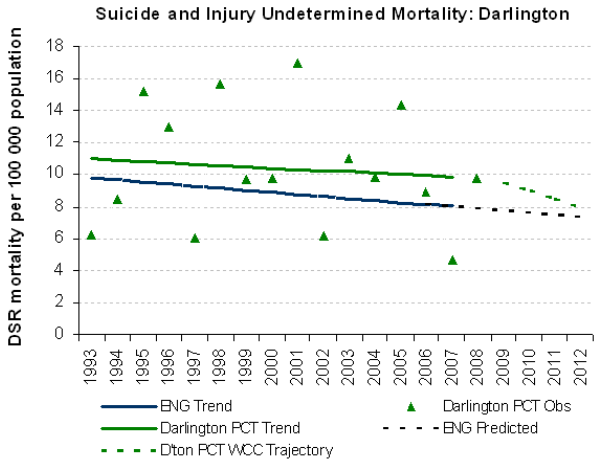
Darlington JSNA shows that 44% of IB claimants are claiming for mental health reasons while County Durham JSNA shows that 43.3% of IB claimants are claiming for mental health reasons.

Patients show 2:1 preference for psychological therapies over medication.

Layard et al 2007 calculate NHS savings resulting from access to an IAPT service per person treated at £300 over a two year period including both physical and mental health services. Layard also calculates the saving to the exchequer to be £900 per person, plus NHS savings.

Impact



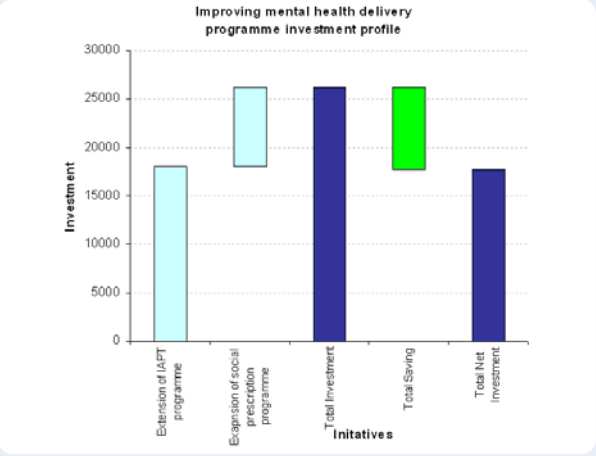


Key Performance Indicators

		Y1	Y2	Y3	Y4	Y5
Number of new patients treated each year under IAPT	County Durham	N/A	702	1403	1403	1403
	Darlington	N/A	140	281	281	281
	Total	N/A	842	1684	1684	1684

		Y1	Y2	Y3	Y4	Y5
Number of new patients referred per year under social prescribing	County Durham	N/A	417	854	1000	1000
	Darlington	N/A	83	171	200	200
	Total	N/A	500	1025	1200	1200

Investment



Timeline

Year 1

Deliver of pilot phase of arts for wellbeing and evaluate (funding in pla
Raise professional awareness of social prescribing

Develop market of new providers and secure additional provision

Year 2.

Expansion of social prescription options to additional groups.

Begin Time Bank Pilot in North Durham

Mainstream arts programme and expand coordinating function to new areas if appropriate

Year 3

Complete delivery and evaluation of time bank pilot and mainstream in area

Continued delivery of coordinated range of social prescriptions

Year 4

Roll out of time bank successful components to further 3 areas

Continued deliver and service review of range of social prescriptions

Year 5

Social Prescriptions service review

Risk

Impact risk
Poor mental health is linked with factors beyond health care, such as unemployment (Dorling, 2009). As more people find themselves out of work we need to ensure that there are services with the capacity to help them if they become unwell. Initially, more people with anxiety and depression will present at a primary and community care level. Sufficient capacity in the system is vital in order to facilitate early.

Financial risk
Service may have to be capacity limited.
Unidentified needs could increase demand for service.
Social Prescribing Service is in higher than anticipate demand and exceeds budget available.
Inadequate resource as the increase in common mental health problems grows associated with the economic downturn. Work on MH block contract due for completion Aug 2011.

Delivery Risk
Providers are not available for social prescribing – market development tools will be employed to support competency in this new workforce.
Services are reliant on whole pathway of care e.g. if Clinicians do not "buy in" to social prescribing concept the system will fail.
Potential providers for psychological therapies (in particular voluntary sector) are destabilised before funding for the service becomes available.

Resource

Additional capacity
Require a range of high intensity and low intensity mental health workers and third sector support and development. GPs do not need any further resources to deliver this service. It is assumed that there is a neutral impact on primary care due to potential higher numbers of people coming forward being offset by a reduction in repeat attendances

Skills and capabilities
Need to liaise with a range of agencies and across a range of disciplines through the voluntary and statutory sector to secure a coordinated primary care mental health service
Social prescription providers require market development investment to ensure providers are competent to deliver to vulnerable groups and that organisations are fit to practice under NHS contractual requirements. Third sector development capacity is currently contracted on a demand led basis and could be utilised to support this

PCT resource to drive initiative
Current investment in the IAPT service stands at 6.6 million from 20010/11-12/13 investment requested will "top up" this service to the required level For IAPT an increase of 0.2 WTE in project management is required.

Likely impact on the provider landscape

The Improving Mental Health delivery programme will see a reduction in acute mental health services and increase in community based mental health services. There will also be a reduction in A&E attendances and emergency admissions through reductions in episodes of self harm.

Older People With Mental Health Needs Delivery Programme

Overview

Initiative 1

Diagnostic Services – to improve access to early diagnosis and specialist support to enhance the quality of life and reduce the need for access to residential and nursing care. This includes collecting baseline data relating to GP registers for people of any age with co-morbidity of LD and dementia.

Initiative 2

Acute Liaison Service – enable timely discharge to an appropriate setting.

Rationale

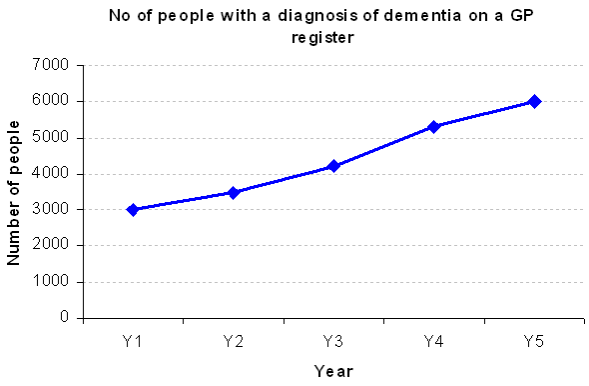
Compared to the England national average of 4% prevalence of dementia, County Durham & Darlington has a higher rate of 5%.

The National Dementia Strategy identifies that in the next 30 years the number of people with dementia in the UK will double with costs trebling. Local data identifies predicted overall costs of day care, residential care and home care for dementia of £35m by 2021.

The National Dementia Strategy suggests that people who are diagnosed early in the process of the disease are more likely to receive pharmaceutical and therapeutic interventions that will enable them to live active lives for longer and delay or prevent transition into residential/nursing homes.

DH modelling estimates that savings of 6-20% on residential/nursing care costs can be achieved over a period of 10 years with savings commencing after year 4, If memory clinics and community support teams are in place.

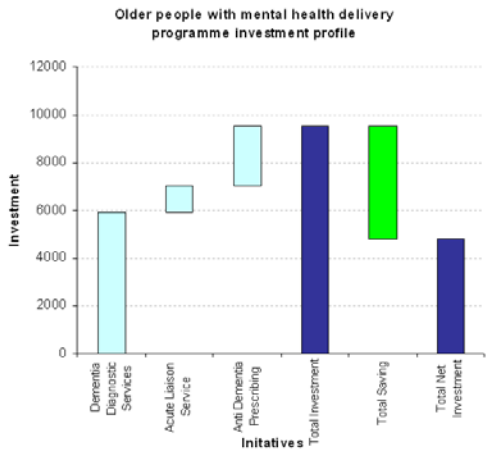
Impact



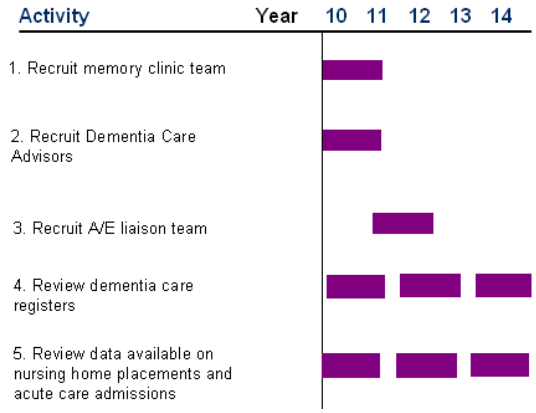
Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Reduction in the number of people entering nursing care					0.01
Reduction in the length of stay for patients in acute hospital settings with a secondary diagnosis of dementia				2 days	3 days
Number of people prescribed anti-cholinesterase	450	560	680	800	1000

Investment



Timeline



Risk

Impact risk
DH data regarding reduction in need for nursing/ residential care financial modelling is estimated.
Changes in NICE recommended treatment options could increase the cost over time.
Reduction in nursing/residential care costs is dependant on social care partners continued financial commitment.
Initiatives will be dependant on clinical acceptance of new referral pathways and potential benefits.

Financial risk
Additional cost associated to GP register increases.
Impact of changes to acute care tariff currently unknown.

Delivery risk
Additional training costs identified from national pilots for dementia care advisors.
Availability of required workforce.

Resource

Additional capacity
Increased nursing (band 6) and occupational therapy (band 5) and dementia care advisors (bands 3 and 4) will be required to deliver the service.
Capacity within the acute sector to meet additional demand for dementia diagnosis.
Informatics and IM&S skills and resources.

Skills and capabilities
Specialist mental health services able to deliver the whole pathway except the dementia care advisors who can be recruited through the voluntary sector.
Training needs of dementia care advisors through national pilots currently underway will need to be accounted for as they emerge.
GPs will need increased awareness training to refer for diagnosis at early stages.
Expertise in the use and application of ‘Map of Medicine’.

PCT resource to drive initiative
Input from procurement, market development, performance management, finance and contracting and commissioning will be required initially at an intensive level but reducing as services develop.

Likely impact on the provider landscape

The Older People with Mental Health Needs delivery programme will see a reduction in lengths of stay in the acute sector and ultimately a small reduction in the number of people entering nursing homes.

End of Life Strategy Delivery Programme

Overview

Expand scope of existing QOF palliative care registers to extend to long term conditions beyond cancer e.g. COPD.

Roll out a training package to train GPs on the expectations of the “Good Death” charter and criteria of adding patients to the register, with explicit reference to non-cancer.

Roll out a series of public, practice based commissioning and provider events around the principles of the “Good Death” charter. This will ensure that there is wide consultation of the public’s views on what constitutes a good death so that service and models of care can be reviewed.

A review of national data in August 2010 from the Marie Curie model in Lincoln will review the inclusive coordination centre approach.

Whilst waiting for those results we will run a localised pilot working with all providers to review the role of localised coordination centres, which will be evaluated against the national model for the clinical programme group to assess the preferred model of care. This recommendation to go to our Board prior to the development of a service specification that ensures 24/7 access to rapid coordinated care.

Rationale

Demand for high quality palliative care is increasing.

An ageing population leads to increased demand for palliative care (over 85 population).

Public consultation has raised issues on care at end-of-life, and dignified death.

There is a national mandate to co-ordinate care by adapting national model of best practice (Lincoln model) to local conditions.

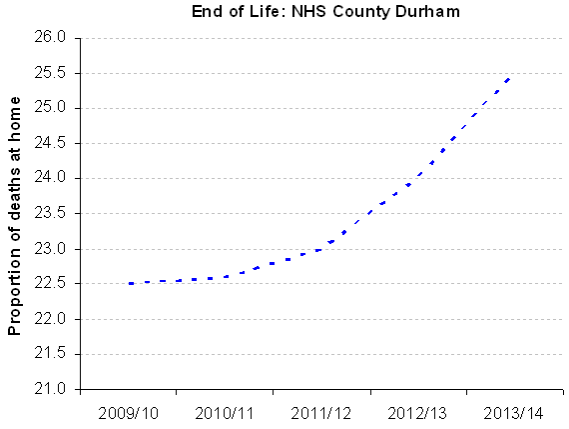
Anecdotal evidence: non-cancer patients receive inferior support at end of life because they are not on the register.

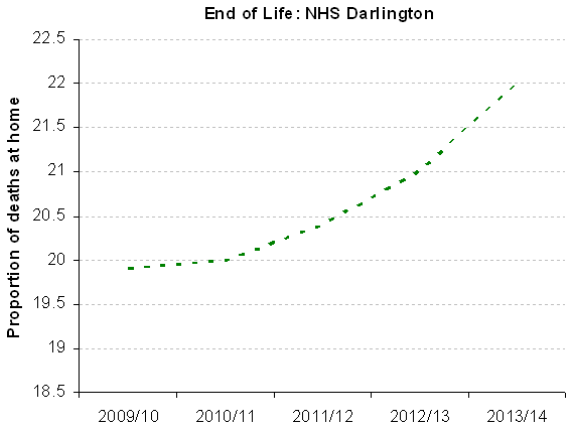
Hospice utilization is low (66% - 80%) and average length of stay is 10 days.

In Easington, where the 24/7 model exists, 72% of deaths occur at home (with 80% able to die in their preferred location), whereas 28.6% in County Durham and 19.9% in Darlington.

There is a significant quality and productivity gap between County Durham and Durham and best practice.

Impact

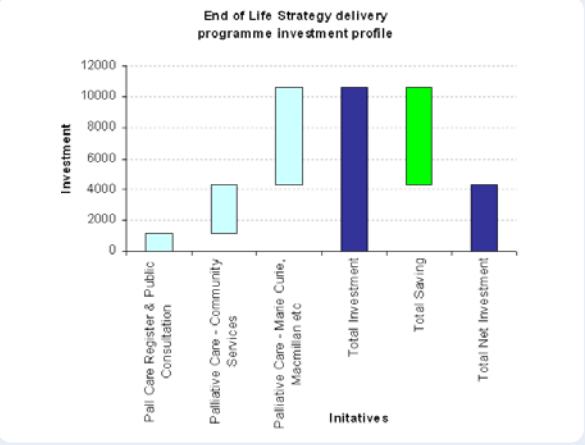




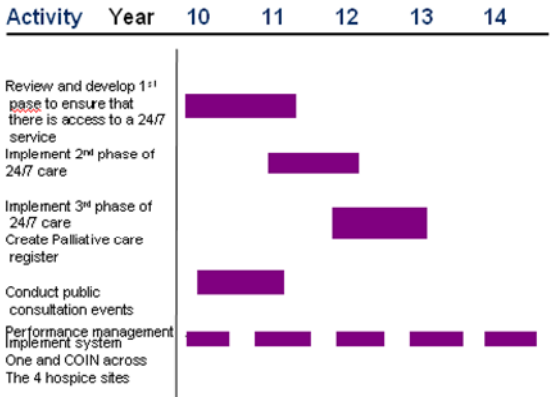
Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Percentage of patients obtaining preferred place of death	20%	25%	35%	42%	50%
Percentage of people on a palliative care register					98%
Percentage of people who have an advanced care plan					98%

Investment



Timeline



Risk

Impact risk
There is a lack of national data from Marie Curie to evaluate the impact of a centralised co-ordination.

Financial risk
The unknown number of patients that are actually admitted with end of life need as apposed to disease exacerbation.

The cost of the coordination as per the gaps identified in service review for 24/7 care coordination of care, we have assumed will equate to around £3.18 million which includes uplifting Hartlepool hospice to 50 % funding as in line with our other hospices.

There may be additional capital costs of IT equipment if current systems are inadequate.

Delivery risk
Delivery of the single coordination of care through new model is yet to be proven as the ultimate model for delivery. Until that data is available this is still unclear. If this was the preferred solution then giving notice to all providers to re-procure the model will this lead to interruptions and destabilisation of delivery pathway in the intervening time. It is possible that no provider is willing to undertake delivery of care co-ordination.

A review of the IM&T infrastructure needed to deploy coordination of care including the use of summary care record as a electronic solution to the paper record.

Resource

Additional capacity

Skills and capabilities
Workforce and aging profile of workforce could provide issues in the short term whilst the service model is developed and implemented.

The role of map of medicine in end of life and the initiation of a project for the implementation of SytemOne and COIN networks in other institutions such as hospices.

Review of options for telehealth\telemedicine and digital technologies to improve communication with patients and the public.

PCT resource to drive initiative
A project manager is already in place to undertake the review and develop specification. Further resources around business analysis to assist in the data assumptions will be needed alongside workforce and procurement.

Likely impact on the provider landscape

The End of Life Strategy delivery programme will see a reduction in non-elective activity in the acute sector.

Care Closer to Home

Overview

Initiatives:

Review of musculo-skeletal and orthopaedic services including pain management focusing on tier 1, tier 2 and diagnostic pathways.

Community diagnostic programme including endoscopy services, non-obstetric ultrasound, MRI and CT scans.

Review of ophthalmology services.

Review of dermatology services.

Community ENT service.

Community gynaecology service.

Rationale

The current range of planned care services represents the greatest opportunity to move appropriate services out of hospital into a location closer to the patients' homes. This will provide greater choice and accessibility for patients and will release efficiencies that can be re-invested into priority areas.

Currently there are several providers of MSK (tier 2) and community physiotherapy (tier 1) operating different models of service. Waiting times and staffing levels also vary across the county and patients are being denied the chance to try treatments alternative to surgery.

There are several examples of community based endoscopy services operating elsewhere in the country (including Norfolk, Saffron Walden, Huntingdon and South East Essex) that have demonstrated more accessible and cost effective models then currently exist in County Durham and Darlington.

NICE guidance on Glaucoma and Ocular Hypertension was issued in April 2009 that will widen referral criteria and significantly increase secondary care activity. We have already developed a service specification for a community based service that will provide additional capacity and create a diversion for secondary care.

Currently four of the six localities (including Darlington) have access to a community based dermatology and minor surgery service. Sedgefield and Durham and Chester-le-Street localities do not have access. The patients of those two localities access hospital based services charged at full consultant led service tariff.

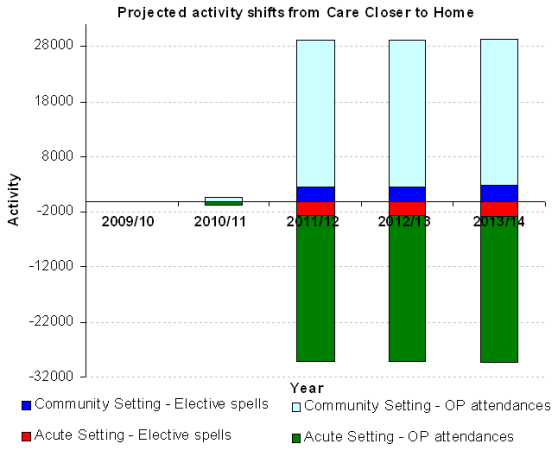
Practice based commissioning groups are currently piloting community ENT and gynaecology that offer services closer to patients homes. These pilots will be evaluated for cost and clinical effectiveness with the potential for county wide roll out.

Key Performance Indicators

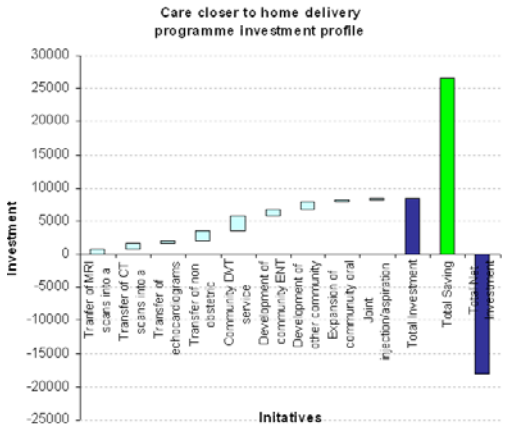
	Y1	Y2	Y3	Y4	Y5
HCAI - reported MRSA cases	0	0	0	0	0
Recurring Serious Untoward Incidents of the same type	0	0	0	0	0
Failure to investigate a complaint of a serious untoward incident	0	0	0	0	0
Adverse advice line reports	0	0	0	0	0
Patients waiting over 18 weeks	0	0	0	0	0

There will also be service specific KPIs including compliance with relevant NICE guidance and Core Standards for Better Health and maintenance of appropriate staffing levels

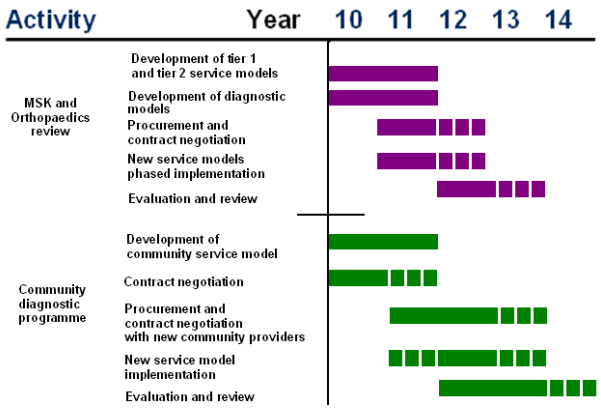
Impact



Investment



Timeline



Risk

Impact risk
Failure to get a clinically agreed service model that manages demand and agreed clinical pathway.
Impact of requirements to implement NICE guidance.
Difficult to measure impact due to data and information limitations from existing community based providers.

Financial risk
Anticipated savings may not be realised or the projected shift of activity may not materialise.
The risk of double running costs in some services which could be mitigated through contract negotiation.
IMT infrastructure investment for the range of sites involved including mobile technologies, telecare and telehealth and staff capacity in informatics and I&MT departments internally and with providers.
Changing payment mechanism (block to tariff) or a change in overhead costs may affect viability.

Delivery risk
Failure to develop the market.
Failure to identify and train staff particularly GPSIs and nurses.
Lack of suitable mentorship/supervision to support the training of the GPSIs.
Impact of the timescales involved in developing the competences for the GPSIs accreditation and training for nurses.

Resource

Additional capacity
We will utilise the regional TUPE framework to support the re-alignment of staff, whilst CPD education and training will support staff to work flexibly and in new settings. The services will be provided from within existing facilities. Suitable theatre accommodation with recovery and waiting facilities will be required, likely to be in community hospitals or primary care centres.

Skills and capabilities
Expertise in the use and application of 'Map of Medicine' and the use of digital technology for social marketing.
Trained endoscopists (inc consultants, GPSIs and specialist nurses) with CPD education and training to support staff working flexibly and in new settings.
Training will be required to ensure GPSIs and specialist nurse capacity meets likely demand.
Trained opticians and ophthalmologists (including consultants, GPSIs, opticians and specialist nurses), with CPD education and training to support staff working flexibly and in new settings.
The existing providers have the expertise to deliver the CATS model and physiotherapy service dependent on the agreed service model.

PCT resource to drive initiative
Project lead, PBC and finance support, estates, workforce, business analysis and market development, I&MT.

Likely impact on the provider landscape

The likely cumulative of these initiatives is a shift in activity away from the secondary care setting to community and primary care settings. Some individual initiatives may primarily focus on the community and diagnostic elements of clinical pathways.

Reform of the Urgent Care System

Overview

Initiative 1
Single point of access (SPA). We are leading the country on a DH initiative introducing the 3 Digit Number '111' which will link directly to single point of access – this will ensure that access into the Urgent Care services are noncomplex with a consistent assessment of all patients. This single point of access initiative supports the reform of the urgent care system.

Initiative 2
Rapid Medical Assessment Centre (RMAC). These units are nurse practitioner-led services which create a separate pathway for patients requiring rapid medical assessment but who are stable enough not to require admission via a medical assessment unit (MAU). They will operate whilst the new urgent care system embeds itself and until a full service specification including exclusion criteria can be completed.

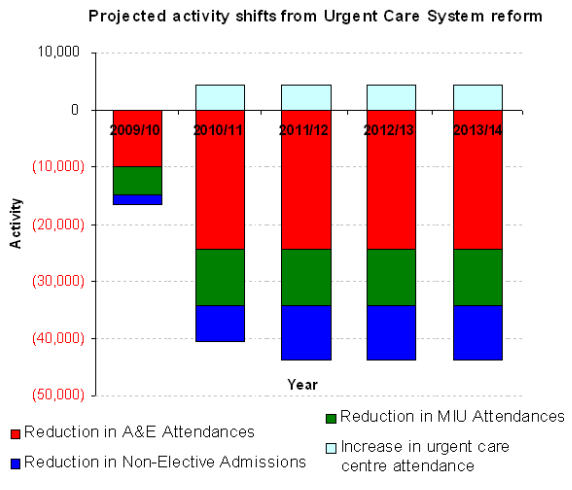
Initiative 3
Acute GP Service. This pilot will test the hypothesis that a GP working in partnership with the medical admissions unit in the acute trust can provide a high quality, safe, effective, and patient focused service. This will augment existing acute medical patient care pathways.

Rationale

We introduced a new urgent care model in October 2009 and we will evaluate the success of the model from early implementation.

The current under-utilisation of the Urgent Care Service has allowed the implementation of pilots which also assist in care closer to home and reduce the costs associated to secondary care. Whilst the service model is new, evaluation may still present an opportunity for redesign.

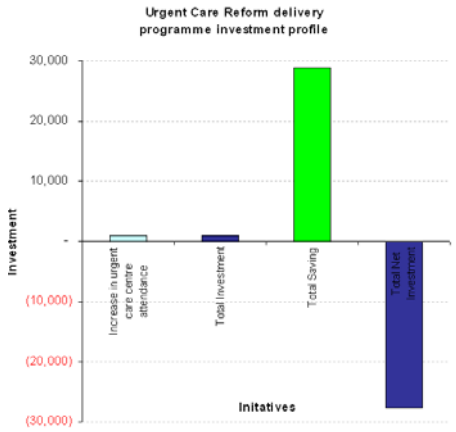
Impact



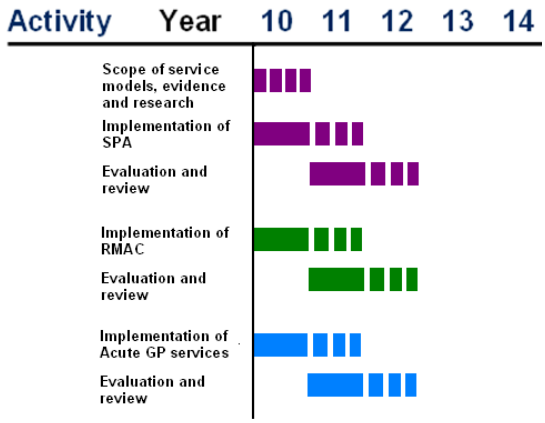
Key Performance Indicators

	Y1	Y2	Y3	Y4	Y5
Maintaining 4 hour A&E target	98%	98%	98%	98%	98%
HCAI - reported MRSA cases	0	0	0	0	0
Recurring Serious Untoward Incidents of the same type	0	0	0	0	0
Failure to investigate a complaint of a serious untoward incident	0	0	0	0	0
Percentage of calls which are life threatening referred to ambulance service within 3minutes	95%	95%	95%	95%	95%
Percentage of urgent calls with clinical definitive assessment within 20 minutes	95%	95%	95%	95%	95%
Percentage of non-urgent calls with definitive assessment within 60 minutes	95%	95%	95%	95%	95%
Percentage of face-to-face consultations within 1 hour for emergency patients	95%	95%	95%	95%	95%
Percentage of face-to-face consultations within 2 hours for urgent patients	95%	95%	95%	95%	95%

Investment



Timeline



Risk

Impact risk
A shift of activity to UCC, not from ED, but from Primary Care, patients using SPA and UCC for treatment of non-urgent conditions or the management of LTC due to perceived difficulty in accessing other primary care services.
Patients unaware of the services available at an UCC.
Differing levels of support provided by GP partners.
Impacting strategies not implemented i.e. Intermediate Care, Palliative Care, Community Nursing therefore support services not available 24/7.
Lack of IT interface between Social and Acute care
Partnership working with commissioning extra services from NEAS may impact on their core delivery of meeting targets for 999 services.
Risk of high demand in early stages of implementation of RMAC.
Acute GP pilot relies on collaboration between consultants and GP staff.

Financial risk
Patients do not use Urgent Care instead of Emergency Department, therefore paying twice.
Risk that forecast numbers of prevented admissions are not prevented.

Delivery risk
Access to specialist with ability to install appropriate systems required.

Resource

Additional capacity
Resource is required with regards to expert in telecommunications for 3DN, expert in using map of medicine.
Suitable community premises required.

Skills and capabilities
Urgent care and general practitioners.
Nurse practitioners Pitch as Acute Physician firstly with medical support. Trained Acute/Urgent Care GPs required.

PCT resource to drive initiative
Project lead, PBC support, finance support. Joint post of business analysist/ IT trainer to interrogate the systems to ensure systems can be interrogated to provide correct information for commissioning decisions.

Education: For patients and professional – to understand this replaces OOH services; to be aware of the alternatives to A&E supported by GP Partners to avoid confusion to patients.

Workforce: Commissioning of education to assist in the increase of choice settings of treatment.
Some primary/community care specific training modules e.g. emergency care for primary care at Northumbria.
CPD and NMET and possibly funding to support skill mixing for the bands 1-4.

Likely impact on the provider landscape

The Urgent Care System delivery programme will see a reduction in A&E minor attendances and an increase in Urgent Care Centre attendances and episodes of self care following a telephone consultation.

4.6 Prioritising the goals and programmes that deliver them

Whilst NHS County Durham and Darlington will seek to achieve all of its strategic goals, it is necessary to prioritise them as part of planning for the possibility of different future financial scenarios.

The strategic plan includes twelve delivery programmes to improve the health of the local population. It also includes two quality and productivity delivery programmes that will release efficiencies that can be re-invested into priority areas and three enabling delivery programmes (workforce, estates and health informatics) that allow effective service change.

These delivery programmes have been reviewed to ensure they:

- consider whether the balance of investment and allocation of resources is correctly weighted
- assess impact on health outcomes necessary to meet our goals and trajectories
- ensure that the strategy is designed to deliver improvements in both quality and productivity
- understand and articulate the implications for the provider landscape
- identify critical enablers are robust (business enablers for cluster, system enablers for the health economy) and based on best available evidence

From this review, the delivery programmes that combine to give the greatest impact in terms of contribution to reducing excess mortality, improving poor quality services and reduction in health inequalities have been prioritised.

The selection and prioritisation of goals will be reviewed annually as new health need and financial information becomes available and our delivery programmes objectives are reached.

We will do this using our health economic prioritisation tool that was developed in conjunction with the Institute of Health and Society at Newcastle University. This tool was developed by members of the public, clinicians and our staff to prioritise areas of highest need and uses criteria covering health benefit, quality, access and value for money of delivery programmes.

4.7 Priority areas

Reducing CVD mortality

CVD is the biggest single contributor to the gap in life expectancy between County Durham and Darlington and England. By focusing on CVD it is expected to reduce CVD mortality from 86.6 (Durham) and 84.5 (Darlington) to under 40 per 100,000 population. For stroke, there are approximately 1,300 strokes each year of which 20-30 die within one month.

The programme initiatives include extending the Annual Health Checks programme, developing a five tier obesity management pathway, further improvement to stroke services through investment in rapid diagnosis and treatment, linking with regional work to develop hyper acute stroke services and making more intensive use of community hospital facilities for rehabilitation. This will result in a change to the provider landscape as the use of primary and community care settings increases over the next five years.

Reducing cancer mortality

Low awareness of cancer combined with negative beliefs about the disease all lead to late presentation in primary care. This in turn means that patients are being diagnosed when their cancers are more advanced and thus experiencing poorer survival rates. The delivery programme initiatives that focus on smoking and tobacco control, extending screening programmes and increasing access to earlier diagnosis are therefore vital. The trajectories and projected health outcomes within these delivery programmes have been benchmarked against best performing PCTs nationally.

These investments will increase life expectancy and lead to better health outcomes. The provider landscape will be shaped by increasing referrals to secondary care for earlier screening, increased demand on primary care and access to diagnostic services.

Reducing harm associated with alcohol

Compared to the England average County Durham and Darlington has significantly higher rates of hospital admissions for alcohol related harm for both men and women, a higher proportion of adults that binge drink and higher levels of claimants on incapacity benefit as a result of alcohol.The challenge posed by rising alcohol related admissions has lead to investment in community based alcohol services, a 4 tier alcohol pathway and integrating service requirements with CQUIN arrangements with providers.

Quality and productivity

The quality and productivity programme is also a priority as it is a key cross-cutting programme that ensures efficiencies are released to be reinvestment into the three priority areas.

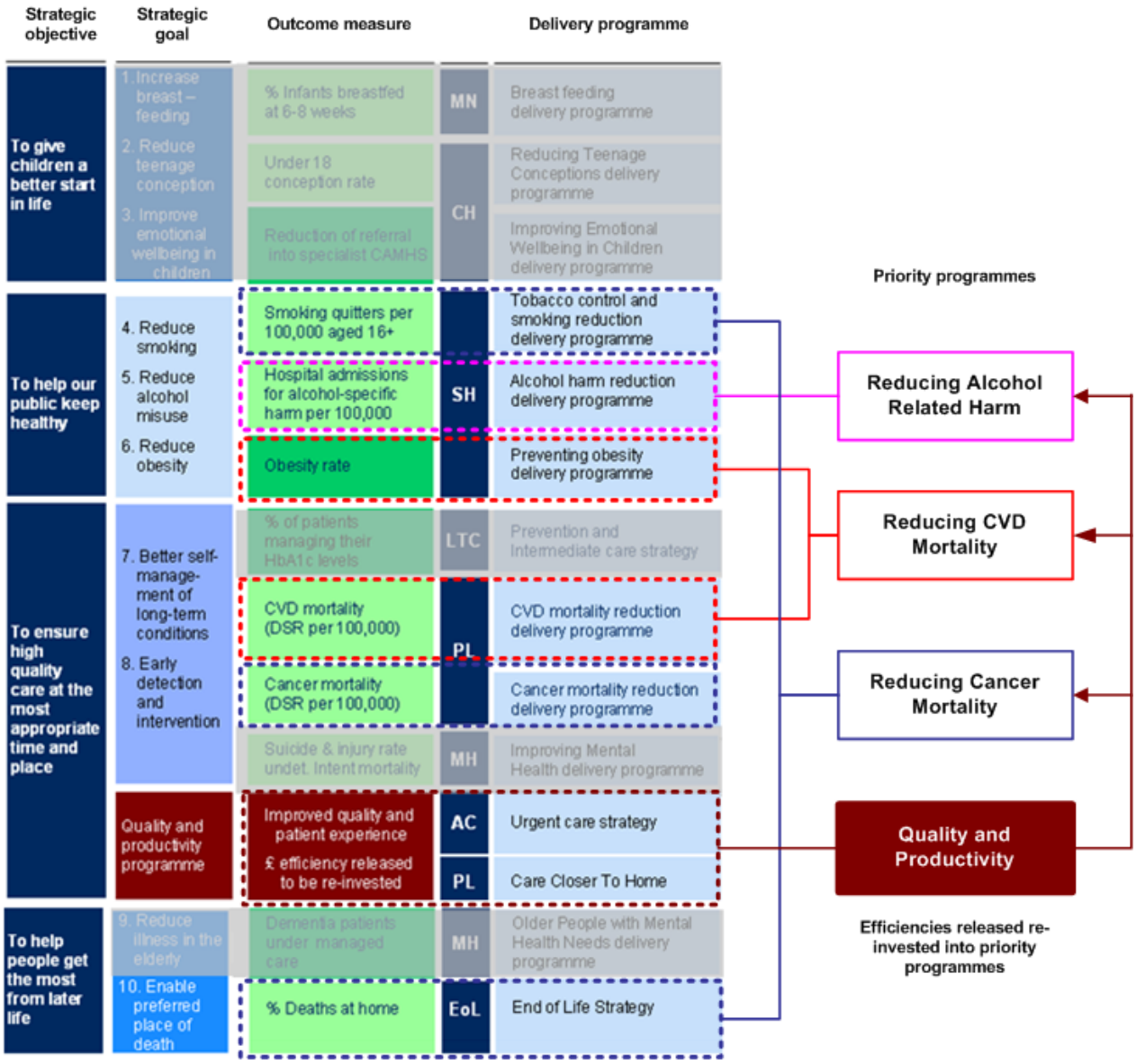


Figure 19: Prioritisation of strategic goals and delivery programmes

4.8 Financial scenarios

Due to uncertainty in the level of funding allocations in the future, we have tested our strategic investment and disinvestment plans against a series of possible financial scenarios. These scenarios represent financial environments in which we may have to delivery our strategy. A summary of the basis of the three scenarios used can be seen in figure 20.

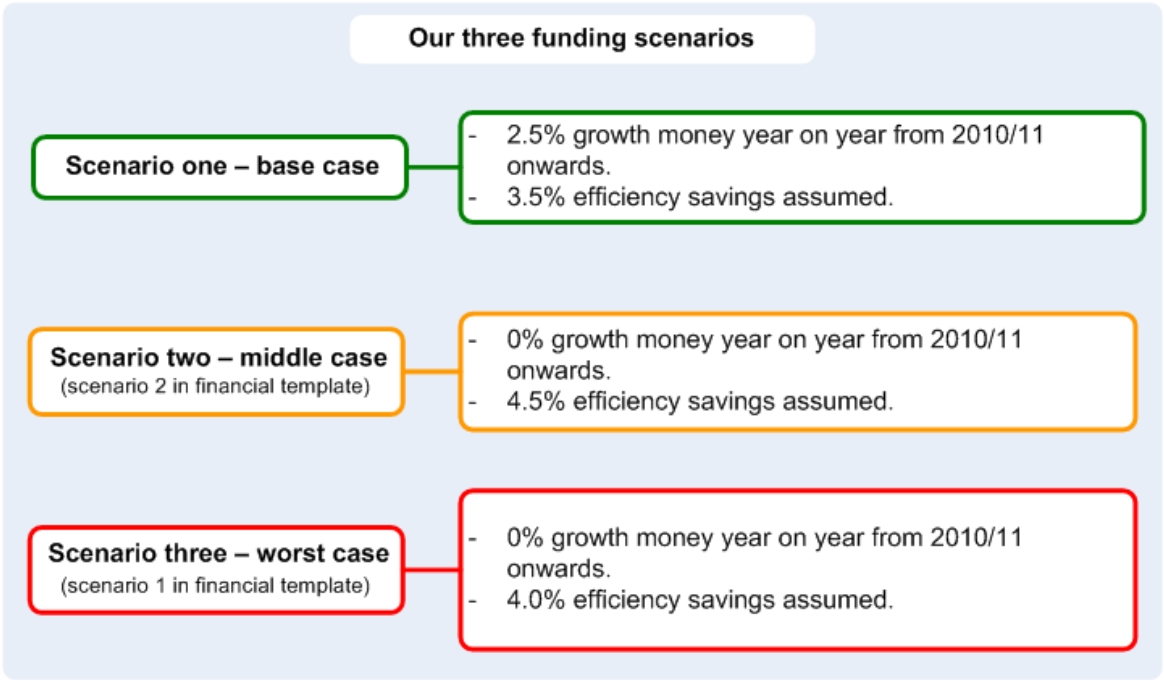


Figure 20: Summary of our three funding scenarios

Each of these scenarios would have different implications for the way in which we would fund the delivery of our strategy and how we would prioritise delivery accordingly.

Base case scenario

In the base case scenario we receive a 2.5% uplift in the allocation year on year from 2011/12 for the lifetime of the strategy. There is an assumed 3.5 % level of efficiency savings across most sectors.

In this scenario we would fully fund all initiatives within all of the delivery programmes.

We would also bring forward our long term health improvement strategy into year three of the strategic planning period.

This long term strategy has two key themes:

1. To commission an intermediate care service for patients with long term conditions with a focus on prevention.

People with long term conditions are the most intensive users of health and social services and the prevalence of these conditions increase with age. Taking into account assumptions about the increasing number of older people, the increase in prevalence of common long term conditions will lead to the biggest proportionate growth in hospital activity in County Durham and Darlington.

International experience has shown that the best practice for managing long term conditions is based on the principles of delaying the progression of the disease, promoting self management and 'shifting the balance of care' from hospital to closer to home. Based on this evidence, an investment in an intermediate service in the primary care and community sector will reduce the overall cost of managing people with long term conditions.

2. We will incentivise further quality improvement through an enhanced local CQUIN scheme. We would extend the national CQUIN framework to incentivise improvements in clinical quality, patient experience and safety across the health economy.

In the base case scenario all potential risks that have been identified would be covered and our 2% contingency is available on a non-recurrent basis to stimulate innovation and improvement.

Figure 21 shows the underlying movements in income, costs and investments and demonstrates that we can maintain a sustainable financial position over the lifetime of the strategy in the base case scenario.

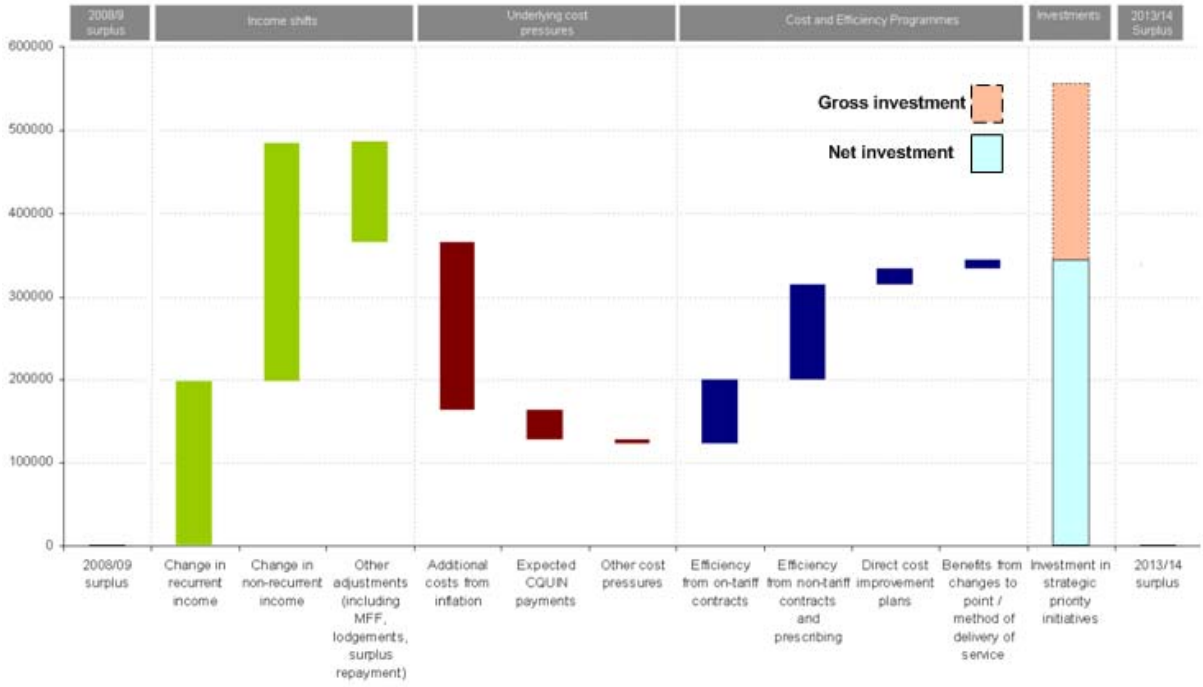


Figure 21: Financial movements in income, cost and investment in the base case scenario

Middle case scenario

In the middle case scenario (scenario two in the financial template that supports this strategy) we would receive a 0% uplift in allocation from 2011/12 year on year for the remainder of the strategy. There is an assumed increase in efficiency savings compared to the base case of 1.0%, to 4.5% across most sectors.

In this scenario we would fully fund all initiatives within all of the delivery programmes. We would also bring forward the long term health improvement strategy but on a smaller scale, targeting areas of highest need and the most prevalent long term conditions. All initiatives would be reviewed to determine that full investment in each is still required to deliver the benefits in health outcomes each is seeking.

We would focus more management resource on driving quality and productivity activities. An extra £6 million in efficiency savings by 2013/14 would also be generated through the programme of service reviews in the Quality and Productivity delivery programme.

All potential risks that have been identified would be covered and the 2% contingency is available on a non-recurrent basis.

Figure 22 shows the difference between the middle and base case scenario, including the action we would take to maintain a sustainable financial position.

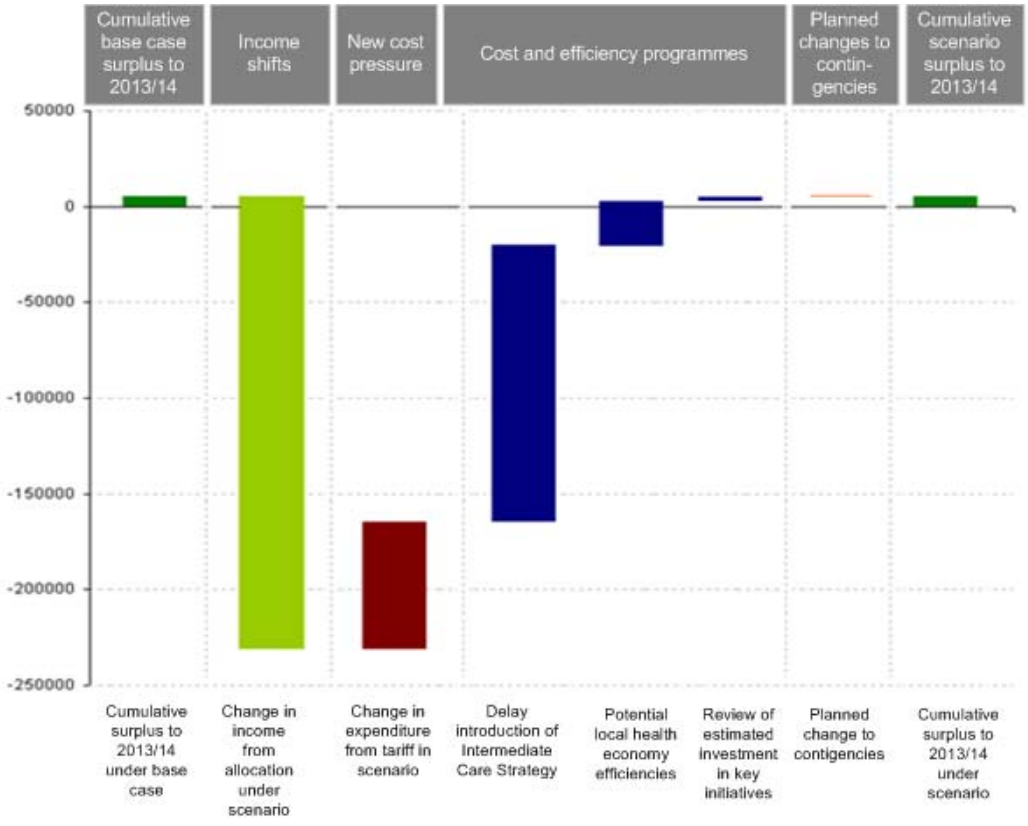


Figure 22: Changes between middle case and base case scenarios

Worst case scenario

In the worst case scenario (scenario one in the financial template that supports this strategy) we would receive a 0% uplift in allocation 2011/12 year on year for the remainder of the lifetime of the strategy. There is an assumed increase in efficiency savings compared to the base case of 0.5%, to 4.0% across most sectors.

In this scenario we would still fully fund all initiatives within all of the delivery programmes. All initiatives would be reviewed to determine that full investment in each is still required to deliver the benefits in health outcomes each is seeking.

We would focus even more management resource on driving quality and productivity activities. An extra £9 million in efficiency savings by 2013/14 would need generated through the programme of service reviews in the Quality and Productivity delivery programme.

All potential risks that have been identified would be covered in this scenario and the 2% contingency remains available on a non-recurrent basis.

Figure 23 shows the difference between the worst case and the base case scenario, including the action we would take to maintain a sustainable financial position.

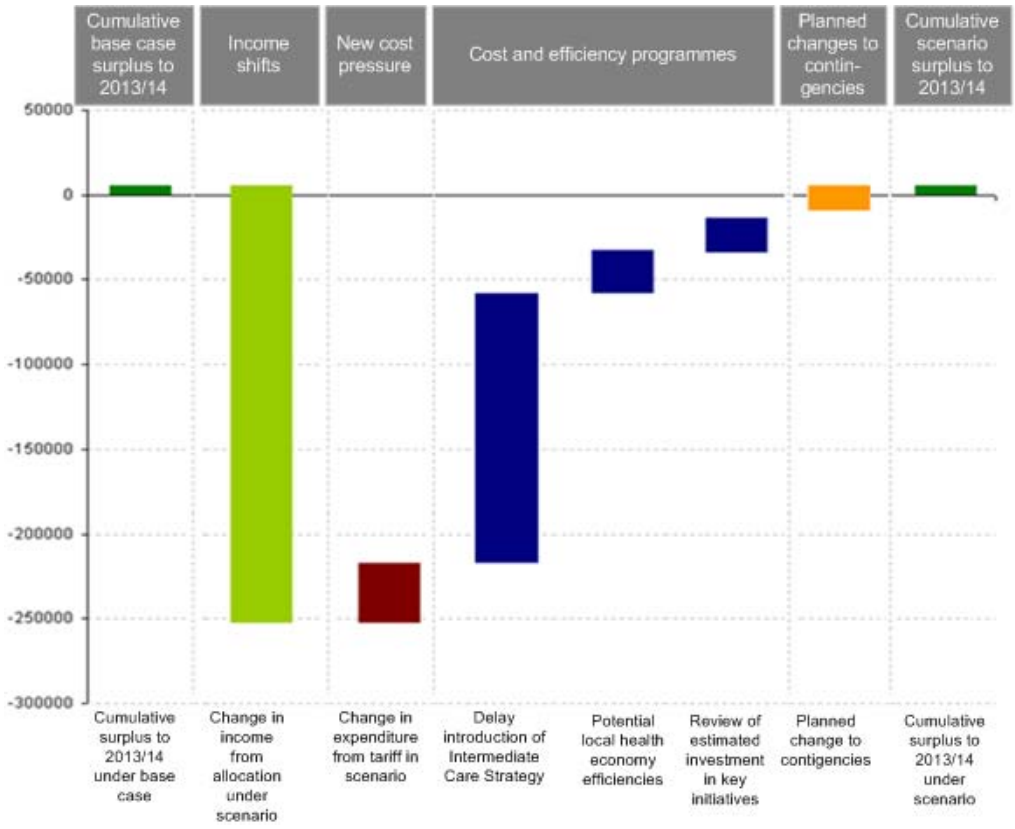


Figure 23: Changes between worst case and base case scenarios

Planning beyond worst case

In the unlikely event of the financial situation worsening even further, in our “beyond worst case” scenario we would continue driving even harder for efficiencies through improved quality and productivity until such point that:

- The management cost in staff time necessary to release these efficiencies creates only a marginal benefit in improving the financial situation
- The impact of new ways of working, cost improvement programmes or disinvestment from poorly performing services within the health economy begins to destabilise providers or put patient safety at risk

In this situation we would begin to examine the trade offs between investment and relative health gain across all the delivery programmes and initiatives. In these circumstances our three key programme groups, namely reducing CVD mortality, reducing cancer mortality and reducing alcohol related harm would be prioritised.

Full details are available in the medium term financial strategy that can be found in appendix A.

Delivering the strategy

In this section you will see:

- How we plan to implement the strategy.
- Examples of what we have delivered in the past twelve months.
- How we will engage clinicians and practice based commissioners.
- The enabling strategies that will aid delivery.
- The main organisational development priorities of NHS County Durham and Darlington.
- A risk management profile of the strategy.

Section 5. Delivery

5.1 Delivery schedule for initiatives

The initiatives within the delivery programmes have been sequenced to maximise health impact by assessing the level of difficulty of implementation and the level of investment required. Scheduling the initiatives has also been considered as part of the scenario planning exercise.

This programme management approach will ensure that key milestones for the delivery programmes are monitored and that key interdependencies and risks are identified.

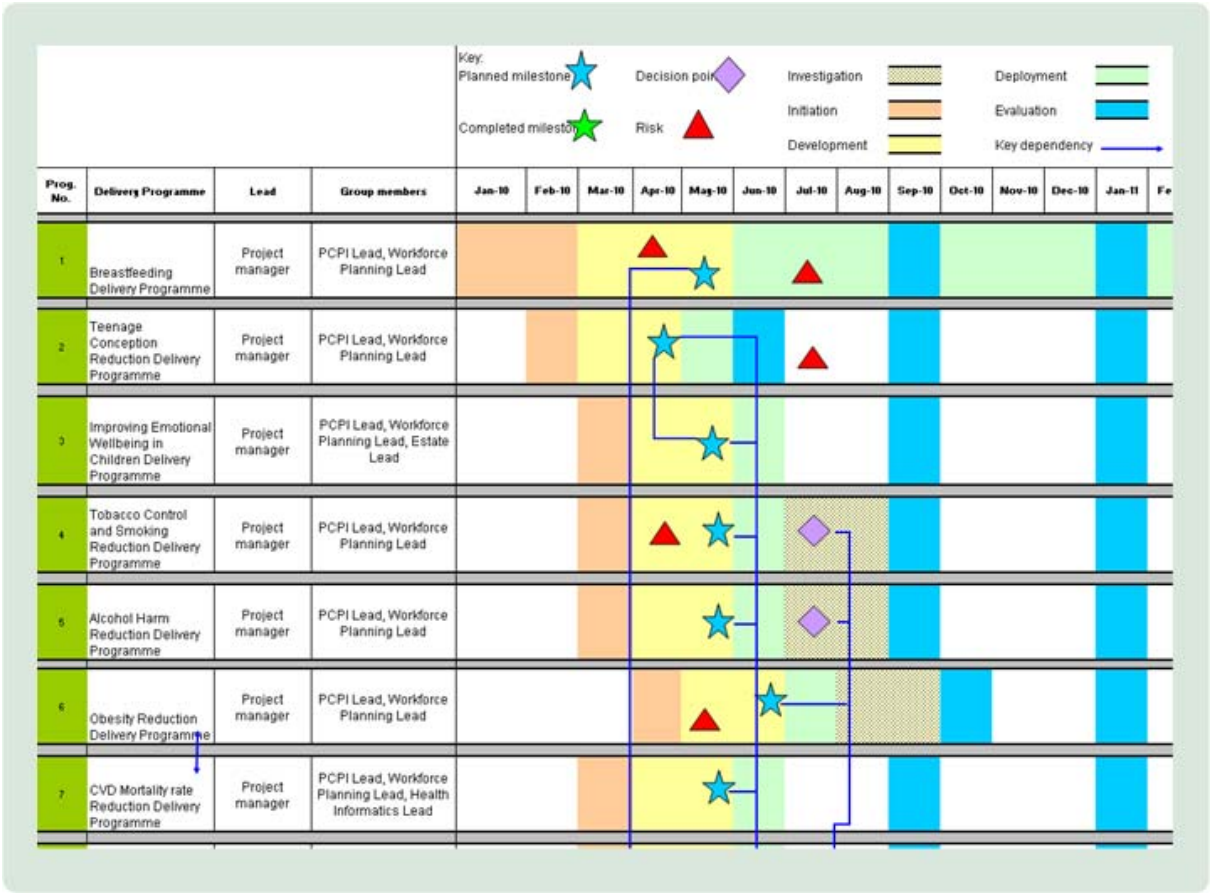


Figure 24: Example of the use of milestones, timelines and risks in the delivery schedule

5.2 Past delivery performance

NHS County Durham and Darlington has delivered significant improvements in key strategic areas since the publication of the initial commissioning strategy last year. Examples can be seen in figure 25:

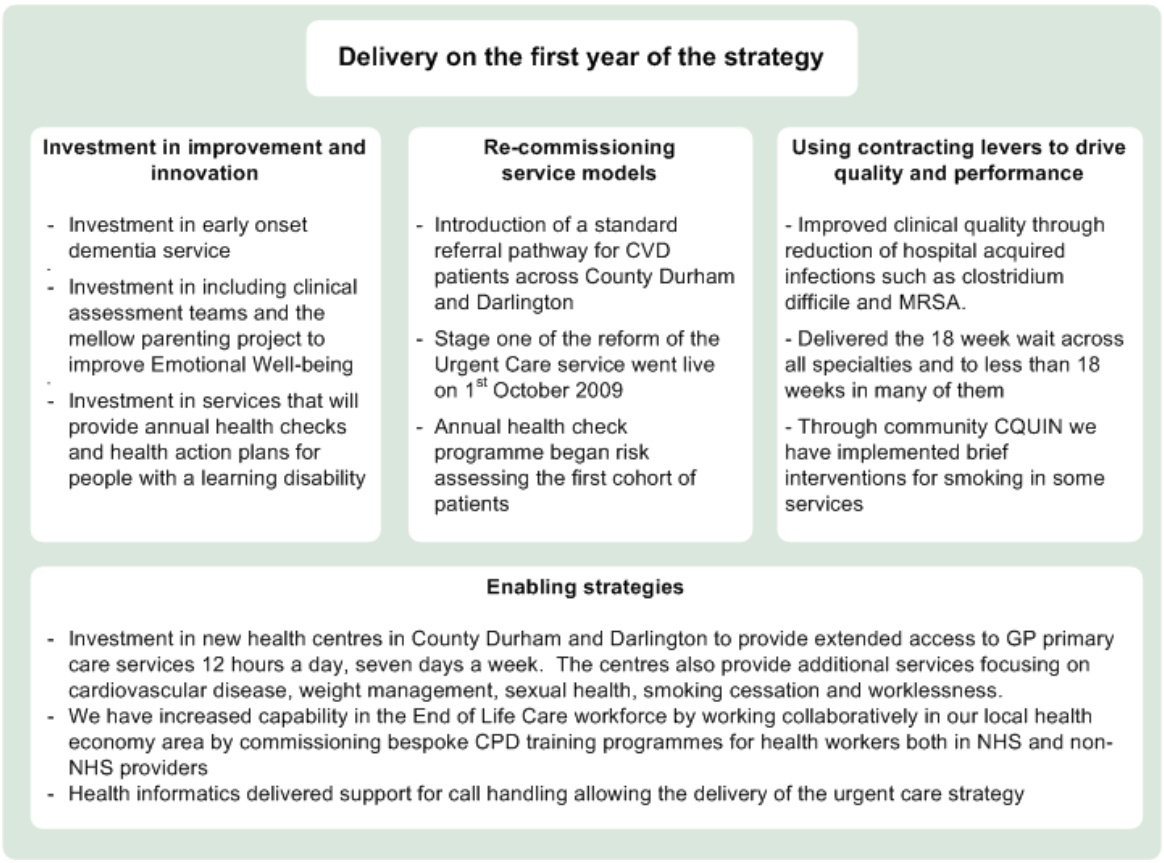


Figure 25: examples of delivery of the strategy in year one

There have been several critical success factors to the delivery of these improvements. Clinical engagement in the development process has been vital in the creation and introduction of standardised referral pathways. Providers have worked hard to reduce hospital acquired infections.

Key to many of our accomplishments in the past year has been the availability of growth money to invest in the extension of capacity or re-design of services. We recognise however that we need to change our approach in light of the future financial environment. Greater emphasis will be placed on development work that will release efficiencies through improved quality and productivity that can be re-invested into priority areas. This will include the utilisation and incorporation of key clinical technologies such as Map of Medicine and ISABEL Healthcare.

5.3 Strengthening clinical engagement

Over the last year we have significantly strengthened clinical engagement in the development of strategy and in overseeing our delivery plan. We have done this by creating Clinical Programme Groups (CPGs) built around the clinical themes outlined within Our Vision, Our Future.

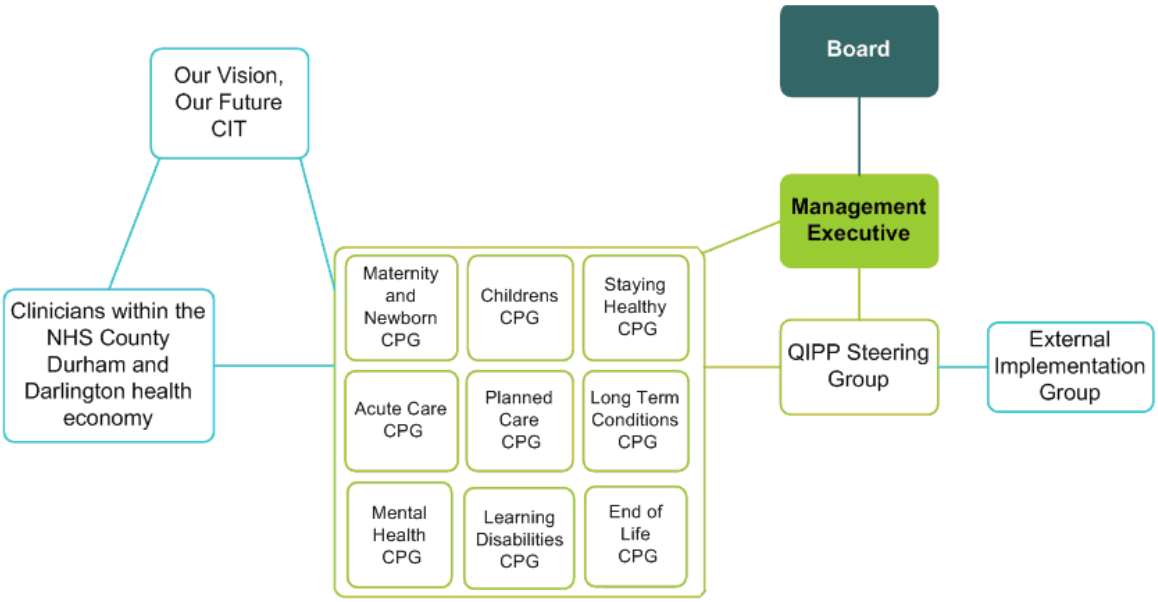


Figure 26: Clinical programme groups

These nine CPGs are clinically led and have the following core membership:

- Practice Based Commissioning Chair to ensure alignment with practice based commissioning
- Clinical champion(s) who represent a wide range of clinicians including dentists, pharmacists, nurses and allied health professionals
- Our policy manager to direct our commissioning activities in the relevant clinic area
- Our planning manager to provide support and technical expertise in planning issues in the relevant clinic area
- Our Public Health lead to provide support and technical expertise in disease needs in the relevant clinic area

Clinical programme groups will help embed clinical innovation into our commissioning process and also provide a link to the NHS North East Clinical Improvement Teams, aligning regional and local action on Our Vision, Our Future activities.

The CPGs have five main objectives:

- Provide vision and strategic direction that influences transformational change and ensures health promotion and disease prevention needs are translated into planning and prioritisation of investment
- Inform effective decision making through the interpretation of benchmarked data, standards, guidance and performance indicators
- Ensure best value by making investment decisions within our programme budget structure, prioritised to reflect PCT wide and locality level need
- Provide clinical scrutiny on safety, quality and the patient experience in service innovations
- Provide leadership, communication and engagement with stakeholders, partners and providers in the delivery of our strategy

CPGs provide the platform for Practice Based Commissioners to influence our strategic direction. CPGs will hold, develop and oversee the implementation of the key delivery programmes which will provide the framework through which the vision and strategic aims of NHS County Durham will be delivered.

5.4 Practice Based Commissioning

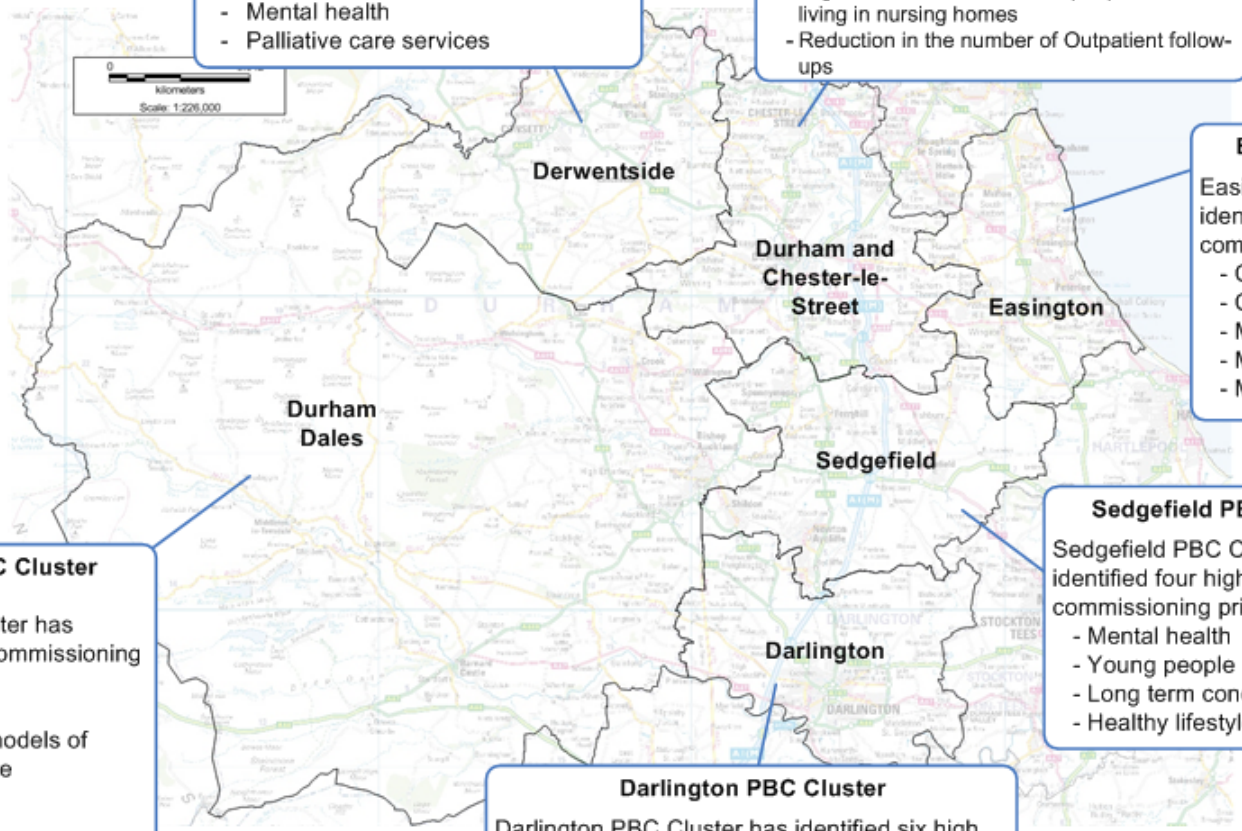
Practice Based Commissioners are vital to delivering our strategic objectives and goals. Practice based commissioning (PBC) leads the transformation of services at a local level and is integral in shaping strategic commissioning decisions.

This role includes local leadership, working with partners, patients and the public, helping to determine and manage Local Area Agreement targets, prioritising investment and promoting improvements and service innovation. NHS County Durham and Darlington works with six PBC Clusters; each with a five year strategic plan that describes the vision for health and healthcare in each locality. These strategic plans also outline the role that PBC will play in shaping local developments to better meet the needs of patients and their carers.

These plans reflect views of patients and local partners about the need to retain and develop sustainable health services within the locality, whilst at the same time seeking to improve health and reduce health inequalities.

Each of the strategies fully align with our five year strategic plan and sets out how each PBC cluster will assist in achieving our key health outcomes.

The PBC strategies also identify local priorities which take account of specific local needs and reflect the uniquely different requirements of each of the cluster areas.



Derwentside PBC Cluster

Derwentside PBC Cluster has identified eight high level commissioning priorities:

- Staying healthy
- Care closer to home
- Urgent care services
- children and young people services
- Long term conditions
- Mental health
- Palliative care services

Durham and Chester-le-Street PBC Cluster

Durham and Chester-le-Street PBC Cluster has identified five high level commissioning priorities:

- Young Person's Lifestyle Centre
- Integrated dermatology / minor surgery service
- Primary care based prostate cancer monitoring
- Urgent Assessment of older people and those living in nursing homes
- Reduction in the number of Outpatient follow-ups

Easington PBC Cluster

Easington PBC Cluster has identified five high level commissioning priorities:

- COPD
- Community services
- Mental Health
- Musculo-skeletal
- Maternity Matters

Sedgefield PBC Cluster

Sedgefield PBC Cluster has identified four high level commissioning priorities:

- Mental health
- Young people
- Long term conditions
- Healthy lifestyles

Durham Dales PBC Cluster

Durham Dales PBC Cluster has identified six high level commissioning priorities:

- Staying healthy
- Integrated delivery models of health and social care
- Care closer to home
- Urgent Care
- Rural-friendly mental health services
- Development of services in Primary Care

Darlington PBC Cluster

Darlington PBC Cluster has identified six high level commissioning priorities:

- Reduce emergency admissions
- Care closer to home
- Improve access to psychological therapies
- Long term conditions (COPD and diabetes)
- Staying healthy (obesity and alcohol)
- Child health services

5.5 Organisational requirements

Workforce development

The workforce within our health economy is a major component in ensuring the successful delivery of our strategic aims. As a commissioner we are continuously seeking assurance that a workforce with the right capacity and capability is in place locally to deliver our strategic plan.

The workforce assurance process identifies the workforce implications of our strategy, annual operating plan and commissioning intentions. We identify local workforce risks taking into account national and regional workforce risks, and identify and implement solutions to mitigate against them. A summary of the headline messages of these risks can be seen in figure 27. Delivery of the workforce assurance process requires a collaborative and integrated approach across our local health economy involving all our key stakeholders and partners.

By aligning our workforce needs with our commissioning strategy we are able to respond to changing environments across the provider landscape and to policy drivers like Transforming Community Services.

Strategic workforce development will also play a key role in increasing productivity and releasing efficiency that can be re-invested into services for patients. We will do this by innovation in role redesign and managing the use of the staff passport to help minimise the risk of redundancies through service change by easing the transfer of employees between different employers in health and social care.

We continue to seek assurance and manage risks on an ongoing basis with our providers through the commissioning process using workforce quality markers in commissioning, contracting and performance management. We will continue to develop these markers in light of patient experiences, evidence and research highlighting specific areas of workforce development required to improve quality and the patient experience (for example the findings of the Boorman review and the importance of healthy places and the effect on patient care).

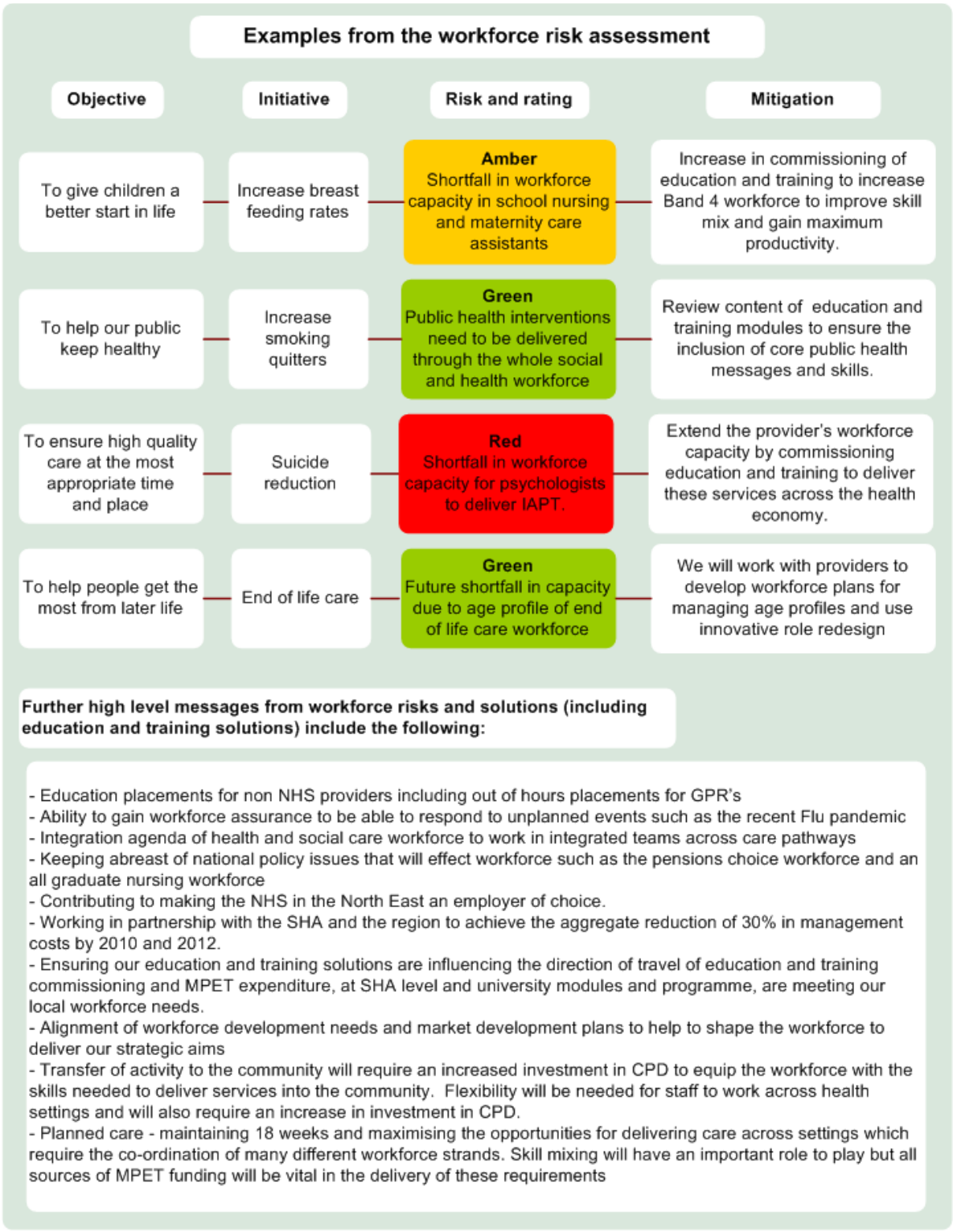


Figure 27: Examples of high level and initiative specific risks from the workforce risk assessment

The continued alignment of workforce to our strategic aims and ensuring the ongoing development of the workforce assurance process will form our strategic workforce programme for the next 5 years.

Health Informatics

A flexible and modern workforce, that is becoming increasingly community based, needs access to systems and information that allow integrated working across the local health community including social care. More closely integrated systems offering higher quality information helps to drive improvements in clinical safety and increased operating efficiency.

We lead the County Durham and Darlington local heath community (LHC) in its approach to the health informatics agenda and we are responsible for encouraging collaborative working and shared governance towards integration of health informatics systems, regardless of organisational boundaries. This is facilitated by the Informatics Clinical Quality Group which reports to the Quality sub-committee of the integrated business board. All the major providers of health and social care services within the health economy are represented in the LHC.

An updated national strategic direction for health informatics and the use of digital technology is to be developed over the coming months in collaboration with the NHS and its partners, to move from a ‘replace all’ to a ‘connect all’ philosophy. Alongside the national strategy, our local health informatics strategy will support the delivery of our key programmes of work whilst adhering to agreed national standards for data and infrastructure.

Examples of these developments include the Summary Care Record (SCR) and Map of Medicine, the Electronic Prescription Service 2 (EPS 2), mobile technology, telehealth, telecare, telemedicine, PACS and the expansion of the community of interest network (COIN).

A patient's SCR is an electronic record containing key health information including details of allergies, current prescriptions and adverse reactions to medicines. This can be extended to include most information from the detailed care record held by the patient’s GP if a patient requests it or the health community agrees it. Each time a patient uses any NHS health services, details about any current health problems, summaries of their care and details of the healthcare staff treating them may be added to their SCR and made available to other NHS care settings (although patients can choose to opt out of the programme). It is accessible in any NHS care setting and is not dependent on a particular clinical system for access.

The summary care record provides relevant and timely access to clinical information at the point of care and will improve quality and continuity of care provision. This clinical information also improves the incidence, speed and appropriateness of patient assessment and treatment. The SCR programme could also potentially reduce medication errors and improve levels of patient safety.

The SCR programme will initially be a key enabler for the delivery of the our Urgent Care Strategy, with potential further use which will be fully explored for the CVD pathway, end of life care, dementia and long term conditions and will help improve access to safe, patient centred services across the health economy.
Initial aims are to have all 86 GP practices and 2 health centres uploading details to the SCR by March 2011 for use by appropriate urgent care centres.

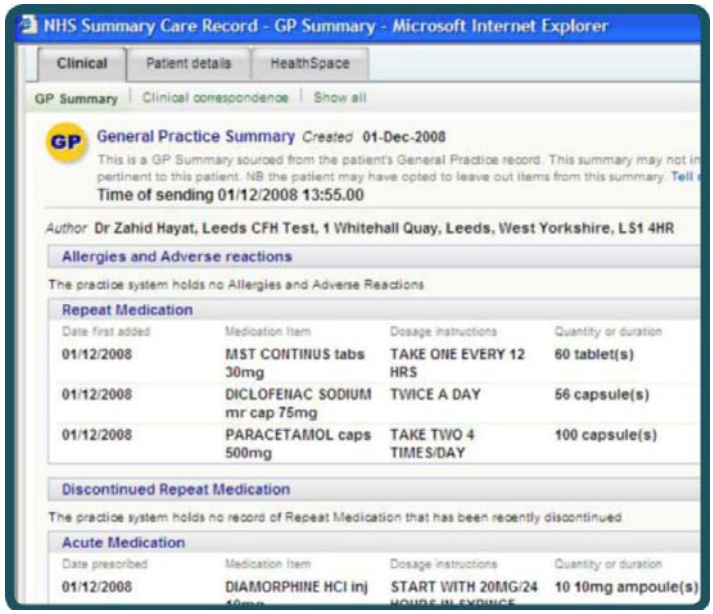


Figure 28: Example summary care record

The Map of Medicine provides end-to-end patient-focused pathways which span all care settings, allowing us to view and consider a whole system approach to care delivery. It encourages NHS organisations to act in a coordinated way ensuring that patients are at the centre of all decision making on care design and delivery. Deployment of the map is a Local Health Community clinically led activity. Within County Durham and Darlington we will use map of medicine to streamline processes and improve patient pathways of care for all health initiatives.

Telehealth and telecare are services which enable delivery of health and social care direct to people's homes. Telecare involves the use of equipment such as alarms, sensors and detectors by patients and their carers. Telehealth involves the use of medical devices to allow patients to monitor their vital signs at home, with the information accessible by health care professionals who can take action as required.

Telemedicine systems uses include the transmission of clinical images for diagnosis, face to face remote outpatient appointments and remote mental health assessment and recommendation.

Telemedicine systems have already been successfully implemented into the four prisons within County Durham during 2009 to provide high quality consultant-led care to prisoners, keeping them within the Prison facility and so minimising the security risks whilst also responding to prisoner's health needs. Further uses of telemedicine will be explored as part of this strategy to support health and quality initiatives.

The benefits of telehealth, telecare and telemedicine will include reduced hospital admission rates, supporting patients with long term conditions, preventing emergency admissions, reducing numbers of home visits and offering patients a much higher quality of life as a result.

Health informatics will also improve quality and productivity with the local health economy. For example EPS 2 will be implemented to provide a more accurate and efficient prescribing system. This system will have specific benefit for those with long term conditions, dementia and for end of life care. The implementation of COIN will be completed and the benefits from its introduction realised. This will include its use in all GP practices for the transmission of Holter tape results for the early detection of arrhythmias. Future estates developments will also ensure that the COIN is available from all NHS County Durham and Darlington sites. The COIN will also be expanded to include the four hospices.

The informatics initiatives which are outlined in the annual Operating Framework Informatics Planning guidance will also be addressed. Many of these underpin the developments described above and include infrastructure improvements, use of the NHS number, the information governance toolkit, use of NHSmail by all NHS organisations and exploitation of choose and book. Use of NHSmail by all independent contractors will be explored and exploited where possible and affordable.

All health informatics developments will be supported by workforce development plans that will ensure that specialist informatics staff, clinical, managerial and other staff have the appropriate capabilities to maximise the benefits of these new ways of working.

Strategic estate development

An aligned estates and facilities management strategy is an essential element of the implementation of our strategic plan. This alignment will ensure that the people of County Durham and Darlington have a safe, sound, accessible and secure patient care environment, which is fit for purpose and meets the needs of 21st century health care delivery. Making best use of the estate within the County Durham and Darlington health economy will also play a key role in increasing productivity and efficiency.

We believe that we have the capacity in our current stock of community and primary care estate to allow care to be provided closer to home. This will reduce the over-reliance on acute hospital care and allow the integration of clinical and community services around the needs of the patient.

The development of the Commissioner Investment and Asset Management Strategy (CIAMS) by March 2010 will prove this assertion. This work will look at space utilisation and help with any rationalisation, aimed at:

- maximising the use of space which is fit for purpose for 21st Century patient care
- ensuring on-going statutory compliance
- reducing energy consumption and costs through more modern building design
- providing better access to a range of services for the community

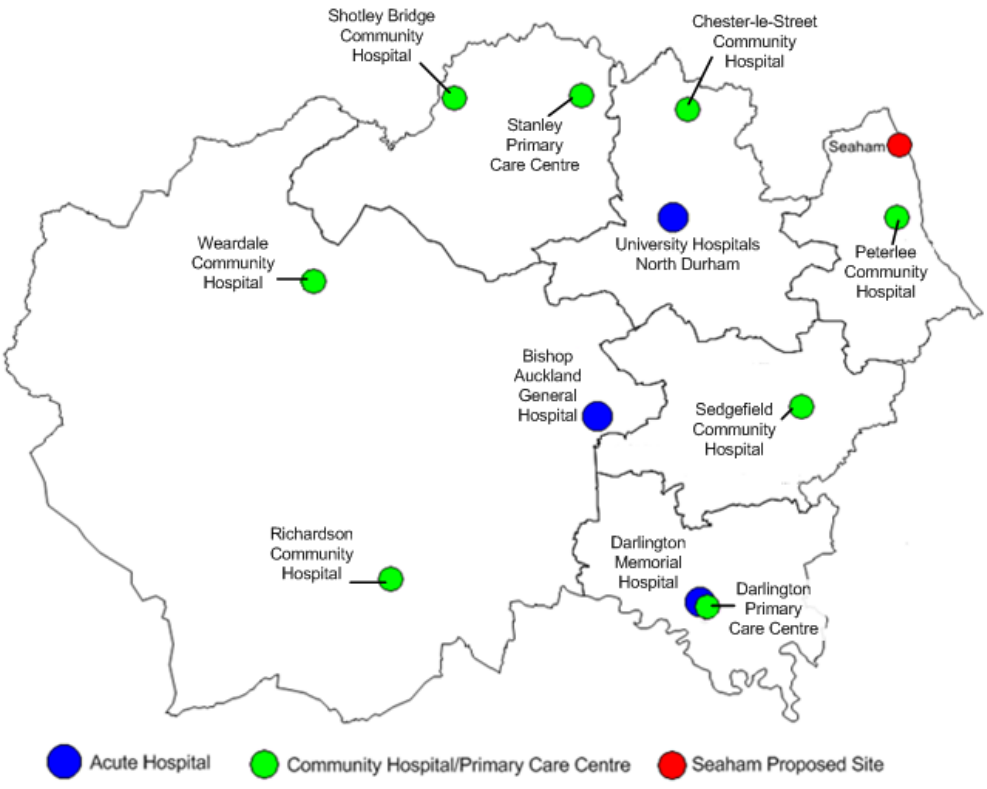


Figure 29: NHS County Durham and Darlington Community and Primary Care estate

NHS County Durham currently acts as a landlord of our community estate in line with Transforming Community Services. Community hospitals act as a local community resource and provide a bridge between home and specialist hospital care, through the delivery of ambulatory, elective and diagnostic services.

We have recently purchased two community hospitals and are also supplementing the reach and capacity of our community hospitals with the development of two new primary care centres in Stanley and Seaham. By doing so we are better able to facilitate market entry into the community sector to multiple providers, across the county.

Our five community hospitals will be used to form integrated networks with acute hospital providers. These community hospitals can provide a One Stop Shop approach with streamlined processes enabling complete assessment, diagnostic and intervention in one place/attendance, and in addition can house multi-disciplinary integrated assessments. They will also enable us to provide diagnostic services more efficiently, allowing us to re-invest in other areas such as health promotion.

Once our current estate is fully developed we will not plan for the further expansion of dedicated health facilities. In recognition of local needs, particularly in our smaller and more rural communities, we will increasingly look to work with partners such as NHS providers, local authorities, fire and rescue services and the police, to develop community facilities which include a health component alongside, for example, schools, Surestart or children's centres and libraries.

In developing these facilities we will also take account of, and work with, regeneration schemes such as Growth Point. As well as developing increased health service demand through additional homes, these schemes provide opportunities to build in new facilities for the planned increased population.

Our estates and facilities strategy will support our ambitions to provide a more personalised and responsive service that meets the needs of our population.

5.6 Main organisational development needs

In order to maximise the chance of delivering our strategic objectives we have identified the organisational development priorities we need to address over the next five years. This exercise resulted in the definition of eight organisational development work streams which we have prioritised as indicated in the matrix illustrated below.

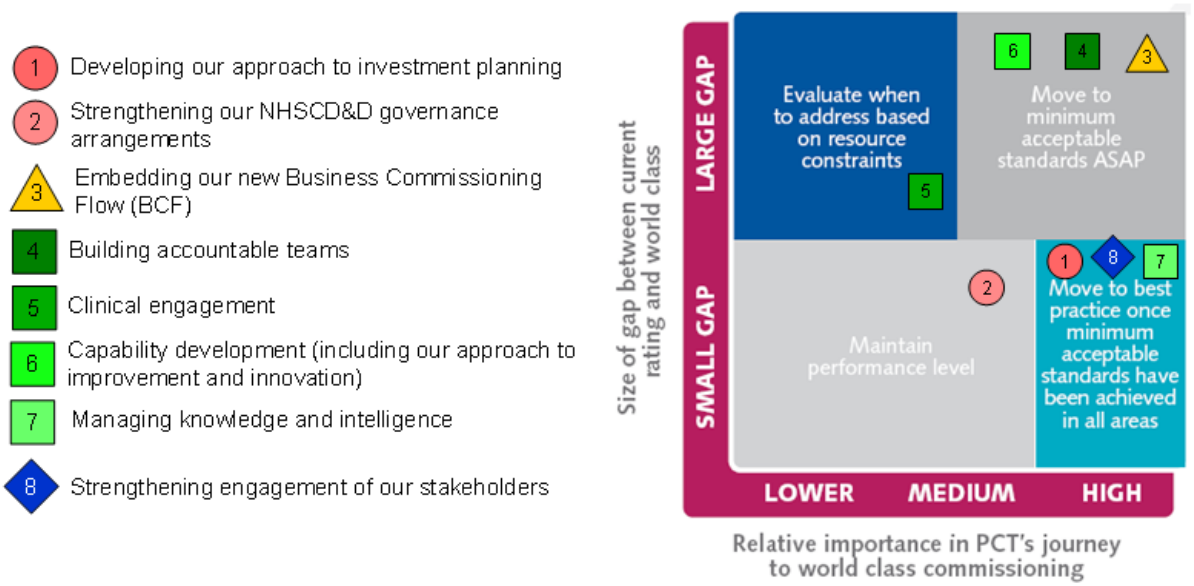


Figure 30: Prioritisation matrix of organisational development need

Out of the eight priorities identified for the next five years, three work streams have been accorded top priority for 2010. These are critical to the development of our core commissioning business and are:

- embedding our new business commissioning flow
- building accountable teams
- capability development (including our approach to improvement and innovation)

By focusing on our three top priority work streams in 2010 we will embed our recently co-created business commissioning flow, address the capability gaps within our core business teams, and build teams that are accountable for the delivery of our strategic objectives.

A full description of our approach to organisational development can be found in the NHS County Durham and Darlington Organisational Development Strategy.

5.7 In year monitoring

Each delivery programme contains a set of key milestones for implementation and each initiative within the programme has a set of key performance indicators to measure success. The implementation of these programmes of initiatives will be monitored in the following ways:

1) The Integrated Business Board will receive routine performance reports on progress in terms of health outcome trajectories and the impact on finance and activity resulting from the initiatives within the delivery programmes

2) The Finance and Performance strategic sub-committee will monitor and review the financial and activity planning for NHS County Durham and Darlington to ensure delivery of the strategic plan.

3) The Quality strategic sub-committee will receive routine information on the quality and performance levels of services covered by the delivery programmes.

4) The Clinical programme groups will oversee the implementation of the relevant delivery programme(s).

5) A programme management office will track each initiative during the development phase and report progress to the Management Executive via the accountable Executive Director (the Director of Innovation and Development)

6) The contract management and performance management teams will monitor the key outputs of the affected service through routine contract management and performance meetings.

7) The Quality and Productivity delivery programme will be overseen directly by the Management Executive.

The overall monitoring of the delivery of the strategy will be undertaken by the Management Executive and reported to the Integrated Business Board.

5.8 Provider requirements and plurality of provision

The implementation our strategy will have significant implications for the provider landscape. The majority of delivery programmes focus on the prevention of ill health or the early detection and diagnosis of conditions at a stage that will require less invasive intervention. The underpinning initiatives within these programmes see the introduction or redesign of services to make better use of primary care and community settings. The reform of the urgent care system and the move to have care provided closer to home will also see a shift in activity away from the acute sector.

Figure 31 provides an overview of the impact in movement of activity between the care settings over the lifetime of the strategy.

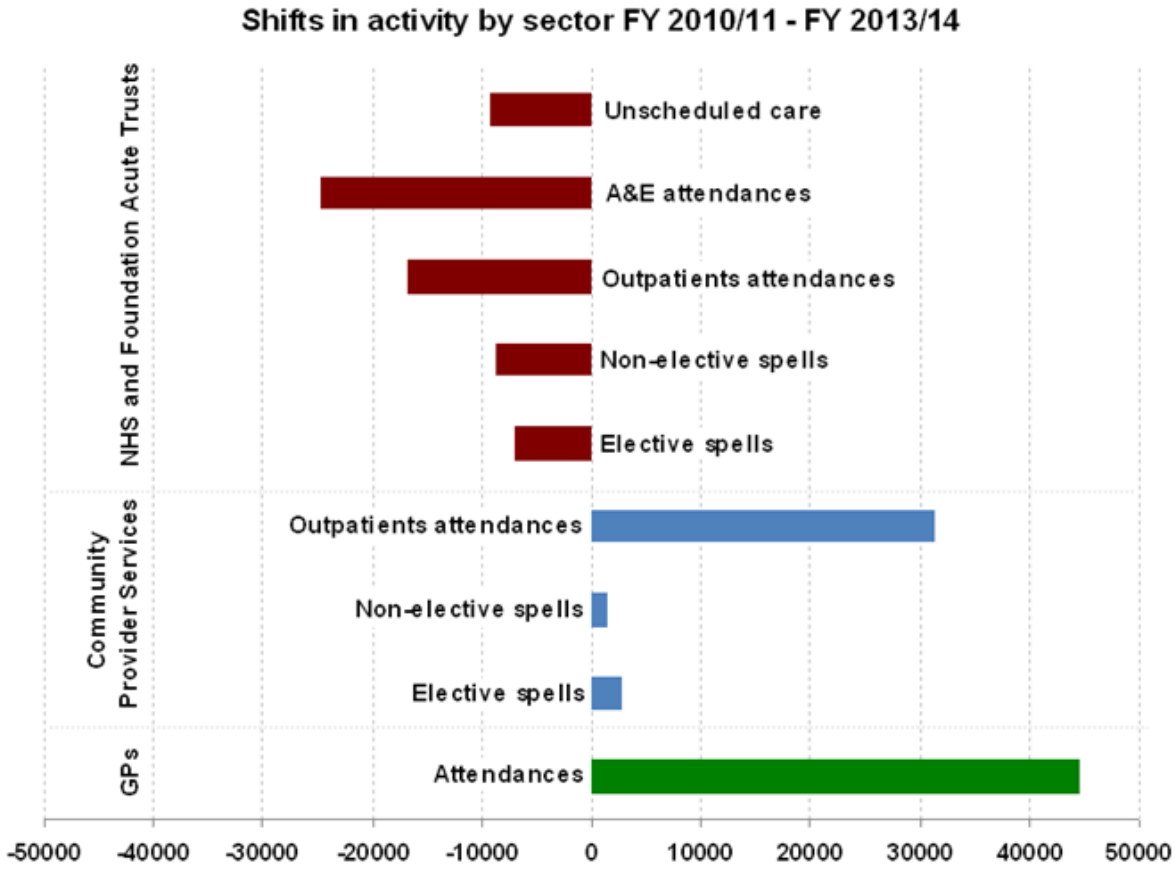


Figure 31: Changes in the pattern of activity between 2010/11 and 2013/14

As the pattern of activity changes following the implementation of the delivery programmes, so will the funding flowing into each sector. Figure 32 describes the changes in funding by sector. This funding will also be spread across more providers as we look to develop the healthcare market in order to drive quality and productivity.

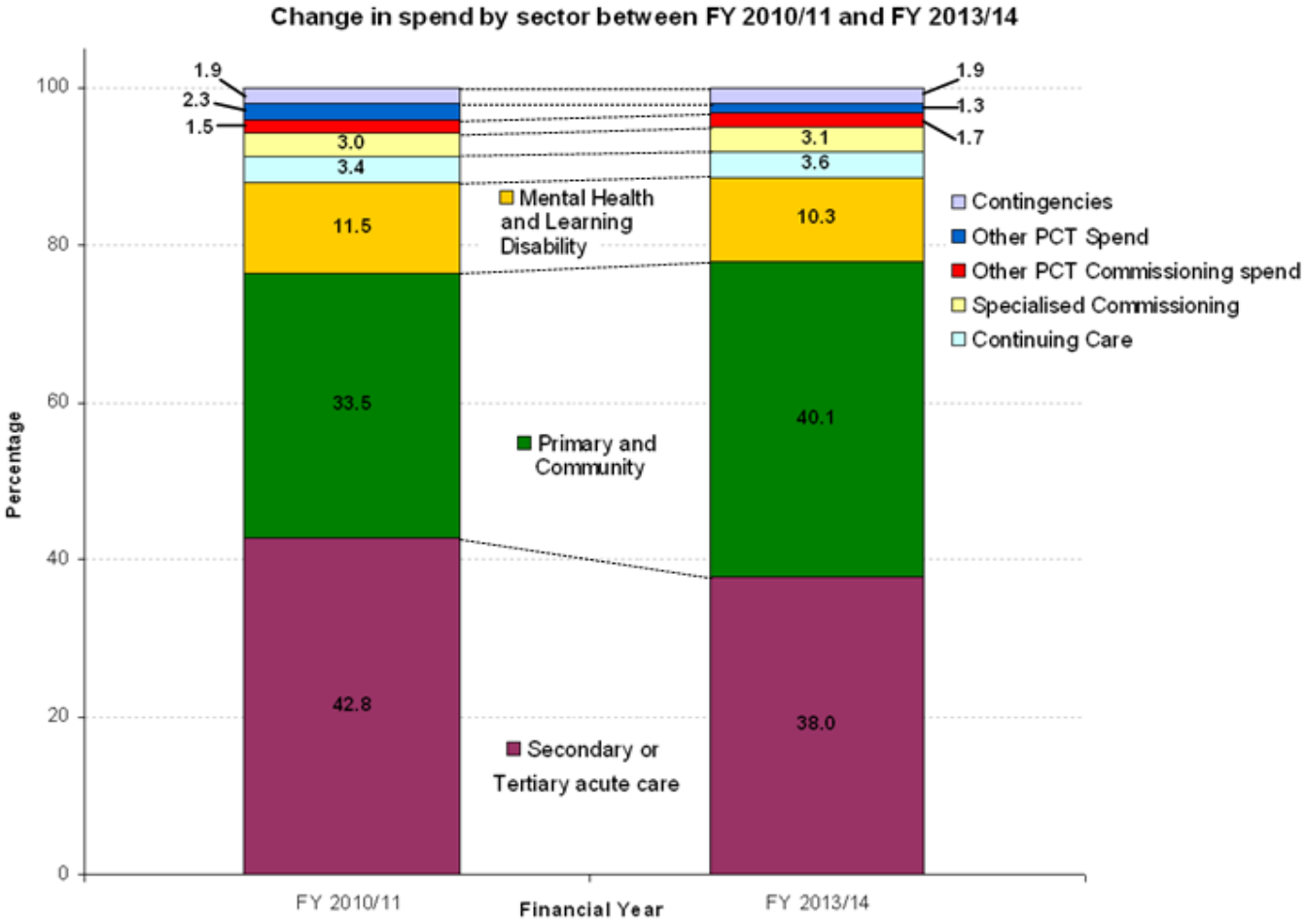


Figure 32: Changes in the funding each care setting between 2010/11 and 2013/14

In our main acute provider, a significant programme of change is already underway. County Durham and Darlington NHS Foundation Trust's Seizing the Future programme rationalises clinical services between their three acute hospital sites (University Hospital North Durham, Darlington Memorial Hospital, Bishop Auckland Hospital) to improve patient safety and ensure robust clinical services. Key specialities undergoing rationalisation include Accident and Emergency/Urgent Care, rehabilitation, surgery and Childrens' services.

The proposed changes in Seizing The Future were subject to major public consultation led by the PCT. The delivery of changes is being overseen by the PCT-led Oversight Steering Board which includes both local overview and scrutiny committees, both Local Involvement Networks and the active involvement of the Integrated Business Board.

We are also aware of changes to the provider landscape in other health economies that may have an impact on our own in the lifetime of this strategy. For example we will need to be aware of the potential impact of the Momentum project in North Tees and Hartlepool.

Momentum is a whole systems approach to health services in the North Tees area and includes the proposed re-provision of the University Hospitals of North Tees and Hartlepool onto one site at Wynyard. This will be designed to accommodate a shift of care from a hospital setting to the community.

For the PCTs in Teesside this includes the development of a number of primary care centres to accommodate this shift. For North Easington and Sedgefield patients (who currently use the existing acute hospitals) the community shift will be accommodated using Sedgefield and Peterlee Community Hospitals.

We will also need to be aware of future plans to bring social care into the control of the NHS and the potential impact this may have on more integrated models of care provision.

Supporting providers through the transition

As the local leader of the NHS we will support our providers through the changes the delivery of this strategy will bring about. When describing shifts in activity from acute to community we are referring to settings and not providers. Acute providers may wish to respond to tenders to provide community services through our procurement process whilst primary care practitioners may wish to provide services more usually associated with community service organisations.

We will work with providers to help offset fixed costs when moving services into a community setting and closer to patient's homes. We will do this through our local workforce collaborative to help re-train staff in new roles and by working within the regional TUPE arrangements. We will also work across the health economy to make use of public sector estate, rationalising where necessary.

We will also work with providers on services developments that may have no-direct bottom line saving for us as a commissioner due to contractual and tariff rules but that may release efficiencies that providers can use to offset losses incurred through service changes.

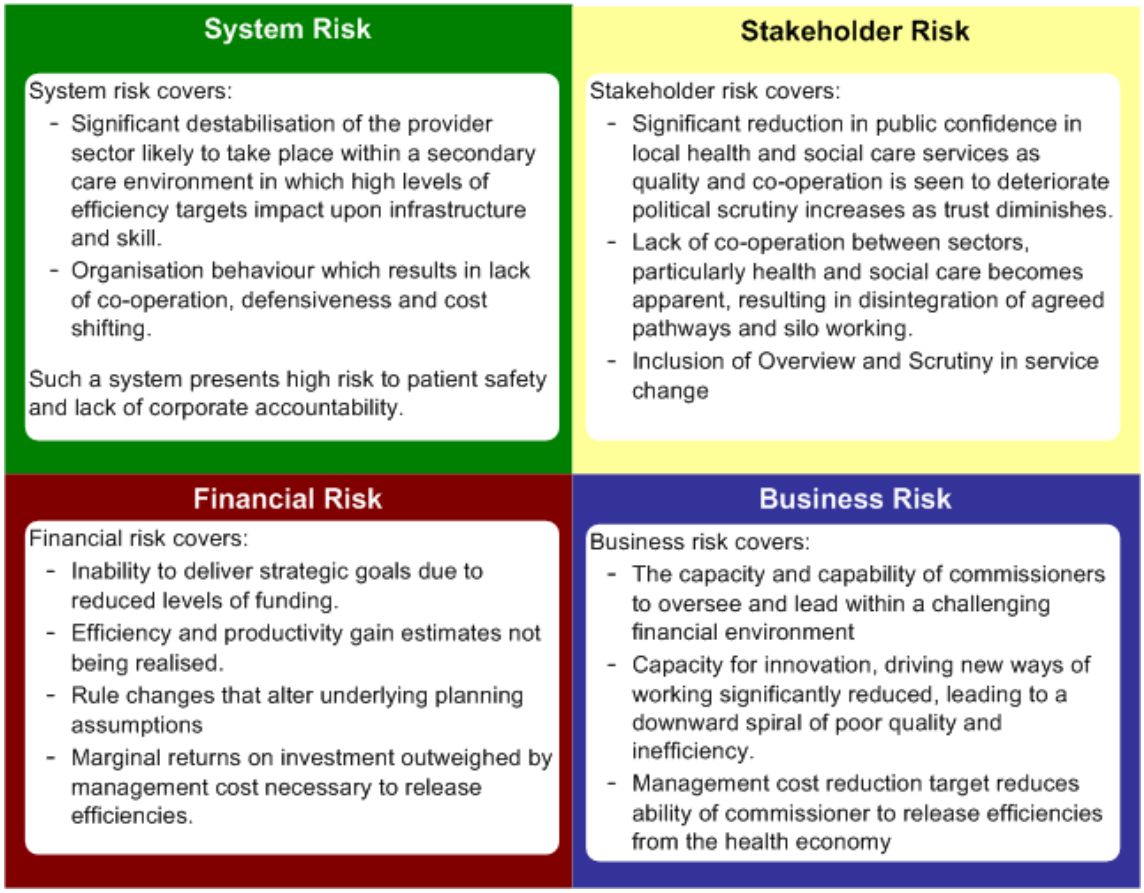
Most importantly we will engage widely, openly and continuously with all providers throughout the change process.

5.9 Managing risk

In refreshing our strategic plan we have explored three main financial scenarios which recognise the need to focus upon:

- The delivery of our key programmes and initiatives to maximise health gain and reduce health inequalities.
- To continue to drive productivity and efficiency across the health system.

As outlined above we have assessed the impact and associated risks for four key dynamics which respond to our three key scenarios. These are:



The individual risks within these areas are rated for severity and likelihood to give a composite risk score. A summary of the high level risks in each of the four key dynamics can be found in figure 33 and figure 34.

Compound risk

Whilst we have identified individual and groups of risks and put processes in place to monitor and mitigate them, we are also aware of the implications of compound risk; when two or more risks combine.

By modelling a compound risk score (by multiplying individual composite risk scores) supported by sensitivity analysis we have modelled scenarios against which we can test our strategic plan.

System Risks

Strategic Risk	Issue	S	L	R	Impact	Mitigation
System management	Destabilisation of acute secondary care providers	5	4	20	Clinically unsafe and non viable acute secondary care providers	Robust modelling and impact assessment strong framework for dialogue and engagement both transformational and transactional levels
	Lack of capacity in primary and secondary care to address shift in secondary care activity	5	4	20	Inability to shift secondary care activity impacting upon cost and access services	Ensure capacity and capability in primary and community services through transforming community services, ensure robust planning for primary care capacity
	Lack of coherent investment and disinvestment strategy	5	3	15	Ambition outlined in strategy not affordable	Rigourous approach to dis-investment via QIPP planning process effective contract management robust modelling at initiative level
	Improvement in health does not match ambition	4	4	16	High utilisation rates and secondary care continue	Strategies and metrics focusing upon maximising impact for health improvement
Maintaining effective enabling activity	Lack of robust informatics capacity and infrastructure	4	4	16	Reduction in ability to utilise technology to modernise and streamline services	Effective informatics strategy agreed across the local health community
	Lack of workforce capacity and capability and skills	5	4	20	Unable to deliver new ways of working and ensure safe patient centred services	Workforce development strategy underpinned by risk assessment programme across all key delivery programmes
	Estate not fit for purpose	4	4	16	Reduced options for service redesign, reduced ability to delivery high quality patient centred services which maximised efficient use of resources	Estates strategy focuses upon effective use of all assets and delivery of high quality patient centred services

S - Severity	1 – Least severe	5 Most severe
L - Likelihood	1 – Least likely	5 Most likely
R - Rating	8-15 High Risk	16+ Extreme Risk

Stakeholder Risks

Strategic Risk	Issue	S	L	R	Impact	Mitigation
Stakeholder engagement	Lack of local political ownership and increased scrutiny	4	4	16	Lack of support for strategic initiatives and slowing of key reform and modernisation of services	Robust communication and engagement strategy with locally elected stakeholders
	Lack of effective clinical engagement in determining and agreeing key strategic priorities	5	3	15	Lack of clinical ownership and evidence base to underpin delivery of key initiatives	Development of strong clinical leadership and engagement in delivering key strategic goals programmes and initiatives
	Lack of public ownership in addressing changes in behaviour and lifestyle	5	3	15	Likelihood for achieving key health outcome trajectories reduced	Delivery of robust social marketing initiatives as part of communication and engagement strategy
	Concerns by the public regarding the threat to NHS services related to financial downturn	4	4	16	Lack of confidence in local NHS negative media coverage	Robust communication and engagement strategy
Managing the impact of social economic factors	Factors directly out with the control of the PCT will have a significant impact on health status i.e. unemployment, educational attainment	5	4	20	Overall health status of the population does not improve to the planned levels maintaining dependency on the health care system	Strong alignment of priorities and initiatives within LSP
	Lack of ownership of vision and strategic objectives by local authority partners	5	3	15	Reduced effectiveness of LSP increased potential for cost shifting across local health and social care sectors	Ensure strong alignment within Chief Officers group across County Durham and Darlington to ensure shared vision and objectives

S - Severity	1 – Least severe	5 Most severe
L - Likelihood	1 – Least likely	5 Most likely
R - Rating	8-15 High Risk	16+ Extreme Risk

Figure 33: Details of system risks and stakeholder risks

Financial Risks

Strategic Risk	Issue	S	L	R	Impact	Mitigation
Financial environment	Assumption of growth funding in base case not realised	5	4	20	Threat to delivery of improvements in health outcomes	Clear plans to deliver strategy in medium and worse case scenarios
	Lack of clear prioritisation for finding of those initiatives having the most significant impact upon health status	5	4	20	Initiatives identified as top priority are not fully implemented	Key initiatives are identified and prioritised to maximum health impact initiatives are costed and funding identified beyond worst case scenario
	Lack of robust modelling and financial scenario planning to reflect volatility of financial environment over the lifetime of the strategy	5	4	20	Funding of key initiatives unable to be supported threat to financial viability of PCT	Clear identification and understanding of main financial scenarios and the likely impact upon delivery over the lifetime of the strategy
	Quality and Productivity delivery programme fails to deliver expected level of efficiency	5	4	20	Initiatives having a major impact upon health status are not fully implemented	Key initiatives are identified and prioritised to maximum health impact initiatives are costed and funding identified beyond worst case scenario
Financial rule changes	Changes to rules on Payment By Results tariffs for the acute sector in future years	5	3	15	Funding assumptions need revising possibly creating cost pressure or efficiency shortfall	Drive harder for efficiency. Move to different case scenario to deliver strategy. Possibly fund only key priority areas in scenario beyond current worst case.
	Introduction of Payment By Results tariffs in non-acute sectors in future years	5	3	15	Funding assumptions need revising possibly creating cost pressure or efficiency shortfall	Drive harder for efficiency. Move to different case scenario to deliver strategy. Possibly fund only key priority areas in scenario beyond current worst case
	Changes to primary care contract values (e.g. GMS, GDS)	4	3	12	Funding assumptions need revising possibly creating cost pressure or efficiency shortfall	Drive harder for efficiency. Move to different case scenario to deliver strategy. Possibly fund only key priority areas in scenario beyond current worst case

S - Severity	1 – Least severe	5 Most severe
L - Likelihood	1 – Least likely	5 Most likely
R - Rating	8-15 High Risk	16+ Extreme Risk

Business Risks

Strategic Risk	Issue	S	L	R	Impact	Mitigation
Not embedding changes to the way we commission	Recent major review in the business commissioning flow not followed through	5	3	15	Key strategies and initiatives will not be delivered in a timely and robust manner	Strong leadership systems and process put in place to ensure commissioning business flow is implemented 100%
Delivery of 30% management costs	Delivery of 30% management costs destabilises internal PCT infrastructure and reduces capacity to deliver	5	4	20	None delivery of all key elements of the strategic plan and associated delivery plan	Utilisation of LEAN methodology to eliminate waste and maximise focus upon delivery of core business only
Strengthening business critical skills	Business critical skills are not understood, supported and developed within the PCT	5	4	20	The PCT does not have the skills, capacity and capability to deliver the systems processes and outputs outlined within the business commissioning flow	A needs assessment, training and organisational development plan put in place
Knowledge management	Knowledge management is not significantly supported and developed as a key enabler for delivery within the PCT	5	3	15	Significant rework in the way in which knowledge and intelligence is managed within the PCT lack of analytical skills to enable robust modelling and scenario planning	Clear and robust knowledge management strategy including training and development of key analytical skills
Management of change	There is a requirement for strong leadership and significant change management of delivering the action initiatives and outcome outlined within the strategy refresh. Leadership and skills management skills have been highlighted as an issue as part of the strategy refresh	4	4	16	Change process will not be taken forward. Impact upon local health community will be minimal	Leadership development programmes and change management methodology supported across the PCT

S - Severity	1 – Least severe	5 Most severe
L - Likelihood	1 – Least likely	5 Most likely
R - Rating	8-15 High Risk	16+ Extreme Risk

Figure 34: Details of financial risks and business risks

Section 6. Board sign off

The statutory boards and the integrated business board have been fully engaged in developing our strategic plan over the last 18 months. This has included a high level input into the strategy refresh undertaken over the last six months. Input by the statutory boards and the integrated business board have been facilitated through planned seminars as well as discussion, debate and challenge including:

- the rationale and selection for priority health outcomes
- overall methodology for prioritisation
- rationale for selecting particular programmes providing the biggest impact to health improvement and reducing health inequalities

The statutory boards and the integrated business board understand how we will address the highest priority health needs for the local population and can explain how initiatives will deliver the vision articulated within the strategy.

During the development of the strategic plan and the refresh process the board has focused on the need to ensure:

- High quality of patient centred services.
- Maximum opportunities for health improvement and the reduction of health inequalities.
- Maximum productivity gains through robust contract and performance management.

The statutory boards and the integrated business board utilise a robust performance framework to gain assurance that key strategic initiatives are delivering their milestones and desired impact.

In developing our strategic plan prior to the most recent refresh there has been wide ranging engagement with patients, public and stakeholders to ensure alignment with patient and public expectation and local area agreement targets and metrics.

Appendix A: Medium Term Financial Strategy

NHS County Durham and NHS Darlington

Medium Term Financial Strategy 2009/10 - 2013/14

Foreword

As commissioners of health and healthcare for NHS County Durham (NHSCD) and NHS Darlington (NHSD) we are working towards delivering excellence today for a healthier tomorrow.

Despite a significantly harsher economic environment than was the case when the first five year strategic plan was written 12 months ago we will continue to invest our funding of over £1bn to ensure quality, promote innovation, maximise efficiency and maintain a focus on prevention.

This five year medium term financial strategy (MTFS) is a key element of the framework setting out our ambition for the future and as such forms an integral element of the PCTs' five year strategic plan.

While the MTFS does not explicitly address the issues of equality and diversity this is a requirement for all PCT initiatives and work programmes.

The MTFS is supported by the PCTs' governance infrastructure including Standing Orders, Standing Financial Instructions and a Scheme of Delegation that clearly identifies budget responsibility. Past performance demonstrates that we achieve our objectives so approval and delivery will be through existing processes and procedures.

Pat Taylor
Director of Finance

January 2010

1 Introduction

Organisations that do not plan their finances properly are unlikely to achieve their strategic objectives or make the best use of their resources. The Audit Commission has identified the need for NHS organisations to prepare and then adhere to a robust medium term financial strategy (MTFS).

The MTFS is a financial expression of the PCTs' strategic plan for the five years 2009/10 to 2013/14. As such it has been developed from a shared understanding of staff from all disciplines and across all functional groups. It will be communicated to all staff and partner organisations. Delivery began in 2009/10 aligned to our strategy and the 2009/10 Annual Operational Plan together with supporting revenue and capital budgets so that both operational and financial targets are achieved.

2 Background

2.1 Purpose

The MTFS is intended to describe the PCTs' financial intentions and so support commissioner led provider development across the County Durham and Darlington health economy.

In addition the MTFS provides assurance to the Integrated Business Board (IBB) that:

- Commissioning intentions and service plans described in the five year strategy and supporting documents are both realistic and achievable.
- Value for money will be delivered over the medium term timescale as well as the short term.

The MTFS has been updated to reflect the 2010/11 Operating Framework and revised resource and expenditure assumptions since September 2008. The key change relates to the expected impact of the economic downturn on public sector finances over the medium term and the lower expectation of growth in NHS funding.

2.2 Strategic objective

The objective is to achieve recurring financial balance whilst delivering our strategic plan.

2.3 Key financial intentions

The key intentions underpinning this MTFS are as follows:

- Achievement of recurrent balance in each of the years covered by the MTFS with all recurrent and non-recurrent resources and expenditure separately identified to minimise the danger of developing unaffordable strategies where non-recurrent resources mask recurrent deficits.

- Available financial resources will be allocated over the five year timeframe of the MTFS to enable effective management of developments and resources.

- All services commissioned by NHSCD and NHSD will be undertaken within a clear financial framework. Service plans will link performance targets that include clearly defined outputs, outcomes and efficiencies to the required investment. They will identify associated risks and have exit plans prepared should performance deviate irreconcilably from target.

- Assets held by the PCTs will be reviewed annually in order to ensure the best use of resources and achievement of clear, agreed service improvements.

- Recognising the service development pressures facing the NHS and finite funding available through the allocation process we will actively seek all appropriate external funding and explore all opportunities to make efficiency savings with local partners and national agencies to ensure value for money in the medium as well as the short term.

- Management of financial risk by maintaining a contingency amounting to 2% of recurrent revenue funding which if not required will be deployed non-recurrently to support change and innovation.

- We will engage with local organisations across sectors to ensure that the healthcare market is well placed to deliver the best healthcare and to manage the financial risks to the health economy collaboratively.

2.4 Timetable and process

The timetable for the production of a refreshed MTFS comprises of four stages and these are set out in table 1 below:

Table 1 - MTFS timetable

Key stages	Nature of work	Timetable
Stage 1	Scoping and validation including audit views	Aug - Nov 2009
Stage 2	Engagement and planning including input in relation to collaborative commissioning arrangements	Sep 2009 onwards
Stage 3	Phased implementation and incorporation into Annual Operational Plan and annual budget setting process	April 2010 onwards
Stage 4	Monitoring and review including annual refresh	April 2010 onwards

The refreshed MTFS will be presented to the IBB for consideration and approval at its meeting in January 2010. Interim progress reports, based on continuous horizon scanning, will be presented to the management executive and IBB during the year. These reports will be on an exceptional basis identifying issues or risks which impact on the strategy and may require its amendment before the annual refresh.

The second stage of the process begins with a review of the success of the previous year's MTFS and this year has also included the incorporation into our strategy the work to deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda. This stage is conducted in conjunction with other PCTs across the North East and the strategic health authority, NHS North East.

The fourth stage of monitoring and review includes an impact assessment of the PCTs' rolling programme of service reviews to establish whether any require amendment to the strategy.

2.5 Leadership and engagement

Our strategy and the MTFS are prepared by multi disciplinary teams utilising existing forums such as the Strategy Delivery Group, established task and finish methodologies, as appropriate, and led by the relevant executive directors. The directors are accountable to both the management executive, which includes clinical and practice based commissioning representation, chaired by the Chief Executive,

as well as the IBB. Both forums provide the opportunity for discussion and challenge before the final version of the MTFS is approved and used as the basis of the subsequent year's Annual Operational Plan and annual budgets.

One of the most challenging aspects of financial management in an economic downturn is delivering a change in organisational culture and mind set of staff. We recognise this challenge and have engaged staff in a review of the commissioning process. Existing methods of engaging staff will be used for the delivery of our strategy and the MTFS. PCT and team briefs, intranet and website information dissemination are some of the tools used to ensure staff understand what is happening in our PCTs and how their role contributes to the achievement of organisational objectives.

Routine meetings with key local partners including Durham County Council and Darlington Borough Council ensure alignment of strategic plans across the local populations that the organisations serve. Our strategy and the MTFS also embody the outcome of public and patient engagement. This year, in addition to input into the pan county Health and Wellbeing Partnership, the strategic financial planning for all public sector organisations across County Durham was presented for discussion and feedback to all fourteen Area Action Partnerships and Talking Together in Darlington.

3 Financial situation

3.1 Financial history

NHSCD was created when five predecessor primary care trusts (PCTs) came together in October 2006. At that time 3 of the 5 organisations were in deficit and this was inherited by NHSCD. Since formation we have established a sound track record of financial stability, delivery of statutory duties and achievement of key financial targets.

NHSD’s successful delivery of cost improvement schemes on a recurrent basis has seen the severe financial challenges of previous years overcome, allowing 2008/09 to begin on a sound financial footing.

The achievements of both PCTs in respect of revenue resource can be seen in table 2 below. We also met our capital and cash limit targets. PCTs are assessed on these targets whilst still needing to achieve the operational targets set out elsewhere in this document.

Table 2 - Historical financial performance

Financial Year	NHS County Durham	NHS Darlington
2006/07	All limits met Revenue under-spend: £242k	All limits met Revenue under-spend: £56k
2007/08	All limits met Revenue under-spend: £981k	All limits met Revenue under-spend: £101k
2008/09	All limits met Revenue under-spend: £918k	All limits met Revenue under-spend: £301k

3.2 Delivery of revenue, capital and cash limits

Both organisations entered 2009/10 with a history of good financial performance which has enabled them to continue to forecast delivery of financial balance and to remain within revenue, capital and cash limits. Financial pressures have emerged in-year in acute healthcare, continuing healthcare and prescribing. Continued strong financial management and contract management will be required to ensure that these pressures are managed within revenue, capital and cash limits without adverse impact on operational performance targets.

3.3 Financial trends

NHSCD and NHSD 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 new recurring funding available (growth) for NHSCD and NHSD is shown in table 3 below:

Table 3 - Recurrent baseline and growth

	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%)
Expected total recurring revenue allocation	£888.8 m	£937.6 m	£164.1 m	£172.7 m

The above table demonstrates the recurrent revenue funding available for the cluster of £1,053m in 2009/10 and £1,110m in 2010/11.

3.4 Distance from target allocation

The Department of Health allocates funding directly to PCTs on the basis of the relative needs of their populations. A weighted capitation formula determines each PCT's target share of available resources, its target allocation, to enable them to commission similar levels of health services for populations in similar need, and to reduce avoidable health inequalities. Depending on how their current funding position then compares to their target allocation, PCTs receive growth in line with the pace of change policy.

Following the substantial investment shown above, NHSCD will still be under the allocation target by 5.4%. In contrast, NHSD will be 0.9% over the allocation target.

The position shown for NHSCD is an average for the PCT's entire population and as such it does not reflect the wide variation across the PCT. The variation can be seen in table 4 below which shows the last reported position of NHSCD's five predecessor PCTs. This must be viewed with caution and as an indication of the position locally at a specific point in time. Since then NHSCD has worked hard to reduce local health inequality and level up healthcare provision across the total population served.

Table 4 – Distance from target allocation

Primary Care Trust	Distance from target - %age
Derwentside	-4.09%
Durham and Chester le Street	+1.34%
Durham Dales	+0.76%
Easington	-16.23%
Sedgefield	- 2.36%

3.5 Key financial risks

The key financial risks reported at 31 December 2009 are shown in table 5 below:

Table 5 - Key risks

		5x5 Risk Rating		
NHSCD or NHSD	**Nature**	**Impact**	**Likelihood**	**Rating**
Both	Achievement of action plans and measures in place to address over-activity and assist in achievement of financial balance	5	4	**20**
Both	Acute healthcare contract over-performance due to activity and introduction of HRG4	5	4	**20**
NHSD	Continuing healthcare – impact of increasing case numbers along with ongoing non-performance of database impacting upon delivery of robust financial information	4	5	**20**
Both	Flu pandemic contingency – impact of H1N1 on organisational resources and on commissioned secondary care services. The potential impact of this risk is currently difficult to predict and this will continue to be closely monitored as more clarity is obtained	4	3	**12**
Both	Increasing use of independent sector contracts (s23/64 agreements) without a corresponding reduction in activity at NHS contracts. This includes the nationally negotiated contract with Spire Healthcare	4	3	**12**

Note: Impact and likelihood of risk are rated on a scale of 1 (negligible / rare) to 5 (significant / almost certain). The resultant rating is then presented, with a score above 15 deemed to be an extreme risk, one above 8 a high risk and one above 4 a medium risk with anything lower deemed low risk.

3.6 Use of resources

The PCTs are assessed by the Audit Commission each year as part of the review of annual accounts to determine our score under "Use of Resources". This is an externally validated assessment against a number of key lines of enquiry (KLoE) under the headings of

- Managing finances
- Governing the business
- Managing resources

In 2008/09 both organisations achieved an overall rating of 2. It is our ambition to improve this score in all areas in order to achieve a rating of 3 in 2009/10 and beyond.

4 Statutory and financial duties

The MTFS has been prepared on the basis that we will continue to achieve our financial duties and not exceed either revenue, capital or cash limits.

NHSCD divested its provider services to NHSD in August 2008 and as such the requirement to demonstrate full cost recovery in relation to provider services has ceased to be applicable. NHSD is still required to demonstrate full cost recovery as the provider services moves towards autonomous status.

Government bodies including PCTs are required to adopt International Financial Reporting Standards (IFRS) and the impact of adherence to the Standards is reflected in the MTFS.

5 Five Year Financial Plan and Model

The five year financial plan presented to each PCT Board in March 2009 has been significantly updated to reflect a range of issues, the most important of which are set out below:

- UK economic downturn
  Given the UK economic downturn we are now planning on no real terms growth from 2011/12. This supports all the information available at the current time that significant efficiencies will be required from within the public sector, which is likely to mean very low or nil real terms growth for the NHS.

- Implications of the QIPP initiative on the local health economy
  The QIPP initiative has been developed to help with the management of the likely financial pressures to be experienced from 2011/12 and the need to generate significant efficiencies. QIPP is fully integrated into the PCTs' strategic planning and the financial impact has been incorporated into the financial plan.

- Impact of implementation of HRG4 on tariff pricing
  Further intelligence on the impact and implications for local NHS organisations on the introduction of the new tariff pricing system (HRG4) indicate there will be additional recurrent costs for the PCTs.

- Current year activity pressures
  In year information on material activity pressures have been reflected in the revised plan, particularly in respect of the acute secondary care sector and continuing healthcare.

- Refreshed Joint Strategic Needs Assessments (JSNAs) and local inequality across County Durham and Darlington
  Both PCTs have worked with their Local Authority to produce refreshed JSNAs which have informed the planning process and have shaped the initiatives included in the five year strategy and this MTFS.

- Moving care closer to home
  The PCTs' strategy reflects the continued drive to move care closer to home wherever this is both practical and desirable recognising as paramount the need to commission healthcare services which are safe and secure.

Taken together these changes will substantially reduce the scope for new investment during the planning period. It is expected that the QIPP initiatives will generate combined efficiencies of over £180 million over the planning period through innovation, tariff changes and service redesign, which will be used to fund additional strategic investments and cost pressures arising from the demographic changes for example. Demand-led cost pressures will need to be robustly managed for this methodology to be successful and to ensure that the increased activity levels experienced in the current year do not absorb a significant element of the expected efficiency savings.

The financial plan considers how the total resources of both NHSCD and NHSD, rising from £1,108m to £1,159m per year over the period of the plan, may be deployed. In addition it focuses in some detail on the impact of potential changes in activity, price/cost inflation as well as on priority areas for new investment.

In support of the our strategic objectives over the course of the five years there is increased investment in care closer to home, improvements in health and addressing inequalities across the region. We do not expect to be able to deliver the investment required without achieving greater efficiencies. In particular we will be looking at the level of services provided through the acute secondary care setting and areas where the local health system compares unfavourably with the national position, such as the level of follow ups and length of stay in secondary care. Our target is to have achieved over £180m of recurrent efficiency savings by 2013/14.

The combined impact of the performance savings and investment in our priorities is expected to result in a reduction in the relative level of expenditure on hospital based activity and an increase for community and primary care based services.

NHSCD and NHSD have developed a five year financial model that allows dynamic scenario modelling and risk assessment. This will ensure we can provide swift financial information on the impact of changing health needs, revised economic planning assumptions and evolving environmental and political factors.

In addition to the ongoing scenario modelling, which will be continually reviewed and refreshed throughout the planning period, the financial model will be formally reviewed and updated on at least an annual basis or more frequently when issues with a significant financial impact become apparent.

The five year financial model is an integral element of our strategy.

The financial plan is also supplemented by a suite of financial management and governance policy documents including the cash management policy, standing financial instructions, standing orders and a comprehensive scheme of delegation.

The five year financial model itself takes the form of a set of interdependent spreadsheets. Based on the input of basic funding and expenditure information, predicted activity and inflationary and growth assumptions, the spreadsheets produce operating cost statements and balance sheets for a five year period, covering a range of scenarios.

The financial model incorporates expected future developments and the related resource implications through the inflationary and growth assumptions applied, as well as additional investment included in respect of the initiatives highlighted in our strategy. The impact of any other potential developments and risks are assessed via scenario planning and sensitivity analysis.

6 Key assumptions

In preparing the five year financial forecast NHSCD and NHSD have utilised the planning assumptions developed regionally and agreed with NHS North East.

For 2009/10 and 2010/11 figures are based on the NHS Operating Frameworks published in December 2008 and 2009 any subsequent announcements.

For 2011/12 to 2013/14, assumptions have been determined for three different scenarios which incorporate potential differences in the level of tariff uplift to be agreed nationally, together with the level of funding allocation received from the Department of Health. Table 6 below sets out the key assumptions:

Table 6 – Key assumptions across 3 scenarios

	2009/10 - 2010/11	2011/12 – 2013/14 Best Case	2011/12 – 2013/14 Worst Case	2011/12 – 2013/14 Middle Case
PCT Allocation Uplift				
NHS County Durham	5.5%	2.5%	0.0%	0.0%
NHS Darlington	5.2%	2.5%	0.0%	0.0%

	2009/10 - 2010/11	2011/12 – 2013/14 Best Case	2011/12 – 2013/14 Worst Case	2011/12 – 2013/14 Middle Case
PBR Tariff				
Gross PBR Tariff (excluding efficiency and CQUIN)	3.5%	2.5%	2.5%	2.5%
Efficiency	3.5%	3.5%	4.0%	4.5%
CQUIN	1.5% cumulative (0.5% 2009/10)	1.0%	1.0%	1.0%
Net impact	1.5%	0.0%	-0.5%	-1.0%
Non PBR Tariff				
Gross Uplift (excluding efficiency and CQUIN)	3.5%	2.5%	2.5%	2.5%
Efficiency	3.5%	3.5%	4.0%	4.5%
CQUIN	1.5% cumulative (0.5% 2009/10)	1.0%	1.0%	1.0%
Net impact	1.5%	0.0%	-0.5%	-1.0%
Prescribing				
Gross Uplift (excluding efficiency)	6.0%	5.0%	5.0%	5.0%
Efficiency	3.0%	3.0%	3.0%	3.0%
Net impact	3.0%	2.0%	2.0%	2.0%
GP Contract (PMS & GMS)				
Gross GP Contract: PMS & GMS (excluding efficiency)	5.0%	3.5%	3.5%	3.5%
Efficiency	3.5%	3.5%	4.0%	4.5%
Net impact	1.5%	0.0%	-0.5%	-1.0%
Dentist Contract				
Gross Dentist Contract (excluding efficiency)	5.0%	3.5%	3.5%	3.5%
Efficiency	3.5%	3.5%	4.0%	4.5%
Net impact	1.5%	0.0%	-0.5%	-1.0%

	2009/10 - 2010/11	2011/12 – 2013/14 Best Case	2011/12 – 2013/14 Worst Case	2011/12 – 2013/14 Middle Case
Community services				
Gross Community services (excluding efficiency)	5.0%	3.5%	3.5%	3.5%
Efficiency	3.5%	3.5%	4.0%	4.5%
Net impact	1.5%	0.0%	-0.5%	-1.0%

The main non-financial assumption within the plan is that from 2009/10 there will be no increases in elective referrals and emergency admissions to secondary care other than those driven by demographic changes. The model, however, does build in the recurrent impact of forecast out-turn activity for 2009/10 and sustaining capacity to ensure delivery of the 18 week wait target beyond 2009/10. Where known we have included specific changes in demand, for example in respect of specialised services.

7 Income and expenditure

7.1 Revenue resources

An extract from the five year financial model showing income and expenditure forecasts for 2009/10 to 2013/14 under the most likely 'base case' scenario is included in tables 7 and 8 for NHSCD and NHSD below.

Table 9 summarises the position in respect of the alternative scenarios and demonstrates a sustainable financial position for both PCTs.

Table 7 – Base case NHSCD

NHS County Durham FINANCIAL STATEMENTS	**BASE CASE**					
	Actual	*Forecast periods*				
	FY 2008/09 £000s	**FY 2009/10** £000s	**FY 2010/11** £000s	**FY 2011/12** £000s	**FY 2012/13** £000s	**FY 2013/14** £000s
Operating costs statement						
Income						
Previous year's recurrent baseline	786,188	841,597	888,847	937,622	961,062	985,089
Changes in recurrent baseline	55,409	47,250	48,775	23,441	24,027	24,627
New recurrent baseline	841,597	888,847	937,622	961,062	985,089	1,009,716
Non-recurrent allocations received every year	27,880	35,776	49,423	49,423	49,423	49,423
Non-recurrent allocations	(5,738)	3,639	-	-	-	-
Lodgements	(1,100)	14,296	9,214	711	-	4,518
Return of prior year surplus/(deficit)	-	918	1,000	1,000	1,000	1,000
Total Income	**862,639**	**943,476**	**997,259**	**1,012,196**	**1,035,512**	**1,064,657**
Expenditure						
Primary and Community						
GPs	69,800	71,778	70,051	70,878	71,197	71,835
Prescribing	87,234	90,372	94,910	96,267	98,822	101,737
Dentistry	21,133	19,175	21,789	22,111	21,976	21,906
Community Provider Services	24,193	-	-	-	-	-
Pharmacies	7,793	8,836	17,726	17,726	17,726	17,726
Other Primary and Community	87,545	122,696	130,826	145,322	178,511	215,348
Total Primary and Community	**297,698**	**312,857**	**335,301**	**352,304**	**388,232**	**428,552**
Mental Health and Learning						
Mental Health	74,176	77,758	82,213	83,940	80,082	76,223
Learning Disability	38,175	33,557	35,055	35,860	35,860	35,860
Total Mental Health and Learning Disability	**112,351**	**111,315**	**117,268**	**119,800**	**115,942**	**112,084**
Continuing Care						
Continuing Care	24,210	32,636	34,365	35,701	36,709	37,770
Total Continuing Care	**24,210**	**32,636**	**34,365**	**35,701**	**36,709**	**37,770**
Secondary or Tertiary acute care						
NHS and Foundation Acute Trusts	343,054	391,892	397,091	382,721	379,241	373,266
ISTCs and Other Independent Sector	3,661	6,930	8,373	8,534	8,534	8,534
Ambulance Trusts	14,025	18,665	19,123	19,445	19,445	19,445
Total Secondary or Tertiary acute care	**360,740**	**417,487**	**424,586**	**410,700**	**407,220**	**401,245**
Specialised Commissioning						
Specialised Commissioning	19,929	23,894	26,892	28,750	29,234	29,708
Total Specialised Commissioning	**19,929**	**23,894**	**26,892**	**28,750**	**29,234**	**29,708**
Other PCT Commissioning spend						
Other pay (e.g., public health related)	7,431	7,882	8,955	9,277	9,277	9,277
Other non-pay (e.g., public health related, external spend on social marketing)	7,763	10,004	7,781	13,375	11,846	11,021
Total Other PCT Commissioning spend	**15,194**	**17,886**	**16,736**	**22,652**	**21,123**	**20,298**
Other PCT Spend (e.g., estates, management, other overheads - not provider services)	31,599	26,401	22,378	22,088	16,371	13,826
Contingencies (only commissioning contingencies)	-	-	18,733	19,202	19,682	20,174
Total Expenditure	**861,721**	**942,476**	**996,259**	**1,011,196**	**1,034,512**	**1,063,656**
PCT Surplus/(Deficit)						
PCT Surplus/(Deficit) reported	**918**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

Table 8 - Base case NHSD

NHS Darlington
FINANCIAL STATEMENTS

BASE CASE

	Actual	*Forecast periods*				
	FY 2008/09	**FY 2009/10**	**FY 2010/11**	**FY 2011/12**	**FY 2012/13**	**FY 2013/14**
	£000s	£000s	£000s	£000s	£000s	£000s
Operating costs statement						
Income						
Previous year's recurrent baseline	157,792	156,788	164,059	172,683	177,000	181,425
Changes in recurrent baseline	(1,004)	7,271	8,624	4,317	4,425	4,536
New recurrent baseline	156,788	164,059	172,683	177,000	181,425	185,961
Non-recurrent allocations received every year	7,569	8,170	10,832	10,832	10,832	10,832
Non-recurrent allocations	(2,705)	(1,195)	-	-	-	-
Lodgements	(114)	450	751	-	-	1,953
Return of prior year surplus/(deficit)	-	301	300	300	300	300
Total Income	**161,538**	**171,785**	**184,566**	**188,132**	**192,557**	**199,046**
Expenditure						
Primary and Community						
GPs	13,251	14,528	14,691	14,249	14,200	14,168
Prescribing	15,852	16,828	17,498	17,740	18,222	18,774
Dentistry	5,513	6,025	6,643	6,698	6,671	6,657
Community Provider Services	3,536	13,442	13,644	13,644	13,644	13,644
Pharmacies	1,418	1,496	3,060	3,060	3,060	3,060
Other Primary and Community	3,830	3,509	6,196	9,730	15,149	22,976
Total Primary and Community	**43,400**	**55,828**	**61,732**	**65,122**	**70,946**	**79,280**
Mental Health and Learning						
Mental Health	13,039	13,133	13,479	13,748	13,256	12,764
Learning Disability	7,013	5,495	5,439	5,577	5,577	5,577
Total Mental Health and Learning Disability	**20,052**	**18,628**	**18,919**	**19,326**	**18,834**	**18,342**
Continuing Care						
Continuing Care	5,614	6,931	7,255	7,653	7,912	8,179
Total Continuing Care	**5,614**	**6,931**	**7,255**	**7,653**	**7,912**	**8,179**
Secondary or Tertiary acute care						
NHS and Foundation Acute Trusts	75,651	72,669	75,279	74,395	73,729	72,573
ISTCs and Other Independent Sector	1,768	2,383	2,631	2,659	2,659	2,659
Ambulance Trusts	2,380	2,943	2,932	2,987	2,987	2,987
Total Secondary or Tertiary acute care	**79,799**	**77,995**	**80,842**	**80,041**	**79,374**	**78,219**
Specialised Commissioning						
Specialised Commissioning	3,382	3,800	4,364	4,442	4,442	4,442
Total Specialised Commissioning	**3,382**	**3,800**	**4,364**	**4,442**	**4,442**	**4,442**
Other PCT Commissioning spend						
Other pay (e.g., public health related)	154	103	99	155	155	155
Other non-pay (e.g., public health related, external spend on social marketing)	2,333	2,440	2,646	3,008	3,008	3,008
Total Other PCT Commissioning spend	**2,487**	**2,543**	**2,746**	**3,162**	**3,162**	**3,162**
Other PCT Spend (e.g., estates, management, other overheads - not provider services)	6,503	5,760	4,955	4,546	3,957	3,404
Contingencies (only commissioning contingencies)	-	-	3,454	3,540	3,629	3,719
Total Expenditure	**161,237**	**171,485**	**184,267**	**187,832**	**192,257**	**198,747**
PCT Surplus/(Deficit)						
PCT Surplus/(Deficit) reported	**301**	**300**	**300**	**300**	**300**	**300**

Table 9 – Scenario 1 and 2 for NHSCD and NHSD

NHS County Durham
FINANCIAL STATEMENTS

	SCENARIO 1						SCENARIO 2					
	Actual	*Forecast periods*					*Actual*	*Forecast periods*				
	FY 2008/09 £000s	FY 2009/10 £000s	FY 2010/11 £000s	FY 2011/12 £000s	FY 2012/13 £000s	FY 2013/14 £000s	FY 2008/09 £000s	FY 2009/10 £000s	FY 2010/11 £000s	FY 2011/12 £000s	FY 2012/13 £000s	FY 2013/14 £000s
Operating costs statement												
Total Income	**862,639**	**943,476**	**997,259**	**988,757**	**988,045**	**992,564**	**862,639**	**943,476**	**997,259**	**988,757**	**988,046**	**992,563**
Expenditure												
Total Primary and Community	297,698	312,857	335,302	339,947	350,137	381,921	297,698	312,857	335,302	339,131	354,529	380,327
Total Mental Health and Learning Disability	112,351	111,315	117,268	118,502	114,248	109,316	112,351	111,315	117,268	118,404	113,560	108,565
Total Continuing Care	24,210	32,636	34,365	35,525	36,355	37,234	24,210	32,636	34,365	35,349	36,003	36,704
Total Secondary or Tertiary acute care	360,740	417,487	424,587	406,550	402,528	390,739	360,740	417,487	424,587	404,702	398,857	386,393
Total Specialised Commissioning	19,929	23,894	26,892	28,615	28,963	29,302	19,929	23,894	26,892	28,481	28,695	28,901
Total Other PCT Commissioning spend	15,194	17,886	16,736	21,659	19,929	17,503	15,194	17,886	16,736	21,715	20,735	18,711
Other PCT Spend (e.g., estates, management, other overheads - not provider services)	31,599	26,401	22,376	21,968	16,152	12,525	31,599	26,401	22,376	21,349	15,934	13,229
Contingencies (only commissioning contingencies)	-	-	18,733	14,991	18,733	13,024	-	-	18,733	18,626	18,733	18,733
Total Expenditure	**861,721**	**942,476**	**996,259**	**987,757**	**987,045**	**991,564**	**861,721**	**942,476**	**996,259**	**987,757**	**987,046**	**991,563**
PCT Surplus/(Deficit)												
PCT Surplus/(Deficit) reported	**918**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**918**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

NHS Darlington
FINANCIAL STATEMENTS

	SCENARIO 1						SCENARIO 2					
	Actual	*Forecast periods*					*Actual*	*Forecast periods*				
	FY 2008/09 £000s	FY 2009/10 £000s	FY 2010/11 £000s	FY 2011/12 £000s	FY 2012/13 £000s	FY 2013/14 £000s	FY 2008/09 £000s	FY 2009/10 £000s	FY 2010/11 £000s	FY 2011/12 £000s	FY 2012/13 £000s	FY 2013/14 £000s
Operating costs statement												
Total Income	**161,538**	**171,785**	**184,566**	**183,815**	**183,816**	**185,768**	**161,538**	**171,785**	**184,566**	**183,815**	**183,815**	**185,768**
Expenditure												
Total Primary and Community	43,400	55,828	61,732	61,853	64,580	69,694	43,400	55,828	61,732	62,102	64,770	69,880
Total Mental Health and Learning Disability	20,052	18,628	18,919	19,229	18,591	17,806	20,052	18,628	18,919	19,133	18,449	17,773
Total Continuing Care	5,614	6,931	7,255	7,616	7,837	8,065	5,614	6,931	7,255	7,579	7,762	7,952
Total Secondary or Tertiary acute care	79,799	77,995	80,842	79,280	78,017	76,073	79,799	77,995	80,842	79,223	77,765	75,832
Total Specialised Commissioning	3,382	3,800	4,364	4,420	4,398	4,376	3,382	3,800	4,364	4,398	4,354	4,311
Total Other PCT Commissioning spend	2,487	2,543	2,746	3,147	2,981	2,666	2,487	2,543	2,746	3,132	3,100	3,069
Other PCT Spend (e.g., estates, management, other overheads - not provider services)	6,503	5,760	4,955	4,520	3,909	3,336	6,503	5,760	4,955	4,494	3,860	3,268
Contingencies (only commissioning contingencies)	-	-	3,454	3,449	3,204	3,454	-	-	3,454	3,454	3,454	3,384
Total Expenditure	**161,237**	**171,485**	**184,267**	**183,514**	**183,516**	**185,468**	**161,237**	**171,485**	**184,267**	**183,515**	**183,515**	**185,468**
PCT Surplus/(Deficit)												
PCT Surplus/(Deficit) reported	**301**	**300**	**300**	**300**	**300**	**300**	**301**	**300**	**300**	**300**	**300**	**300**

7.2 Capital expenditure and asset management

NHSCD's asset base includes five community hospitals and occupation of numerous other freehold and leasehold premises. NHSCD is also a member of the County Durham and Tees Valley Local Improvement Finance Trust (LIFT). NHSD has a smaller asset base comprising a number of freehold and leasehold properties.

The planning assumptions around estates maintenance and development are based upon a prudent level of funding but are realistic about the costs of maintaining and supporting an asset base as at 31 March 2009 of £48.6m for NHSCD and £7.4m for NHSD when adjusted for the impact of IFRS.

As part of the PCTs' drive to identify efficiencies within their own cost base, asset management will include reviews of operational and capital efficiency to ensure best value for money is achieved, as well as any local or national initiatives to reduce the organisations' carbon footprint. A clear and robust process for asset management in respect of estates is focused on a commission investment asset management strategy (CIAMS) for both PCTs which will be completed by the end of the 2009/10 financial year in accordance with a national timetable. CIAMS aligns the commissioning strategy with the current estate and identifies the future requirements of the primary and community care estate and will confirm earlier work which suggests there will be an overall reduction in the total size of the estate. CIAMS builds upon and consolidates previous work on estate utilisation and the creation of a comprehensive property database.

There is a continuous stream of investment in new and improved GP premises during the life of the MTFS which comprises both capital and revenue funding.

7.3 Informatics, other internal strategies and financial management

The MTFS includes the revenue consequences of informatics developments for both PCTs.

Further development of the local IT infrastructure in partnership with the local acute foundation trust and GP practices as a community of interest network (COIN) is included as are requirements identified under the National Programme for Information technology (NPfIT). It is assumed that IM&T requirements of future premises developments will be funded by the estates capital programme.

The workforce planning requirements of our chosen initiatives are included in the MTFS to ensure the capacity and capability exists to deliver the investment programme. Through investment in training, development and leadership programmes we will ensure we have the capacity and skill base to support world

class commissioning and deliver our vision of excellence today for a healthier tomorrow.

The financial model which supports the MTFS is based upon a demand plan formulated by commissioning and performance staff. The output from the model is then tested against capacity plans with provider organisations to ensure that the requirements of the demand plan are realistic and identify areas in the provider healthcare market where additional investment is required.

The model is supported by robust financial management processes evidenced by those for asset management set out above and also those in respect of invoice processing and debt management. The provider invoice audit process allows for appropriate challenge by finance, performance and commissioning teams which has been financially beneficial. The debt management process reports routinely to audit committee and board on approved invoicing processing improvements and effective credit control whose value for money is monitored by the audit committee.

8 Scenario Planning

There are a significant number of up and downside risks to the assumptions included in the plan and, as a consequence, work has begun to review the impact of different scenarios.

As one of our key goals is sustainable financial health, the ability to flex the financial plan to take account of new and as yet unforeseen requirements and opportunities, whilst remaining in recurrent balance, is very important. Our in-year contingency reserve is just one element of our approach to risk management. Another is our approach to investment planning. A third is the flexing of the timing and scope of implementation of some of the initiatives identified in line with the QIPP agenda, and increasing the pace of service redesign/innovation to secure a more cost effective delivery of services to patients.

In terms of upside risks (or opportunities), we have been very prudent in our assumptions around securing new income from sources other than the general allocation from the Department of Health. It may also be possible to bring forward the profile for delivery of the £180m efficiency savings. Both could result in the ability to accelerate our healthcare investment programme.

On the downside, our assumptions around limiting the growth in hospital activity may prove too optimistic, and future national decisions on tariff uplifts and pay increases could add further cost pressures. Whilst this could be addressed using our general contingency reserves, investment profiles will need to be kept under continuous review and the drive to secure best value for money in all areas of operations must be relentless.

As highlighted above, assumptions have been developed and agreed with NHS North East for three different scenarios, each with different assumptions around the level of the tariff uplift and allocation of funding. Section 6 has identified the figures used in each of the three scenarios.

9 Cost Drivers

Our financial plan and the level of investment required is impacted by a range of cost drivers and the approach to the forecasting of costs is determined by our ability to influence and control those costs.

Factors influencing the future position can be categorised into those that are external (driven by factors external to the PCTs) and internal (those within the PCTs' decision making).

Applying the well recognised PESTEL (Political, Economic, Sociological, Technological, Legal/regulatory) methodology the following cost driver headings are identified:

- External cost drivers:
    - Economic, legal, regulatory and national policy
    - Demographic, technological and environmental

- Internal cost drivers:
    - Efficiency/savings programme
    - Investment programme

Economic, legal, regulatory and national policy drivers include:

- PCT growth uplift
  The annual growth increase in the PCT resource limit which is influenced by weighted capitation targets intended to ensure an equitable distribution of funding

- Tariff uplift – the annual uplift for healthcare providers operating under Payments by Results (PbR) which reflects the impact of inflation, service quality enhancements and efficiency improvements

- Legal changes – an example is the impact of legislation upon health and social care budgets of changing continuing healthcare eligibility criteria

- IFRS – the impact of the implementation of IFRS upon the PCTs' financial position

- National policy changes – this area includes the annual operating framework which sets out policy initiatives and health targets which impact upon PCT budgets.

Demographic, technological and environmental drivers include:

- Population growth – estimated changes in total population numbers

- Population mix – demographic changes in terms of age, gender, ethnicity within the overall population

- Deprivation – the impact of deprivation within communities compromising the total population

- New technologies and drugs – the effect of technological change within the NHS and of new drugs approved for general use by the National Institute for Health and Clinical Excellence (NICE)

- Impact of patient choice and expectations – the financial impact of increasing patient expectations in respect of access to and quality of healthcare

The key internal cost drivers include:

Efficiency/savings programme – within the financial plan are both national and local expectations in respect of efficiency gains to be delivered over the period covered by the MTFS.

Investment programme –we have a framework for developing investment proposals that is consistent with world class commissioning competencies and which although demonstrating value for money do impact upon our financial position.

Where we have a significant degree of control over costs, financial forecasting is largely based on activity forecasts and predictive planning of cost drivers.

Where we have limited indirect control or no control over costs, benchmarking such as programme budgeting and some trend analysis is performed, along with additional scenario planning and sensitivity analysis.

10 Investments and support for the five year strategy

The investments made under the Annual Operational Plan in 2009/10 are set out in table 10 below:

Table 10 – Source and application of funds in 2009/10

	NHSCD £000	NHSD £000
Source of funds		
New funding in 2009/10	47,251	7,271
Total recurrent funding	**47,251**	**7,271**
Application of funds		
Net inflation uplift	-22,838	-4,313
Cost pressures & new developments	-24,413	-2,958
Total funds applied recurrently	**47,251**	**7,271**
It is currently assumed that acute sector and continuing healthcare pressures will be offset by savings delivered from efficiency programmes and re-phasing investments still to start		

The financial plan makes provision over the course of the five years for investment in the initiatives set out in our strategy to support delivery of our strategic objectives. However, at this stage, the business cases to support most specific developments need to be completed in greater detail. It is, however, important to note that not all initiatives will require additional resources, as some are as much about changing the way services are delivered and the way we work with strategic partners and local communities.

Our aim is to have a transparent and accountable process for prioritisation of investment which will allow our partners, including provider organisations and local patients and the public, to have a clear understanding of our priorities and direction of travel. We will build upon our Public Value work and stakeholder engagement.

The key strategic aims and initiatives which are highlighted in our strategy are outlined in further detail as part of our commissioning intentions, which are published separately, and are supported by our financial plans.

The current investments within the financial plan have been determined following a process of review and prioritisation based upon a combination of updated population needs assessments and national and local targets. The risks related to the proposed investments are taken into account as well as the wider impact to the health system as a whole. The final decisions on investments over the next few years will be defined and agreed following our well-established business and investment planning processes, including the determination of exit strategies as required.

Internal processes that are now embedded produce and review business cases to ensure investment decisions are based upon achievement of required clinical outcomes, value for money and sustainability. The process allows for both clear financial information and robust challenge at different levels throughout the organisation. Regular review of investments against criteria used in the investment planning process will be undertaken and will help to inform the disinvestment process. Capital expenditure is subjected to an equally rigorous review and we have developed and implemented a decision model to help prioritise capital expenditure investments. Capital developments that support further expansion of the services that can be provided in a community or primary care setting are an important part of our financial strategy.

Further use of benchmarking and comparative performance information is fundamental to our approach to become a truly world class commissioning organisation. Programme budgeting information linked to public health outcome measures is being used to monitor progress and outcomes from investment as well as to inform financial investment and disinvestment strategies. While the absolute data is not robust at this stage, it is anticipated that this will improve over the financial planning cycle and will facilitate improved healthcare investment decision making.

Careful financial planning and strong financial management and forecasting over the planning period will allow us to remain on a sound financial footing and therefore to deliver our strategic objectives. However given the current financial uncertainty we should not be over-ambitious in recurrently committing funds in the first two years of the plan.

In light of current uncertainty around the wider economic climate and the likely impact on public sector funding over the next five years, a contingency has been set aside within the financial plan from 2011/12 of 2% of our recurring baseline. This will allow us to manage in year pressures without compromising service delivery or financial balance.

The flexibility of the contingency reserve can only be maintained if commitments against it are non-recurrent. This is achieved by:

- funding cost pressures from recurrent resources in the following year
- implementing service redesign to redeploy equivalent resources the following year
- implementing a non-recurrent investment programme each year

11 PCT community services

NHSCD divested its provider services to NHSD in August 2008. NHSD is intending to establish an autonomous provider organisation in the longer term and this is reflected in the PCT's financial planning with separate plans for County Durham and Darlington Community Health Services although ultimate accountability remains with the Chief Executive and Director of Finance.

12 Practice Based Commissioning

As part of the alignment of clinical and financial responsibility Practice Based Commissioning (PBC) gives all practices responsibility for managing resources and redesigning services for patients.

PBC commissioning intentions are an integral element of our planning process and as such our ambitions are understood and shared with practices. PBC is seen as a key vehicle for delivering service redesign and releasing system inefficiencies. This is evidenced by the development of PBC budget management, engagement in our Clinical Programme Groups and work on revised commissioning processes.

13 Risk assessment - sensitivity analysis and risk mitigation

Additional work has been undertaken to model the impact of potential changes in assumptions. This work will continue throughout the planning period and the investment of our total resources will be reviewed to ensure that operational objectives are deliverable regardless of the economic environment.

Examples of the key risk areas are summarised below together with the financial consequences and mitigating action.

13.1 Activity and cost assumptions in respect of demand for secondary care are insufficient

Shorter waiting times can drive supply induced demand and increased GP referrals can create cost pressures. We will continue to work with PBC groups to ensure high quality clinically appropriate referrals. Risk assessments of secondary care activity pressures have been undertaken to quantify the financial impact and these have been factored into affordability calculations. The demand plan upon which the MTFS is based has allowed for demographic change, outturn activity in 2009/10 and further growth based upon past experience and assumptions developed by commissioning, performance and finance staff. The potential risk in respect of further additional

adverse activity pressures for 2010/11 is £4m for NHSCD and £1.5m for NHSD with a likelihood of 20%.

In addition we have been road testing the proposed PbR tariff for 2010/11 and included this as well as the scheduled expansion of PbR to encompass mental health and community services in future years into sensitivity analysis on this key area. A potential risk amounting to 2% of the associated costs or £1.4m for NHSCD and £0.4m for NHSD has been identified with 30% likelihood.

13.2 Activity assumptions in respect of Continuing Healthcare prove insufficient

The significant increase in the elderly population of County Durham and Darlington is clearly seen in the JSNAs of each organisation. High cost drugs and specialist placements are financial pressures that have been recognised for several years and we have provided for a level of growth moving forward that will enable the budget to be managed within identified resources rather than by reliance upon under-spends in other budget areas to cover the financial risk.

The potential increase in demand has been assessed as giving rise to a risk amounting to £5m for NHSCD and £4m for NHSD with a likelihood of 20%.

13.3 Prescribing budget assumptions are not delivered due to price and volume changes

The prescribing budgets moving forwards have been set with an appropriate level of uplift to cover anticipated growth. Furthermore additional work with PBC groups will take place building on current cost effective prescribing initiatives like the implementation of Scriptswitch.

From 2010/11 onwards the risk of expenditure exceeding annual budgets has been assessed as £900k per annum for NHSCD and £300k for NHSD with a likelihood of 30%.

13.4 Increase in inflation above planning assumptions

A key risk is the assumption in respect of tariff uplifts from April 2011 onwards, however this is determined nationally and as such the risk for individual PCTs is low based upon the Operating Framework for 2010/11 published in December 2009.

As in previous years and to ensure equity, the financial model has applied the PbR uplift consistently across all providers and our cost bases. However there is a risk that pay and non-pay pressures outside the public sector will impact on our ability to

enter contracts with all providers on this basis. Work is ongoing to quantify the potential impact on us although this is difficult to do given the high number of variables involved. However an inflationary increase of 1% per annum in 2011/12 with a likelihood of 35% results in a financial pressure of £5m for NHSCD and £0.9m for NHSD. Mitigating action to address this risk includes the work set out in section 13.6 below.

13.5 Failure to deliver financial savings associated with technical and allocative savings programme

As the risk is highest early in the five years covered by the strategy while the programme of savings initiatives has yet to mature and take hold, a prudent approach has been taken in anticipating when savings will be delivered.

Based upon the sensitivity analysis conducted as part of the development of our QIPP programme the risk attributable to allocative measures was assessed at £26m in 2010/11 rising to £9m in 2011/12 before tailing off in later years with 30% likelihood.

Given the need to protect investment in the initiatives set out in our strategy and captured in the financial plan, should either adverse scenario occur additional savings would be required and have been included in the plan. Should the adverse scenarios not be realised the funding generated will be applied using our model for investment prioritisation to secure further gains in health and healthcare commissioning.

13.6 Opportunities - investment planning and benchmarking

The development of investment planning will be taken forward in conjunction with local universities and will require an assessment of each area of expenditure using benchmarking information. The JSNA is the main reference to health needs and the linkage of this to the analysis of our total healthcare expenditure will identify the opportunities moving forward where service reviews will be able to free up resources for either general mitigation of the above mentioned risks or further investment into new initiatives without the requirement for additional growth in resources year on year.

14 Cash management and other financial policies

The management of revenue and capital resources cannot be undertaken in isolation. There is a clear relationship between the cash limit, resource allocations and income and expenditure levels. All three elements must be planned and managed through both the short and the medium term. To facilitate this there is a separate cash management strategy that highlights the cash management arrangements within the financial services team to ensure robust and accurate cash management.

The current cash management strategy is undergoing its annual review and will shortly be presented for board approval when work is complete on understanding and incorporating into the strategy the impact of changes to government banking services and the move to provider services autonomy within NHSD.

In addition the delivery of the MTFS will need to be underpinned by effective and robust financial management procedures. This will help ensure awareness of the financial position, both recurrent and non-recurrent, and facilitate improved financial planning by investment planning, commissioning and performance, public health and finance teams. The financial governance framework will be kept under review to ensure that it remains fit for purpose and well suited to the environment in which we operate. The review is ongoing and the last request for amendment to the financial limits in respect of all categories of expenditure and budget virements and variations was approved by the two audit committees at their meeting in November 2009.

15 Financial training

Robust financial management and strong governance arrangements require clear communication of accountability and responsibility along with a common understanding of our arrangements and how these shape the behaviour of our staff at all levels. Following the move to autonomous provider services a financial training plan is being prepared which will ensure that both finance and non finance staff appreciate their budgetary responsibilities and the requirements of the corporate and financial governance arrangements. Our Organisational Development Plan addresses this issue in greater detail as well as the delivery of training to ensure that staff are well equipped for the demands of the rapidly changing environment in which we operate. Examples of training planned for 2010/11 which will support the delivery of the MTFS include business case preparation, investment and disinvestment planning and financial scenario and sensitivity modelling.

16 Conclusion

Both NHSCD and NHSD have worked hard to establish a good track record in delivery of financial targets and health outcomes. The MTFS has prioritised investment in programme areas linked to need as identified by the JSNA and benchmarking of cost.

The uncertain economic environment into which we are moving means that there are many assumptions and risks attached to this strategy which will require a regular annual review looking a further five years ahead and refreshing of the strategy as necessary.

In the NHS there is an underlying duty of care to ensure that public funds are spent on the purposes for which they were intended and that good value for money is sought. This MTFS supports that duty of care by providing a robust financial planning framework to support the five year strategy of NHSCD and NHSD.

Appendix B: Equality and Diversity Impact Assessment

Name of function/strategy/policy/service: Refreshed five year strategic plan
Date of Review: February 4th 2010

a) Please provide a brief description of the function/strategy/policy/service:

NHS County Durham and Darlington's role is to commission health care that will improve health outcomes, reduce health inequalities and ensure access to high quality, safe, patient-centred services. As we do this we will strive to ensure value for money for every pound of tax-payers money that we spend.

This strategic plan also explains how we will implement national policy from the Department of Health and regional strategies from NHS North East and Government Office North East on their behalf, and in partnership.

In particular we have a significant role to play in commissioning inclusive services that will implement the national Next Stage Review, which will be delivered via the regional vision for health and healthcare services 'Our Vision Our Future', and that meet the principles and values outlined in the NHS Constitution.

In this strategic plan we outline our approach to continue tackling the biggest challenges we face in poor health and wellbeing, from birth until late in life. We demonstrated how we intend to deliver a responsive, excellent healthcare system that will provide our public with help they need, when needed and delivered where needed.

Whilst we are not expecting significant changes to our level of funding, we need to anticipate the impact of cost increases linked to inflation, new technology, an expanding drugs bill and new pressures on services – especially linked to people living longer.

This is a huge commissioning challenge for the NHS over the coming years this challenge means that we will have to think differently if we are to achieve our objectives.

Our providers of healthcare services, such as hospitals, community services and general practitioners, will see within this plan how we intend to move care closer to home, and how they can work with us to respond to the challenges we face.

Our strategic plan has been developed over the last two years by listening to and working with patients, carers, the public, clinicians, practice based commissioners and other key local stakeholders and partners through a wide ranging programme of engagement. It is underpinned by our Single Equality Scheme and the NHS Constitution to embed the principles of equality and accessibility.

b) What type of positive and negative equality & diversity implications are you aware of that arise from your function/strategy/policy/service?

The strategic plan is a significant commissioning commitment to ensure that everyone within County Durham & Darlington has access to specific services relevant to their needs. The predominant focus of the plan is to target health inequalities and deliver improvements to services for the whole of the community. There are examples throughout the document of good equality practice demonstrating inclusion/accessibility. A clear statement is made by the Chief Executive at the beginning of the document regarding equality and linking this strategic plan to the Single Equality Scheme which demonstrates that this document is relevant for everyone within the community. As this is predominantly a large, technical document, there is also an Executive Summary being developed to share with the wider community and voluntary groups, which will include real life case studies that have taken place.

c) In line with our statutory duty under equality legislation do your functions/strategies/policies/services make reference to equality wherever relevant?

■ . **If yes - provide examples of how they aim to:**
■ **If no – what action is required:**

In line with the Race Equality Duty to eliminate discrimination, harassment, promoting equality of opportunity and good relations between people of different racial groups	This document has a specific focus upon health inequalities and a specific statement has been made by the Chief Executive to ensure that the reader is aware that this document is written for everyone within the community, regardless of size or type of community group within the population. This document is backed up by the PCTs Single Equality Scheme which aims to mainstream equality into everything the organisation does.
In line with the Disability Equality Duty to promote positive attitudes towards disabled persons and encourage participation by disabled people	
In line with the Gender Equality Duty to eliminate unlawful discrimination and harassment & promote equality of opportunity between men and women	
Other relevant equality legislation/best practice?	

OUTCOMES OF THIS NEED TO BE INCLUDED IN THE ACTION PLAN

d) What relevant groups have a legitimate interest in the function/strategy/policy/service?

Does it impact differently on particular minority groups?
If Yes – Which Groups are affected, and how are they affected?

Group	Impact
The whole community	The Strategic Plan should have no adverse effect upon any under represented group within the community as it is focused specifically upon health inequalities. The reduction of health inequalities and the objectives within the plan are inclusive – which means everyone within the target groups are included. A consultation process has also commenced to include views form as many under-represented groups as possible. Our staff have been involved in the consultation process of the strategic plan.
Our staff	

e) Please outline below any work you have carried out to assess, monitor, address and review the equality implications of your function/strategy/policy/service and identify additional work that needs to be carried out to meet requirements of our statutory duties.

Area of Work	Work already carried out / Measures in Place	Work Required	Time-scale
Consultation	Insights from patients, the public, clinicians and local partners have taken place in many forms detailed at page 34. Staff have had access to regular internal bulletins, directorate and leadership meetings. Strengthening clinical engagement by the development of clinical programme groups.	Executive Summary will be circulated broadly to voluntary and statutory groups and available on the PCTs website asking for comments from anyone within the community. The developing employment relations communications process will also include involvement from staff representatives.	March 2010 – April 2010
Monitoring & Target Setting	There is a wealth of national and regional demographic data within the document relating to health inequalities linked to the PCTs strategic objectives.	Work may be required to further develop the mechanism for collating data at regional level to include better information relating to under represented groups.	

Access to Information & Services	- Our consultation processes highlighted concerns with access to transport and information – a "Transport to Health" group has therefore been introduced to help improve access for those living in outlying areas. Our communication and engagement strategy recognises the need for increased information and an online survey has produced valuable information to assist with this. A major objective within the Single Equality Scheme is to ensure accessible information is available for everyone within the community.	Concerns from seldom heard or hard to reach groups – further social marketing exercises will be progressed to identify how best to support under represented communities and access services in an equitable way. Further work will also be developed to increase levels of engagement with partners. Language and Translation facilities under review. Review of other accessible media.	
Marketing & Promotion	The document includes specific elements for the following: - Our vision "Excellence today for a healthier tomorrow" - Goals and aspirations outline the targets which are required to reduce health inequalities.	Executive Summary will be circulated broadly to voluntary and statutory groups and available on the PCTs website asking for comments from anyone within the community.	

	- County Durham & Darlington demographic information is available within the document which clearly outlines health needs per locality. - The current provider landscape is outlined demonstrating the diverse range of healthcare settings.		
Organis-ational development	Identification of organisational development priorities to be addressed over next 5 years. Eight organisational development work streams developed to cover investment planning, governance, business commissioning flow, accountable teams, clinical engagement, and capability development, managing knowledge and intelligence and strengthening stakeholder engagement.		
Training / Briefing staff Employment issues	The workforce within the health economy is a major component in ensuring the successful delivery of our strategic aims.	Specific areas of workforce development will include developments to improve quality and patient experience.	

	Work is ongoing to ensure that the right people in the right numbers are employed to deliver the services required. Health informatics plays a vital role in the delivery of integrated working systems.	An updated national strategic direction for health information and the use of digital technology is to be developed in collaboration with the NHS & partners. An aligned estates and facilities management strategy is an essential element of the implementation of our strategic plan.	
Review & Evaluation	Managing risk scenarios have been explored. Key performance indicators developed for each delivery programme. Overall monitoring on strategy delivery undertaken by the management executive and Integrated Business Board.	Integrated Business Board to receive routine performance reports. Finance & Performance subcommittee will monitor and review the financial activity and planning. Quality sub-committee will receive routine information on quality & performance. Clinical programme groups will oversee implementation of relevant delivery programmes. Contract management will monitor key outputs of services through contract management.	