"Improving quality and length of life"

NHS Bassetlaw Strategic Plan 2009-2014

25.01.2010

1 Foreword

Welcome to our Strategy

In 2008 we produced our initial 5 year strategic plan to deliver added Life to Years and Years to Life. We have taken the opportunity to re-develop the strategy and emphasise our determination to build on our reputation for listening and responding to the residents of Bassetlaw. We have also responded to the changing economic climate to produce a strategy that will improve quality and productivity through innovation and prevention.

NHS Bassetlaw has been committed to improving health and reducing health inequalities in the local population since its inception in 2001. We have seen improvements in outcomes for many conditions and diseases and we have a solid record of delivery on key national and local targets, including early achievement of eighteen week referrals. We have a strong track record of clinical engagement and a close relationship with our partners and our public.

We have learned from the first year of World Class Commissioning. Our response to the feedback we received has been to strengthen senior leadership within the organisation and to review and change our model of clinical engagement to develop clinical commissioning. Our delivery approach is being strengthened by a move to programme management and good examples of innovative delivery have stared to emerge. This redeveloped strategy is underpinned by a financial plan that has funding and disinvestment clearly linked to our strategic initiatives, additionally it sets out an ambitious programme of efficiencies to ensure resources are available to support our goals.

The purpose of this redeveloped strategy is to describe our goals and aspirations for the health and well-being of the residents of Bassetlaw over our 5 year plan. It builds upon our previous position and challenges us even more to commission the best for our population to achieve improved outcomes.

Our mission is to “improve the quality and length of life” for the people of Bassetlaw. Our strategic goals are prevention, healthy lifestyles, quality and patient experience.

The health outcomes we will achieve and the strategic initiatives that we will deliver have been redeveloped in partnership with patients, the public, our clinical community and our key stakeholders. Both our outcomes and our initiatives are broadly similar to those that we prioritised in 2008. We will make quality our organising principle to drive forward to our mission, and create opportunities for service integration to maximise the health gains for patients, clinicians and the PCT as the strategic leader of the local NHS.

Dean Fathers

Chairman

Felicity Cox

Interim Chief Executive

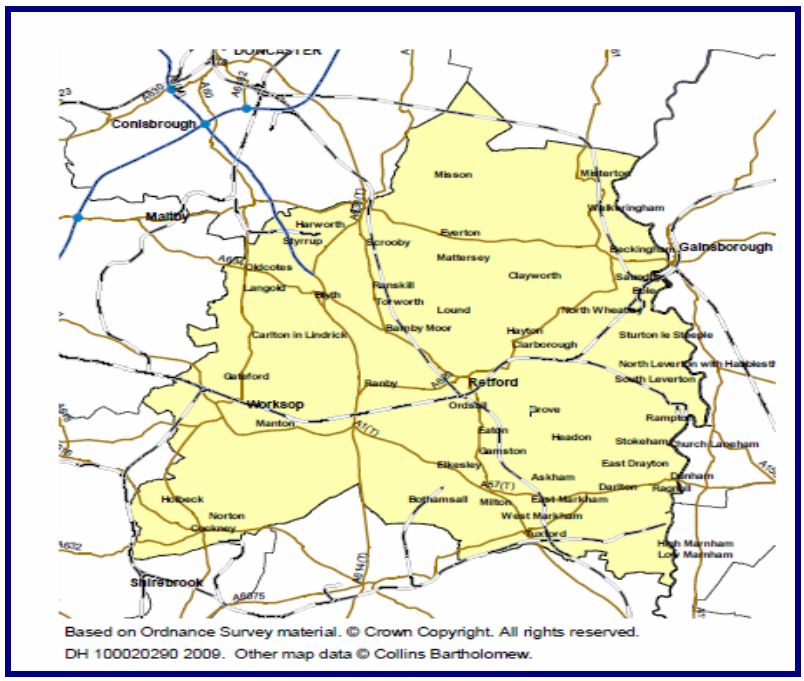
2 Overview of our 5 year strategy

We have redeveloped our strategic plan for 2009-2014 to strengthen our key initiatives in light of a challenging economic environment. This first section provides an overview of our 5 year strategy.

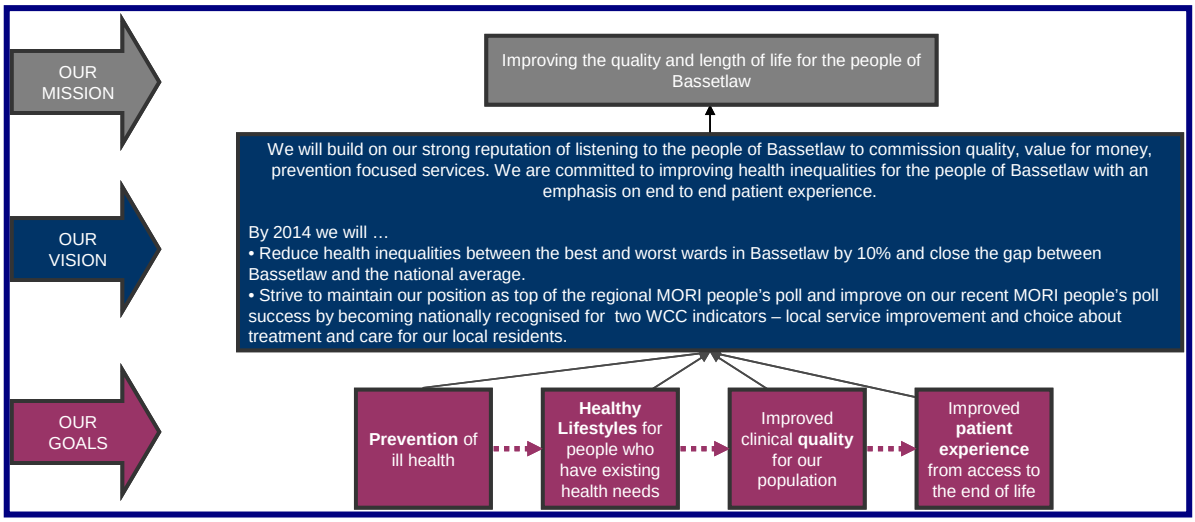
2.1 Bassetlaw Context

Bassetlaw at a glance - POPULATION 111,700
➢ The health of people in Bassetlaw is generally worse than the England average.
➢ Life expectancy is significantly lower for both men and women living in Bassetlaw compared to the England average.
➢ Levels of deprivation, drug misuse, hospital stays for alcohol related harm, hip fractures in over-65s and deaths from smoking are all worse than the average for England.
➢ There are inequalities within Bassetlaw by gender and level of deprivation.
➢ Over the last ten years rates of deaths from all causes and early deaths from cancer have improved but are higher than the average for England.
➢ Rates of early death from heart disease and stroke have also improved and are now similar to the England national average.
➢ Levels of breast feeding initiation and Children's health in Bassetlaw are similar to the England average although physical activity of children in schools is worse than the England average. Levels of children in poverty and children's tooth decay are better than the England average.
➢ The rate of road injuries and deaths is higher in Bassetlaw than the England average.
➢ The Nottinghamshire Local Area Agreement has prioritised tackling physical activity, drug misuse, smoking, alcohol misuse, obesity, teenage pregnancy, road injuries and deaths, and all age, all cause mortality.
APHO Health Profile for Bassetlaw, 2009

Map of Bassetlaw



2.2 Our redeveloped mission, vision and strategic goals – the core of our strategic ambition



Our strategic ambition has been redeveloped in light of the current financial climate, the Department of Health Quality, Innovation, Productivity and Prevention (QIPP) agenda and in accordance with our Board approved prioritisation framework. The table below defines the measures by which we will monitor the delivery of our 5 year strategic ambition.

Fit with our strategic ambition	Outcome	2009/10	2013/14	change
Supporting our vision and our 4 strategic goals	Life expectancy (Males) at time of birth, years	78.07	79.65	Increase by 2.02%
	Life expectancy (Females) at time of birth, years	82.57	84.04	Increase by 1.78%
	Health inequalities (Males) Slope index of inequality for life expectancy at birth LSOA	6.6	6.1	Decrease by 7.58%
	Health inequalities (Females) Slope index of inequality for life expectancy at birth LSOA	3.65	3.45	Decrease by 5.48%
Goal 1: Prevention of ill health	% infants breastfed at 6-8 wks	35.29%	51%	Increase by 15.71%
	Prevalence of obesity in Reception children (as measured by the National Child Measurement Programme)	11.01%	8.60%	Decrease by 2.41%
	Rate of emergency admissions for FNOF per 100,000 (Age 65 or older)	580	450	Decrease by 22.41%
	Number of vascular health checks	3000	28125	26,125 vascular checks
Goal 2: Healthy Lifestyles for people who have existing health needs	Rate per 100,000 population aged 16 and over smoking quitters	900	1000	Increase by 11.11%
	Rate per 100,000 of hospital admissions for COPD & Diabetes *There are also other areas within LTC where cost savings will be demonstrated	COPD - 222 Diabetes - 90	COPD - 189 Diabetes - 77	Decrease COPD & Diabetes hospital admissions by 15%
	Rate per 100,000 population of hospital admissions for alcohol related harm	1588	1352	Decrease by 14.86%
Goal 3: Improved clinical quality for our population	Cancer Mortality Rate Directly standardised rates from all malignant neoplasms (ICD-10 C00-C97) Premature mortality (under 75 yrs)	119	112.5	Decrease by 5.46%
	Stroke deaths within 30 days - Indirectly age and sex standardised rates per 100,000 persons Deaths in hospital and after discharge between 0 and 29 days (inclusive) of an emergency admission to hospital with a stroke.	29315	24020	Decrease by 18.06%
Goal 4: Improved patient experience from access to the end of life	% of all deaths that occur at home	18%	25%	Increase by 7.00%
	Strive to be top of the East Midlands patient satisfaction MORI poll and recognised nationally for listening to our local population			

Other areas will be monitored by tier 3 vital signs.

2.3 How we redeveloped our mission, vision and strategic goals

To reach agreement on our redeveloped mission, vision and goals we engaged with our staff, patients and the public, the Board, clinicians and our local stakeholders.

Engaging with our Staff: We asked our staff to record their views of what NHS Bassetlaw should look like in 2014 and 2020 from the perspective of both patients and PCT staff. The output was fed into a visioning session with our Board.

Engaging with our Patients and the Public: We asked our patient and public representatives from our Modernisation Board to record their views of what NHS Bassetlaw should look like in 2014 and 2020 from a patient perspective. This output was fed into a visioning session with our Board.

Engaging with our Board: We then held a Board session to agree our strategic plans 5 year mission, vision, and strategic goals. We considered the inputs recorded from our staff and patients and the public to ensure that our ambition aligned to the views of our stakeholders.

We also sought to ensure that our redeveloped mission, vision and strategic goals were aligned to national, regional and local ambition. We achieved this by undertaking a mapping exercise to cross check national, regional and local alignment. We also researched and fed into our Board session approaches to strategic plan refresh and redevelopment being undertaken by our partners, NHS Nottinghamshire County and NHS Doncaster.

Engaging with our Clinicians: We involved clinicians and PBC leads in the redevelopment of our strategic mission, vision and goals by seeking comments and challenge. We also held a clinical prioritisation session to support decisions around our 5 year strategic initiatives.

Engaging with our Stakeholders: We held a large multi-stakeholder event with patients and the public, clinicians, PBC leads, providers, local partners, and Third Sector representatives to support the redevelopment of our 2009 - 2014 strategic plan. We asked our stakeholders to comment on our redeveloped mission, vision and strategic goals which we then used to redevelop and shape our 5 year strategy.

2.4 Alignment of our Mission, Vision and Goals

		Goals	Transforming Community Services, 2009	East Midlands 'Better Care, Better Health'	QIPP
Mission	Vision	**Prevention** of ill health	"commissioning focussed approach for falls prevention and achieving a reduction in fracture neck of femur"	Improvement in health & reduction in health inequalities	Prevention & Productivity
		Healthy lifestyles for people who have existing health needs	Raising awareness around healthy lifestyles for smoking, obesity, alcohol & people with LTCs	Improvement in health & reduction in health inequalities	Productivity
		Improved clinical **quality** for our population	"…a clear direction of travel with an emphasis on improving quality…"	Safe high quality effective care	Quality
		Improved **patient experience** from access to the end of life	"Services should work across organisational boundaries putting the patient at the heart of all that they do."	A positive patient experience	Quality & Innovation

Our cross cutting local priorities Value for money & Equality of services for all

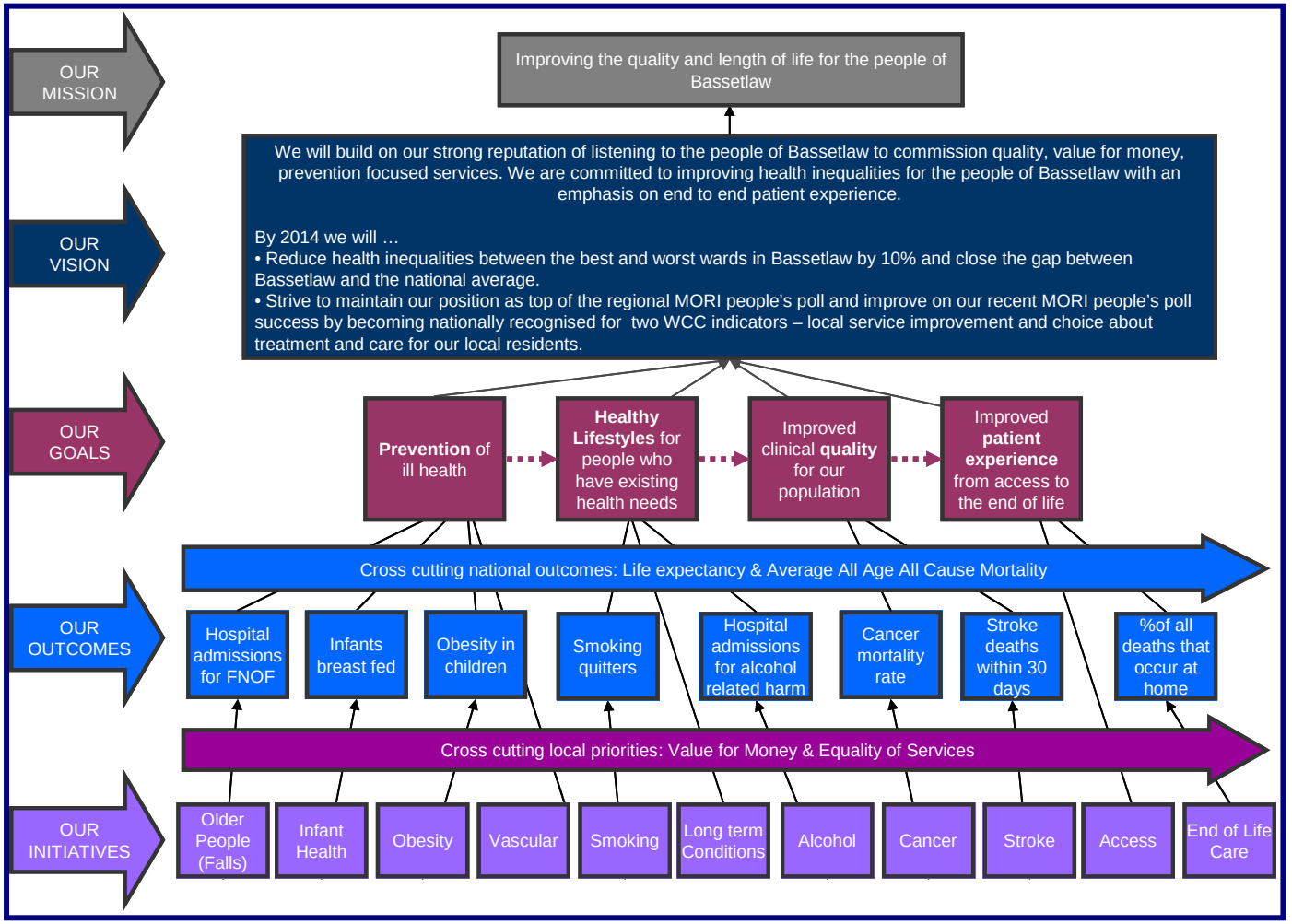
2.5 Our Outcome Rationale

Our World Class Commissioning (WCC) outcomes have not changed because they align to Bassetlaw's population health needs, our redeveloped mission, vision, and strategic goals and our strategic planning engagement process

Our Health Outcomes	Rationale for Selection
Life expectancy	A national priority and an explicit underpinning theme within A Picture of Health.
Health inequalities	A national priority and an explicit underpinning theme within A Picture of Health.
Breastfeeding	Bassetlaw is an outlier and has the lowest breastfeeding rate in the East Midlands. It is an important public health priority and a key factor in addressing inequalities.
Childhood Obesity	A major local public health priority and LAA and LOP priority. Prevalence is increasing and has a significant impact on health in later year's e.g. higher rates of cancer, reduced life expectancy, increased risk of diabetes.
The number of smoking quitters	We have set an ambitious target for this priority outcome area supported by a robust smoking initiative. However smoking remains the number one public health issue in Bassetlaw and reducing smoking prevalence in the population is a key priority.
The number of alcohol related hospital admissions	A major national issue with a mix of acute and chronic implications. Significant local issue and a LOP and LAA priority. Has significant impact on reducing alcohol related illness, crime, domestic violence and avoidable injuries including Road Traffic Accidents.
Falls/Fractured neck of Femur (FNOF)	Major local priority. Bassetlaw is an outlier and has the worst rate of hip fracture in the over 65's in Nottinghamshire. Bassetlaw has a high disability and death rate which is largely preventable. Falls has a significant sign up from the local authority.
Stroke mortality	A national and local priority (LOP) and a clinical priority for action within A Picture of Health.
Cancer mortality	The second main cause of death and a LOP priority. Significant health inequalities across the district.
Deaths at home	A clinical and quality priority for action within the Evidence to Excellence vision and locally. Major issue for patients and carers which is seen to be overlooked. Our Board approved that health services are cradle to grave and that quality in end of life care is as important as prevention and treatment.

2.6 NHS Bassetlaw's strategic pyramid, 2009-2014

Our full strategic pyramid for 2009-2014 links together our mission, vision, goals, national and WCC outcomes, and our strategic initiatives to deliver our strategic ambition.



In addition to the delivery of our 11 core strategic initiatives we will undertake a series of projects in line with Quality Innovation Productivity and Prevention initiative designed to release funds for reinvestment into our strategic initiatives.

These projects have been identified through two sources:

- Those associated with our strategic initiatives – reduction in emergency admissions (falls, alcohol, long term conditions, end of life, vascular and stroke), and reduction in prescribing (psychological therapies)

- Those identified through detailed benchmarking using a range of national and local data such as the National Institute Toolkits, Programme Budgeting and Dr Foster. Target areas identified include improving performance in the areas of outpatient, elective care and prescribing.

Additional projects will concentrate on reducing levels of urgent care through projects currently underway with our main acute provider, and reducing management costs in line with Operating Framework guidance.

2.7 Our existing performance against national and local priorities

In shaping our strategic ambition we also considered our performance against national and local targets, in particular our Vital Signs, Care Quality Commission and WCC assurance year 1 performance.

We have assessed our performance against existing national and local priorities.

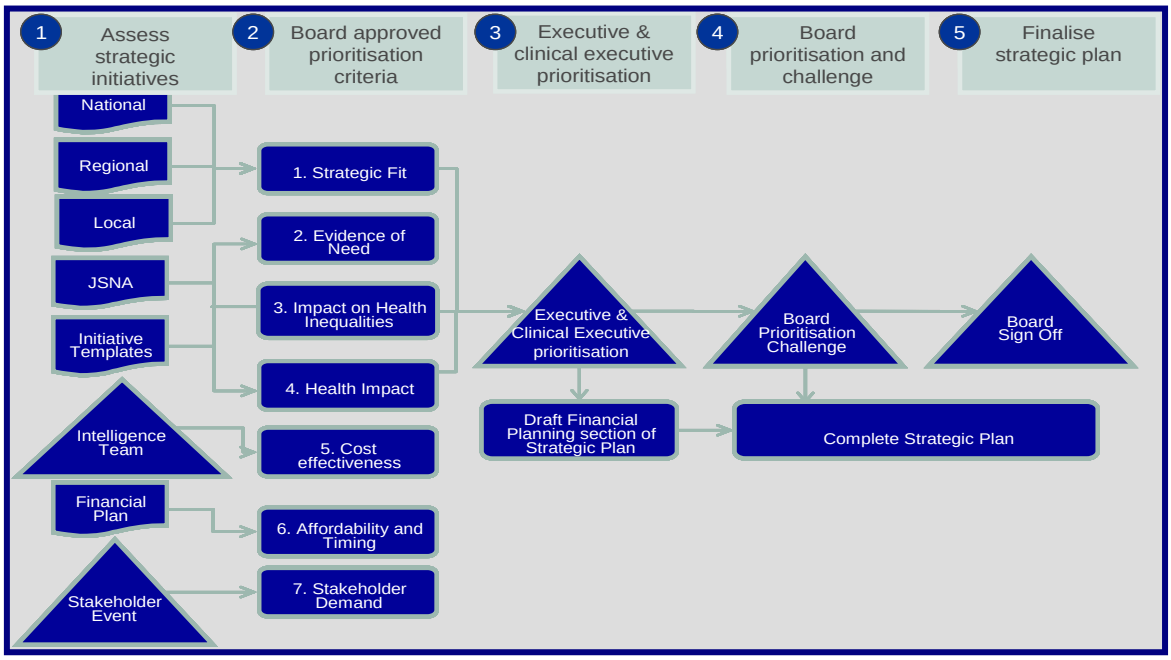
National	Local
Strong performance	**Strong performance**
▪ C Difficile VSA03 ▪ Elective Care Waits VSA04 ▪ Cancer VSA11-13 ▪ Smoking Quitters VSB05 ▪ Maternity VSB06 ▪ Breastfeeding VSB11 ▪ CAMHS VSB12 ▪ Chlamydia VSB13 ▪ Quality of commissioning rated 'Good' by the CQC 2008/09	▪ In the first 3 months we conducted 851 vascular checks, 57 of these were screened for atrial fibrillation. ▪ Our ongoing strategic commitment to improve access to psychological therapies.
Disappointing performance & risks	**Disappointing performance & risks**
▪ Stroke VSA 14 ▪ Immunisation VSB10 ▪ Dental Services VSB18	▪ Proportion of all deaths that occur at home ▪ People with long term conditions feeling independent and in control of their condition ▪ Achieving independence through rehabilitation ▪ Rate of hospital admissions for alcohol related harm
Mitigating Actions ▪ Commission stroke services for local people via the stroke strategic initiative in line with national and international best practice ▪ Improve immunisation of children via the infant health strategic initiative ▪ Action activities to improve access to Dental services via the access initiative	**Mitigating Actions** ▪ People dying in their chosen place of death will be improved via our End of Life initiative ▪ People living independently at home and being offered rehabilitation forms the basis of our long term conditions initiative ▪ We will improve on reducing alcohol related hospital admissions via our alcohol initiative

World Class Commissioning	
Strong performance	**Disappointing performance & risks**
▪ Goal 1: **Prevention** of ill health ▪ Goal 2: **Healthy Lifestyles** for people who have exiting health needs ▪ Goal 4: Improved **patient experience** from access to the end of life ▪ Level 2 in WCC competencies 1 & 2 (2008)	▪ Goal 3: Improved clinical **quality** for our population ▪ Level 1 for WCC competencies 3-10 (2008) ▪ Amber strategy in WCC assessment 2008
Mitigating Actions ▪ We will focus on improved quality of services for stroke care in particular. ▪ We will continue our good work aligned to the prevention agenda. ▪ NHS Bassetlaw will remain committed to its Vital Signs requirements. Our past performance highlights that we are on track to exceed our VS commitments as detailed in our ambitious outcome aspirations.	

What Works For Us: Our strong performance is usually characterised by a strategic relationship with providers, clinical and public health leadership in developing pathways and service specification, and robust contract management. We recognise this strength and will continue to apply this approach to build on areas of strong performance, but particularly to address areas where performance has been disappointing.

2.8 Strategic Prioritisation

Our strategic ambition was validated through a five step prioritisation process for our strategic initiatives.

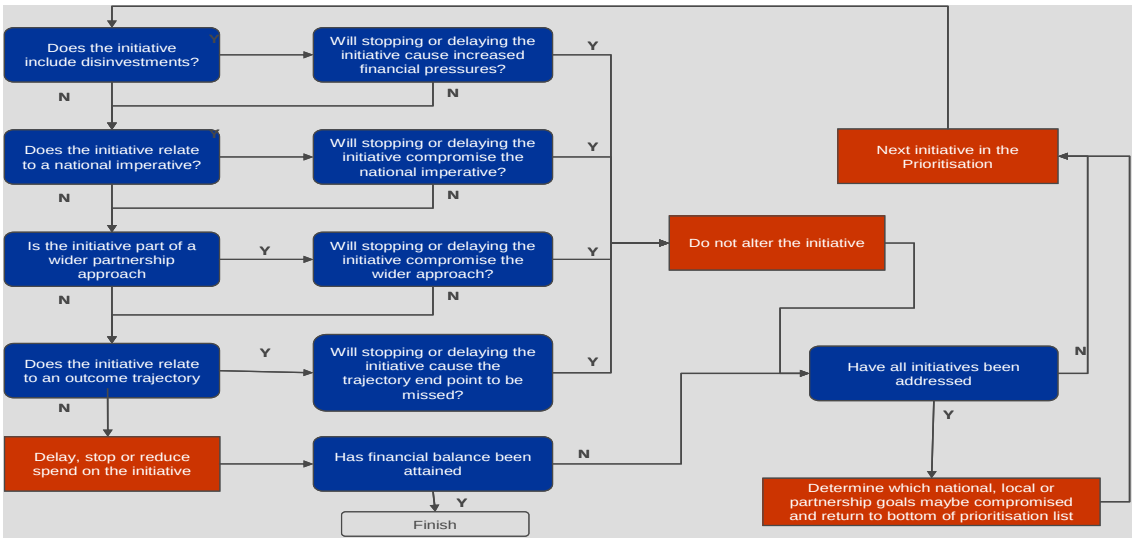


Step 1: We assessed our existing strategic initiatives against national, regional and local need, including our JSNA, ensuring that we were meeting local need and achieving local and national targets. We devised initiative templates for initiative leads supported by our PCT intelligence team which guided cost effectiveness conversations. We also gathered insights from our financial plan and our large stakeholder event.

Step 2: We then used our prioritisation framework to assess our strategic initiatives against each other. Our framework has seven criteria, each of which is allocated a points weighting.

Step 3: We then undertook a prioritisation session with our Executive and Clinical Executive to draw together insights from step one and two of our process. Sessions provided the opportunity to prioritise each initiative. Only initiatives with new spend over our 5 year plan were prioritised.

Step 4: We held a Board session to challenge the results of our prioritisation and to determine the trade-offs that would be necessary in different financial scenarios. The Board agreed to a decision tree to support future trade-off decisions where financial and policy imperatives will need to be considered. This decision tree is displayed below.



Step 5: Our Board have agreed the above prioritisation process and signed off our 5 year strategic ambition. In addition we will use the decision tree to support future prioritisation around financial scenarios and trade-offs as part of our ongoing QIPP work.

As an adjunct to the above process we have already, and are continuing to seek, engagement from Bassetlaw's clinical leaders. This will ensure that future prioritisation relating to potentially stopping, starting or halting key milestones within our strategic initiatives or entire strategic initiatives has robust clinical input.

2.9 Bassetlaw's financial position

We have a good track record of delivery, and have annually met our statutory financial duties. We have ended every financial year in surplus since our inception, have managed cash within our allocation and have consistently achieved Better payment Practice Code targets. We are on course to deliver our target surplus for 2009/10 and are managing downside risks (around secondary care activity and prescribing) to its delivery. We have received significant growth over recent years but are still "below target" in terms of Resource Limit funding.

The rapidly changing financial backdrop means there is less certainty as we move from a period of "investing with growth" to one of " investing with savings". These savings however, have to be delivered from a review of the totality of our expenditure portfolio to ensure we are delivering best value, not just a review of our intended strategic initiatives. This review has been undertaken and forms the backbone of our efficiency programme.

We have developed more than one financial plan to account for different potential scenarios. Our strategic plan incorporates three financial scenarios and resource limit and inflation assumptions developed in conjunction with the East Midlands Strategic Health Authority. We have complied with the requirements of the 2010/11 Operating Framework and plan to deliver a surplus in each financial year. In line with the Operating Framework we are planning a 1% surplus in 2010/11, with this decreasing slightly each year to around 0.83% in 2013/14. Downside risk in the plans will be mitigated by utilisation of the contingency reserve, bringing forward disinvestments and a reprioritisation of the investments. Upside risk will allow the PCT to bring forward prioritised schemes planned for future years or invest in further initiatives which benefit the health of the population in Bassetlaw. NHS Bassetlaw will ensure that its internal processes of budgetary management, monitoring and forecasting are reviewed and enhanced, where appropriate, to reduce the impact of variation on our finances.

2.10 Our Strategic initiatives at a glance

G1A) **Older People (Falls)**	**Objective:** To reduce the rate of avoidable hospital admissions for falls and fractures by promoting the prevention and early identification of people at risk of falling and being admitted to hospital. To develop integrated care pathways to support patients to maintain their independence and enhance quality of life. **Activities:** Organisational change, including the review of provider and medicines management services, integrated partnership working and the development of a district wide falls strategy, compliance with NICE guidance and the implementation of level 2 and 3 falls prevention. **QIPP incentive:** Reduce the admission rate for fractured neck of femur (FNOF) from 583 per 100,000 to 450 per 100,000 by 2013/14. Saving 157 admissions for FNOF in 2013/14 & 370 during the 5 year period. **Investment:** £0.9m over the 5 year plan. **Disinvestment:** £2.0m over the 5 year plan.
G1B) **Infant Health (A&B)**	**Objective:** To implement improved maternity services for women in Bassetlaw, for antenatal and postnatal episodes. **Activities:** Align Maternity services with national policy and recommendations, shifting services from primary care to community based services in a range of settings such as Children's Centres; ensure women are booked with a maternity professional by 12 week gestation; implement infrastructure to improve homebirth rates; further develop neonatal services across the network to ensure compliance; conduct a workforce review; maintain effective and consistent preconception care for all women via proactive provision of health promotion advice. **QIPP Incentive:** Reduction in LOS and overall number of caesarean sections, reduction in poor infant health due to increased breastfeeding levels, reduction in the number of low birth weight babies and the number of pregnant women smoking. **Investment:** £3.5m (including the cost of maternity matters) over the 5 year plan.

G1C) **Obesity**	**Objective:** To halt the year on rise in obesity prevalence across Bassetlaw by significant investment into a universal prevention programme across the whole population which will include the commissioning of a range of evidenced based prevention and treatment programmes, targeting initially areas of highest deprivation. **Activities:** Implement the Change for Life programme across Bassetlaw; introduce interventions to establish healthy eating and adequate levels of physical activity in children centers and other early year's provision; introduce interventions in all primary schools to increase the number of children who are eating a healthy diet and participating in one hour's physical activity a day; introduce a family centered programme to increase healthy eating and physical activity in collaboration with the local authority. In addition evidenced based weight management programmes delivered in a range of settings, brief intervention training on healthy eating and WM for a range of front line staff, the delivery of local cook and eat sessions and a comprehensive range of physical activity interventions delivered across the district. **QIPP Incentive:** Reduce the costs of obesity related hospital admissions and associated diseases, with an emphasis on the prevention agenda. **Investment:** £1.4m over the 5 year plan.
G1D) **Vascular**	**Objective:** To reduce the risk of people developing vascular disease and identify those with, or at high risk of developing vascular disease. **Activities:** Establish and implement a LES in Primary Care; ensure practices have adequate and appropriate software and that systems are updated to undertake risk assessment and management; implement a social marketing campaign targeting population groups less likely to take up vascular checks; and participate in the lifestyle improvement activities. **QIPP incentive:** It is anticipated that this initiative for patients referred onto the vascular programme will save 4 lives, prevent 19 heart attacks and strokes, prevent 8 people from developing diabetes and provide earlier diagnosis of 50 cases of diabetes or kidney disease every year. **Investment:** £1.1m over the 5 year plan. **Disinvestment:** £0.2m over the 5 year plan.
G2A) **Smoking**	**Objective:** To reduce harm from smoking in Bassetlaw by aiming to reduce smoking prevalence across the district, targeting the most deprived communities. **Activities:** Introduction of a choose and book system for smoking cessation; Develop a social marketing programme to delay the onset and initiation of smoking in young people; GP practices LES delivery; establish a smoke free homes project with children's centres; and introduce a gold standard smoke free workplace policy with LSP partners. **QIPP incentive:** Decrease levels of smoking related illness. **Investment:** £0.5m over the 5 year plan.
G2C) **Alcohol**	**Objective:** To reduce alcohol related mortality and morbidity by reducing harm associated with excessive drinking. To ameliorate access to alcohol interventions in the community. **Activities:** Increase the number of patients offered specialist alcohol interventions and alcohol community detoxification via an effective Tier 3 Alcohol service; increase the number of hospital inpatients offered specialist alcohol interventions. **QIPP incentive:** Reduce the number of alcohol related admissions in Bassetlaw from a currently higher than national average rate of 1679 per 100,000 to 1352 per 100,000 by 2013/14. This is equivalent to preventing 385 admissions in 2013/14 and in excess of 1200 during the period of this plan. **Investment:** £1.2m over the 5 year plan. **Disinvestment:** £2.1m over the 5 year plan.
G2B) **Long Term Conditions**	**Objective:** Develop Diabetes care that meets national guidance and best practice guidelines; to improve access to and uptake for pulmonary rehabilitation for people with COPD; and to promote personalised care for people with long term conditions using the virtual ward model, predictive modelling and telehealth. **Activities:** Offer Personal Health Plans to people with long term conditions; develop and implement the COPD pathway; invest in diabetes services; commence telehealth and evaluate pilot; aim for district wide roll out of telehealth and implement Virtual Ward. **QIPP incentive:** Reduce hospital admissions per 100,000 for COPD by 15% and reduce hospital admissions per 100,000 for Diabetes by 15%. **Investment:** £2.4m over the 5 year plan. **Disinvestment:** £1.4 m over the 5 year plan.
G3A) **Cancer**	**Objective:** To improve screening services knowledge in the population - when to consult a professional; expand radiotherapy capacity; deliver chemotherapy closer to home; increase awareness and improve public education of cancer symptoms for earlier cancer diagnosis; encourage patients to present at their GP sooner to reduce cancer mortality; and adhere to NICE approved prescribing for new cancer drugs. **Activities:** Compliance with national best practice and the North Trent Cancer Network; evaluation of early diagnosis and awareness lung cancer campaign. **QIPP incentive:** The lung cancer pathway review will support better quality service for patients via more measured quality and experience metrics. **Investment:** £6.2m over the 5 year plan.

G3B) **Stroke**	**Objective:** To reduce the physical, emotional and economic damage of Stroke through a radical transformation of the whole Stroke Pathway in line the National Stroke Strategy, the National Clinical Guidelines for Stroke, NICE Guidance CG68 Stroke, and NICE Guidance on Thrombolysis. **Activities:** Develop the Hyper acute stroke and TIA pathways; enhance long term support for Stroke patients; develop stroke social marketing from external providers. **QIPP Incentive:** Improve quality of care and improve outcomes - reductions in the percentage of people who die from their stroke, and reductions in the degree of disability for people who have had a stroke. **Investment:** £1.8m over the 5 year plan. **Disinvestment:** £0.1m over the 5 year plan.

G4A) **Access**	**Objective:** To commission accessible acute, primary and community care. **Activities:** Implementation of PPCI; conduct a review of acute services; work with clinical commissioners to create a compelling local vision for more services closer to home in non acute settings. **QIPP Incentive:** To rapidly reduce costs in acute, urgent and secondary care in line with our ongoing acute services consultation and our 18 week targets. **Investment:** £6.6m over the 5 year plan. **Disinvestment:** £0.5m over the 5 year plan

G4B) **End of life care**	**Objective:** To implement an End of Life pathway, integrating services and supporting individuals to die in a place of their choice at the end of their life, whilst ensuring that all patients have an end of life care plan. **Activities:** Review EoL investment comparing to National best practice and develop an understanding of local End of Life Care Needs in Primary Care; integrated communication and co-ordination service across all settings; joint commissioning of carer support and voluntary sector stimulation; promotion of End of Life care services and pathway, including health promotion. **QIPP Incentive:** Avoidable admissions related to general end of life care. **Investment:** £1.3m over the 5 year plan. **Disinvestment:** £0.3m over the 5 year plan.

2.11 Creating a compelling clinical vision for care in Bassetlaw

As well as delivering on our strategic initiatives we are creating a new and compelling vision for care in Bassetlaw. We are working closely with the wider clinical and professional community to build a consensus around a new vision for care. There are a number of supporting strategies that will inform our shaping; predominantly these will be the new acute strategy, and the existing primary care and community services strategies.

Supporting strategies and programmes to influence & drive efficiencies

- Our ongoing leadership in developing a **commissioning strategy for acute services** and exploring opportunities for improved models of care integration to support the delivery of our strategic goals. We will carry out this work in 2010/11 with our main commissioning partner NHS Doncaster.

- Our efficiency programme which will look to disinvest in areas of care without detrimentally impacting upon quality. This will release funding from current services to help fund our strategic initiatives.

- Our **Transforming Community Services (TCS) strategy** will influence the changing nature of our community based services. Our TCS commitments around Falls & Foot Care, End of Life, COPD and Muscular Skeletal services align to our initiatives for Older People, End of Life and Long term Conditions and our four strategic goals.

- Our **Primary Care Strategy** supports our strategic commitment to improve access to primary care services, whilst supporting our quality and patient experience strategic goals.

2.12 Our Enabling Strategies

To support our strategic plan we have also redeveloped our Organisational Development (OD), Communications and Quality Strategies.

- To support the delivery of our strategic initiatives we have identified three core OD outcomes: Improved WCC competence in 6, 9 and 11; staff supported to achieve their career pathway; and robust, agile, VFM delivery of our strategic initiatives. This will be realised by OD specific initiatives to commission competency development, introduce NHS Bassetlaw performance and talent management, and implement programme management, board leadership and mandatory and statutory staff training.

- Our **Communication and Involvement strategy** supports the achievement of our strategic vision by pledging ongoing commitment to working in partnership with our local stakeholders. A good example of this is the development of our existing stakeholder database to enable members of the local community to be consulted on their chosen areas of interest in a way that suits them.

- Our **Quality Strategy** focuses on two core elements of quality, 1) Quality Assurance (getting the basics right); and 2) Quality Development (constantly improving towards excellence). We are committed to the quality agenda at a local, regional and national level. Our commitment to quality and patient experience (two of our strategic goals) are also a core focus of our quality strategy which will support the achievement of our strategic ambition.

2.13 Our Values

Underpinning all of our strategic commitments are our values.

Throughout our strategic plan redevelopment we tested our values and it has been agreed that our existing values will remain and will continue to guide how we commission services.

- Listen and respond to local needs and priorities.
- Bring openness, honesty and a caring approach to all that we do.
- Work in partnership with other local stakeholders to improve health and the quality of services.
- Value and recognize the individual contribution made by those who work in our local healthcare community and be committed to supporting and developing them.
- To offer a range of choices of different services wherever possible.
- To ensure that services are provided as close to people's homes wherever possible whilst ensuring that services that are being delivered are safe and of a high quality.
- Promoting creativity and innovation to drive the improvement of services for the benefits of patients and the community.
- To be cognisant of the diverse needs and the aspirations of our patients, the community, our employees and stakeholders and ensure that they are taken into consideration in the way we commission and deliver our services.
- We will respect the confidentiality of patients and service users throughout the process of care.
- Ensure that services deliver value for money.

2.14 Summary Board Approval

Our Board have approved our 5 year strategic ambition. They have played an integral role in shaping the direction and content of our 5 year plan. Our Board have been engaged in the shaping of our strategic mission and vision, the forming and signing off of our strategic goals, and in the refined focus of our strategic initiatives.

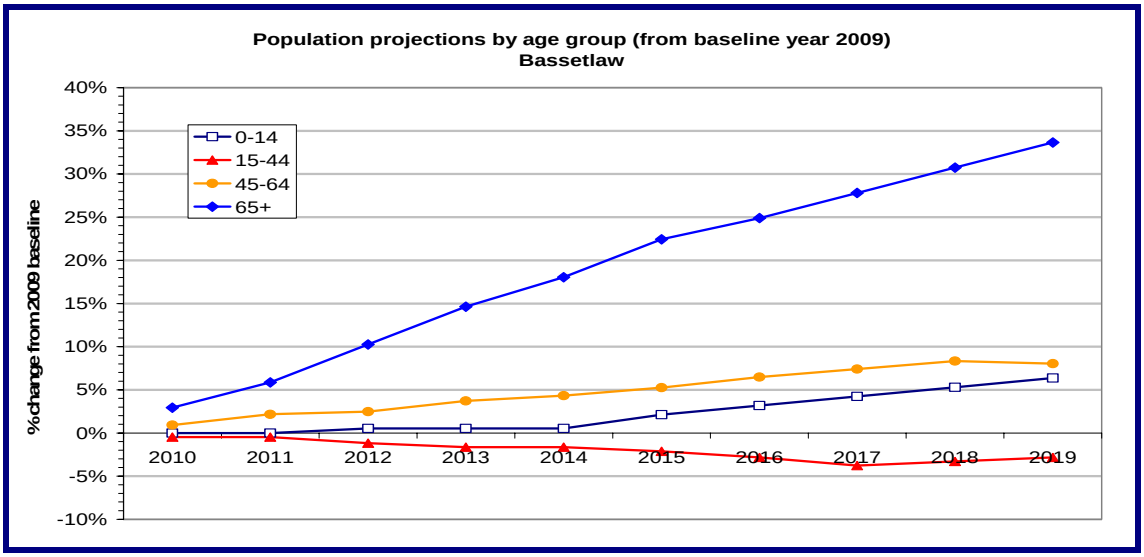
3 Context

3.1 Bassetlaw Demographics, Health Needs and Clinical Quality

3.1.1 Bassetlaw Locality

Bassetlaw is located in the North of Nottinghamshire and covers 246 square miles, almost a third of the area of the County of Nottinghamshire and forms part of the sub-regional area of North Nottinghamshire. The area is predominantly rural with two major market towns, Retford and Worksop serving as the hub of communication for the villages, most of which have a population of less than 3,000. However, 41.7% of the District's population live outside the main centres of Worksop and Retford. Bassetlaw sits at the crossroads of England with Yorkshire, Derbyshire and Lincolnshire on its borders. The area has excellent road, rail and air links.

3.1.2 Population Projections



(ONS, 2006)

Bassetlaw resident population 000s		
Year	**2009**	**2019**
Female	57.2	61.5
Male	56.8	62.0
Total	114.0	123.5

(ONS, 2006)

Bassetlaw population insights over the next ten years:

- There is an overall population growth of approximately 4%.
- There is growth in the numbers in the 5-9 age bands but a significant reduction in the 10-14 age bands.
- There is a significant reduction in the numbers aged 35-39.
- There is a significant growth in the number of people in all the age bands from 65-69.

3.1.3 Ethnicity

98.55% of the local population is white (Census, 2001). However, we know from work conducted by the Local Strategic Partnership (LSP) that there are approximately 18 different ethnic minority communities now living in Bassetlaw. We need to recognise this fact even if it is not reflected in official statistics. We must also ensure that the commissioning of our services reflects the diverse populations we now serve. We also have "hard to reach" communities in Bassetlaw including gypsies and travellers, homeless people and offenders who are at greater risk of experiencing health inequalities.

3.1.4 Bassetlaw current trends and aspirations

The health of the population is generally worse than the England average (APHO & DH, 2009). There are significant health inequalities between Bassetlaw and England. To reduce inequalities the health outcome indicators in Bassetlaw need to improve to meet the England average.

Our Communities Levels of deprivation are significantly worse than the England average with 23.7% of the population living in the 20% most deprived areas of England. The relationship between health outcomes and deprivation is well established. GCSE achievement is also poor with 38.3% of pupils at Key Stage 4 achieving 5A*-C (including English and Maths) compared to the England average of 48.3%. Educational attainment is an important determinant of health.

Children and Young Peoples Health: Children's health in Bassetlaw is similar to the England average. Levels of breast feeding initiation and physical activity of children in schools are worse than the national average. 58.7% of mothers initiate breast feeding in Bassetlaw compared to 71% nationally. In schools 13.6% of 5-16 year olds fail to spend a minimum of 2 hours per week on high quality PE and school sport. Obesity levels in reception year children are 10% and teenage pregnancy in under 18's is 42.3% which are not significantly different from the England average. Bassetlaw has a lower number of children in poverty than the England average with 19.2% of children living in families receiving means tested benefits compared to 22.4% nationally.

Adult's health and lifestyle: It is estimated that 23% of adults smoke and 17.7% of adults binge drink which is not significantly different for the England average. In addition 88.9% of adults do not participate in the recommended 30 minutes of moderate physical activity at least 3 times per week which is similar to the national average. It has also been estimated that only 23.1% of adults eat 5 portions of fruit and vegetables per day and that 27.6% of adults are obese which is significantly worse than the England average.

Disease and Poor Health: Hospital stays for alcohol-related harm are worse than the England average with a rate of 1587.6 admissions per 100 000 population which equates to 2168 admissions. Significantly worse than the England average is drug misuse with a rate of 13.6 per 1000 population aged 15-64 and the rate of the working age population claiming incapacity benefits for mental illness which is at a rate of 35.1 per 1000, equating to 2390 people per year. Hip fractures in people aged over 65 are worse than the England average with 138 emergency admissions per year.

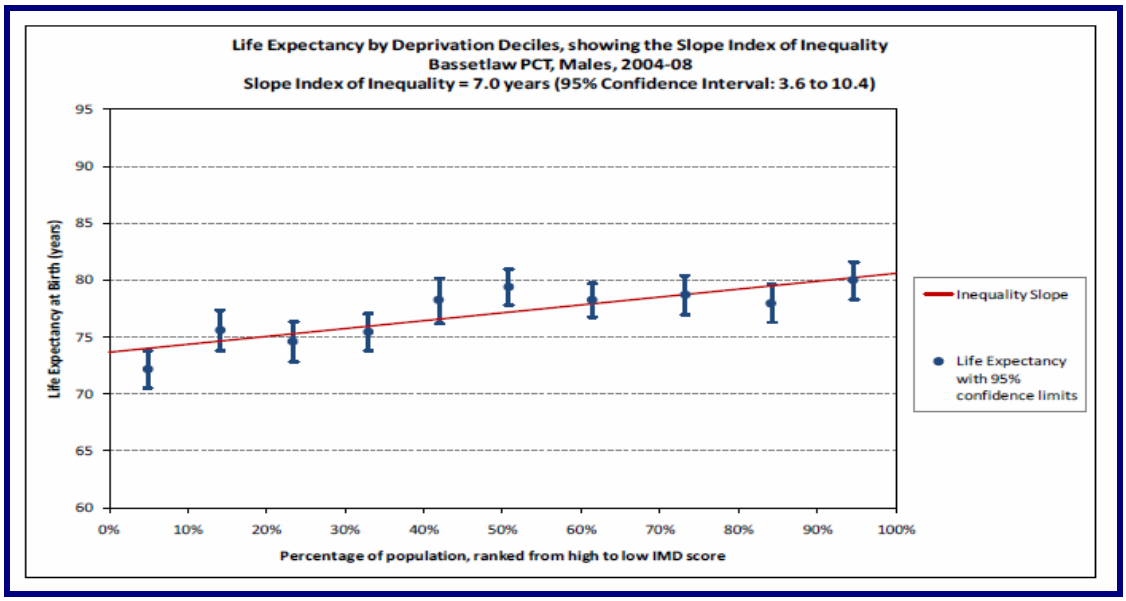
3.1.5 Life expectancy and health inequalities

There is a substantial body of evidence that demonstrates the correlation between deprivation and health. This can be demonstrated by assessing the differences in life expectancy between men and woman living in the most affluent areas of Bassetlaw compared to those in the most deprived areas. This is illustrated in the graphs below which show that -

- Men living in the most affluent decile in Bassetlaw can expect to live 7 years longer than men living in the most deprived decile.

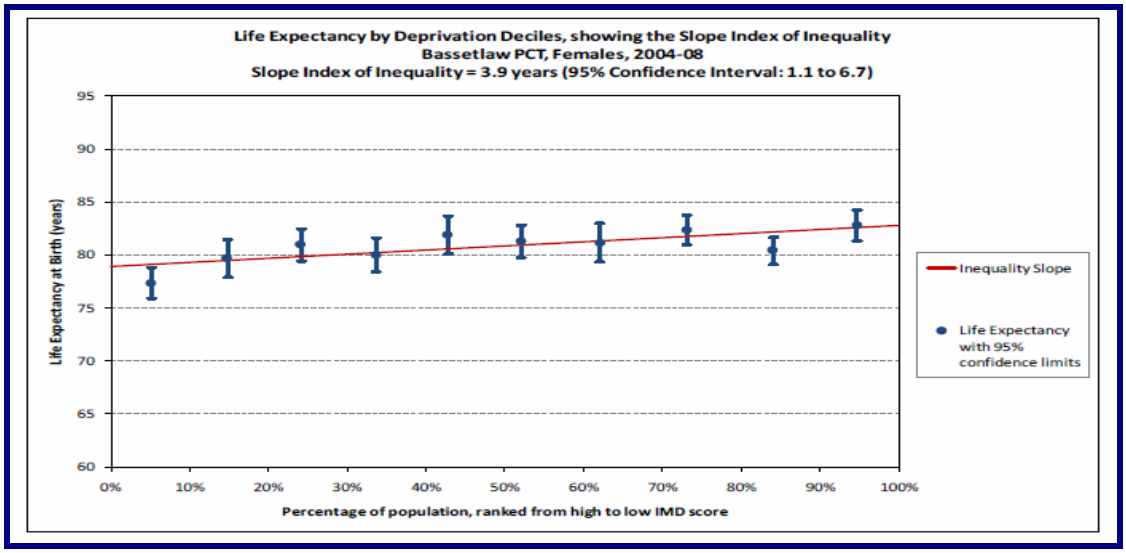
- Women living in the most affluent decile in Bassetlaw can expect to live 3.9 years longer than women living in the most deprived decile.

Male life expectancy and deprivation in Bassetlaw



(APHO, 2009)

Female life expectancy and deprivation in Bassetlaw



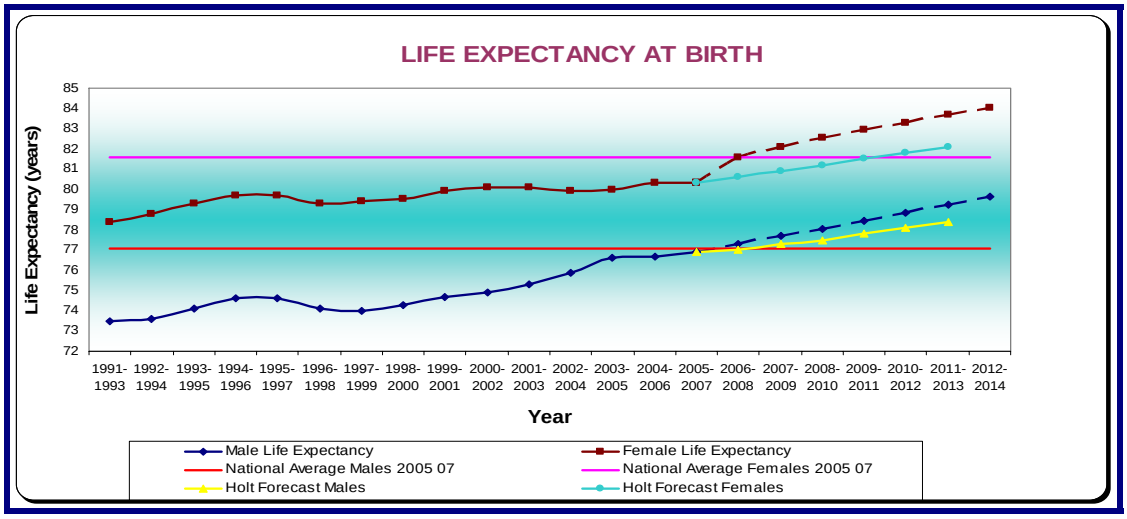
(APHO, 2009)

Life Expectancy

Our life expectancy ambition

- We will increase male life expectancy from 78.07 in 2009/10 to 79.65 years in 2013/14.
- We will increase female life expectancy from 82.57 in 2009/10 to 84.04 years in 2013/14.

Our life expectancy 5 year trajectory



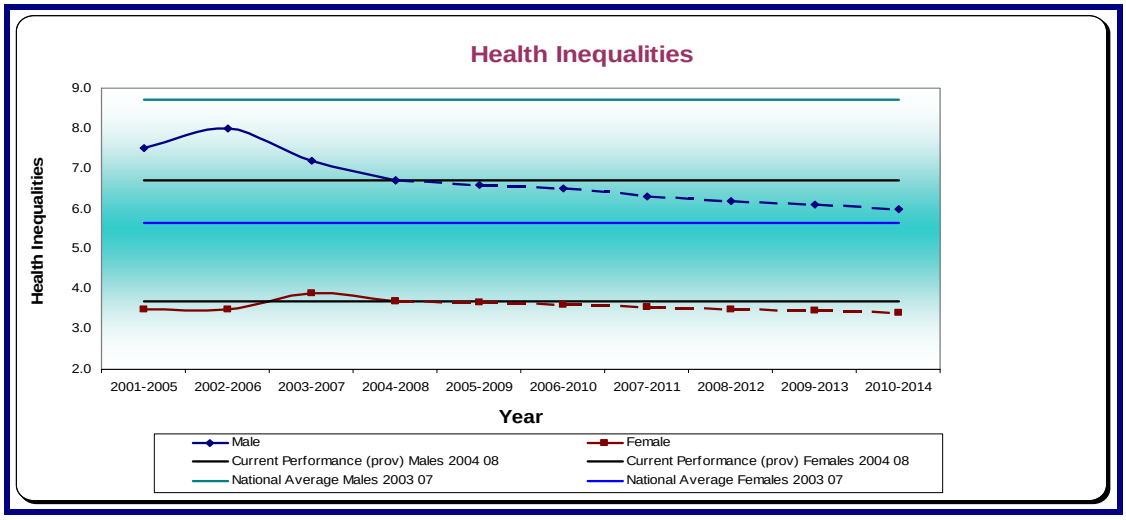
Health inequalities

We will reduce health inequalities between the best and worst wards by 10% and close the gap between Bassetlaw and the national average over our 5 year plan. This will be achieved by targeting our strategic initiative work in those areas of highest need and with the greatest potential impact so that life expectancy increases at a higher rate in the most deprived quintile. Our health inequalities ambition is further demonstrated within our strategic initiative strategy and delivery section of this plan.

Our health inequality ambition

- Decrease male health inequalities from 6.6 to 6.1 in 2013/14
- Decrease health inequalities from 3.65 to 3.45 by 2013/14

Our health inequalities trajectory

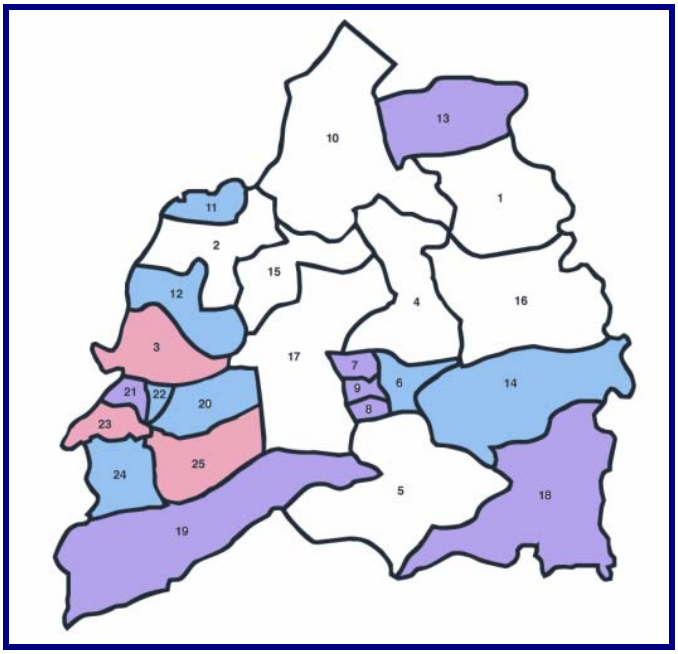


The map that follows indicates deprivation levels within the District based on the Index of multiple deprivation (IMD 2007). The key for the map indicates those wards with Super Output Areas (SOAs) in the top 10%, 20% and 50% nationally, (based on deprivation levels against all domains). The table below is a ward key for the IMD map and shows the number of deprived SOAs. It is important to note however, that the score for Rampton ward is unlikely to reflect an accurate picture, as within this ward there is one of the three NHS secure hospitals in the Country. This has a negative impact on a variety of indicators for that ward:

Bassetlaw Wards including number of SOAs with higher levels of deprivation

		Total No. of SOAs	No. of Top 10% SOAs	No. of Top 20% SOAs	No. of Top 50% SOAs
1	Beckingham	1			
2	Blyth	1			
3	Carlton-in-Lindrick	4	1		2
4	Clayworth	1			
5	East Markham	2			
6	East Retford East	5		2	1
7	East Retford North	4			3
8	East Retford South	3			2
9	East Retford West	3			2
10	Everton	1			
11	Harworth/ Bircotes	5		1	4
12	Langold	2		2	
13	Misterton	2			1
14	Rampton	1		1	
15	Ranskill	1			
16	Sturton	1			
17	Sutton	1			
18	Tuxford	3			2
19	Welbeck	2			2
20	Worksop East	4		1	3
21	Worksop North	5			2
22	Worksop North East	4		1	1
23	Worksop North West	5	1	1	1
24	Worksop South	4		1	
25	Worksop South East	5	4	1	

Map of Bassetlaw wards and associated deprivation



	Top 10% Super Output Area		Top 20% Super Output Area		Top 50% Super Output Area

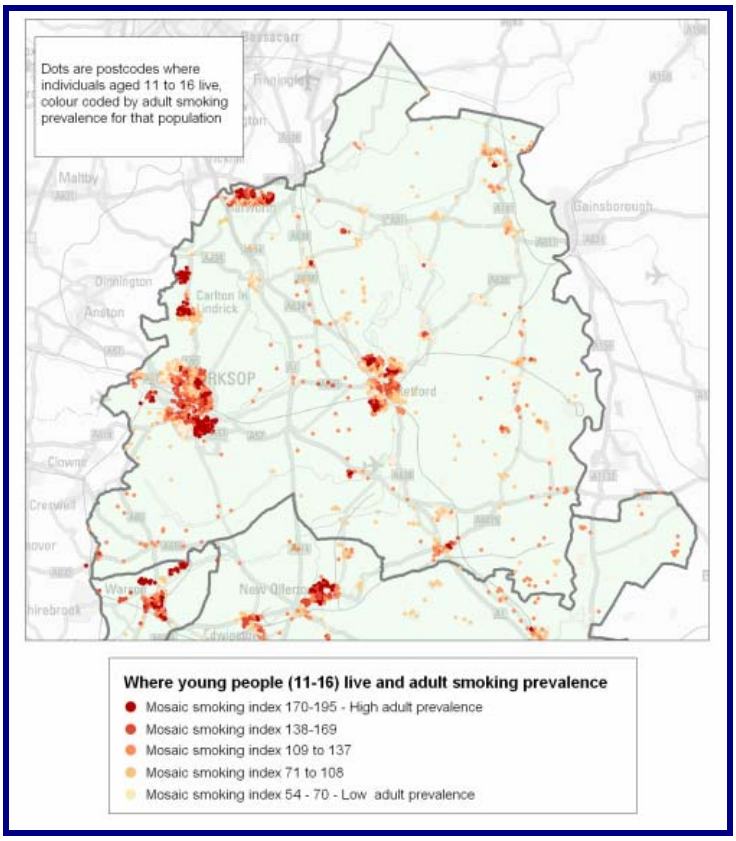
Almost half of all local authority wards in Bassetlaw have high levels of deprivation. The Bassetlaw wards of Worksop North West, Worksop South, Worksop South East and Carlton-in-Lindrick have the highest concentration of deprivation in the district and fall into the worst 10% of super output areas nationally for deprivation. To increase life expectancy and decrease health inequalities we have set ourselves ambitious outcome trajectories (as defined earlier in this section).

The Bassetlaw wards of East Retford East, East Retford North, East Retford West, Langold, Harworth/Bircoates, Worksop East and Worksop North East also experience high levels of deprivation and these fall into the worst 20% of super output areas nationally for deprivation.

Population groups with higher levels of socio economic deprivation generally experience poorer health outcomes. The negative impact on the determinants of health of such high levels of deprivation is reinforced when we examine health profiles at a ward level. For example, we know that educational attainment for Key Stage 4 pupils in Bassetlaw at 38.3% is significantly worse than the England average of 48.3%. However at a ward level only 4.7% of pupils in Worksop South, 8.6% in Harworth and 20% in Worksop East achieved 5+ A*-C grade GCSE's including English and Maths (2006-07).

Similarly teenage pregnancy rates in Bassetlaw are lower than the national average. However there are hotspots within the district with rates per 1000 under 18s female population of 82.3 Worksop South East, 82.5 in Carlton in Lindrick, 63.0 in Worksop East and 60.0 in Harworth. These are all wards with high levels of deprivation.

Low birth weight (less than 2500 grammes) is a major cause of infant mortality and is an important indicator of future health. Two key contributors to low birth weight are smoking during pregnancy and poor diet in mothers. 11.6% of babies born in Worksop South East 10.6% in Harwoth, and 10.2% in Langold are of low birth weight which is greater than the county (7.6%) and regional (8%) averages. In addition work we have undertaken to determine in which areas of Bassetlaw young people are more likely to take up smoking, we can see a correlation with areas of highest deprivation as illustrated in the map below.



Tackling health inequalities in Bassetlaw through targeting those population groups whose health status is significantly worse than the averages for the district, the county, the region and the country remains a priority. Focusing on the determinants of health and improving outcomes in the most deprived communities will have a positive impact on reducing inequalities by raising the health status of those with the poorest health opportunities.

3.1.6 Unmet Need

As part of the Nottinghamshire Partnership to develop and extend the scope and relevance of the JSNA a consultation exercise involving residents, partner organisations, clinical networks and staff across NHS Bassetlaw has identified gaps in information included in the JSNA; these include a section on housing need and an extended benchmarking exercise for all relevant National Indicators. NHS Bassetlaw and Nottinghamshire County Council have also commissioned jointly a local information system to bring the JSNA online and interactive. This will provide access to the latest available data and allow analysis of need down to ward or smaller population levels.

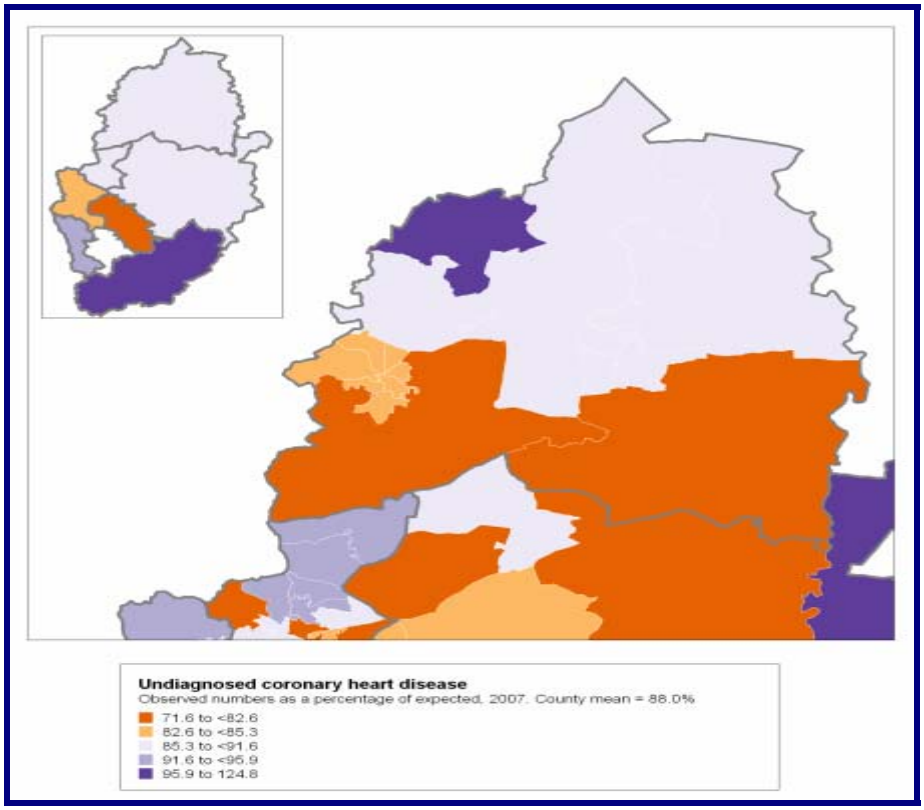
An analysis of the difference between expected and observed prevalence for some common conditions has provided an indication of unmet need in Bassetlaw. The unmet need numbers for COPD, Stroke, CHD and Hypertension in Bassetlaw are highlighted in the table below. This analysis, together with the Public Health Board reports and the JSNA, has helped with the prioritisation of strategic initiatives in those areas in Bassetlaw where need (both met and unmet) is highest.

Estimated numbers of undiagnosed / recorded patients in Bassetlaw

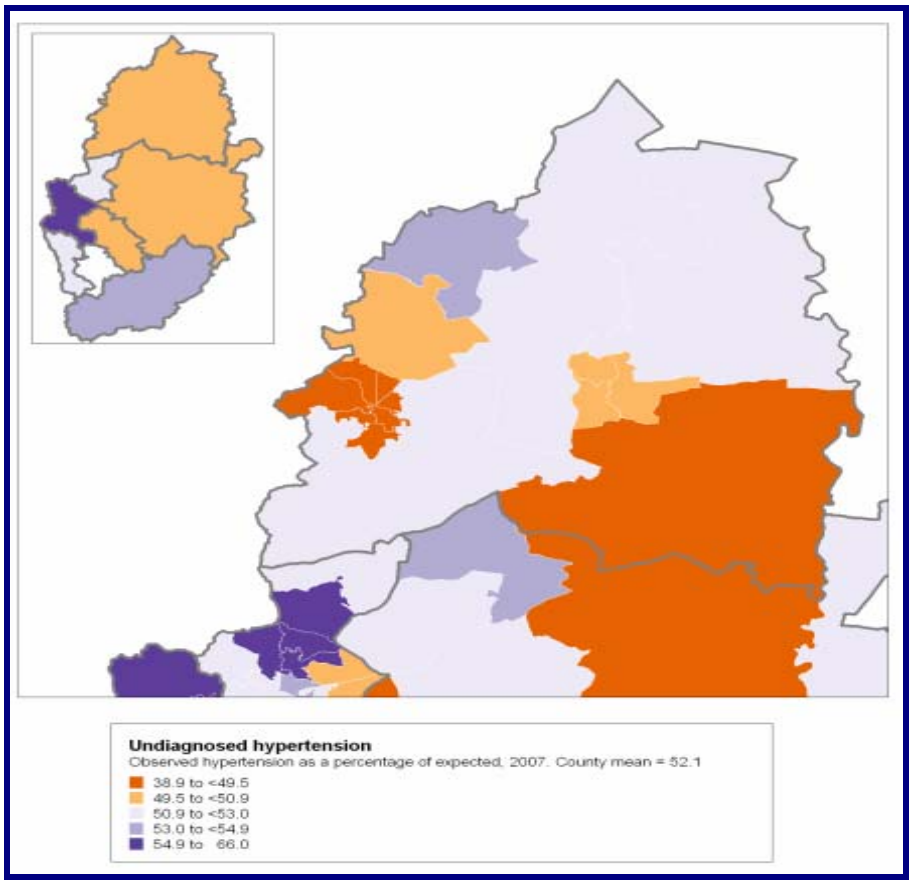
	COPD		Stroke		CHD		Hypertension	
Bassetlaw	Estimated number undiagnosed	Obs/Est %	Estimated number undiagnosed	Obs/Est %	Estimated number undiagnosed	Obs/Est %	Estimated number undiagnosed	Obs/Est %
	888	71.2	286	87.8	764	86.1	14652	50.1

(QOF Practice Level Data, 2007)

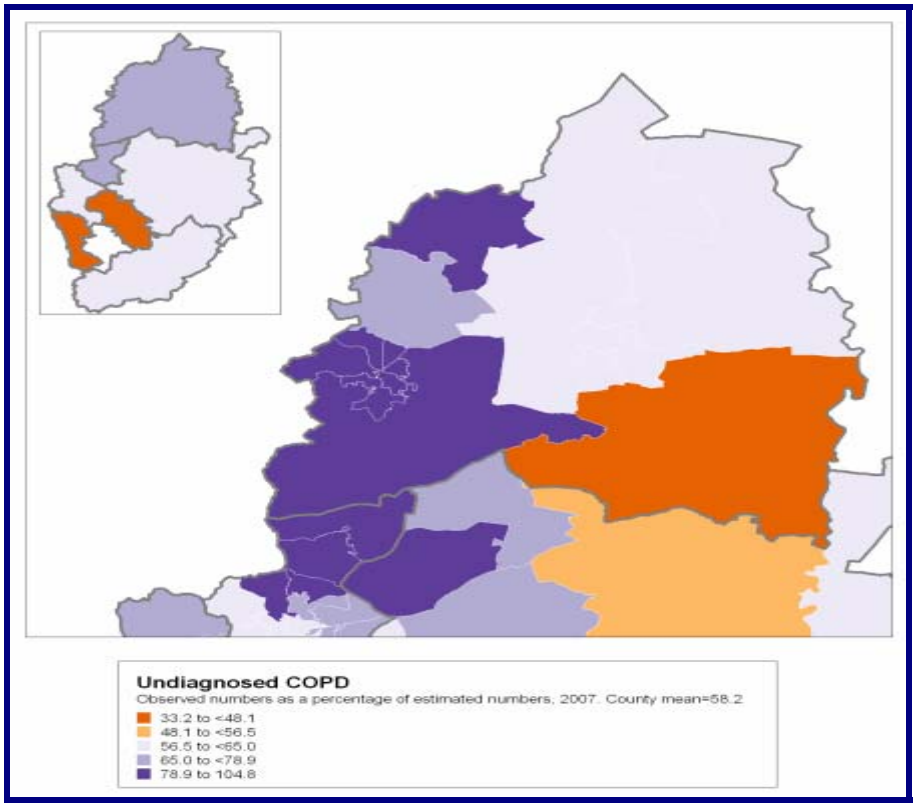
The unmet need maps which follow compare the number of people on GP registers for certain conditions to the estimated number that we expect given the age, sex and other demographic data for GP populations. They identify areas with the highest proportion of undiagnosed patients (areas shaded orange) and thus indicate unmet need at a local level.



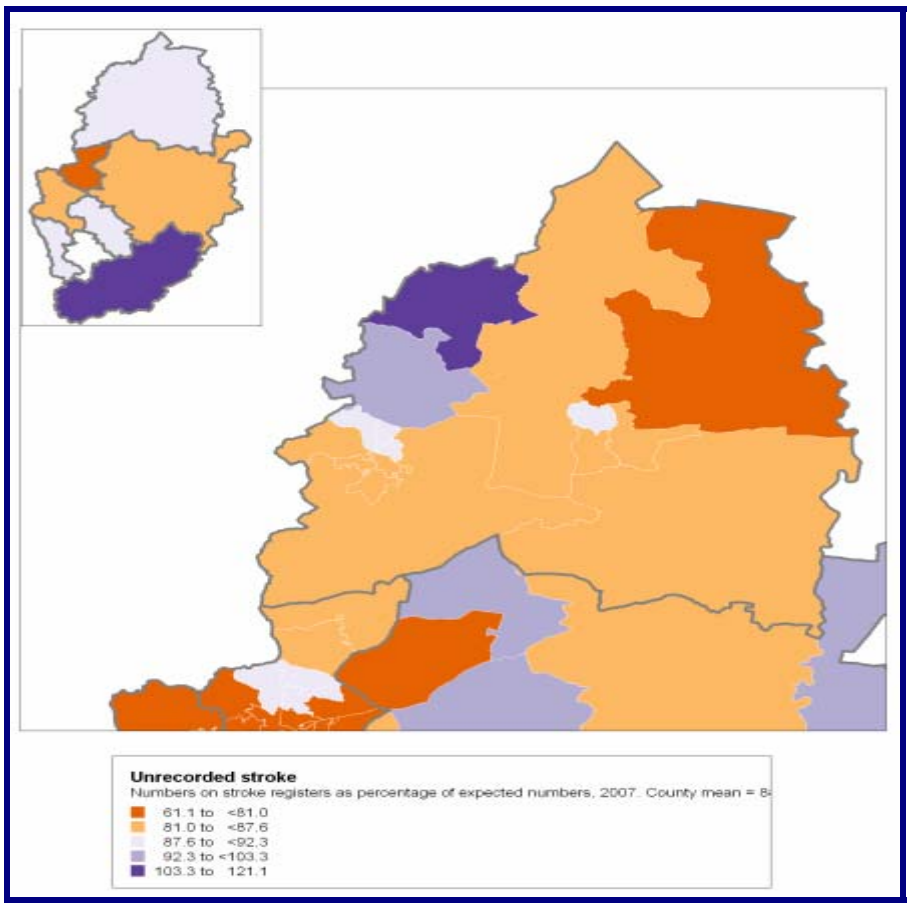
(2007/08 QMAS prevalence data, The Information Centre)



(2007/08 QMAS prevalence data, The Information Centre)



(2007/08 QMAS prevalence data, The Information Centre)

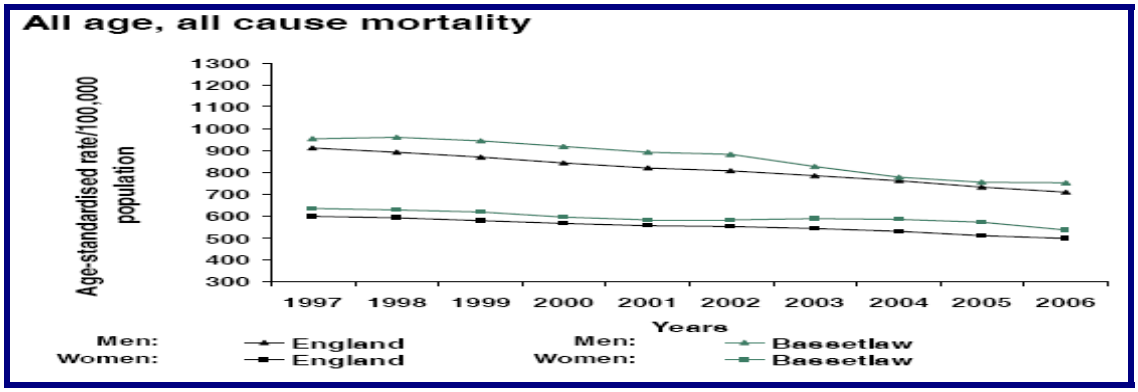


(2007/08 QMAS prevalence data, The Information Centre)

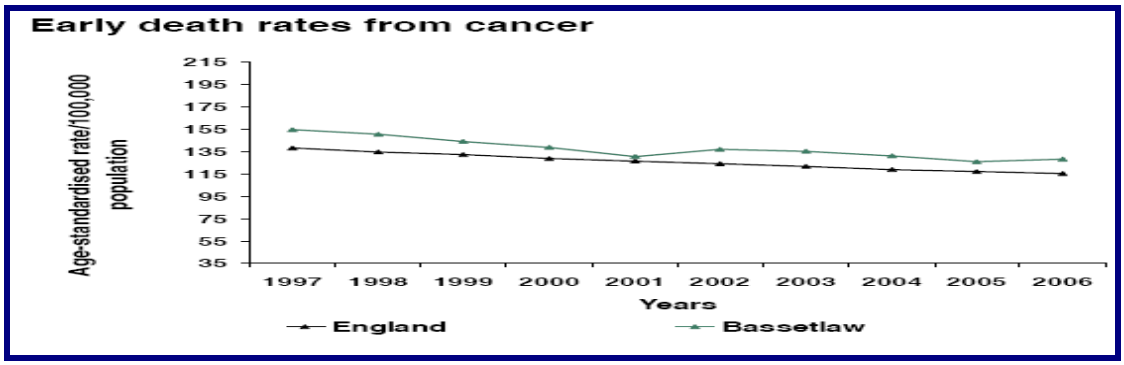
3.1.7 Life expectancy and causes of death

Life expectancy for both men and women living in Bassetlaw is significantly lower than the national average. There are also inequalities in life expectancy within Bassetlaw by gender and deprivation. According to 2005-07 data male life expectancy in Bassetlaw is 76.9 years and female life expectancy is 81.1 years (APHO, 2009).

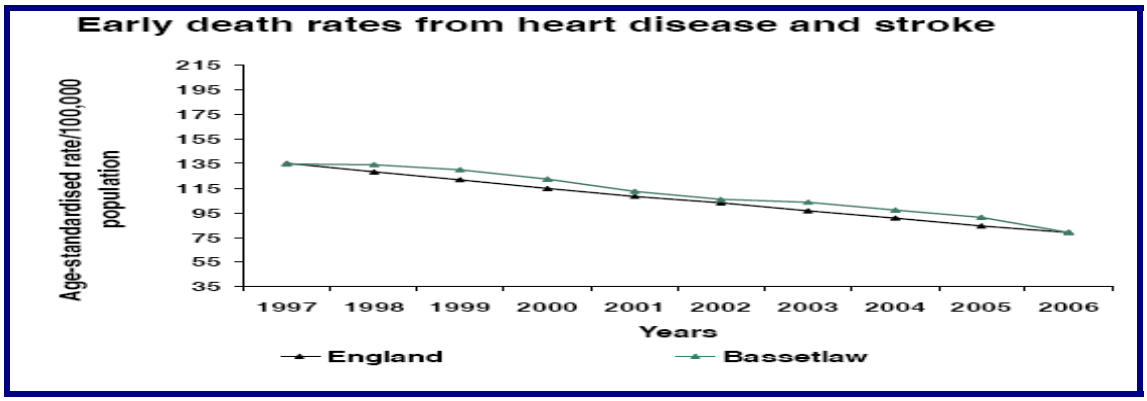
Death rates from all ages and causes have improved during the last ten years; however these remain higher than the England average.



Cancer Mortality: Early deaths from cancer have improved during the last ten years; however these still remain higher than the England average. In 2007, 163 people aged under 75 died from cancer in Bassetlaw.



Heart & Stroke Mortality: Over the last ten years premature deaths from heart disease and stroke have also improved and are now similar to the national average.



3.2 Stakeholder Engagement

We will continue to listen to our local people to improve end to end patient experience for the people of Bassetlaw.

3.2.1 Our MORI Poll Success

Bassetlaw achieved excellent results in a recent Ipsos MORI survey of local people across the East Midlands. The survey was conducted to determine what local people know about their local Primary Care Trust and how well they thought it was doing its role. Two sets of telephone interviews were carried out between 24th October and 7th December 2008, and between 6th April and 17th May 2009.

- **90% of those surveyed agreed that NHS Bassetlaw provides them with a good service**
- **89% of those surveyed agreed that NHS Bassetlaw helps to improve the health and wellbeing of them and their family**

NHS Bassetlaw was rated highest of nine PCTs in the East Midlands for the number of people who -

- were able to identify the name of their local PCT
- felt that they can influence decisions affecting local NHS services
- felt that the local NHS in Bassetlaw is improving services for people like them
- agreed that their local NHS in Bassetlaw is giving people more choice about their treatment and care
- agreed that they felt able to feedback on health and social care services and believed that their local NHS in Bassetlaw acts on this feedback
- received quality of information about local NHS services in Bassetlaw

NHS Bassetlaw was rated joint highest of the nine PCTs in the East Midlands, for the number of people who -

- agreed that the local NHS and Social Services in Bassetlaw work well together to provide a 'joined-up' service

The survey also recognised regional areas for improvement within the East Midlands - ease of access to an NHS dentist; time taken for an appointment with a GP and services to support end of life care, all of which NHS Bassetlaw has strategic initiatives to address (see section 4).

"I am absolutely delighted with the results of the survey, which show high overall satisfaction with NHS services in Bassetlaw. There are many committed and hard working people both within the PCT and across our partner organisations, who work together to ensure high quality services are available to local people. We will now look to see how we can further improve satisfaction with local services and continue to seek feedback from our local population." ***Dean Fathers, Chairman of NHS Bassetlaw***

3.2.2 Our stakeholder engagement process

To build our redeveloped strategic plan we engaged with our staff, patients & the public, local stakeholders, our Board, and our Executive & Clinical Executive.

1) Staff and Patient and the Public Visioning: We asked our staff, and patients and the public from our Modernisation Board to record their vision for NHS Bassetlaw in 2014 and 2020 from both a staff and patient perspective. Insights and key themes were collated and distributed to the Board to support our redeveloped mission, vision and goals session.

2) Board Mission, Vision, and Strategic Goals session: The Board of NHS Bassetlaw took early ownership of the redeveloped strategic plan through agreement of NHS Bassetlaw's mission, vision and goals. This session was not conducted in isolation, insights and engagement from NHS Nottinghamshire County and NHS Doncaster were discussed to support the redevelopment and prioritisation of our strategic goals as well as insights from our staff, patients and the public.

3) Stakeholder event: Representatives from NHS Bassetlaw's stakeholder community were invited to participate in a consensus building event to build an understanding of the degree of stakeholder support for Bassetlaw's strategic initiatives. Over 45 stakeholders attended, including local Clinicians and PBC leads, Patients and Public, Local Partners, Third Sector representatives, and Providers. Representatives from our PCT Board, our Senior Management Team (SMT) and all strategic initiative leads also attended. During the event our stakeholders were divided into four groups. At the end of the session, stakeholders were asked to prioritise Bassetlaw's strategic initiatives forming one element of our Board prioritisation process (stakeholder demand).

Stakeholders who attended the event commented on the positive experience that they had -

- "Very good event and also an important issue regarding public awareness"
- "We need more of this!"
- "Great day!"
- "Thank you for our public input in the meeting and for listening to our individual concerns. Good meeting."
- "Very enlightening – excellent"
- "Excellent afternoon. Good opportunities to focus on priorities. Thank you."
- "Excellent information sharing session. Good working between providers and commissioning. Thank you."

(Stakeholder feedback, 2009)

4) Executive and Clinical Executive Prioritisation: Following our stakeholder event, our SMT participated in a prioritisation session to gain a relative view of initiatives across the PCT's prioritisation framework. The results of the prioritisation exercise were discussed with the Professional Executive Committee and PBC leads in the Commissioning Forum to sense check the evaluations and to ensure consistency and rigour of approach. A recommendation of likely phasing of initiatives in the event of budget constraints was then taken to the Board.

5) Board confirm and challenge: We then held a Board session to challenge the results of the prioritisation framework and to determine the trade-offs that would be necessary in different financial scenarios. The Board agreed to a decision tree to support future trade off decisions where financial and policy imperatives must be taken into account (as displayed in section 2)

3.2.3 Our in year stakeholder engagement

Our engagement with patients and the public…

Our engagement	Engagement outcomes	What we are doing now
▪ Strategic plan stakeholder event	▪ Patients and the public shaped our mission, vision, goals and initiatives for our redeveloped strategic plan	▪ We are delivering our redeveloped strategic ambition shaped by and for the people of Bassetlaw
▪ Local stroke stakeholder event	▪ We set up multi agency Bassetlaw Stroke Strategy Implementation Group (BSSIG) and two project groups to review aspects of the stroke pathway in greater detail (acute, and post discharge) ▪ We have produced a framework for stroke survivor user involvement	▪ Our multi-agency stroke strategy group supports the delivery of our stroke strategic initiative
▪ Involvement of two long term neurological patients in service procurement	▪ We introduced epilepsy and Parkinson's disease nurses ▪ *"Our epilepsy nurse has been the only person to give us any information with regards to epilepsy. Our lives have been transformed for the better since we had the E nurse to come to us"* (Epilepsy patient) ▪ *"My mother has had a most excellent service all round. We have nothing but admiration for the staff she meets"* (A relative of a patient with Parkinson's)	▪ Ongoing nursing support for long term neurological patients to support the management of the disease in Bassetlaw
▪ Our continued work with the Bassetlaw Maternity Services Liaison Committee (MSLC) to inform the commissioning and provision of local maternity services and to seek the views of women in Bassetlaw	▪ We made significant financial investment to increase the midwifery workforce in Bassetlaw Hospital and the Community ▪ We also formed a Maternity Services Group to inform the commissioning and provision of local maternity services	▪ Needs of women in Bassetlaw are being continually addressed via our Infant Health A strategic initiative (Maternity)
▪ Review of Day Services in Nottinghamshire for Older People with Mental Health Problems (part of the Nottinghamshire joint commissioning partnership)	▪ As a member of the Nottinghamshire joint commissioning partnership the service review led to the development of a new service model structure	▪ Our patient and public engagement continues to influence our approach to the wider Dementia programme, and local action plans for service redesign
▪ Health Fairs for Bassetlaw's 'hard to reach' and our rural population	▪ Greater involvement from hard to reach groups and our rural population	▪ We are continuing to hold health fairs to reduce health inequalities in Bassetlaw by targeting those less likely to access health advice
▪ Listening to you consultation on community services	▪ Most respondents reported that they were very satisfied/ satisfied with community nursing, rehabilitation, & specialist support services	▪ We are continuing to shape community services for the people of Bassetlaw which support a number of our strategic initiatives
▪ End of life care consultation (Dignity at the end of life)	▪ Many patients supported the importance of dignity at the end of life	▪ We are acting on patient feedback within the delivery of our end of life strategic initiative

Our engagement with partners…

Our engagement	Engagement outcomes	What we are doing now
▪ Strategic plan stakeholder event	▪ Our partners were asked to shape the content of our strategic mission, vision and strategic initiatives	▪ We are continuing to work with our partners to action our strategic initiatives, many of which are reliant on strong partnership working
▪ Supporting the creation of the Bassetlaw Vascular Partnership Programme (BVPP) for strategic planning and implementation of commissioning plans for Stroke, Diabetes, Coronary Heart Disease and Renal Disease	▪ BVPP involves the separate disease workstreams and draws them under an overseeing strategic commissioning board ▪ Decisions are now made collaboratively - not in silos, or solely at a Network (regional) level – reducing risk of local duplication, work cross over and gaps in service provision ▪ Clinical, patient and public involvement is central to the delivery of BVPP project workstreams	▪ Clinical leaders sit on the board and influence programme action plans. A service user group made up of members of the public with an experience of using vascular services acts as a shadow board. The programme is underpinned by a communication process linking the programme to the LSP and wider clinical networks ▪ The work conducted by BVPP is central to the delivery of Bassetlaw's smoking, stroke and LTC strategic initiatives
▪ Representing Bassetlaw PCT at the NICE Conference on Stigma in Mental Health	▪ We were the only PCT in the country to present at the national conference	▪ We are maintaining our Nottinghamshire joint commissioning commitments around Mental Health and tackling stigma
▪ LAA review	▪ We have a new health improvement lead to strengthen our presence in LAA negotiations	▪ We have continuous engagement with the LAA to support the delivery of our strategic initiatives (detailed in section 4)
▪ Our evaluation of the Health Local Strategic Partnership (LSP)	▪ We found that the LSP was a very effective partnership, well represented across a range of agencies, including third sector organisations	▪ We are acting on recommendations to have more community representation, to increase opportunities to share information and to deliver training in partnership skills for LSP members. In turn this will also support the delivery of our strategic initiatives

Our engagement with clinicians…

Our engagement	Our engagement outcomes	What we are doing now
▪ Strategic plan stakeholder event	▪ Clinicians and PBC leads helped to shape and challenge our strategic mission, vision and strategic initiatives	▪ Maintaining ongoing engagement with our clinicians regarding the content of our strategic ambition
▪ Clinical involvement in pathway development	▪ We successfully engaged with our clinicians in the development of our Maternity, End of Life & COPD pathways	▪ Clinical pathways are key to the delivery of our Infant Health (A), end of life and LTC initiatives
▪ Shaping our Infant Health (B) strategic initiative	▪ We received positive clinical engagement to support our Infant Health (B) strategic initiative from a local Breast feeding clinical champion	▪ We are continuing to work closely with our breastfeeding clinical champion to deliver our Infant Health (B) strategic initiative
▪ Developing our alcohol strategic initiative	▪ We received strong clinical input from one of our local PBC cluster leads to undertake our alcohol initiative	▪ We are working closely with our local PBC cluster lead to deliver our alcohol initiative
▪ Ongoing clinical engagement	▪ Valuable clinical input to inform the Health LSP and SCG process to agree local priorities	▪ Further clinical support to inform our Health LSP, SCG process and prioritise decisions on the delivery of our strategic initiatives (as appropriate)

3.2.4 Our ongoing Patient and Public Engagement

At NHS Bassetlaw patient and public engagement (PPE) is integral to and not incidental to our commissioning and service provision and the delivery of our strategic ambition

PPE is the active participation of patients, carers, community representatives and groups, and the public in how services are planned, delivered and evaluated. It involves the continued process of developing and sustaining constructive relationships, building strong effective partnerships, and holding a meaningful dialogue with our stakeholders: patients, the public, community and voluntary sector groups, and our partner organisations.

We have redeveloped a comprehensive Communications and Involvement Strategy through consultation and in partnership with our key stakeholders. Our vision is to improve the quality and length of life for the people of Bassetlaw and we can only achieve this by working in partnership with our local community developing meaningful Patient and Public Engagement. Our existing stakeholder database has been further developed to enable members of the local community to be consulted on their chosen areas of interest in a way that suits them.

As Commissioners we act on behalf of the public and patients when making commissioning decisions that reflect the needs, priorities and aspirations of our local population. Our Communications and Involvement Team work alongside Commissioners and all Providers of Services to ensure that we are actively talking to and listening to members of our local community.

Underpinning the engagement work that NHS Bassetlaw carries out are the views that we gather from our Modernisation Board. Meetings bring together members of the Public, Service Users, Carers and Front Line staff to influence local priorities in Bassetlaw. We do this by working in partnership with our Service User Groups which are specific to particular conditions and provide local people with the opportunity to express their views and opinions in terms of the services we provide.

The Bassetlaw Vascular Partnership Programme (BVPP) User Group is made up of patients or carers who have utilised services from within the following disease areas; Renal, Cardiac, Stroke and Diabetes. Over our 5 year plan this group will support the delivery of our stroke and long term conditions strategic initiatives.

Our Readers Panel is made up of members of the local community with the purpose of reviewing patient information and literature to ensure that it is user friendly. We work with representatives from all of our groups regularly, as a combined group and also as part of a wider audience of key stakeholders, for example in our strategic plan stakeholder event.

The Nottinghamshire County Local Involvement Networks (LINk) was established in 2008 and provides a means by which individuals, groups and organisations can independently influence and improve their local health and social care services. A representative for the Nottinghamshire County LINk has a standing invitation to attend both our Trust Board and Modernisation Board meetings to provide a formal link with the PCT. In addition our PPI Manager attends their monthly Board meetings.

Given the increasing diversity of our local population, our key aim is to work more closely and improve engagement with groups that are often seen as ‘hard to reach’ for example, those who live in rural areas, those from Black and Minority Ethnic (BME) communities, the disabled, the young and the old and the local prison population. We will continue to engage with such groups via our health fairs.

3.2.5 Our Clinical Leadership

NHS Bassetlaw recognises that clinical leadership is crucial to deliver our strategic plan. Clinicians must lead the thinking for change, engaging stakeholders and winning hearts and minds, with the manager responsible for the technical work to make it happen. Clinical Leadership is fundamental to achieving our World Class Commissioning ambition and to delivering the Quality, Innovation, Productivity and Prevention agenda.

There must be Clinical involvement at a strategic and tactical level to enable effective execution. To this end we have recently undertaken a clinical diagnostic and must now develop with clinicians the process for implementing the results. Some of the key findings were:-

- The Trust should facilitate the drawing up of a compelling clinical vision for Bassetlaw that draws in a wider clinical community who are then encouraged to make it happen.

- The positive energy of the clinicians in leadership pathway redesign and those who have completed the successful Clinical Leadership programme, need drawing in more formally into the decision making systems within the trust.

- PBC committees have formed out of historical delivery patterns or splintered relationships. They may not be fit for the future.

- Relationships between 1º and 2º clinicians need formalising with the PBC clinical community of Bassetlaw in order to speak with one voice to the FT and other partners.

- PBC confederations of opinion should be encouraged

- Clinical service redesign is also needed in primary care and should include more nurses, pharmacists and other professions than is currently the case.

We are now starting work with the PEC and other clinicians to begin to describe the role of a Clinical Leadership in Bassetlaw. This will include the development of a local clinical leadership network which will become the forum to enable clinicians to debate thorny issues and the challenges of change.

To deliver our QIPP ambitions we must leverage the impact and pace of change of practice based commissioning, ensuring that the clinical leadership infrastructure is not held back by bureaucratic procedures which stifle the innovation that could come from primary care.

Effective clinical leadership and engagement with PBC at the forefront is the key vehicle for change both in secondary and primary care. This must be underpinned by a clear understanding of commissioning and practice based commissioning; the divide between commissioning and provision and the infrastructure, accountability process and outcomes measures/incentives to create the level and quality of engagement that is needed to achieve for all participants.

Our clinical change and engagement programme development will engage widely to ensure a programme which addresses the following:

- An effective working relationship between the PCT and PBC
- Identify and meet information needs
- Establish management infrastructure for PBC support in the PCT and in the PBC environment
- Clarify the Provider /commissioner relationship
- Identify PBC organisational development needs
- Communication and engagement at practice level

- Develop clear PBC commissioning plans and be clear on how PBC support commissioning where the PCT is leading.

The programme progress and deliverables will be reported by the PEC chair and the Director of Commissioning to the PCT Board via the Board assurance processes and delivery highlighting positive developments and challenges, barriers and delays. Board reports will also be made quarterly on PBC performance against budgets and incentive plans.

3.2.6 Our Partnership Working

The Focus	**Learning Disabilities (LD) Good Practice and Strong Partnership Working**
What we did in 2009	A recent report published by the East Midlands SHA (LD Good Practice, 2009) makes references to NHS Bassetlaw's good work in the LD space during 2009, defined as follows – ▪ We have appointed a non-executive director (NED) to act as a Board LD Champion. Our NED was chosen to speak about the NED role at the Celebration Event organised by the EMSHA held Jan 2010 to highlight good practice work being undertaken in Bassetlaw for LD users. ▪ Nurses in Bassetlaw have been trained to carry out face to face interviews with LD users to find out their views and experiences of services ▪ We have an intensive health visiting service which works closely with expectant and new mums and carers who have LD ▪ All providers of health services in Bassetlaw are checked to ensure that they say how the service is equal and makes 'reasonable adjustments' to accommodate LD users ▪ We have a designated children's service for children with LD including an LD nurse working in the Child and Adolescent Mental Health Service (CAMHS) ▪ We know the number of prisoners with LD needs in our local prison (Ranby) and our health facilitator is linking with the prison to assess health action plans ▪ We have clinicians trained in face to face discovery interviews, a method used for LD service user feedback. ▪ All GP practices have undertaken LD training, and all GPs have signed up to the Direct Enhanced Service where annual health checks will be offered to adults with learning disabilities. Further work in 2009 was our LD 'Big Health Day' in June (2009), where 85 people attended (LD service users, carers, PCT, voluntary and prison service representatives). The event was part of the preparation for the self-assessment of LD services (mandatory for PCTs had in 2009). The self assessment focused on 4 key areas: campus re-provision; addressing the health inequalities for people with LD; people with LD being safe in healthcare settings; and the involvement of LD service users in planning/commissioning services. Attendees were tasked with discussing the 4 LD self assessment areas and defining scores for each. Output from the event informed the PCTs self assessment, alongside feedback from other discussions in day centres. Our self assessment scores were then validated in an interview with service users/carers and professionals by the SHA. At the end of 2009 this was all gathered together in our LD action plan to be delivered in collaboration with the Nottinghamshire LD partnership over the course of our 5 year plan.
Impact and ongoing delivery	NHS Bassetlaw is regarded by the East Midlands SHA as being a shining light of good practice for LD service users. Our work in the LD arena demonstrates our strong partnerships with both service user and carer groups. We ensure that service user views and opinions are taken back and shared within the PCT with a direct influence over policy development. Our LD ongoing work – ▪ We are working with the PPI team to ensure that service users and carers are actively included in meetings. ▪ For 2010 the self assessment profile has been amended slightly, and we are currently planning our 2010 equivalent of our LD Big Health Day. ▪ We are on track to hit target our March 31st 2010 target for LD campus re-provision. To achieve this all of our service users who currently live in long-stay NHS provision have to be re-housed, with packages specifically designed for their needs and additional community based services funded to support them during and after this transition. Throughout the delivery of our 5 year plan we will continue to cement our firm partnership relationships in LD with the Nottinghamshire LD Partnership Board.
WCC Competency	2, 3

The Nottinghamshire Joint Commissioning Partnership: A cornerstone of our work with local partners is our commitment to the Nottinghamshire joint commissioning framework. We are committed to joint working over our 5 year plan to ensure high quality health and social care in the following areas: Autistic Spectrum Disorder; Carers; Children and Young People; Learning Disability; Mental Health; Older People – including older people's mental health; and Physical disability and sensory impairment. A success story from our partnership working over the last year is our work around learning disabilities (LD) -

Over the last year Bassetlaw has been a key player in strategic commissioning groups for Mental Health and Learning Disabilities (as defined above). Attendees at these groups include NHS Bassetlaw, NHS Nottinghamshire County, and Nottinghamshire Healthcare Trust, Nottinghamshire County Council, service user representatives and the voluntary sector. It is hoped that the Nottinghamshire joint commissioning framework "will provide a unifying and motivating framework for health and social care professionals to work together and aspire to achieve ambitious improvement." (Nottinghamshire joint commissioning framework, 2009)

The Local Strategic Partnership: Bassetlaw's Local Strategic Partnership (LSP) Board has a number of sub groups: Partnership for Health; Learning Skills; Social & Community Development; Children and Young People; Community Safety; and Economics. The main LSP Board includes the chairs of all the subgroups, together with the police, community groups, and faith groups. Bassetlaw is actively involved in the Partnership for Health and Children and Young people's sub groups. Members of the Local Strategic Partnership (LSP) Children's sub group include Bassetlaw commissioners and providers, Connexions, Nottinghamshire County Council, Children's Centre representatives, the voluntary sector, youth service, district council, play service, and leisure services, school inclusion, local social care, the education department, the district and county council.

Our Mental Health Partnership Working

We are…

- Linked into the East Midlands wide work on specialist mental health, including perinatal mental health, eating disorders, and low secure services. The work is reviewing best practice and commissioners are looking at the most cost-effective way to deliver them
- Continuing to fund a post in the third sector which supports volunteering, as a way back into work for people affected by mental illness
- Working with Nottinghamshire Healthcare Trust and Doncaster and Bassetlaw Hospitals on improving the inpatient facilities locally for mental health
- Funding dementia support workers to support individuals and families where a diagnosis of dementia has been received
- Reviewing the model of delivery of secondary mental health provision into the local prison
- Looking at transition for young people from CAMHS services into adult services
- Following a tender process with City and County PCTs, funding a new IMHA (Independent Mental health Advocacy) service
- Working to equalise the services available to adults of working age, and those available to older people
- Reviewing the implications of the national dementia strategy and how these can be implemented
- Working with Bassetlaw LSP on reducing the stigma associated with Mental Health

3.2.7 Our ongoing Stakeholder Engagement plans

To support the good stakeholder engagement work that we have undertaken over the last year below are some further ways that we plan to continue…

- Establishing a membership scheme to enable people from all sections of the community to participate in the work of NHS Bassetlaw.
- Sending additional invitations to Service Users to be involved in procurement processes of future NHS Bassetlaw services providing a different but equally valuable perspective.
- Running more Health Fairs to target Bassetlaw's 'hard to reach' groups and rural communities.
- Running more 'Listening to You' articles on the development of future PCT services.
- Acting upon our review of clinical leadership in Bassetlaw.
- Developing our partner based relationships including our commitment to the Local strategic partnership and the Nottinghamshire joint commissioning partnership.
- Conducting an annual stakeholder event to raise public awareness of the dangers of Heart Attack and Stroke.
- Ongoing stroke consultation (as below)

Our ongoing Stroke Consultation	
What we heard…	**What we are doing as a result…**
"It's daunting if you have never done it (been a carer) before" and "experts don't always know best" and "as carers we get nothing--you're a carer, get on with it" (Stroke patient x)	We are planning a carer "buddy" system by which new carers/survivors are helped by another carer to share practical tips. To be part of a wider package of support and training for carers
"hard to imagine in hospital what your needs will be at home" and "no one checked up on us, we were left to sink or swim" (Stroke patient y)	We are planning a Community Stroke Coordinator role to act as a central contact point, sign-poster, and liaison person for people who have has a stroke.

The examples above are a highlight of our plans for ongoing stakeholder engagement to deliver our strategic ambition. Our strategic initiative and delivery (section 4) defines our engagement plans for each strategic initiative and for additional detail please see our Communications and Involvement Strategy.

3.3 Provider Landscape

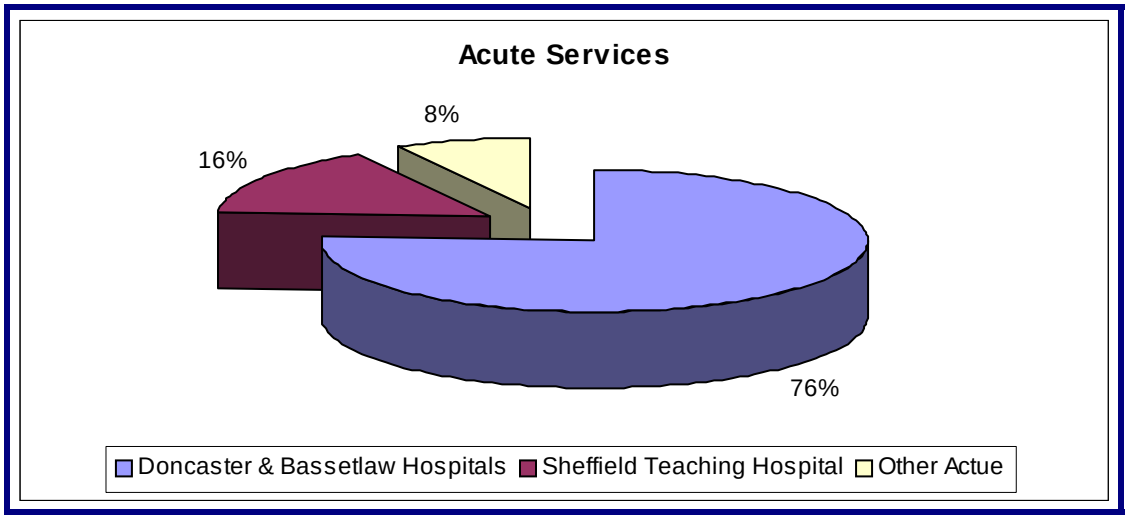
3.3.1 Current Picture

NHS Bassetlaw is administratively situated within the county of Nottinghamshire. Due to historical social and organisational factors, NHS Bassetlaw commissions acute services from providers who reach across the South Yorkshire, Bassetlaw and North Derbyshire communities, mental health services from a Nottinghamshire based provider and community services predominantly from the PCT provider services. NHS Bassetlaw holds contracts with a range of primary care providers and a wide range of independent and third sector providers.

3.3.2 Summary Details of Key Providers

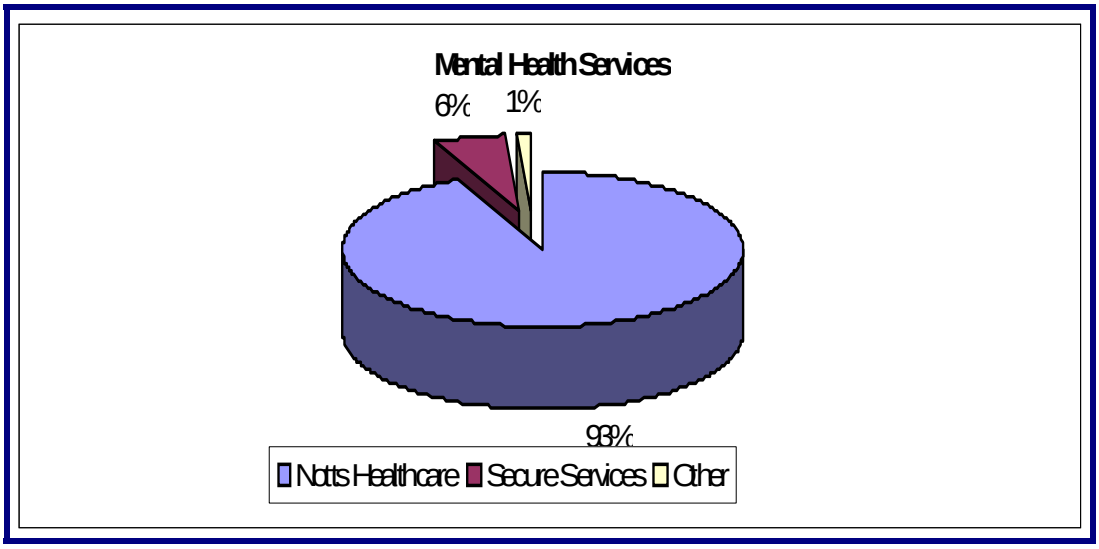
Acute Services

NHS Bassetlaw commissions acute services from a range of acute providers. The key providers are all Foundation Trusts and work as part of a range of clinical networks including cancer, coronary heart disease, intensive care, and renal services. The two largest contracts are with Doncaster and Bassetlaw Hospitals NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. The graph below illustrates the proportion of acute spend by each main contract and shows the relative size of the NHS Bassetlaw contract income in relation to Trust turnover.



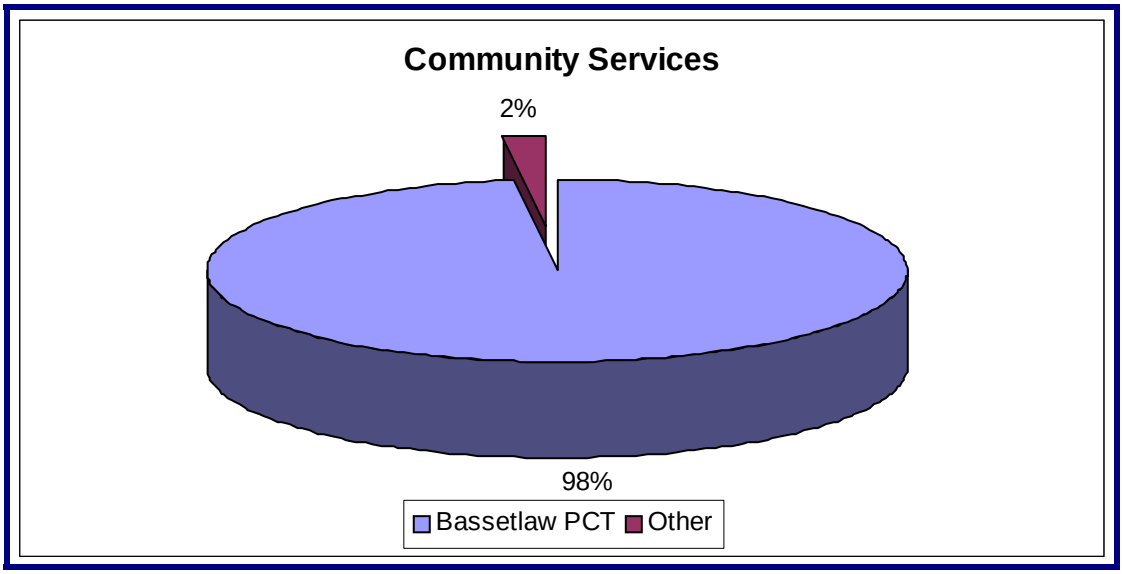
Mental Health Services

NHS Bassetlaw's key contract is held with Nottinghamshire Healthcare NHS Trust. This is a large and complex provider and currently holds a near monopoly position in the locality. The graphs below illustrate the proportion of mental health spend by contract and shows the relative size of the PCT contract income in relation to Trust turnover.



Community Services

NHS Bassetlaw holds a significant contract with its provider arm and smaller contracts with neighbouring PCT's services. The graphs below illustrate the proportion of community spend by each main contract and shows the relative size of the NHS Bassetlaw contract income in relation to Trust turnover.



Primary Care

NHS Bassetlaw holds contracts with twelve General Practices (three of whom cover nearly 70% of the PCT population), 19 dentists, 24 opticians and 16 pharmacy contracts.

General Practice Contract	Number of Practices	Registered Patients (as at Oct 09)	Number of GPs	Single-Handed Practices	Training Practices
GMS	6	24,302	16	1	1
PMS	5	83,646	47	0	4
PCTMS	0	0	0	0	0
APMS	0	0	0	0	0
GP WIC	1	0	2	0	0
Total	**12**	**107,948**	**63**	**1**	**5**

Other Providers

There are in addition to the NHS providers a wide range of independent and third sector organisations providing a range of acute, counselling and other services.

What Do We Currently Know?

Information is known for all the key current providers in relation to size, turnover, services provided, and a range of quality indicators. NHS Bassetlaw is also clear what the contribution is of each provider in relation to the service portfolio that is commissioned by value and activity for its population.

3.3.3 Summary Spend by Key Providers in 2008/09

Doncaster & Bassetlaw Hospitals	**53,768,503**
Medical Services (GP)	**15,393,083**
Nottinghamshire Healthcare	**13,665,281**
Sheffield Teaching Hospitals	**9,624,842**
NHS Bassetlaw Community Service	**10,943,327**
Other NHS Providers	**10,199,263**
Dental Services	**4,689,530**
Continuing Care	**3,277,069**
East Midlands Ambulance Service	**2,511,349**
Nottingham University Hospitals	**752,982**
Sheffield Children's Hospital	**1,601,050**
Pharmaceutical Services	**1,934,465**
Ophthalmic Services	**1,124,483**
Non NHS Providers	**1,431,897**

3.3.4 The Current Landscape – Strengths and Weaknesses

Detailed below are a few points in relation to the current provider landscape.

- Historically primary care is of a high quality and historically recruitment has not been an area of challenge. In some areas there is only one choice of general practice. Market entry has been created, and a new provider has recently been introduced to this market.

- Demand for dentistry (despite significant investment) is still slightly higher than supply but the position is much improved compared to four years ago. Market entry is being pursued for both community and prison based dental services.

- Acute care provision is dominated by Doncaster and Bassetlaw Hospitals NHS Foundation Trust and Sheffield Teaching Hospitals NHS Trust. Both have a track record of delivery. They dominate the landscape due to patient choice as there are actually at least five other acute providers within an hours travelling time. There is also an Independent Sector Treatment Centre (ISTC) provider locally who has provided significant levels of orthopaedic capacity in the last three years.

- The key acute specialty capacity constraint is within orthopaedics and discussions are on-going as to how demand can be met recurrently.

- Planning for services both specialist and non-specialist has been a strength across clinical networks within North Trent and this continues to be the case as we jointly consider the impact of the Next Stage Review and new clinical guidance on a range of conditions such as stroke and major trauma. A range of market entry and market exit issues are under active discussion.

- Community services are predominantly provided by the PCT provider arm. The services are of a high quality but there is little choice for patients. Market entry has created a new community based service for patients with a neurological condition.

- Mental health services are provided by one key provider. They provide a full range of services from primary care based nursing services to highly specialist forensic care. There is choice of treatments and care options for patients but no choice of provider unless patients choose to travel. Market entry has been created for patients into required psychological support.

In summary the strengths of our current pattern of provision are:

- Providers who are assessed highly by external bodies such as the Healthcare commission.
- A comprehensive range of acute and community services with tertiary services available at Sheffield.
- Strong clinical networks to support delivery.
- Good clinical outcomes.
- A range of choices particularly in acute care.
- High quality primary care provision
- High quality estate in primary and secondary care

In summary the weaknesses of our current pattern of provision are:

- Choice is restricted in some key areas e.g. mental health
- Some capacity constraints particularly in orthopaedics
- Current rising demand for Emergency Care which may be more appropriately cared for outside of hospital.

We have already started to build on our strengths, so for example:

- We are creating a more strategic relationship with our main providers through more regular Board and senior management discussion about how providers can more actively support our strategic goals.

- We are working more closely with our main commissioning partner for acute services NHS Doncaster. This includes the commitment to work together on the development of a commissioning strategy for acute services.

- We are able to benefit from regional commissioning in both the East Midlands and Yorkshire and Humber. These benefits include market analysis and market development, as well as supporting strategies such as social marketing exercises related to stroke services.

We have already started to address some of the challenges:

- We have created market entry opportunities for mental health and primary care providers where choice has previously been limited.

- We are negotiating an increased plurality of choice for patients in areas where capacity has previously been limited.

- We have driven an accelerated change programme to the urgent care pathway so that patients can receive care from providers of primary and community care to address the issues of limited capacity in acute care.

3.3.5 Our Market and Procurement Processes

NHS Bassetlaw Board approved its Market Management Strategy in June 2009. Since then significant strides have been made to use the development and management of markets to improve services for the benefit of patients.

NHS Bassetlaw has built on the market analysis overview carried out during 2008 with a granular analysis of both the acute, and community markets during 2009. These activities have led to clear delivery plans for prioritised community services (End of Life, Chronic Obstructive Pulmonary Disease, and Falls). Additionally, the acute analysis has been used to produce improved system levers which are now starting to drive change. This acute analysis has been carried out internally and is an excellent example of how we have embedded the skills required to develop and manage markets.

Additionally, NHS Bassetlaw has carried out 'deep dive' analysis of the markets for weight management services, and for community based neurological services. Both of these have led to accelerated service improvements that patients are already benefiting from in 2009.

NHS Bassetlaw now regularly holds provider forums (specific to planned procurement activity), and provider market places (general discussions to stimulate market entry). During the previous year, provider forums have been held for procurements related to dental services, psychological therapies and weight management. Market places have been held to stimulate provider support for NHS Bassetlaw healthy lifestyle programme, and support to the

transformation of End of Life Care, COPD and Falls in older people. This approach is leading to greater plurality of provider and improved choice for patients.

During the year we have successfully concluded related procurement exercises with new services in place for prison healthcare, prison pharmacy, and community based rehabilitation for patients with a neurological condition, and GP services with extended hours. We are well advanced with procurements that will introduce new services in 2010 for children's weight management, community dental services, and access to psychological therapies.

We will work with the NHS as preferred provider. However, our risk assessment of deliyer and market assessment tells us that we will need to continue to use market levers to improve performance. We have a rolling programme of market analysis that we will use to ensure that we are shaping the market in a way that makes sure the milestones in are strategic initiatives are met.

We have established a new Procurement sub committee of the Board. This has already strengthened our related governance and we now have a process that has a Non Executive Chair with independent clinical input and specialist procurement advice. This Committee is responsible for:

- Methods of market entry and pricing.
- The process for awarding, retaining and renewing business.
- The development of market contestability plans.
- The development of strategic relationships.

It is our intention to continue to develop strategic relationship with our main providers whilst balancing this with maximising the systems and contract levers that are available to the commissioner.

3.3.6 Overview of our Plans Regarding the NHS Bassetlaw Provider Arm

NHS Bassetlaw has a provider arm which provides a range of predominantly community based services for example; district and specialist nursing, health visiting, podiatry, dentistry and school nursing. It has an annual income of approximately £15m. Services are commissioned primarily from NHS Bassetlaw but smaller contracts are also held by the provider arm with NHS Doncaster and Rotherham.

NHS Bassetlaw will agree with NHS East Midlands the future organisational structure of all current PCT provided community services within the national timescale. As set out the structural change will be driven by improvements to the delivery of services with new models of care under active consideration.

3.4 Activity Commissioned

As part of being a world class commissioning organisation Bassetlaw is proud to highlight two of our commissioning success stories

The Focus	**Long Term Neurological Services**
What we did in 2009	We commissioned a dedicated community based rehabilitation services for individuals with long term neurological conditions. The project used a whole systems approach crossing both professional and organisational boundaries. Throughout the course of the project key Bassetlaw representatives, NHS resource and specialist clinical input and patient/carer involvement were utilised. This led to the development of a service specification to ensure that the service commissioned would be both comprehensive and suitable in meeting the needs and requirements of patients, carers and commissioners. The seven step procurement processes within our pathfinder integrated procurement framework (IPF) were applied, with knowledge transfer and shared learning. Patient/carer involvement was actively sought and encouraged with representatives involved throughout the process. Clinical leadership was provided by a Neuro Consultant from Sheffield Teaching Hospitals who provided expert advice and contributed to the whole procurement process. Patient case studies were also provided to potential suppliers, who were required to present their rehabilitation plans for these studies as part of the evaluation process.
The impact and ongoing delivery	The project has been fully operational since Sept 2009 under the Bilateral Community Services contract including CQUINS (Commissioning for Quality and Innovation Payment Framework). As a consequence of effective commissioning the service is focused to deliver the specific needs of long term neurological patients and their carers in Bassetlaw.
WCC Competency	4, 9

The focus	**Commissioning a successful Chlamydia Service for hard to reach groups**
What we did 2007-2009	A sexual health needs assessment was conducted jointly by Nottinghamshire County and NHS Bassetlaw to define, amongst other things, the evidence of need for Chlamydia screening. In addition to support Chlamydia screening pathway development a sexual health investment review was undertaken by NHS Bassetlaw. The review aimed to shift investment to prevention and primary care as opposed to diagnosis and treatment and more specialised secondary care. Evidence of need resulted in a new third-sector provider (THT) being commissioned for Chlamydia screening by NHS Bassetlaw. Baseline screening data was used to map against the target for 07/08 to screen 15% of 15-24 year olds, increasing to 17% in 08/09. The new service is a different and more accessible (young person friendly) service. The service was commissioned across a consortium (South Yorkshire and Bassetlaw) to obtain economies of scale and to make the contract appealing to independent sector organisations.
The impact and ongoing delivery	Ongoing Chlamydia pathway development work has been conducted for both Nottinghamshire County and NHS Bassetlaw in an effort to shape service design across Nottinghamshire County, which has included proactive clinician engagement to inform and drive pathway development. The new Chlamydia screening service is comprised of youth workers, outreach workers, and represents a less medical model e.g. service provision in local pubs and clubs. This service has enabled more effective Chlamydia screening, supporting screening uptake within marginalised communities, thus tackling health inequalities.
WCC Competency	2, 4, 10

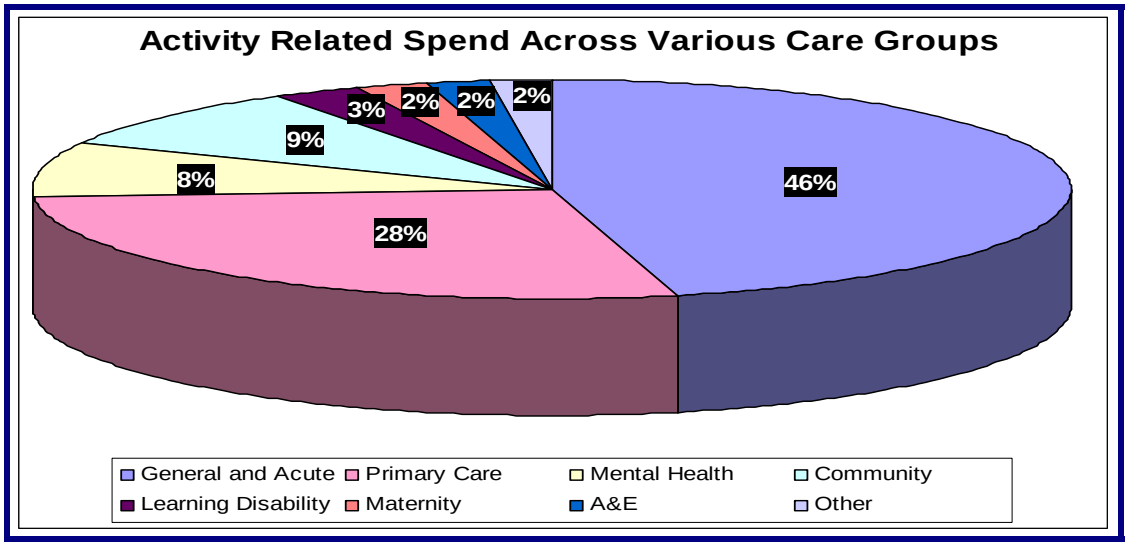
3.4.1 Spend on services commissioned

The chart below details the range and spending on services commissioned across care groups. The current operating plan has commissioned sufficient activity across all sectors of care to meet patient demand and to meet national and local targets.

In recent years we have experienced increased pressures particularly for acute care. Referrals have increased slightly (approximately 3%) but demand for emergency and critical care services particularly at our local acute provider.

In relation to future planning the initiatives have all taken account of:

- Overall population growth
- Population growth by age band
- The impact of the 18 week wait being achieved on referral thresholds
- The impact of driving down waiting times over the life of the new strategy
- Each initiative has had to consider the financial and activity impact of each of the activities downstream, using national and local evidence and models



3.4.2 Provider Quality and Safety

Patient safety is at the heart of all commissioning processes and all key provider contracts have quality schedules within them.

Progress has been made in 2009/10 and additional quality metrics have been included in the new contracts based on the national model contracts and local priorities for quality.

This plan commits NHS Bassetlaw to taking new innovative approaches to our relationships with patients and the public. We will expand on patient satisfaction measures and makes increasing use of Quality Accounts and the Commissioning for Quality and Innovation (CQUINs) scheme.

We will also seek to maximise national and local tariffs to incentivise providers to maximise both the efficiency and quality of care provided.

For additional information on Bassetlaw's commitment to quality please see the Bassetlaw Quality Summary for further information.

3.4.3 Our Joint Commissioning Arrangements

NHS Bassetlaw continues to play an active role in NORCOM, this successful collaborative commissioning model continues to drive improvements to acute services in South Yorkshire. As part of the Yorkshire and Humber Specialised Commissioning Group (YHSCG) NORCOM ensures excellent governance is in place for the commissioning of services where safety issues are always paramount such as paediatrics, and it ensures robust service specifications and financial plans are in place for new services such as the new Renal service introduced locally in 2009.

NORCOM also is the hub for acute based clinical networks, these continue to be strong and play an effective part in delivering on our clinical vision, In addition to the clinical networks for specialised services the North Trent Networks for cardiac care, and stroke care are coordinating the response to the 'Next Stage Review', and examples of recent services improvements include the introduction of PPCI's during 2009 delivered through clinically led service specifications now linked to contracts.

East Midlands Specialised Commissioning Group (EMSCG): In addition to participating in NORCOM, we are one of nine PCTs involved in the East Midlands Specialised Commissioning Group (EMSCG) which aims to ensure that the entire population of the East Midlands receives timely access to all specialised services of the highest possible quality delivered within available resources. The EMSCG's vision reads as follows:

- The entire population of the East Midlands will have fair and equitable access to the full range of specialised services.
- All care will be patient centred, pathway based and delivered as near to home as possible.
- Each patient will receive the right treatment in the right place at the right time.

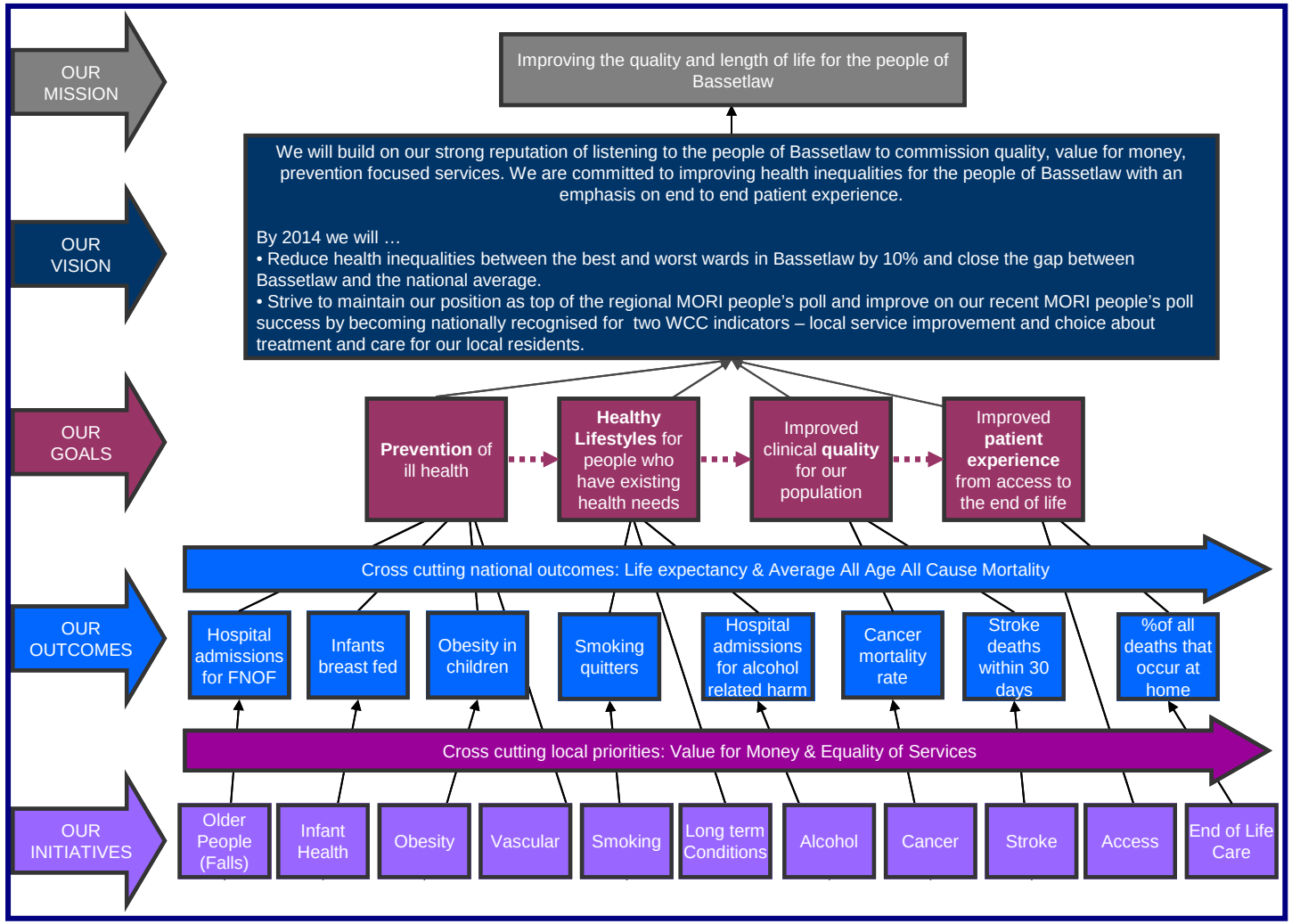
The local arrangements for the commissioning of specialised services have evolved over a number of years. The East Midlands Specialised Commissioning Group (EMSCG) was established in April 2007 in response to the Department of Health sponsored national review of specialised services (Carter Review) – led by Sir David Carter. The underpinning rationale for this national review was the number and variety of commissioning arrangements across England. This led to confusion for service providers, commissioning colleagues and patients and their carers.

The current configuration of specialised services in the East Midlands is based on Strategic Health Authority boundaries and for the first time the whole of the East Midlands has one clear commissioning structure for specialised services - the East Midlands Specialised Commissioning Group (EMSCG). Over the last year the EMSCG has also worked on a number of areas that sit outside of specialised commissioning. This is an important step in creating collaborative working between local NHS organisations. Examples of this include the development of fair polices for individual funding requests and top up treatments so that all East Midlands patients can now pay for additional private healthcare on top of their NHS treatment, and the management of chemotherapy budgets.

Nottinghamshire joint commissioning partnership: We are committed to joint working to deliver our 5 year plan and to ensure consistent high quality health and social care in the following areas: Autistic Spectrum Disorder; Carers; Children and Young People; Learning Disability; Mental Health; Older People – including older people's mental health, and Physical disability and sensory impairment. Our commissioning approach is focused on improving outcomes for people who use health and social care services. It is hoped that the Nottinghamshire joint commissioning framework "will provide a unifying and motivating framework for health and social care professionals to work together and aspire to achieve ambitious improvement." (NJCA, 2009)

4 Strategy & Delivery

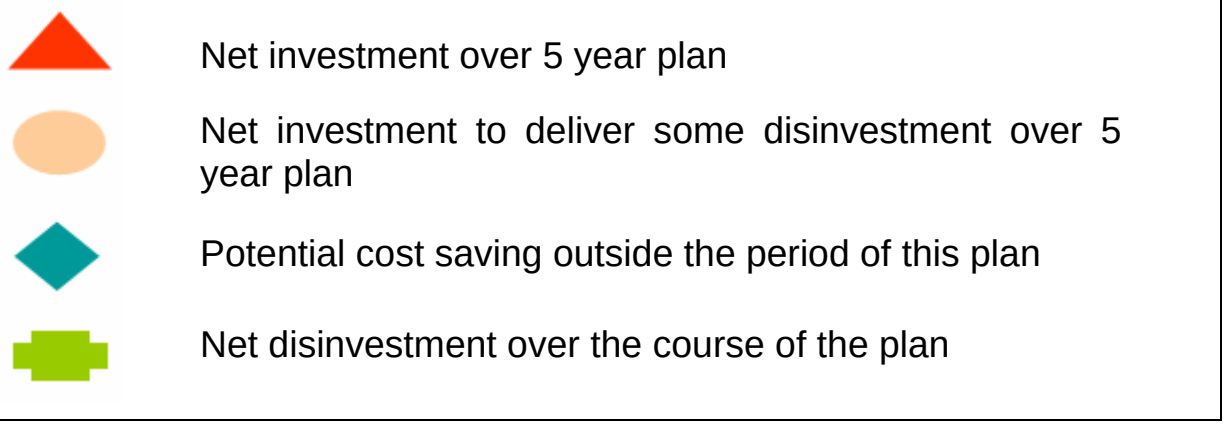
4.1 A reminder of our strategic ambition: Our mission, vision and goals, our outcomes and strategic initiatives



4.2 Overview of NHS Bassetlaw's goals and initiatives

Our strategic goals have been prioritised during the redevelopment of our 5 year strategic plan. Each goal has been mapped to national, regional and local commitments and our WCC outcomes to confirm alignment with our mission - to improve the quality and length of life for the people of Bassetlaw.

Goals	Core Initiatives	Cross cutting Commitments	
Goal 1: **Prevention** of ill health	Older people (Falls)	Value for money	Equity of access
	Infant Health A (Maternity)		
	Infant Health B (Breastfeeding)		
	Obesity		
	Vascular		
Goal 2: **Healthy Lifestyles** for people who have existing health needs	Smoking		
	Long term conditions		
	Alcohol		
Goal 3:Improved clinical **quality** for our population	Cancer		
	Stroke		
Goal 4: Improved **patient experience** from access to the end of life	Access		
	End of Life		



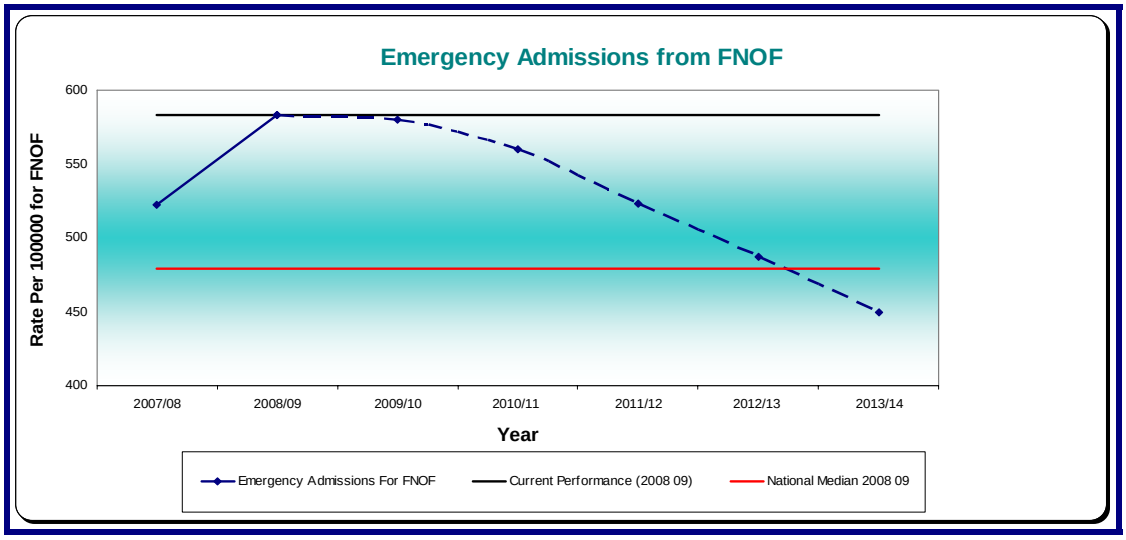
4.3 Our Strategic Goals

Our ambition to reduce health inequalities and increase life expectancy is a key focus of our strategic initiatives to enable us to achieve our mission and vision. In addition we have specific targets for our 4 strategic goals.

Overview	Rationale	Initiative Improvements
Goal 1:Prevention of ill health ▪ Reduce the rate emergency admissions for falls (FNOF) per 100,000 by 22.4%, from 580 in 2009/10 to 450 in 2013/14 ▪ Increase the % of infants Breastfed (6-8 weeks) by 15.7%, from 35.29% in 2009/10 to 51% in 2013/14 ▪ Reduce the prevalence of obesity in reception year by 2.41% from 11.01% in 2009/10 to 8.60% in 2013/14	▪ We are committed to the improvement of primary prevention focused services over our 5 year plan ▪ We know that investing in prevention is more cost effective and better for the people of Bassetlaw in the long term	▪ NHS Bassetlaw has reviewed existing services and performance benchmarking data leading to the development of the older people, infant health (breastfeeding & maternity) and obesity initiatives to deliver our strategic ambition
Goal 2: Healthy Lifestyles for people who have existing health needs ▪ Increase the rate of smoking quitters aged 16 and over by 11.1% per 100,000 from 899.57 in 2009/10 to 1000 in 2013/14 ▪ Reduce the rate of alcohol related hospital admissions per 100,000 by 14.9% from 1588 in 2009/10 to 1352 in 2013/14 ▪ Reduce the rate of hospital admissions per 100,000 for COPD and for Diabetes admissions by 15%	▪ We need to target people who smoke, drink excessively, and who have a long term condition (LTC) in our population to encourage their return to a healthy lifestyle ▪ We know that in the long term focusing on healthy lifestyles leads to cost savings and improved health outcomes for our patients and the public	▪ Our smoking initiative has become more ambitious, while our services performed well, our prevalence remains high ▪ Our LTC initiative encourages people with LTC to take greater ownership and responsibility for their care to support the delivery of better health outcomes – namely reduced emergency admissions
Goal 3: Improved clinical quality for our population ▪ Reduce the cancer mortality rate (DSR) by 5% from 119 in 2009/10 to 112.5 in 2013/14 ▪ Reduce the rate (Indirectly age and sex standardised rates) of stroke deaths within 30 days per 100,000 by 18% from 29,315 in 2009/10 to 24,020 in 2013/14	▪ We are committed to improving the clinical quality of services for the people of Bassetlaw, in particular for stroke and cancer care ▪ Quality is a core local, regional and national focus	▪ NHS Bassetlaw performance has been benchmarked against stroke mortality within 30 days of admission and for levels of cancer mortality. It is clear that the two key chronic conditions should be focusing on radical clinical quality improvement over our 5 year plan
Goal 4: Improved patient experience from access to the end of life ▪ Strive to be top of the regional MORI people's poll and improve on recent MORI people's poll success by becoming nationally recognised for two WCC indicators – local service improvement and choice about treatment and care for our local residents ▪ Increase the % of people offered, wishing to and able to die at home, by 7% from 18% to 25%	▪ Our ambition is to build on our current successes within the East Midlands MORI patient & public satisfaction poll and become nationally recognised for listening to the people of Bassetlaw	▪ All of our strategic initiatives involve listening to our patients and the public. This will continue to shape the effective delivery of our planned initiatives ▪ We have revised our end of life pathway to ensure that people are offered the choice to die at home

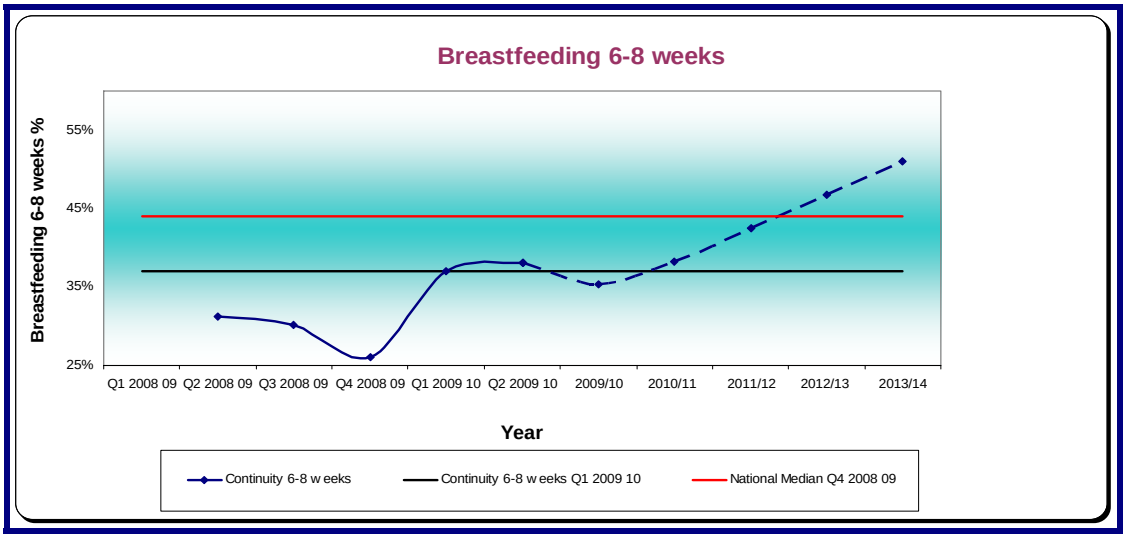
Goal 1: Prevention of ill health

Over our 5 year plan we will reduce the rate emergency admissions for falls (FNOF) per 100,000 by 22.4%, from 580 in 2009/10 to 450 in 2013/14



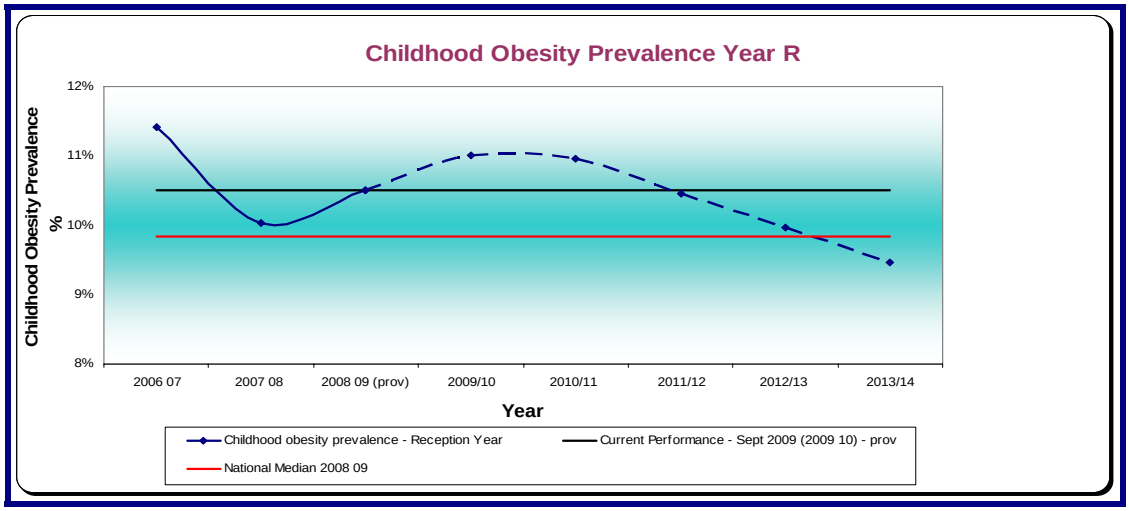
Bassetlaw is above the national average for emergency admissions for fractured neck of femur (FNOF). Bassetlaw is an outlier and has the worst rate of hip fractures in the over 65's in Nottinghamshire. The rate of 2006-07 emergency admissions for FNOF was 579.2, compared to 479.8 nationally and 515.8 in Nottinghamshire.

Over our 5 year plan we will increase the % of infants Breastfed by 15.7%, from 35.29% in 2009/10 to 51% in 2013/14



Breast feeding at 6-8 weeks in Bassetlaw was 30.8% in 2008-2009 compared with 41.99% nationally. Bassetlaw has the lowest breast feeding rates in the East Midlands.

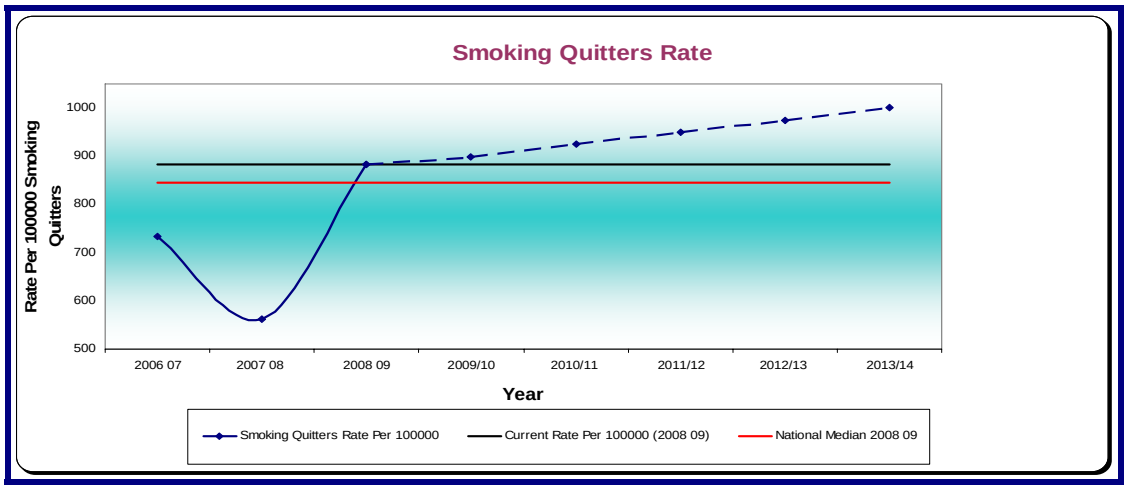
Over our 5 year plan we will reduce the prevalence of obesity in reception year by 2.41%, from 11.01% in 2009/10 to 8.60% in 2013/14



Obesity prevalence in reception year (School year 2008/9) was 10.5%. Bassetlaw plans to focus on the prevention of obesity in children to improve the overall prevalence of obesity within the population.

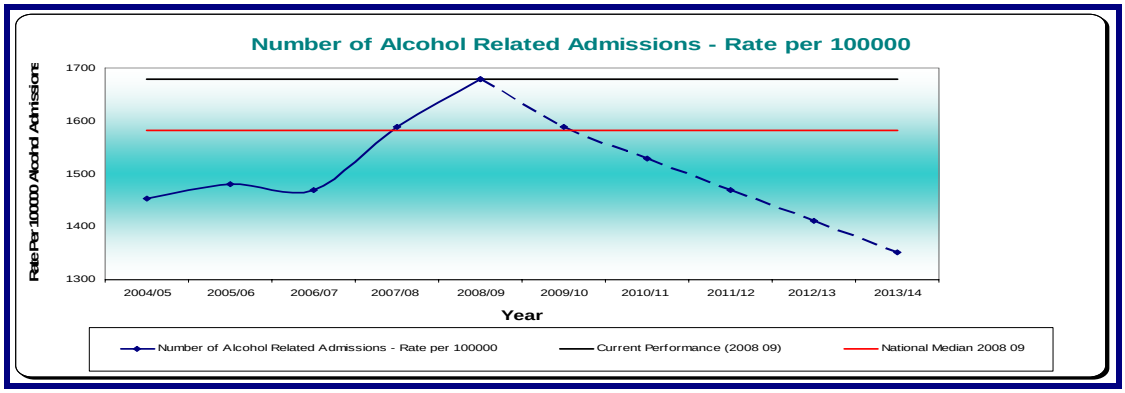
Goal 2: Healthy Lifestyles for people who have existing health needs

Over our 5 year plan we will increase the rate of smoking quitters aged 16 and over by 11.1% per 100,000, from 899.57 in 2009/10 to 1000 in 2013/14



23% of people smoke in Bassetlaw, 1% higher than the Nottinghamshire estimate (22%). All Bassetlaw wards fall in the 3 highest bands for smoking rates, with Worksop South East identified as one of the top five deprived wards in the East Midlands with an estimated smoking rate of 42%.

Over our 5 year plan we will reduce the rate of alcohol related hospital admissions per 100,000 by 14.9%, from 1588 in 2009/10 to 1352 in 2013/14



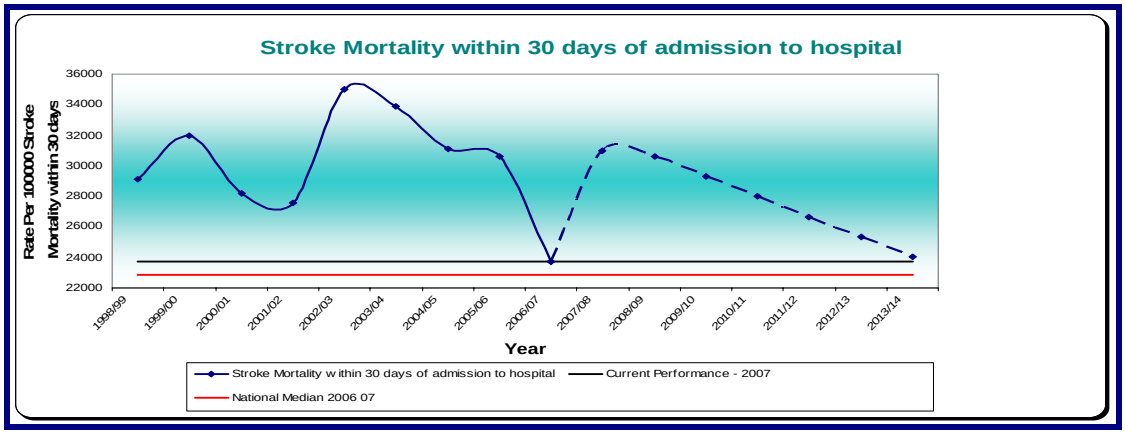
Bassetlaw has a high level of alcohol related harm and is in the worst 25% of districts in the country. There are high numbers of hazardous drinkers (more than 3-4 units per day in males or 2-3 units per day for females). Admission rates for alcohol problems are continuing to rise locally; while the mortality rate is increasing both nationally and locally.

Over our 5 year plan we will reduce the rate of hospital admissions per 100,000 for COPD and Diabetes admissions by 15%

The reduction in emergency hospital admissions will be realised via the improved management of long term conditions (LTC) in primary and community care. We are focusing here in particular on people with Chronic Obstructive Pulmonary Disease (COPD) and Diabetes. The introduction of Personal Health Planning will also encourage (where appropriate) people to take greater control and responsibility for the management of their LTC. This is one way that we plan to measure improved health outcomes within our LTC initiative.

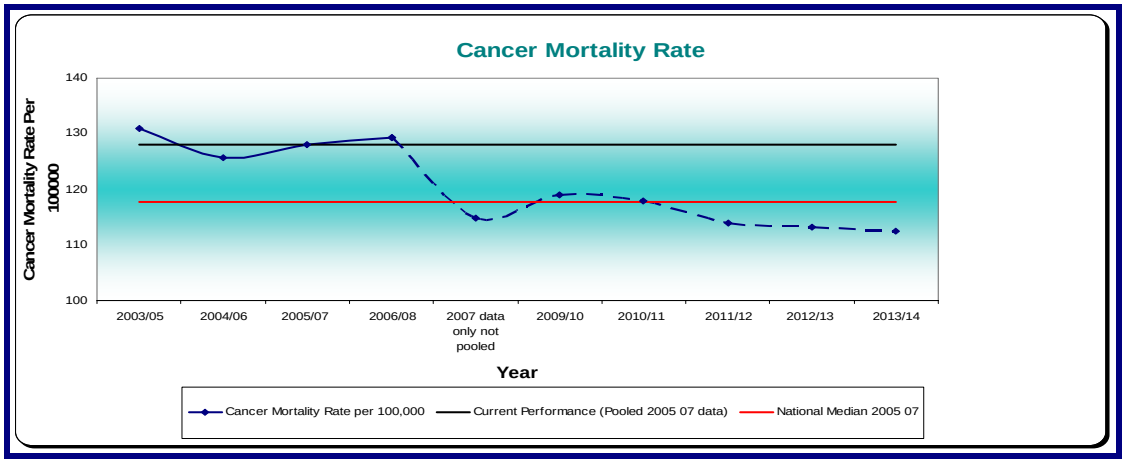
Goal 3: Improved clinical quality for our population

Over our 5 year plan we will reduce the rate (DSR) of stroke deaths within 30 days per 100,000 by 18%, from 29315 in 2009/10 to 24020 in 2013/14



Bassetlaw has performed poorly on Vital Sign 14 Stroke and has a higher than national average stroke mortality rate. As a result stroke is a major local priority in addition to being a big issue raised as part of the Our NHS Our Future (ONOF) process.

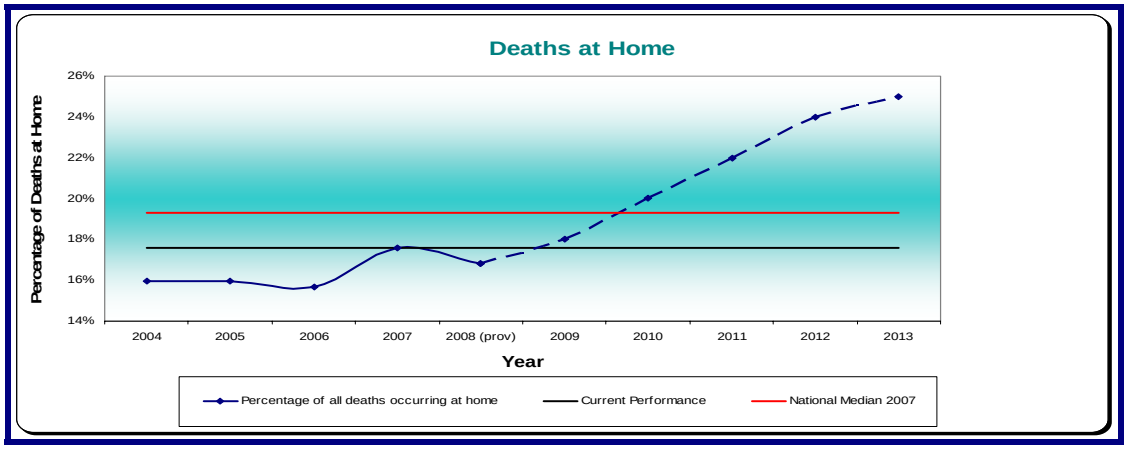
Over our 5 year plan we will reduce the cancer mortality rate (IASSR) per 100,000 by 5.4%, from 119 in 2009/10 to 112.5 in 2013/14



Cancer is the second commonest cause of death after cardiovascular disease. In 2007, 163 people aged under 75 died from cancer in Bassetlaw. The mortality rate for cancer in Bassetlaw is higher than the national average. We are therefore committed to improving the quality of cancer care for the people of Bassetlaw.

Goal 4: Improved patient experience from access to the end of life

Over our 5 year plan we will increase the % of deaths at home by 7% from 18% in 2009/10 to 26% in 2013/14. This will be achieved by providing people at the end of life with the choice to die at home.



There are around 1100 deaths in Bassetlaw every year, however fewer of them than nationally have access to services that allow a home death. There are also inequities of access within NHS Bassetlaw for patients with a non-cancer diagnosis, older people, ethnic minorities and the socially deprived.

Over our 5 year plan we will strive to be top of the regional MORI people's poll and improve on our recent MORI people's poll success by becoming nationally recognised for two WCC indicators – local service improvement and choice about treatment and care for our local residents.

4.4 Our Strategic Initiatives – Strategy and Delivery

This next section details our completed and our ongoing strategic initiatives within our 5 year plan (2009-14).

Our strategic initiatives are focused on reducing inequalities in health and increasing life expectancy by tackling the most deprived communities in Bassetlaw. We aim to increase life expectancy and reduce health inequalities in the most deprived communities to bring about a wider step change in reducing the overall level of health inequalities in Bassetlaw and increasing life expectancy for both men and women.

To successfully deliver and implement our strategic initiatives we have and will be maintaining our string commitment to partnership working maximising (where appropriate). This is comprised of a combination of collaboration with providers (acute, primary care and community), the Third sector, the local authority (district and local), clinicians, practice based commissioners and patients and the public. The specifics of partnership working for each strategic initiative are included in each of the initiative strategy and delivery plans.

In light of the financial climate we have set aside £200k per annum for social marketing to optimise the impact of our strategic initiatives. A prioritisation team will make recommendations to our Board to determine where social marketing spend is prioritised as required. In 2009/10 we have decided to prioritise our social marketing spend within our vascular and smoking strategic initiatives.

4.4.1 Our Children and Young People's Agenda

Children and Young People progress in 2009

- We have installed life channels into Children's Centres, including the design of a range of campaigns (enabling the PCT access to all their previous health/wellbeing information for 3 years).
- We have funded 2 x 0.5 whole time equivalent children's workers to support children affected by domestic violence.
- Following plans in our 2008 strategic plan we have decided not to pursue the actual mirror scheme (a programme running in NHS Doncaster around intervention in families with 9–13 year olds where there was significant risk identified). This is because we are looking at other ways of supporting families locally.
- We have continued to support disabled children in particular with short breaks for them and their families, linked to the Nottinghamshire-wide pathfinder work.
- We have agreed an SLA with Bluebell Wood Children's Hospice for their input to caring for children with life-limiting diseases; this puts their services onto a firmer footing with NHS funding in addition to charitable funding. They are also being funded to deliver some day care services, linked to the disabled children pathfinder.
- We have funded a third sector organisation which supports survivors of sexual abuse, including children.

Ongoing milestones for 2010 onwards –

- The Life Channels in Children's Centres will produce material tailored specifically for Bassetlaw to be built into wider campaigns/promotions which Bassetlaw are running, such as a campaign about keeping children safe. This gives Bassetlaw a real opportunity to tailor messages to local need.
- We are actively engaged, via the Children's Trust in Nottinghamshire, in identifying ways of working with at risk children and families to support them.
- We are a core partner in work taking place across the county to look at tackling the health related issues of children and young people via new ways of working.
- We are actively engaged in the rising governmental agenda of children and young people around Domestic Violence. We are actively engaged with the County Council to look at ways of supporting vulnerable children.
- We are commencing work in conjunction with partners about children/young people at risk of entering the criminal justice system to see if more can be done through youth offending services.
- We are committed to achieving the 10 improvement priorities in the multi agency Nottinghamshire Children and Young Peoples Plan 2009-11, via effective partnership working and commissioning:

1. Protect the most vulnerable children and young people
2. Improve educational attainment (how well children and young people achieve at school)
3. Reduce the numbers of children and young people missing school
4. Increase the proportion of 16-18 year olds who are learning or working, focusing particularly on vulnerable groups
5. Provide children and young people with more places to go and things to do
6. Reduce the amount of crimes committed by young people, and stop children and young people from being as scared about becoming victims of crime
7. Reduce the problems caused by drugs and alcohol for children, young people, families and communities
8. Improve the emotional well-being of children, young people and families
9. Reduce obesity among children and young people
10. Improve the sexual health of young people, and reduce teenage pregnancy

How our strategic initiatives focus on Children and Young People -

The children and young people's agenda has been integrated into other key strategic initiatives so that it is rigorously embedded in our plan. Key priorities with a focus on improving health outcomes for children and young people include -

Smoking –- commissioning a social marketing campaign which will reduce the uptake of smoking in young people aged under 19.

Obesity – to implement an obesity prevention programme targeted at primary school children and there families.

Alcohol – to continue to work in partnership with DAAT to commission programmes to reduce the problems caused by alcohol in children, young people and families.

Infant health – improving breastfeeding initiation and maintenance and introducing baby-led health weaning.

Cost and cost effectiveness: No new spend is projected for 2010. Currently committed spend will be honoured.

Affordability and timing: Life Channels have been paid for until 2012. A programme for 9 - 13 year olds was planned for 2011 and has now been withdrawn due to limited financial resources.

4.4.2 G1A) Older People (Reducing Falls and Fractured Neck of Femur, improving bone health and quality of life)

Lead: Older People Programme Lead **Director:** Director of Commissioning

Initiative Focus:

- To reduce the rate of avoidable hospital admissions for falls particularly for Fractured Neck of Femur (FNOF) by promoting the prevention and early identification of people at risk of falling and being admitted to hospital.
- To support patients through the development of integrated care pathways to maintain their independence and quality of life.

Progress over the last year:

- Hosting of a falls multi-agency stakeholder event with engagement from over 35 stakeholders to develop a knowledge base of all services currently provided for falls prevention and intervention within Bassetlaw.
- Development of a draft district wide Falls strategy that increases the awareness of falls in later life and promotes independence and quality of life.
- Commissioning a service within the Bassetlaw Community Health Falls team to ensure early identification, assessment and treatment of people at risk of falling or who have fallen.
- An evaluation of current physical exercise and activity options available within the local community, which support the prevention of frailty and preserve bone health in older people. In particular, reviewing the availability of evidenced based exercise programmes to maintain balance and postural stability.
- Development of an evidenced based activity programme in collaboration with the local authority to promote physical activity with frail older people.

The main impact of this initiative to date has been to engage with representatives from all agencies committed to the falls prevention agenda and to secure agreement for the need to integrate services across the whole care pathway by developing effective partnerships.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

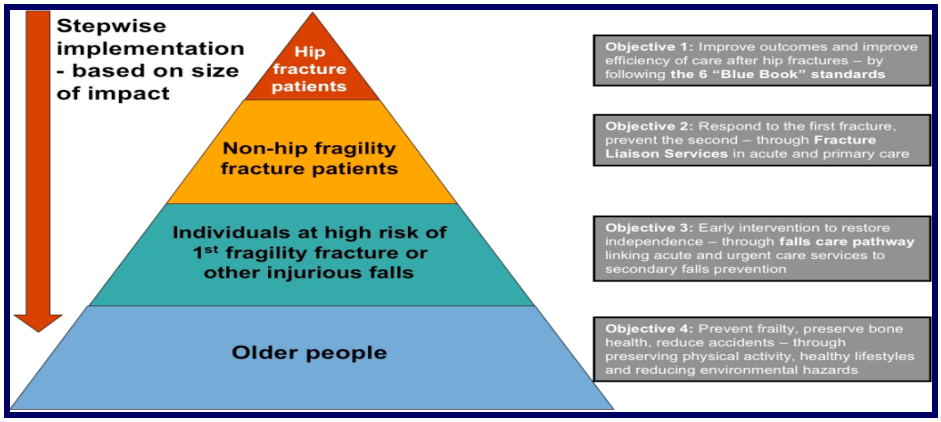
Mission: Improving quality and length of life by reducing falls in older people.

Vision: Support for prevention focused services.

Strategic Goal: Prevention of ill health.

Outcomes: Reduction in hospital admissions for Fracture neck of femur (FNOF), life expectancy and all age all cause mortality.

National Fit: The DH (July, 2009) introduced a Prevention Package for Older People, to raise the focus on older people's prevention services and to promote well being and independence. This comprises resources for falls and fracture care in relation to effective interventions in health and social care, development of a local JSNA, and exercise training to prevent falls and foot care. The diagram over the page defines the four key areas of intervention -



(DH, 2009)

This initiative is also aligned to NICE guidance 21 (2004) which states that all front line health staff should routinely ask people if they have fallen in the last 12 months, also noting the nature, characteristic, and context of the falls. The RCP National Audit of the Organisation of Services for Falls and Bone Health for Older People (2009) highlighted the need for more opportunistic case finding to identify those at risk of falls. Additional national guidance which supports the falls prevention agenda includes - NSF 2001 Older People; NICE Guidelines 2004; A New Ambition For Old Age (DH, 2006); Our Health, Our Care, Our Say (DH 2006); The British Orthopaedic Association standards; Care of Patients with Fragility Fractures (2007) and 'Be active, Be Healthy' (DH, 2009).

Regional Fit: The East Midlands Government office is strongly advocating the DH Prevention Package (2009) best practice toolkit for falls prevention across the region. This initiative also fits with the LAA, working collaboratively with the local authority and voluntary sector to address falls prevention and frailty.

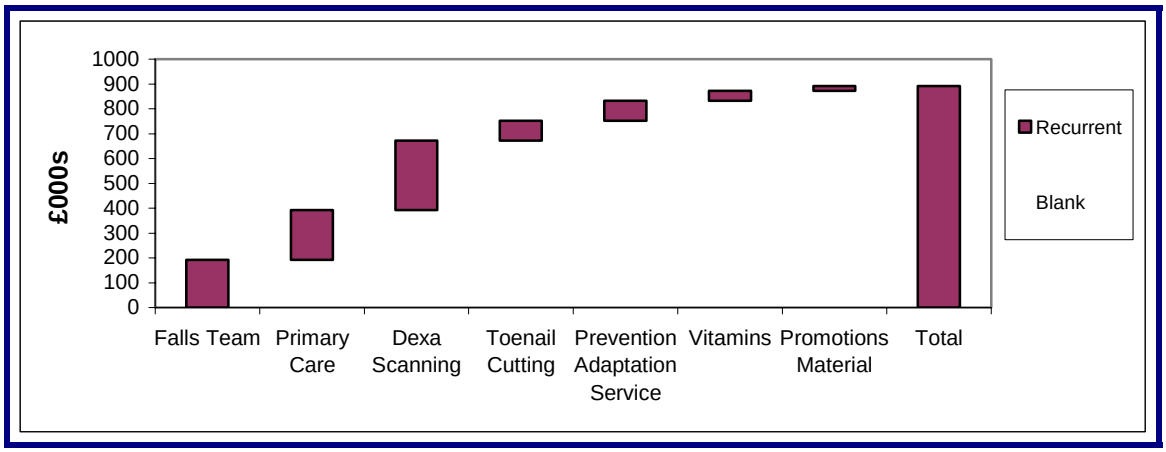
Local Fit: Admission rates for falls and fractures are significantly higher in Mansfield, Ashfield and Bassetlaw compared to Newark and Sherwood, although there is no significant difference in the mortality rates (JSNA, 2008).

2. Evidence of need: All older people aged 65 and over irrespective of their gender, culture and ethnicity, and those over 50 with clinically apparent fragility fractures (DH 2009) will benefit from falls prevention. Bassetlaw has the worst rate of FNOF for over 65s in Nottinghamshire with associated high disability and death rates which are largely preventable. Bassetlaw sits within the worst quintile in the East Midlands and is significantly worse than the England average (579.2 in Bassetlaw verses 479.8 respectively DSR 2006/7) for which early identification will reduce risk. Also rates of death for women in Bassetlaw have decreased but are still higher than the English average. The falls prevention initiative will address this by identifying women early on who have poor bone health and who are at risk of fractures and associated disability and death.

3. Health impact: The falls initiative will have a significant impact on the retention of independence of older people living at home by reducing the risk of falling and associated disabilities. It will increase life expectancy by the prevention of falls and fracture promoting health and well being.

4. Impact on health inequalities: There are variations in fracture rates within and between the wards in Bassetlaw. There is a direct correlation between FNOF and known deprived neighbourhoods. Reducing the incidences of FNOF will bring Bassetlaw in line with other areas in the region as well contributing to reducing the death rate for women in particular.

5. Cost and cost effectiveness: The falls initiative will require a strategic investment of £1.1m over the 5 year plan. However, the initiative will also result in significant disinvestment in relation to the associated costs of FNOF admissions.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	40	213	213	213	213	**892**
Non-recurrent Cost	-	-	-	-	-	**-**
Disinvestment	-	- 149	- 387	- 622	- 867	**- 2,025**
Net Cost	40	64	- 174	- 409	- 654	**- 1,133**

The initiative aims to reduce the admission rate for FNOF from 583 per 100,000 to 450 per 100,000 by 2013/14, saving 157 admissions for FNOF in 2013/14 and 370 during the 5 year period. There will also be an associated cost saving with the reduction in admissions. This has been estimated at £1m over the 5 year period. The falls project would therefore represent a net saving to the PCT of more than £1m over 5 years.

6. Affordability and timing: Bassetlaw's spend in the area of trauma and injuries are higher than both the national average and its peers. In 2007/08 Bassetlaw spent £62 per head of population (unified weighting) on trauma and injuries compared to £57 nationally and £56 amongst Bassetlaw's peers. This initiative will reduce the required spend in this area associated with reduced admissions for falls. The reduction in falls and FNOF admissions are expected to follow quickly from the investment with the benefits from a reduction in admissions also being realised quickly.

7. Patient demand: There is a general realisation that there is a significant need for this service but currently this is not quantifiable. However it is well documented that a third of older people aged 65 and over will fall in a year and this will increase to 45% in those aged 80 and above. Given that there is increasing evidence that the number of falls will rise as people are living longer demand for this service will increase. Therefore preventing older people falling is the key challenge through raising awareness.

8. QIPP

Quality: Promotion of health, well being and independence in older life.

Innovation: Recognition of the need for a more integrated approach across all stakeholders to develop a seamless pathway of care with a focus on the early prevention and early intervention of falls.

Productivity: Reduced costs associated with hospital admissions for FNOF.

Prevention: Reduced A/E attendances, hospital admissions, length of bed stay and mortality rates following falls. Promotion of bone health by identifying people at risk of potential secondary fractures and promotion of falls awareness in the population and associated risk factors will contribute to the prevention of dependency.

9. Delivery

Start Date: 2009 **End Date: 2014**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Decrease the rate of hospital admissions per 100,000 for FNOF by 9.8% from 580 to 523	▪ Cost saving of reduced hospital admissions for FNOF of £0.5m by year 3
Year 5 (2013/14)	Decrease the rate of hospital admissions per 100,000 for FNOF by 14% from 523 to 450	▪ Cost saving of reduced hospital admissions for FNOF of £2.0m by year 5

Milestones (PEC approved Dec 2009)	Delivery Date
Organisational change ▪ Agree service outcomes required ▪ Negotiate with Provider services in review of service specifications ▪ QIPP analysis and apply fresh thinking to investments ▪ Medication review and management ▪ Co-ordinate appropriate access to services	Feb 2010
Partnership Working ▪ Development of District wide strategy to support falls prevention ▪ Development of a fully integrated seamless care pathway, agreed at strategic level ▪ Integration of services between all providers ▪ Integrated discharge planning from A&E to Primary care ▪ Bi yearly focus meetings with all stakeholders to cement ownership and delivery of the falls prevention agenda and delivery targets ▪ Case finding of people needing prevention support in primary care ▪ Agreement on role of primary care in prevention and ongoing care	March 2010 March 2010 April 2010
Compliance with NICE guidelines and audit findings ▪ Promote opportunistic case finding. All frontline staff should routinely ask people whether they have fallen in the past year, and the context of the fall ▪ Medication review within multi factorial falls risk assessment (Falls team) ▪ Education and training all frontline staff in recognising when older people are at risk of falling	April 2010
Commissioning key actions- level 2 and 4 on commissioning triangle ▪ Adaptation scheme ▪ Early identification ▪ Home foot care service ▪ Implementation of revised pathway ▪ Increased Dexa Scans ▪ Supply of supplements to housebound and care home residents ▪ Promotion of falls awareness	 2009 Sept 2009 Apr 2010 Apr 2010 Apr 2010 Apr 2010 Apr 2010

NHS Bassetlaw capability and capacity: Bassetlaw Community Health has a falls team. This has the capacity to deliver and support the prevention agenda. The workforce is in post and smarter/effective ways of working will be required to ensure that the initiative is a key success by reducing the number of avoidable hospital admissions for falls. Currently over 25% of referrals do not merit a full assessment. Current capacity is difficult to assess as it is only measured by face-to-face contacts. There is a need to

develop more relevant performance indicators to demonstrate capacity with regards to the actual number of people accessing the service, the number of people who require intervention and the health outcomes.

Organisations engaged in the initiative: Primary care, Bassetlaw Community Health, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, EMAS, Adult Social Care, Local Authority, voluntary sector, independent sector care homes, service users and lay representatives.

Provider implications: A review of the community falls team referral process is required to ensure alignment with NICE guidelines, as referral numbers have significantly increased since it was established in 2004. The newly developed falls prevention strategy will encourage choice and plurality of falls services across Bassetlaw in addition to the existing community falls team.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to support effective delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of Success: A reduced rate of hospital admissions for FNOF per 100,000 by 22.41% over 5 years.

4.4.3 G1B) Infant Health (A)

Lead: Service Development Manager **Director:** Pubic Health Consultant

Our Maternity success story

The situation	Establishing a direct service for pregnant women in Bassetlaw
What we did in 2009	The maternity direct access service was set up to enable women to contact a midwife either by telephone, text message or email. The service then arranges for a named midwife to contact the woman to arrange a suitable time for first contact with the women, or alternatively signposts them to the pregnancy termination service. We wanted to improve the uptake of this service amongst key groups. To do this we developed a social marketing campaign. A credit card resource and health promotion leaflet was developed as a result of the campaign and these are to be distributed widely across Bassetlaw. A leaflet details what support a health professional can provide during the early weeks of pregnancy, important lifestyle choices and changes, stressing the importance of early contact within 12 weeks gestation. It also contains the contact details of how to make contact with a midwife which complements the credit card resource. There is also a space for women to write in the name of their midwife and appointment time.
Impact and ongoing delivery	The delivery of the direct access maternity service continually exceeds the Vital Sign target. The evaluation of this service is currently being completed by the Acute Trust. As a result of the service women in Bassetlaw are more widely educated on safe pregnancies, such as not smoking whilst pregnant and encouraging breastfeeding following birth. The service therefore supports the work undertaken by a number of our strategic initiatives - Infant Health A and B and the smoking.
WCC Competency	3, 4, 8, 9

Initiative Focus: To improve women's maternity care, with a focus on antenatal and postnatal episodes.

Progress to over the last year:

- Development of a dedicated maternity service specification, an integral part of the DBH contract.
- Dedicated maternity section of the DBH Quality Schedule.
- Design and implementation of the Integrated Maternity and Child Health Pathway.
- Implementation of the Direct Access to Maternity Services with recurrent investment for the recruitment and retention of maternity staff. This £495,000 investment has supported the recruitment of a total of 15.5 WTE maternity team staff members (Labour ward midwives (5wte); Labour ward healthcare support workers (3wte); Labour ward housekeepers (4wte); Community midwives (2wte); Specialist midwives (1.5wte). These roles will support the Breastfeeding, Screening and Parent education/Obesity agenda.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improving health for women and children in Bassetlaw.

Vision: Supporting Bassetlaw's prevention focused agenda.

Strategic Goal: Prevention of ill health.

Outcomes: Infants Breastfed, Average All Age All Cause Mortality and Life Expectancy.

National Fit: VSB06 - Early Access for Women to Maternity Services and implementation of Maternity Matters and Healthy Child Programme. The Bassetlaw integrated pathway pulls together the core deliverables of the Healthy Child Programme and national clinical guidance from NICE for antenatal, intrapartrum and postnatal care.

Regional Fit: Maternity care is a key priority for PCTs in the East Midlands (East Midlands SHA strategic plan, 2009).

Local Fit: NHS Bassetlaw has worked with local partners to develop local pathways for the delivery of integrated universal services for children 0 – 5yrs.

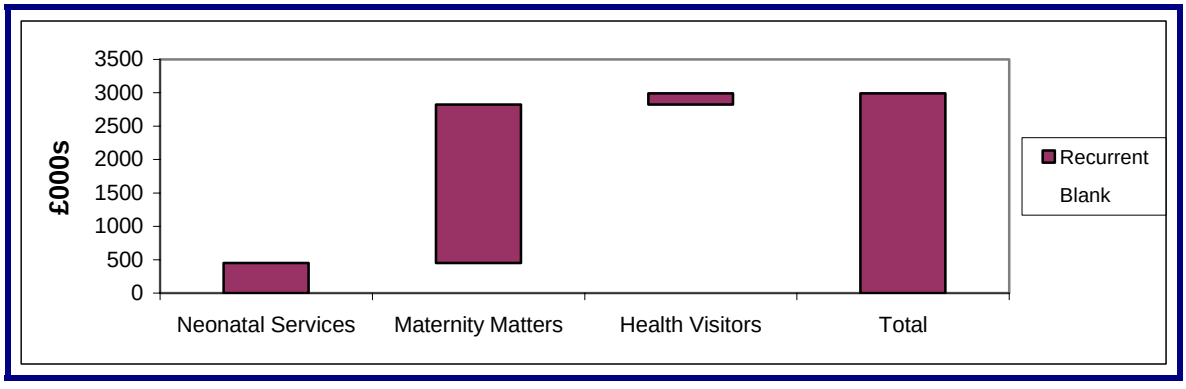
2. Evidence of need: There were 1200 births in Bassetlaw last year. The infant health (A) initiative supports maternities, families, carers and babies in Bassetlaw. The number of children and families who will benefit from the Integrated Maternity and Child Health Pathway on a yearly basis is estimated at 7900 children.

3. Health impact: Pregnant women will have access to maternity services prior to 12 weeks gestation providing a collaborative approach to antenatal care tailored to individual need. The infant health A initiative also supports the promotion of health for children 0-5 years.

4. Impact on health inequalities: Women and their partners will receive a high quality service supporting the following known health inequalities:

- Infant Mortality: Although the causes are complex and varied mortality is linked to social well being and access to antenatal services.
- Maternal Mortality: Maternal deaths are extremely rare but women who are in poorer overall health care, smoke, overweight or who are obese are at higher risk of maternal death. Low Birth Weight has a strong association with maternal smoking and stress and anxiety.
- Caesarean sections: Women who opt for an elective section increase the risk of maternal death, surgical complications and for following pregnancies premature birth and foetal injury.

5. Cost and cost effectiveness: Strategic investment over the 5 year period of £3m. The majority of this (£2.4m) is to be invested in the midwifery workforce to deliver "Maternity Matters".



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	545	612	612	612	612	**2,993**
Non-recurrent Cost	-	-	-	-	-	**-**
Disinvestment	-	-	-	-	-	**-**
Net Cost	545	612	612	612	612	**2,993**

6. Affordability and timing: Bring Bassetlaw's spend closer to that of its peers and the national average in the programme budgeting area of maternity and reproductive health. In 2007/08 Bassetlaw spent £54 per head of population (unified weighting) on maternity and reproductive health compared to £59 nationally and £57 amongst Bassetlaw's peers.

7. Patient demand: A service user questionnaire was completed by 90 women at varying stages of the maternity pathway. The outcome of the survey highlighted the need to improve existing services, consistency and high quality maternity care. Service users were also represented on the NHS Bassetlaw working groups. In these forums service users supported the development of a range of initiatives including the Direct Access Service. Service users were also represented at a stakeholder development event. This workshop provided an opportunity for stakeholders to support the development of the Integrated Maternity and Child Health Pathway.

8. QIPP

Quality: The supervisor of midwife ratio is 1:12, achieved in September 2009. 85% of all patients will have direct booking access to a community midwife at 12 weeks (subject to patient choice). Provide choice about place of birth, midwifery lead/maternity team lead, and increase home births.

Innovation: Collaborative approach between health and social based services to delivery antenatal and postnatal care. Services will be provided closer to home in facilities in the community e.g. Children's Centres.

Productivity: Reduction in Length of Stay and overall number of caesarean sections (CS).

Prevention: 100% of pregnant women with a BMI > 35 at the time of booking are offered a referral for a weight management programme, increasing breastfeeding initiation.

9. Delivery

Start Date: April 2009 **End Date: 2014**

Key Milestones	Delivery Date	Slippage
Maternity services in line with national policy and recommendations. Shifting services from primary care to community based services in a range of settings such as Children's Centres	2009/2010	No
Ensure that all women are booked with a maternity professional by 12 week gestation		
Implement infrastructure to improve homebirth rates – Reduction in hospital based deliveries		
Further develop neonatal services across the network to ensure compliance		
Review workforce (DBH midwifery & NHS Bassetlaw Health Visitor)		
Effective and consistent preconception care for all women via proactive provision of health promotion advice which is consistent and high quality	2011/2012	

Risk to delivery	Impact	Likelihood	Mitigation
Workforce Capacity - Recruitment & Retention	M	M	Ensure good working conditions for our maternity staff

Partnership working - Achieve consensus of PBC Commissioners and other stakeholders	M	M	Maintain good engagement with our PBC commissioners and other stakeholders

Organisations engaged in the initiative: NHS Bassetlaw - Provider Arm, Doncaster & Bassetlaw Hospitals NHS Foundation Trust, Bassetlaw Sure Start Children's Centres, and Bassetlaw Primary Care.

Provider implications: Provision of health promotion will be provided as an extra choice for women in Bassetlaw. The plurality of provision has increased as a result of the review of the DBH Maternity workforce.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to ensure effective delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD Programme Management, Board Leadership, Commissioning Competence and Staff training initiatives.

Measure of Success: Successful performance on the 'Early Access for Women to Maternity Services' vital sign VSB06.

4.4.4 G1B) Infant Health (B)

Lead: Infant Health Improvement Coordinator **Director:** Pubic Health Consultant

Initiative Focus: To increase breastfeeding rates in Bassetlaw in partnership with Doncaster and Bassetlaw Trust, Bassetlaw Sure Start Children's Centre, and Bassetlaw National Childbirth Trust (NCT).

Progress over the last year:

- Registered with UNICEF Baby Friendly Accreditation
- Established partnership working with Provider Arm, Children's Centres, Midwifery & NCT
- Developed breast feeding training schedule
- Breastfeeding policy approved
- NHS innovation fund bid successful for breastfeeding peer counsellors training
- Scoping of a Patient Group Directive for antibiotic treatment to provide a more timely service to mothers with mastitis

Collaborative working has been the key to the progress made so far. The VSB11 targets are on schedule for both coverage and prevalence.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improved health and the quality of life for infants and mothers in Bassetlaw.
Vision: Supports Bassetlaw's focus on prevention of ill health.
Strategic Goal: Prevention of ill health.
Outcomes: Infants breastfed, Life expectancy and Average All Age All Cause Mortality.

National Fit: Prevalence of breast feeding at 6-8 weeks (VSB11); Alignment with the government agenda on improving health outcomes for children and mothers and reducing health inequalities. National policy priorities highlight the need for improved infant nutrition, (WHO, 2003; NSF Children, Young People & Maternity Services, 2004; The Children's Plan 2007), reducing childhood obesity (Healthy Weight Healthy Lives, 2008), and reducing health inequalities (Health Inequalities - progress and next steps 2008).

Regional Fit: Prevalence of breast feeding at 6-8 weeks is a key indicator of child health and is included in PSA 12, monitored through Vital Signs and NHS Bassetlaw quarterly SHA report.

Local Fit: Bassetlaw has the lowest initiation rate in Nottinghamshire and acknowledges that the Priorities and Planning Framework (PPF) target is to deliver an increase of two percentage points per year in the breast feeding initiation rate (JSNA, 2008).

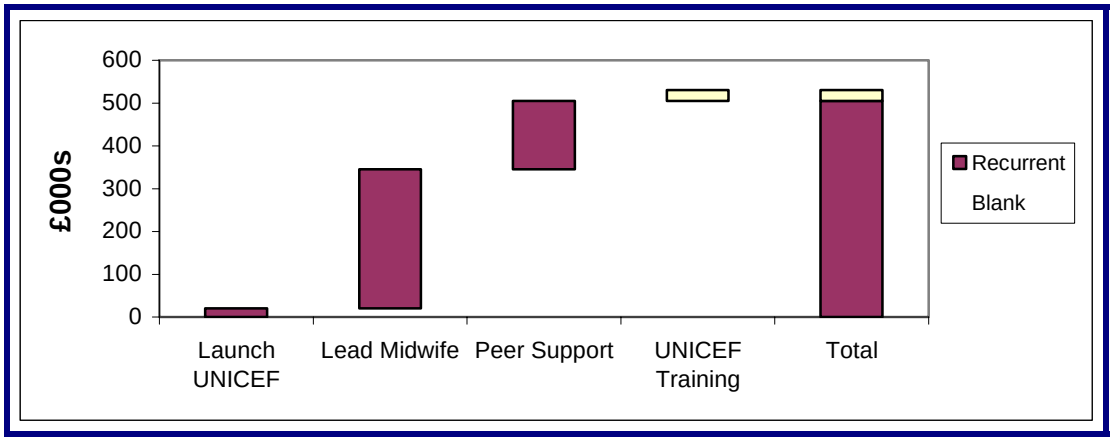
2. Evidence of need: Breast feeding rates in Bassetlaw are amongst the lowest in the East Midlands (JSNA 2008). We are currently achieving 37% (breastfeeding at 6-8 weeks) and working in collaboration with other partners to improve on this. Our target by 2014 is a rate of 52%. In Bassetlaw there are approximately 1200 births a year, of which 43 infants were admitted for gastric-infections during 2008/09.

3. Health impact: Breast feeding supports a reduction of type2 diabetes and breast and ovarian cancer for mothers. For single/low income mother's recent studies suggest that breast feeding supports parenting capability. Children who are breastfed also have improved health benefits with a reduced risk of hospitalisation, lower cholesterol and blood pressure in adulthood. Not breast feeding has significant health risks for both child and mother. Artificially fed babies are at greater risk of gastro-intestinal, urinary, ear and

respiratory infections, necrotising enterocolitis and hospitalisation as a result, allergic disease, obesity, and type 1&2 diabetes (Breast feeding, Maternal & Infant Health Outcomes, 2007). Hospital admissions for infections of infants under a year reduce as breast feeding rates increase.

4. Impact on health inequalities: Significant health inequalities exist in Bassetlaw with almost a quarter of the population living in the 20% most deprived areas in England (JSNA 2008). The duration of breast feeding rates are lowest among families from lower socio-economic groups adding to the inequalities in health and contributing to the perpetuation of the cycle of deprivation (Hamlyn et al, 2002). Bassetlaw is working towards a positive culture of breast feeding. This will be achieved by targeting families who are least likely to breastfeed, such as low income single mothers and teenage mothers with Peer Support work, and by improved support to mothers from skilled professionals.

5. Cost and cost effectiveness: A strategic investment of £0.5m is required over the 5 year period. The majority is an annual cost of £65,000 for a specialist lead midwife to improve the continuity and to improve the breastfeeding rate at 6-8 weeks.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	69	109	109	109	109	**505**
Non-recurrent Cost	-	10	5	5	5	**25**
Disinvestment	-	-	-	-	-	**-**
Net Cost	69	119	114	114	114	**530**

Breast feeding continuity at 6-8 weeks will be increased from 37% to 52%. By 2013/14 approximately 170 more infants will be breastfed in Bassetlaw at 6-8 weeks. During the 5 year period this is a total of 340 additional infant's breastfed. Cost savings will be realised from a reduction in admissions of infants for of gastro-intestinal, urinary, ear and respiratory infections, necrotising enterocolitis, with further cost savings accruing due to the health gain for both the mother and infant in the long term.

6. Affordability and timing: Bassetlaw's spend will be aligned closer to its peers and the national average in the programme budgeting area of maternity and reproductive health. In 2007/08 Bassetlaw spent £54 per head of population (unified weighting) on maternity and reproductive health compared to £59 nationally and £57 amongst Bassetlaw's peers. Increased breast feeding rates are expected to follow very quickly from the investment with short term benefits from a reduction in infant infections. Larger benefits from the reduction in obesity and improved health of mothers are likely to accrue beyond the scope of this strategic plan.

7. Patient demand: The UNICEF Baby Friendly Accreditation audit planned for January 2010 will give an indication of what mothers feel about current feeding support in Bassetlaw.

8. QIPP

Quality: Improved quality of service provided for pregnant and breastfeeding mums which will impact on breastfeeding initiation and maintenance rates.

Innovation: Multi-faceted approach needed to increase breastfeeding rates which include improving skills and knowledge of professionals and developing peer support to see how mothers can be prompted to breastfeed.

Productivity: Fewer admissions due to infant infections. Reduced risk of developing obesity and associated conditions.

Prevention: Prevention of childhood obesity and range of childhood infectious diseases.

9. Delivery

Start Date: 2009 **End Date: 2014**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Increase the % of infants breast fed by 7.2% from 35.3% to 42.5%	▪ Fewer childhood infections ▪ Reduced risk of increasing childhood obesity levels ▪ Improved health prospects for mothers
Year 5 (2013/14)	Increase the % of infants breast fed by 8.5% from 42.5% to 51%	

Key Milestones	Delivery Date
Certificate of commitment from UNICEF Baby Friendly Accreditation	2009/2010
Stage 1	2010/2011
Stage 2	2011/2012
Stage 3	2012/2013

Risk to delivery	Impact	Likelihood	Mitigation
Data collection insufficient	High	Medium	Retrospective data collection and follow up with provider arm if coverage target not met.

Organisations engaged in this initiative: Bassetlaw Hospital, Bassetlaw Sure Start Children's Centres, NHS Bassetlaw, NHS Bassetlaw Provider arm, and GP 'champion' non PEC member.

NHS Bassetlaw capability and capacity: A full time Infant Health Improvement Coordinator has been appointed in Public Health to adopt a multi-agency approach working with healthcare providers; Sure Start; and the Voluntary sector, to raise breast feeding rates at 6-8 weeks and to project manage the UNICEF Baby Friendly Accreditation. NHS Bassetlaw also commissioned a 0.5 wte Infant Feeding Coordinator to increase initiation rates at Bassetlaw hospital.

Provider implications: NHS Bassetlaw provider arm is committed to the UNICEF BFI accreditation.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of success: Increasing the % of infants breast fed by Increase by 15.71% over the next 5 years and achieving VSB 11 (Prevalence of Breastfeeding at 6-8 weeks)

4.4.5 G1C) Obesity

Lead: Health Improvement Principal **Director**: Public Health Consultant

Initiative focus: To commission the following -

- A universal obesity prevention programme targeted at the whole population
- A selective obesity prevention programme targeted at high risk individuals and population groups
- An indicative obesity prevention programme targeted at individuals with existing weight problems
- Evidenced based coordinated weight management programmes targeted at those in need, delivered in a range of settings across Bassetlaw

Progress over the last year:

- Introduction of a LES (Local Enhanced Service) agreement for weight management (WM) with GP practices to deliver weight management programmes
- An evidenced based weight management training programme developed and delivered to practice leads working to the weight management LES, with the aim of promoting consistency in the delivery of WM programmes
- An evidenced based community weight management programme developed (ZEST WM Programme)
- A brief intervention WM training programme developed to provide consistent key messages and appropriate referral into local WM programmes
- Conducted a gap analysis to ascertain current level of tier 1 services available across the area (to enable flow up and down from tier 2 services)
- A series of cook and eat sessions delivered across children's centres
- A holistic exercise referral programme being delivered across Bassetlaw
- A comprehensive range of physical activity programmes being delivered across the district

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improving health and quality of life for the people of Bassetlaw.

Vision: Supporting prevention focused services.

Strategic Goal: Prevention of ill health.

Outcomes: Childhood Obesity, Life expectancy and Average All Age All Cause Mortality.

National Fit: The obesity initiative is in line with national strategic guidance as detailed within 6 priorities within Choosing Health (2004), Healthy Weight Healthy Lives (2008), Delivering Choosing Health (2005) and 'Be Active Be Healthy' (2009).

Regional Fit: In line with the East Midlands Evidence to Excellence (2008), The East Midlands Food and Health Strategy (2006) and the Nottinghamshire Health Weight Healthy Lives (2009).

Local Fit: The Nottinghamshire Sustainable Community Strategy, prioritised within the Local Area Agreement (LAA), (Priority 7), NI 55 obesity among primary school age children in reception year and linked to community cohesion, Priority 3 of the Nottinghamshire LAA as measured by NI 8 - adult participation in sport. Bassetlaw Local Operating Plan (LOP); Health Local strategic partnership (LSP); Priority 2; Bassetlaw Obesity Forum; the Bassetlaw Food and Health Forum; and the Bassetlaw Sports and Physical Activity Forum.

2. Evidence of need: 2. Evidence of need: 27.6% of Bassetlaw residents are estimated to be obese. 10.5% of our reception year children and 19.2% of our Year 6 Children are obese. Only 23.1% of adults are currently eating the recommended 5 portions of fruit and vegetables a day which is the national indicator used to assess a healthy diet. It has been estimated that 88.9% of adults in Bassetlaw are failing to meet the minimum level of physical activity need for health. In addition only 86.4% of children are currently participating in a minimum of 2 hours good quality PE and school sport per week which is significantly worse than the England average. The quality of the diet n the community and levels of physical active, along with energy balance are key determinants of weight gain, leading to overweight and obesity. There is a clearly identified need to address diet, physical activity and energy balance within our population to prevent further incidence of obesity and to reduce the prevalence of overweight and obesity in our population.

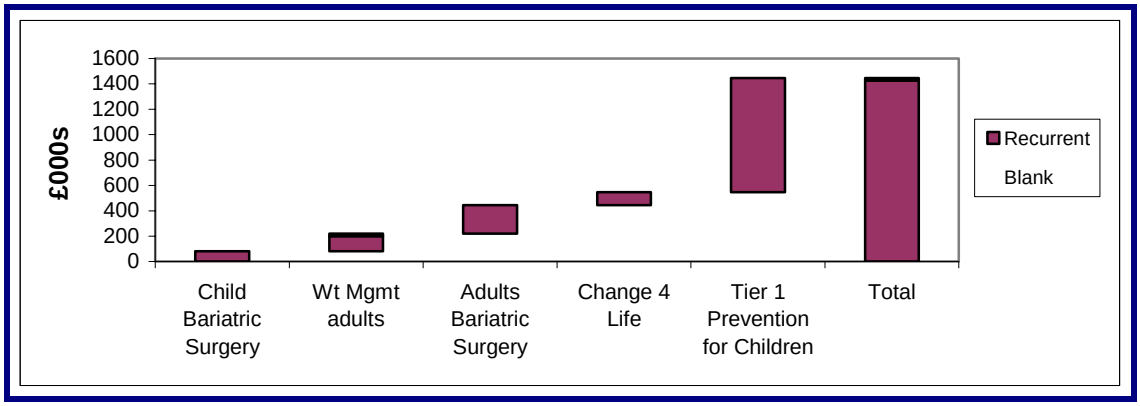
3. Health impact: Obesity is a complex multi-factorial condition which has a significant impact on both physical health and psychosocial well-being. Being overweight or obese has adverse metabolic effects on blood pressure, cholesterol, triglycerides and insulin resistance. Health problems associated with obesity include respiratory difficulties, chronic musculoskeletal problems, skin problems and infertility. The more life-threatening problems fall into four main areas: Cardiovascular disease; conditions associated with insulin resistance such as type 2 diabetes; certain types of cancers, especially the hormonally related and large-bowel cancers; and gallbladder disease.

Obese adults are up to 80 times more likely to develop type 2 diabetes than non obese adults. Particularly worrying is the increasing number of children who are developing type 2 diabetes; a rare occurrence 30 years ago. Raised BMI also increases the risks of cancer of the breast, colon, prostate, endometroium, kidney and gallbladder. Chronic overweight and obesity contribute significantly to osteoarthritis, a major cause of disability in adults. Although obesity should be considered a disease in its own right, it is also one of the key risk factors for other chronic diseases. Risk estimates suggest that approximately 75% and 65%of the cases of hypertension in men and women are directly attributable to overweight and obesity increases the risk of CHD by 2 to 3 times. Mortality from cancer in non-smoking obese people increases by around 40% compared to non obese people.

Levels of overweight and obesity continue to rise in our population. Current trends suggest that around 8% of obese 1-2 year old children will be obese when they become adults, while 80% of children who are obese at age 10-14 will become obese adults, particularly if one of their parents is obese. The Health Profile for Bassetlaw (APHO 2009) estimated that 27.6% of adults are currently obese. The National Child Measurement Programme (2008-2009) shows that 10.5% of reception year children, increasing to 19.2% for year 6 children are obese. Effectively preventing and managing obesity in the population would have a significant impact on improving physical health and psychosocial well-being. Implementing obesity prevention strategies is the most sustainable way of reducing the incidence and prevalence of obesity in our population. Achieving a weight loss of 5-10% in obese people can also bring significant health gains.

3. Impact on health inequalities: There are strong links with deprived areas having higher prevalence of obesity, within Bassetlaw these are Worksop South East, Langold and Harworth. Approximately two thirds of adults were unaware of the government guidelines for physical activity targets and the need to eat healthy food. The problem in Bassetlaw requires a coordinated holistic approach, targeting whole families and people across the generations, working at core prevention and also targeting those already overweight or at risk from future weight gain. The impact on inequalities across the region should be in line with national guidance, although the East Midlands region has a higher than average national prevalence of obesity compared to national trends not only among adults but children also, with 23% of boys and 30% of girls between 2-15 being overweight or obese. This is being targeted through regional strategies including Evidence to Excellence (2008), and the East Midlands Food and Health Action Plan (2006) and Food and Health Forum.

5. Cost and cost effectiveness: Strategic investment of £1.4m over a 5 year period.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	65	235	325	400	400	**1,425**
Non-recurrent Cost	-	20	-	-	-	**20**
Disinvestment	-	-	-	-	-	**-**
Net Cost	65	255	325	400	400	**1,445**

The initiative aims to decrease the prevalence of obesity primarily in children of reception age from 10.5% to 9.5% by 2013/14. While this initiative is unlikely to yield short term financial benefits, the long term benefits of reducing the prevalence of obesity in NHS Bassetlaw will improve the health of the population and reduce demand for services.

6. Affordability and timing: Focusing on obesity brings Bassetlaw spend closer to its peers and the national average in the programme budgeting area of healthy individuals. In 2007/08 Bassetlaw spent £29 per head of population (unified weighting) on maternity and reproductive health compared to £31 nationally and £33 amongst Bassetlaw's peers. A time lag is anticipated between the investment and the reduction in childhood obesity, as most of the investment is to be in primary prevention. The most significant benefits in terms of health gain for the population and cost savings for NHS Bassetlaw from reduced demand on services are unlikely to be seen within the period of this strategic plan.

7. Patient demand: Our Chrysalis weight management programme had over 100 patients on the waiting list earlier this year, and there are queries from local people on a regular basis with reference to what services are available locally to support weight management.

8. QIPP

Prevention: Prevention of the onset of obesity in children in Bassetlaw will lead to long term health gains in terms of diseases associated with obesity.

9. Delivery

Start date: 2009/10 **End Date: 5 years**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Decrease the prevalence of obesity in reception year by 0.71% from 11.01% to 10.3%	▪ Improved long term health outcomes for children in Bassetlaw ▪ Decreased need for health services in Bassetlaw to support obese children
Year 5 (2013/14)	Decrease the prevalence of obesity in reception year by 1.7% from 10.3%% to 8.6%	

Key Milestones	Delivery date
Implement Change for Life programme across Bassetlaw	2010/11
Introduce interventions to establish healthy eating and adequate levels of physical activity in children centres and other early year's provision	
Introduce interventions in all primary schools which will increase the number of children who are eating a healthy diet	
Introduce interventions in all primary schools which increase then number of children who are participating in one hour's physical activity a day	
Introduce a family centered programme to increase healthy eating and physical activity opportunity for families	

Risk to Delivery	Impact	Likelihood	Mitigation
Professionals do not engage with the programme	High	Low	Specification includes requiring to liaise with al relevant agencies, local needs
Children and young people and families do not engage with programme	High	Medium	Specification requires provider to have had experience of working with this client group, make services child and family centred and ask views of users and potential users

Organisation engaged in the initiative: GP practices, Bassetlaw Obesity Forum, the Bassetlaw Food and Health Forum, the Bassetlaw Sports and Physical Activity Forum, and the locally enhanced weight management service.

NHS Bassetlaw Capability and Capacity: Quality and capacity within current services are improving through the development and delivery of the new interventions being implemented. More coordination and investment is needed to develop a menu of services/interventions across the district, aimed at all age groups and across the four tiers.

Provider Implications: NHS Bassetlaw provider functions will need to be reoriented to deliver key outcomes in obesity prevention for the population, in particular children and families. This will be achieved through the contracting process. There is an SLA for the acute provider for a dietician who works on the wider obesity agenda. This contract will be assessed to ensure that it is delivering outcomes which achieve the key strategic actions. There is also an SLA with the local authority (district) for exercise referral/active living. This will be reviewed and updated to ensure it is delivering outcomes which are consistent with those in the strategic initiative targets. A LES with GP practices is already in place; this will need to be extended so that all patients in the district can access services. GP's have been involved in the LES. Providers will be involved in the contract negotiation process. As the focus of the initiative has changed the plan is to hold an obesity summit involving key stakeholders (including providers) to shape the initiative development and implementation plan.

Obesity prevention will only be achieved though effective partnership working. Work will be undertaken outside of the health services to reflect the fact that obesity is essentially a social problem with health consequences. The population will have greater choice and opportunities for eating a healthy diet and participating in adequate levels of physical activity. The health economy will benefit more from investment in the management agenda than the prevention agenda in the short term Reduction in obesity incidence and prevalence will have a significant longer term impact on the health economy. There is an issue to be addressed about offering patients wider choice of weight management opportunities. Currently one practice sub contracts to weight watchers – there may be a need to assess the procurement of adult weight management services to offer greater choice and flexibility.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of success: A decrease in the prevalence of obesity in reception year by 2.41% over 5 years. This will be achieved by having services in place that are used to capacity by Bassetlaw residents from all across the district, for long term weight reduction which are also well evaluated by service users.

Improved performance against VSB09 – Childhood obesity

4.4.6 G1D) Vascular

Lead: Head of Commissioning **Director:** Director of Primary Care

Our vascular checks success story

The situation	Nationally NHS Bassetlaw was required to undertake vascular checks
What we did in 2009	In the first 3 months of delivery, 851 checks were undertaken, 57 of these included screening for atrial fibrillation. The programme has been delivered in the primary care setting using a GP LES. All GP practices have given a commitment to delivering the vascular checks programme. Considerable clinical engagement was involved with developing the LES through the PEC and clinical governance forum. In addition support services required to support patients at high risk of vascular disease have been procured. The programme is fully compliant with national guidance.
The impact and ongoing delivery	People in Bassetlaw who smoke, are overweight or obese, or who need to increase their physical activity levels can access support services free of charge to help them to achieve the required lifestyle changes. A patient experience questionnaire has been developed to assess ongoing patient satisfaction with the service and to make improvements where needed. The vascular checks programme was successful as a result of rigorous planning which included clinical and stakeholder engagement. This was undertaken to meet the needs of the local target population, to ensure improved health outcomes and patient experience for the people of Bassetlaw.
WCC Competency	2, 3, 4, 5, 8

Initiative focus: To implement a vascular (NHS Health Check) primary prevention programme to target the nationally defined at risk population group of people aged 40-74 who have not previously been diagnosed with coronary heart disease, kidney disease or diabetes or who have had a stroke. One fifth of the eligible population will be invited for a health check each year. Individuals who are not assessed as having a vascular disease or of being at high risk of having a cardiovascular event will be invited back every 5 years for a health check. All individuals who undergo a health check will receive appropriate lifestyle advice and will be referred as necessary into specialist lifestyle programmes, such as smoking cessation, weight management and exercise referral.

Progress over the last year

- Developed a locally enhanced service for general practices with strong clinical engagement
- Vascular programme went live on 1 July 2009
- In the first 3 months 851 checks have been undertaken and 57 of these have included screening for arterial fibrillation
- Commitment from all practices to the delivery of health checks

Over the last year a key focus of this initiative has been to ensure that our harder to reach population groups access the health checks programme to optimise the health impact and reduce inequalities – we will continue with this over the next year.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improving the health and quality of life for the people in Bassetlaw
Vision: Supporting Bassetlaw's prevention focused services
Strategic Goal: Prevention of ill health
Outcomes: Average All Age All Cause Mortality and Life Expectancy

National Fit: Vascular checks are part of a national programme, which must be fully implemented in all PCT's by 2012. This is also an intervention which can deliver on QIPP.

Regional Fit: A regional priority with the expectation that all PCT's in the East Midlands will have full implementation and meet national standards by 2012.

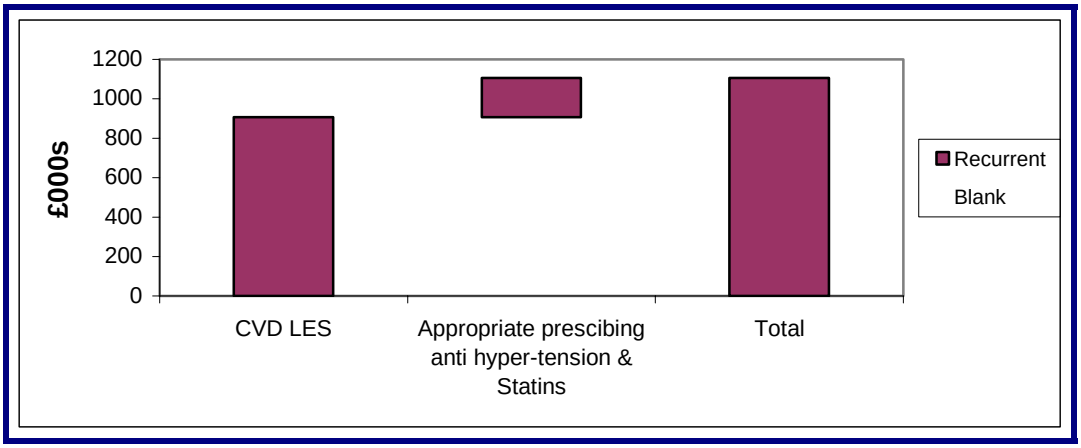
Local Fit: Vascular checks are included in the LOP (vital signs) and were determined as a key priority in the NHS Bassetlaw strategic plan 2008-13. Vascular diseases are a leading cause of death and disability in the district highlighted in the JSNA Chapter 3, Adults, Hard to reach and vulnerable groups.

2. Evidence of need: The target population aged between 40 and 74 who meet the eligibility criteria (i.e. without diagnosed vascular disease and not previously been assessed of having a 20% or greater risk of having a CVD event over the following 10 years) will benefit from vascular checks. Vascular diseases (heart disease, stroke, diabetes and kidney disease) are the biggest cause of death in the UK and a major cause of disability. Although vascular diseases all affect the body in different ways, they are linked by a common set of risk factors and having one vascular condition increases the likelihood of an individual suffering others. Early intervention to reduce 'modifiable' risk (e.g. smoking, blood pressure, cholesterol levels) can prevent, delay and in some circumstances reverse the onset of vascular disease. This programme gives greater focus on the prevention of coronary heart disease, stroke, diabetes and kidney disease, and will help people remain well for longer. Type II diabetes mellitus is a growing public health concern. Its prevalence is increasing and diabetes contributes significantly to overall health inequalities in Bassetlaw. Earlier detection will allow individuals to be better managed and improve their quality of life.

3. Health impact: Early intervention reduces the risk of developing vascular disease and reduces premature mortality from these diseases. It also improves the quality of life for patients by slowing down the development of the disease and through earlier diagnosis to ensure that the condition is managed effectively, reducing morbidity. This also reduces emergency hospital admissions. When fully implemented the vascular checks programme in Bassetlaw will, on an annual basis, have the potential to save 4 lives, prevent 19 heart attacks and strokes, prevent 8 people from developing diabetes and provide earlier diagnosis of 50 cases of diabetes or kidney disease.

4. Impact on health inequalities: Bassetlaw is currently close to the national average for premature deaths for circulatory diseases. The overall trend shows that premature death from circulatory diseases has been reducing at a similar rate to England whilst remaining higher than the national average. A sustainable reduction in the gap between Bassetlaw and England needs to be achieved which will result in Bassetlaw being at, or better than, the England average. Bassetlaw falls within the worst quintile regionally for premature deaths from circulatory diseases. The vascular checks programme will impact on this inequality by improving death rates form circulatory disease providing that it increases at a rate which pushes it to, or above, the regional average to effectively tackle this inequality. There are significant inequalities within Bassetlaw, with parts of Worksop and Carlton in Lindrick falling into the most deprived 10% of wards in England and parts of Retford, Harworth/Bircotes and Langold falling into the most deprived 20% of wards in the country.

5. Cost and cost effectiveness: The vascular initiative will require a strategic investment over the 5 year period of £1.1m.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	109	249	249	249	249	**1,105**
Non-recurrent Cost	-	-	-	-	-	**-**
Disinvestment	-	-	- 61	- 61	- 61	**- 183**
Net Cost	109	249	188	188	188	**922**

As well as delivering benefits in its own right (through the prescribing of anti hyper-tensives and statins) the vascular initiative will help to ensure that other initiatives are more effective by referring to them patients who could most benefit - in particular the smoking and obesity initiatives.

6. Affordability and timing: NHS Bassetlaw has budgeted funds for the vascular initiative as Health Checks are a national priority. The timing of this initiative also fits with the national implementation of Health Checks for people at risk of vascular disease.

7. Patient demand: When fully implemented approximately 7,500 people in the eligible population will be invited for a test each year and of this it is expected that 75% (5,625) will take it up.

8. Delivery

Start date: 2009 **End Date: Ongoing**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Conduct 16,875 vascular checks	▪ Reduced risk of developing vascular disease ▪ Reduced premature mortality from vascular diseases ▪ Improved quality of life for patients by slowing disease development and via earlier diagnosis ▪ Reduced emergency hospital admissions for vascular disease saving £0.2m by year 5
Year 5 (2013/14)	Conduct 28,125 vascular checks	

Key Milestones	Delivery Date	Slippage
Establish and implement a LES in Primary Care	June 2009	Commenced 1 July 2009. All practices committed to delivery by end of financial year
Ensure practices have adequate and appropriate software and that systems	June 2009	Due to licensing issues with System 1 and the Q Risk 2 risk

are updated to undertake risk assessment and management		assessment tool, this slipped. Subsequently the NHS Bassetlaw's financial position resulted in this being stopped and it therefore need to progress into 2010-11
Implement a social marketing campaign targeting population groups which are less likely to take up the offer of a vascular check and to participate in the lifestyle improvement activities.	Completion March 2010	Delays in the procurement process, followed by NHS Bassetlaw's financial position - all initiatives not currently active needed to be halted. This initiative has been deferred to 2010-11.

Risk to delivery	Impact	Likelihood	Mitigation
People may choose not to take up the offer of a check	High	Medium	In areas where the GP LES may not meet the needs of the population, alternative services can be commissioned to ensure equity of access and to address potential inequalities. Plans are also in place to introduce additional community based health check programmes in areas where the LES is not meeting population needs.

Organisations engaged in the initiative: GP Practices; Bassetlaw provider arm; The Local Authority (GP exercise referral scheme); Local Acute Trust (lab testing); Pharmacists (prescribing); potentially local weight management providers if patients choose to access these rather than available adult services.

NHS Bassetlaw capability and capacity: At present NHS Bassetlaw capacity and capability are adequate. Currently the vascular checks programme is delivered in general practice through a LES.

Provider Implications: The programme is currently exclusively delivered through a GP LES so it relies on GP's participating in the scheme. There are also implications for the acute provider which undertakes all the lab tests. The services patients are referred on to are delivered by the NHS Bassetlaw provider arm (smoking cessation and some healthy eating/weight management community work), local authority (exercise referral) and GP Practices (weight management). Other services are already in place and providers will have been involved and leading on the development services in response to need. The programme consists of different providers working together and independently to deliver better vascular outcomes for patients. There is currently limited choice as to where patients can access their checks. However, the strategic initiative plans to increase choice with potential alternative community providers. At this early stage, the most cost effective way of delivering this programme is via the GP practices.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of Success: Improving on current NHS Bassetlaw performance in VSB 02 CVD Mortality and VSC 23 Vascular risk.

4.4.7 G2A) Smoking

Lead: Health Improvement Principal **Director:** Public Health Consultant

Initiative Focus: To reduce harm from smoking in Bassetlaw by aiming to reduce smoking prevalence across the district, targeting the most deprived communities. This initiative is being conducted in partnership with NHS Nottinghamshire and the East Midlands SHA.

Progress over the last year:

- A high performing stop smoking service with regards to four week quit rates.
- Conducted a social marketing research project to gather insights into why people smoke.
- Several GP practices signed up to the LES, with others referring to the stop smoking service.
- Toolkit development to support prevention programmes in schools.
- Seven pharmacists signed up to distribution of the nicotine replacement therapy voucher scheme.
- Successful roll out of the smoke free homes initiative
- Commencement of workplace smoking cessation programmes
- Developed new trajectories to encourage more 4 week quit rates.

Over the last year the Bassetlaw Stop smoking service has developed to provide a wider impact on smoking prevalence across our population. We are hopeful that we will continue to work effectively to promote a downward trend in numbers of people smoking, and to deter smoking onset by young people to help meet local, county wide and national targets.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improving quality and length of life for the people of Bassetlaw by stopping people smoking
Vision: Supporting Bassetlaw's commitment to prevention focused services
Strategic Goal: Healthy lifestyles for people who have existing health needs
Outcomes: Smoking Quitters, Life expectancy and Average All Age All Cause Mortality

National Fit: The white paper 'Smoking Kills' (DH, 1998) detailed a comprehensive tobacco control strategy to reduce the prevalence of smoking amongst the UK population. The initiative also supports the national focus on smoking documented within The Cancer Plan (DH, 2000), Choosing Health (DH, 2004) and Beyond Smoking Kills (2008); and within CHD & Diabetes NSFs to reduce smoking prevalence across the population.

Regional Fit: Countywide local area agreement with one of four blocks (The Health and Well-being Executive group) sitting under the LAA who lead the development of a countywide programme, and a countywide Tobacco Alliance forum.

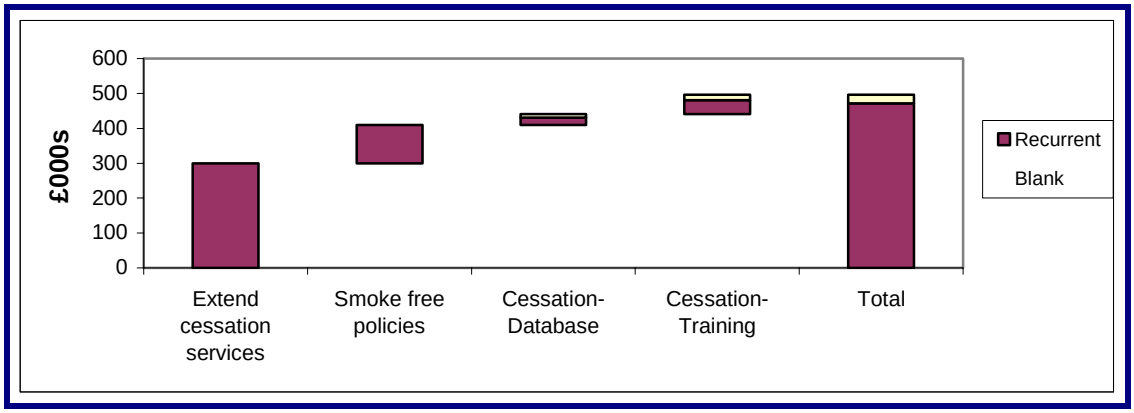
Local Fit: Alignment with the Nottinghamshire Sustainable Community Strategy, LAA and Bassetlaw LSP.

2. Evidence of need: Smoking is responsible for 87,000 deaths in England and 1,300 deaths in Nottinghamshire County. It is estimated that 23% (25,530) of Bassetlaw's population are smokers. Worksop South East (a Bassetlaw ward) is estimated to have a smoking prevalence significantly higher than the national average of 26.5% (JSNA, 2008). According to pooled data from 2005-2007, the annual number of deaths from smoking in Bassetlaw equates to 205. The directly standardised rate is 231.7 deaths per 100,000 population aged 35+ (pooled data 2005-2007).

3. Health impact: Reduction in mortality rates from smoking related conditions such as CHD, Stroke, cancers COPD etc. Primary care stop smoking services aim to treat at least 5% of the local population of smokers in line with NICE best practice recommendations.

4. Impact on health inequalities: Smoking prevalence is entrenched within poverty and deprivation. Inequalities across Bassetlaw are generally higher than the national average; males can expect to live on average for 76.9 years as opposed to the national average of 77.65. Smoking related illnesses contribute to about 50% of the inequality gap in mortality from circulatory diseases. Around 44% of smokers within Bassetlaw are routine and manual workers. The Bassetlaw initiative aims to deliver a series of interventions to target those currently smoking, to support them to quit, and to deter onset amongst young people.

5. Cost and cost effectiveness: Smoking will require a strategic investment over the 5 year period of £0.5m. The majority of this being an annual cost of £100,000 (from 2010/11) for increasing the smoking cessation service availability to meet demand.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	10	35	142	142	142	**471**
Non-recurrent Cost	15	10	-	-	-	**25**
Disinvestment	-	-	-	-	-	**-**
Net Cost	25	45	142	142	142	**496**

This initiative will increase the number of smoking quitters in Bassetlaw from 884 quitters per 100,000 to 1000 per 100,000. This would result in approximately an additional 140 four week quitters in 2013/14 and an additional 380 over the duration of the strategic plan. This project is expected to deliver long term health gains to the population of Bassetlaw, the majority of these gains and resultant reduction in activity (and therefore cost) are expected to occur outside of the time period associated with this plan.

6. Affordability and timing: Bring Bassetlaw's spend closer to that of its peers and the national average in the programme budgeting area of healthy individuals. In 2007/08 Bassetlaw spent £29 per head of population (unified weighting) on healthy individuals compared to £31 nationally and £33 amongst Bassetlaw's peers.

It is expected that prevalence of smoking in Bassetlaw will decline in line with the number of four week quitters achieved. Stopping smoking will lead to health gains for the population in both the short and long term - the greatest benefit associated with long term smoking quitters.

7. Patient demand: Evidence to support people wanting to access smoking services is through the actual numbers that have accessed the programmes and the amount of people that have gained smoke free status at four weeks. In addition the level of interest

shown within uptake of smoke free homes, school initiatives and workplace schemes demonstrates evidence of demand.

8. QIPP

Quality: Significant reduction in smoking prevalence across the population

Innovation: The delivery of a range of smoking cessation interventions across the population in line with LOP and LAA guidance

Prevention: Links to priority 1 around the national, countywide and local health agenda to reduce smoking prevalence and harm from smoking across the population of Bassetlaw.

9. Delivery - Ongoing

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Increase the rate of smoking quitters aged 16 and over per 100,000 by 5.57%% from 900 to 950	▪ Reduction in mortality rates from smoking related conditions such as CHD, Stroke, cancers COPD ▪ Reduced costs to NHS Bassetlaw for treating smoking related diseases in Bassetlaw
Year 5 (2013/14)	Increase the rate of smoking quitters aged 16 and over per 100,000 by 5.57% from 950 to 1000	

Key Milestones	Delivery Date	Slippage
Introduction of a choose and book system for smoking cessation	January 2010	March 2010
Use social marketing insight from Harworth to inform smoking initiative delivery	January 2010	
Develop a social marketing programme to delay the onset and initiation of smoking in young people	Jan 2011	Yes – NHS Bassetlaw financial position
Achievement of GP practices to deliver the LES	On-going	No
Establish a smoke free homes project with children's centres	To commence February 2010, intervention currently being delivered in people's homes –as September 09 162 signed up to scheme	April 2010
Introduce a gold standard smoke free workplace policy with LSP partners	Workplace award scheme being launched in February 2010	

Risk to delivery	Impact	Likelihood	Mitigation
If changes in provider arm delivering services	High	Medium	Look at who else could deliver smoking cessation services
If referrals into the service			Ensure more brief intervention

were not continued			training and awareness raising utilising communication teams
If training for both brief and level 2 was stopped			Look at possibility of peer support training
If primary care and Bassetlaw Stop Smoking Service failed to meet targets identified within Service specifications			

Organisations impacted by the initiative: Provider and primary care, workplaces, and the local community.

Initiative dependencies: Training has to be completed on an on-going basis to ensure front line staff refer into the services.

NHS Bassetlaw capability and capacity: There is currently adequate capacity to deliver smoking cessation services in line with LES for primary care.

Provider Implications: The development of a programme specification to delay the onset of smoking in young people may in the long term require further provision of smoking related intervention services for young people in Bassetlaw.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measures of success: An increase in smoking quitters per 100,000 by 11.11% over the 5 year plan contributing to NHS Bassetlaw's already strong performance against the CQC and LOP vital sign VSB05, Smoking prevalence (Quitters).

4.4.8 G2B) Long Term Conditions

Lead: Long term conditions programme lead **Director:** Director of Commissioning

Initiative focus: This initiative has three areas of focus:

1. To develop Diabetes care that meets national guidance and best practice guidelines;
2. To improve access to and uptake for pulmonary rehabilitation for people with COPD; and
3. To promote personalised care for people with long term conditions using the virtual ward model, predictive modelling, Tele-health and access to rehabilitation to reduce acute admissions by 7.5%.

Progress over the last year:

- Mapped Diabetes provision against NSF/NICE and the National Diabetes E audit tool, which has directed key priorities for development
- Reached implementation stage for the COPD and Diabetes Pathways
- Completed scoping exercise of virtual ward model and Combined Predictive model evidence base supporting the focus of our long term conditions initiative
- Personalised Budgets – our 'Staying in Control' pilot continues, this is now at implementation stage with patients trialling this new approach to providing care
- Conducted public survey on public perceptions of self care and personalised care. Results are being used to inform the development of our Self Care Strategy and the implementation of Personalised Care Planning for patients with a Long Term Condition across Bassetlaw
- Neuro-rehabilitation service has commenced in line with national guidance to maximise health and quality of life outcomes for this patient group

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Fit with improving quality of life via effective management of long term conditions
Vision: Fit with our commitment to improving health inequalities for the people of Bassetlaw
Strategic Goal: Healthy lifestyles for people who have existing health needs
Outcomes: Life Expectancy and Average All Age All Cause Mortality

National Fit: Supports Choosing Health (2004), the NHS & Social Care LTC Model of Care and Putting People First (2008), the Diabetes NSF/NICE and COPD NICE guidelines.

Regional Fit: Fit with Shaping the Future of Care Together and 'Putting People First' within the East Midlands region.

Local Fit: Supports the Bassetlaw Strategic Partnership Community Delivery Plan.

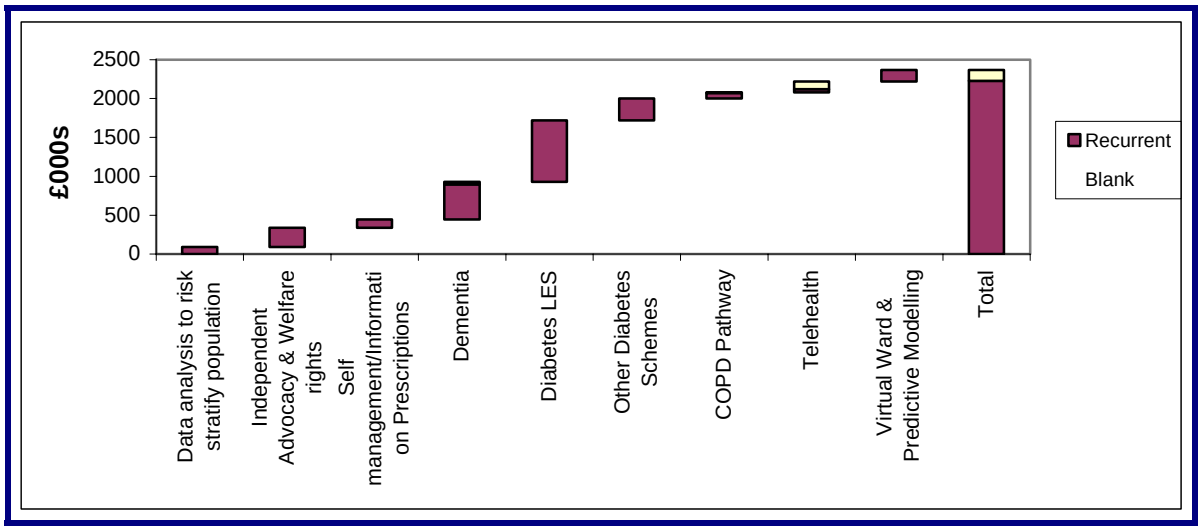
2. Evidence of need: Patients who have been assessed at Tier 2 or 3 (of the Kaiser chronic care model) benefit from more intensive and personalised management within primary care to reduce risk of acute admissions. In Bassetlaw non-elective admissions for Diabetes 2008/09 were 69. (Activity for 200910 is estimated to be 90.) For COPD activity for 2008/9 was 262. Rates for Obesity and Diabetes are higher than the national average. Further development of Diabetes care will assist in reducing disease incidence and standardise diabetes management within primary care. People with Diabetes who have never received Diabetes education show a four fold increased risk of developing

major diabetes complications; the Diabetes LES will address this deficit. In addition, from national work around virtual wards and Telehealth we know that significant reductions can be made in reducing acute COPD admissions.

3. Health Impact: Improved health outcomes will be achieved through preventative care as directed by the Diabetes and COPD Pathways and through effective targeting of resources and promotion of self care principles. This will result in fewer exacerbations for COPD, improve Diabetes care and reduce the incidence of inappropriate admissions. Longer term health gains will be realised through people being proactively supported to take greater ownership and control over the management of their long term condition.

4. Impact on health inequalities: Bassetlaw has areas with high levels of deprivation, poorer health outcomes and a higher incidence of LTC compared to the national average, especially respiratory and circulatory diseases attributable to smoking. In these areas people are often less likely to embrace self care and are generally less well informed about the pathology of their disease. The implementation of the Virtual Ward model and personalised care across all care settings and rehabilitation for patients with LTC will have a significant impact on addressing health inequalities across the locality. This will be achieved by enabling people to feel empowered and able to take greater responsibility over the management of their long term conditions due to additional support mechanisms and rehabilitation service developments within the community.

5. Cost and cost effectiveness: This initiative will require strategic investment over the 5 year period of £2.3m. The majority of this being an annual cost of £300,000 (from 2010/11) for the diabetes LES and other diabetes services. It is expected that this initiative will lead to significant disinvestment in the need for urgent provision among those with a LTC.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	68	264	632	632	632	**2,228**
Non-recurrent Cost	-	92	50	-	-	**142**
Disinvestment	-	-	- 277	- 554	- 554	**- 1,385**
Net Cost	68	356	405	78	78	**985**

The tele-health and virtual wards projects will enable a disinvestment to be made in A&E attendances and admissions saving the PCT £1.4m over the period of the plan. This offsets the cost of the initiative resulting in it having a net cost of only £1.2m for the PCT over 5 years.

6. Affordability and timing: Long Term Conditions span several disease groups and so also several programme budgeting categories. It is therefore difficult to benchmark the affordability of the project based on programme budgeting spend by disease type. However NHS Bassetlaw's spend is typically low in areas of social and community care, which much of this initiative focuses on. It is expected that the benefits from this initiative will begin to be realised when implementation is complete however it will take a longer period for the full benefits to be felt as patients become accustomed to the new model of care delivery.

7. Patient demand: Patients often want to remain at home and to avoid hospital admissions wherever possible. A MORI research study (2009) revealed that whilst people are satisfied with the advice they received to manage their condition, more information about their condition would enhance their ability to self care. General awareness of what training courses are available to provide people with the skills and knowledge to self care was poor. These results have been reflected locally through a small scale public survey (Nov–Dec 2009) of public perceptions of self care which has highlighted peoples desire to be better informed about their disease management and ability to self care.

8. QIPP

Quality: Improve quality of life for patients with LTC promoting the principles of self care. Advocate more effective use of GP and DN time, and a reduction in inappropriate acute admissions.

Innovation: The Diabetes LES is innovative in its approach in that it will pro-actively identify those people at risk of developing diabetes and provide appropriate lifestyle interventions to reduce the likelihood of developing Diabetes and identify and pro-actively manage Pre-Diabetic patients. If diabetes is diagnosed, it will maximise Diabetes care to optimise control of symptoms, thereby reducing the incidence of Diabetes long term complications prevent progression to the Pre-diabetes and Diabetes. Telehealth, will provide an innovative approach to promoting patient choice and the management of LTC within primary care with a clear focus upon preventative, pro-active care.

Productivity: Enabling patients to receive care closer to home and for those with more advanced disease to remain at home with more appropriate use of acute service interventions. Effective use of community matrons skills and time.

Prevention: Investment in Diabetes care will contribute towards disease prevention, standardise management to minimise future complications and reduce avoidable admissions. Promotion of self care and the virtual ward model will assist in the prevention of disease exacerbations and reduce inappropriate/avoidable admissions.

9. Delivery

Start date: 2009 **End date: 2014**

Year	Health outcome realised	Benefit
Year3 (2011/12)	▪ Reduce the rate of emergency hospital admissions per 100,000 for **COPD** patients by 10% from 222 to 200 ▪ Reduce the rate of emergency hospital admissions per 100,000 for **Diabetes** by 10% from 90 to 81	▪ Cost saving of reduced hospital admissions of £0.3m by year 3 ▪ Improved management of LTC in primary and community care
Year 5 (2013/14)	▪ Reduce the rate of emergency hospital admissions per 100,000 for **COPD** patients by 15% from 222 to 189 ▪ Reduce the rate of emergency hospital admissions per 100,000 for **Diabetes** by 15% from 90 to 77	▪ Cost saving of reduced hospital admissions of £1.4m by year 5 ▪ Improved management of LTC in primary and community care

Key Milestones	Delivery Date
Personal Health Plans	April 2010 –Dec 2010
COPD pathway	May 2010

Investment within diabetes services	April 2010
Commence Telehealth	July 2010
Evaluate pilot and report	Sep 2010
Aim for district wide roll out	Nov 2010
Virtual Ward implementation	April 2011

Risk to delivery	Impact	Likelihood	Mitigation
Lack of clinical support from General Practice	High	Low	Ensure clinical engagement at all stages of development
Insufficient resources to fund the initiative through to roll out		Medium	Ensure all options for service re-design have been explored and actioned

Organisations impacted by the initiative: NHS Bassetlaw Provider arm, Primary Care, Public Health, Acute services and Social services.

Initiative dependencies: The initiative also links with the stroke and falls strategic initiatives and could assist with the monitoring of those considered to be at high risk of having a stroke/falls and following acute care episodes, potentially supporting early discharge.

NHS Bassetlaw capacity and capability: Currently NHS Bassetlaw has a community matron resource that is being underutilised; this initiative will enable the effective use of specialised nursing resources for the maximum benefit of patients. For virtual wards initial additional costs will be for project lead, medical lead, admin support and staff training, with additional resources for ongoing roll out.

Provider implications: Providers will be required to support the personalisation agenda. Following the implementation of personalised care planning, which will support patients in managing their own condition and the virtual ward model via Community Matrons, there is anticipated to be a decrease in acute activity.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of Success: Improved NHS Bassetlaw performance against two local priority vital signs - VSC03 Supporting people to live independently and VSC11 people with a Long term condition feeling independent and in control of their condition.

4.4.9 G2C) Alcohol

Lead: Health Improvement Principle (Public Health) **Director:** Director of Primary Care

Initiative Focus: To reduce alcohol related mortality and morbidity by reducing harm associated from excessive drinking in Bassetlaw and ameliorate access to alcohol interventions in the community.

Progress over the last year

- Implemented alcohol LES in primary, September 2008
- Commissioned Tier 2 Alcohol Service to increases the numbers of patients offered brief intervention therapy
- Implemented A&E and inpatient alcohol screening
- Reviewed Tier 3 alcohol services highlighting that access to specialist alcohol interventions was not meeting patient need
- Increased alcohol specialist nursing capacity in Bassetlaw Hospital through commissioning a Band 6 WTE on a 6-month secondment with the aim to review

Through the alcohol LES for Q1&Q2 09/10, 7,984 patients were screened for hazardous, harmful or dependent drinking within 9 of the 11 GP practices in Bassetlaw. Of those screened brief alcohol advice was delivered for 322 patients. The Tier 2 alcohol service for the period April 08 to October 09 delivered extended brief alcohol interventions for patients through the delivery of 21x sessions per week across the Bassetlaw District.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improved quality and length of life for individuals in Bassetlaw who take up alcohol intervention services.

Vision: Supporting people of Bassetlaw to make healthy lifestyle choices, increasing life expectancy and supporting a reduction in inequalities.

Strategic Goal: Healthy lifestyles for people who have existing health needs

Outcomes: Hospital Admissions for Alcohol Related Harm, Life Expectancy and All Age All Cause Mortality

National Fit: Alcohol is a key National Indicator (39 - Alcohol related harm). Alcohol misuse is also a DH priority - Reducing Alcohol Harm (DH, 2008) and Choosing Health (DH, 2004)

Regional Fit: Reducing harmful alcohol use is an East Midlands strategic priority (2009)

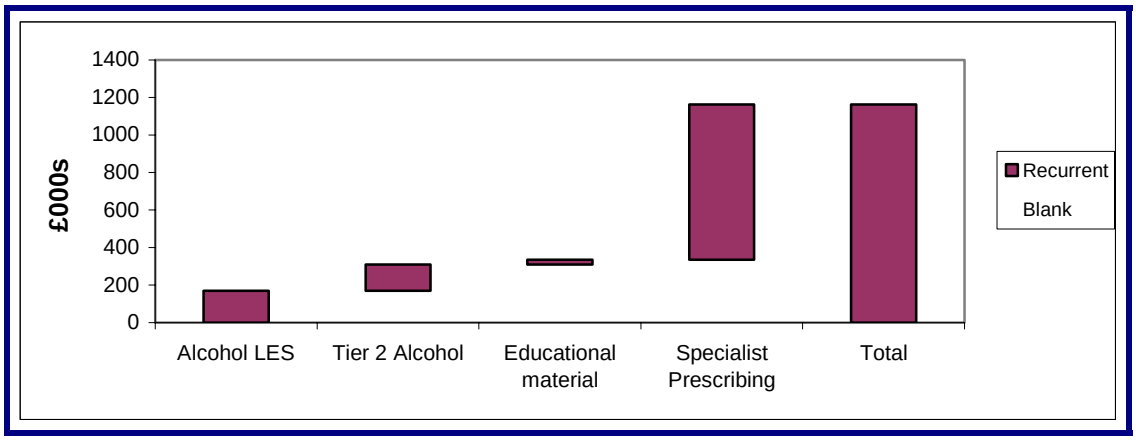
Local Fit: LAA NI-39; Safer Nottinghamshire Board - DAAT and Safe Neighbourhood policing; and Criminal Justice intervention programmes.

2. Evidence of need: Bassetlaw Alcohol related hospital admissions are continuing to rise. Bassetlaw is known to have a high level of alcohol related harm, and is in the worst 25% of districts in England (JSNA, 2009). Hospital stays for alcohol related harm in Bassetlaw for 2007/08 was higher than the England national average (APHO, 2009). However, in comparison to NHS Nottinghamshire County alcohol related hospital admissions have slowed in Bassetlaw. In Bassetlaw the estimated cost of alcohol related admissions is around £3.3 million per year. In addition, Bassetlaw has identified alcohol related unmet need within a review of patient access to Community Alcohol Specialist services uncovering a major gap in Tier 3 alcohol service provision. This has led to an increase in alcohol related hospital admissions due to the lack of provision of community alcohol detoxification and specialist interventions.

3. Health impact: Bassetlaw's alcohol initiative will lead to reduced alcohol consumption and alcohol dependence; ameliorate alcohol-related health problems such as liver disease, malnutrition or psychological problems and social problems such as family and interpersonal relationships and ability to perform effectively at work, avoidance of criminal activity; and lead to general improvements in health and social functioning. Alcohol brief interventions are known to lower alcohol consumption (Solberg et al 2008). For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels (Moyer et al., 2002). Brief interventions delivered in A&E make 0.5 fewer visits to the A&E over a 12-month period (Crawford et al, 2004). Brief interventions for alcohol related harm yields savings of around £2,000 per 'life year' saved (DH, 2008).

4. Impact on health inequalities: Deprived communities in Bassetlaw suffer higher levels of alcohol related harm. The most deprived fifth of the population suffer two to three times greater loss of life attributable to alcohol, three to five times greater mortality due to alcohol specific causes; and two to five times more admissions to hospital because of alcohol than those in more affluent areas (APHO, 2007).

5. Cost and cost effectiveness: A strategic investment over the 5 year period of £1.1m. The majority of this being spent on specialist prescribing. It is expected that this initiative will enable a significant disinvestment in alcohol related admissions.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	95	267	267	267	267	**1,163**
Non-recurrent Cost	-	-	-	-	-	**-**
Disinvestment	-	- 333	- 467	- 604	- 743	**- 2,147**
Net Cost	95	- 66	- 200	- 337	- 476	**- 984**

This initiative will reduce the number of alcohol related admissions within Bassetlaw from a currently higher than national average rate of 1679 per 100,000 to 1352 per 100,000 by 2013/14. This is equivalent to preventing 385 admissions in 2013/14 and in excess of 1200 during the period of this Bassetlaw in excess of £2.3m over the period of the plan. This offsets the cost of the initiative resulting in it having a return of £0.7m for NHS Bassetlaw over 5 years.

6. Affordability and timing: NHS Bassetlaw spends in excess of the national and its peer average on a range of treatment based programme budgeting areas that would be impacted by alcohol related admissions including trauma and injuries and problems of the gastro-intestinal system. This initiative and the associated disinvestment should help to address this.

7. Patient demand: A patient survey conducted in Sept (2009) highlighted that improved access to Tier 2 alcohol interventions addressed and supported patients in reducing their

alcohol consumptions. This same patient survey highlighted that Tier 3 specialist interventions following alcohol detoxification, were not offered and these patients relapsed into drinking. The survey results therefore highlighted a need for improved Tier 3 alcohol specialist interventions as a mechanism for reducing alcohol related harm.

8. QIPP

Quality: Improved access to alcohol community interventions
Innovation: Primary Care alcohol led community detox & prescribing
Productivity: Reduced alcohol related repeat hospital admissions
Prevention: Reduction of alcohol related harm

9. Delivery

Start Date: 2009/10 **End Date: 2013/14**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	▪ Decrease the rate of hospital admissions per 100,000 for alcohol related harm by 9.9% from 1588 to 1470	▪ Cost saving of reduced hospital admissions of £0.8m by year 3 ▪ Enhanced management of alcohol related harm in the community and primary care setting
Year 5 (2013/14)	▪ Decrease the rate of hospital admissions per 100,000 for alcohol related harm by 8% from 1470 to 1352	▪ Cost saving of reduced hospital admissions of £2.1m by year 5 ▪ Enhanced management of alcohol related harm in the community and primary care setting

Key Milestones	Delivery Date	Slippage
Increase the numbers of patients offered specialist alcohol interventions and alcohol community detoxification through commissioning and effective Tier 3 Alcohol service.	Ongoing	No
Increase the numbers of hospital inpatients offered specialist alcohol interventions through commissioning of greater service capacity.		
Participate in regional social marketing campaign on alcohol	Nov/Dec 2009	Yes, due to be implemented early 2010 (lead partners Gov East Midlands)
Implement a cost effective model by changing the Primary Care Alcohol Local Enhanced Service (LES) to Alcohol Directly Enhanced Service (DES), offering improved targeting, alcohol screening and education for at risk groups.	2010/11	
Expand the remit of the current Tier 2 Alcohol service provision to include; alcohol prevention, targeting of at risk groups, and offering after care treatment interventions**.**	2010/11	

Risk to delivery	Impact	Likelihood	Mitigation
Less problematic drinkers identified in primary care	Low	High	Reassess vfm of Alcohol LES
Tier 2 alcohol service outputs lower than expected	High	Medium	Tier 2 - Good performance management criteria in place Tier 3 – new model of working if procured will mitigate the likelihood.
Bassetlaw Hospital Drug and Alcohol service unable to meet alcohol related hospital admissions patient demand	Low	High	Patients discharged from Bassetlaw Hospital without alcohol interventions

Organisations engaged in the initiative: NHS Bassetlaw Provider Arm (Tier 2 Alcohol Service) Primary Care, DAAT, Bassetlaw Hospital, Community Alcohol Team, Bassetlaw Hospital, GOEM, and Patient led self help groups.

Initiative dependencies: Commissioning arrangement of alcohol services.

NHS Bassetlaw capacity & capability: Already employed -

- Tier 2 Alcohol Service – WTE 3.0, WTE 0.5 hospital in-reach, WTE 0.5 alcohol education. (Currently contracted through NHS Bassetlaw)
- Bassetlaw Hospital Alcohol Nurses - WTE 1.0 (currently contracted through Nottinghamshire DAAT)
- - Primary Care GP - led alcohol treatment services - GPSI x 2 delivering 2 x 3.5hr sessions per week. GPs already employed in primary care, 2 sessions need to be contracted.

Providers Implications: NHS Bassetlaw is looking to serve notice to the community alcohol team. In addition, it is anticipated that providers will see less patients in the DBH for hospital related alcohol admissions. From a patient perspective the extended provision of community alcohol services will lead to increased choice of services beyond secondary care.

OD: NHS Bassetlaw will need to employ an additional WTE 1.0 Bassetlaw Hospital Alcohol Nurse and 2 WTE primary care specialist nurses offering alcohol community detoxification and follow-up after care. Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measures of Success: A decrease in the rate of hospital admissions per 100,000 for alcohol related harm by 14.86% over the 5 year plan leading to improved performance against the local vital sign VSC26 (rate of hospital admissions for alcohol related harm).

4.4.10 G3A) Cancer

Our cancer success story 2009/10

The Focus	Raising awareness of skin cancer in Bassetlaw
Outline	The Cancer Reform Strategy (CRS), 2007 outlines the importance of raising cancer awareness to help diagnose cancer sooner and reduce mortality. It states that over half of cancers are preventable and cancer prevention and early diagnosis must be a priority for PCTs. One cancer that is largely preventable is skin cancer or Malignant Melanoma. Melanoma incidence is rising rapidly, such that it is one of the fastest growing types of cancer, almost certainly reflecting patterns of behaviour over recent decades. In light of the rising incidence of skin cancer nationally and recommendations made within the CRS, NHS Bassetlaw (supported by North Trent Cancer Network) undertook a skin cancer awareness campaign during the summer of 2009. The local campaign aimed to: assess the local awareness of skin cancer across Bassetlaw; to highlight skin cancer risk factors particularly amongst children and young people; to promote the benefits of early GP presentation and to encourage behavioural change and attitudes towards excessive UVA exposure.
What we did in 2009	The campaign was formally launched by NHS Bassetlaw's GP cancer lead, Dr Stephen Kell at the Bassetlaw Education Service Training (BEST) professional development event for primary care professionals in May 2009 which coincided with the national skin cancer awareness week. Skin cancer awareness talks were undertaken in secondary school assemblies by Dr Kell with more than 400 pupils attending. The talks focused on pupil awareness of risk factors, staying safe in the sun, prohibiting the use of sun beds, the importance of checking moles regularly and the importance of seeing a GP early. Primary schools also participated in the campaign by placing sunsmart postcards in children's book bags and one primary school held an awareness talk with pupils.
Impact and ongoing delivery	Skin Cancer awareness evaluation forms were completed by pupils aged 11-16 and responses identified that pupils had least knowledge about skin type and the importance of checking moles regularly. The majority of pupils were aware of sunbed dangers and some pupils planned to refrain from using them. One fifth of pupils indicated that their sun behaviour would now change and several pupils also approached their local GP for advice on moles. During May – Sept 2008 there were 117 skin cancer GP referrals in Bassetlaw. During the same period in 2009 there were 121 referrals resulting in a 3% increase GP referrals comparing the same summer period. The campaign will be repeated in 2010 and will focus on sign up of all schools by engaging with the local authority to influence the healthy schools agenda and also to promote awareness amongst outdoor workers and businesses across the locality. Bassetlaw has received national recognition from the National Cancer Action Team for the 2009 campaign and has attracted a small amount of funding to support the campaign in 2010. PCTs across the North Trent Cancer Network will be running similar campaigns in 2010 based on learning from NHS Bassetlaw.
WCC Competency	1, 3, 4, 5

Lead: Head of Acute Commissioning **Director**: Director of Commissioning

Initiative Focus: The Cancer initiative aims to improve the knowledge of the population regarding screening services and when to consult a professional; expand radiotherapy capacity; deliver chemotherapy closer to home where possible; increase awareness and improve public education of cancer symptoms for earlier cancer diagnosis; encourage patients to present at their GP sooner with cancer with an earlier stage cancer to reduce cancer mortality; and to adhere to NICE approved prescribing for new cancer drugs.

Progress over the last year:

- Skin cancer prevention awareness campaign conducted by PCT, local PBC lead and cancer lead during summer 2009 working with GPs and other health professionals, schools, LA, pharmacy, private businesses and the public.
- Ongoing work to improve the lung cancer pathway for patients to remove inefficiency and improve patient experience and outcomes.
- Doncaster and Bassetlaw Locality event held in Nov 09 with clinicians, patients and managers from DBH, primary care, tertiary care, user groups, network and PCT to develop priorities for change and agree action plan to deliver improvements for patients within next 6 months.
- Collaborative working with NTCN and SCG to implement IOGs with local providers, ALL IOGs were implemented on time, and work with Network to deliver requirements in the Cancer reform Strategy.
- Lung cancer awareness and early diagnosis campaign due to start in Jan 2010.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improving quality and length of life for people in Bassetlaw diagnosed with Cancer.

Vision: Implementing best practice cancer services to improve quality of treatment and care for Cancer patients.

Strategic Goal: Improved clinical quality for our population

Outcomes: Cancer Mortality Rate, Life expectancy and Average All Age All Cause Mortality

National Fit: The Cancer Reform Strategy (CRS) (2007) identified six priority areas for improvement; preventing cancer, diagnosing cancer earlier; ensuring better treatment; living with and beyond cancer; reducing cancer inequalities and delivering care in the most appropriate setting. The CRS advocates that by 2010 mortality rates from cancer should be substantially decreased by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole (CRS, 2007). The Next Stage Review, NHS Operating Framework 09/10 and IOG Guidance also support a focus on cancer.

Regional Fit: NHS Doncaster has piloted a similar awareness and early diagnosis campaign in 2008/09 (ELCID) which was successfully evaluated. In addition other PCTs nationally have implemented similar campaigns resulting in more patients being diagnosed with lung cancer.

Local Fit: The local authority is supportive of the awareness campaign. Additional local priorities include cancer prevention – effective education and smoking cessation services, and diagnosing cancer earlier via access to services/diagnostic tests.

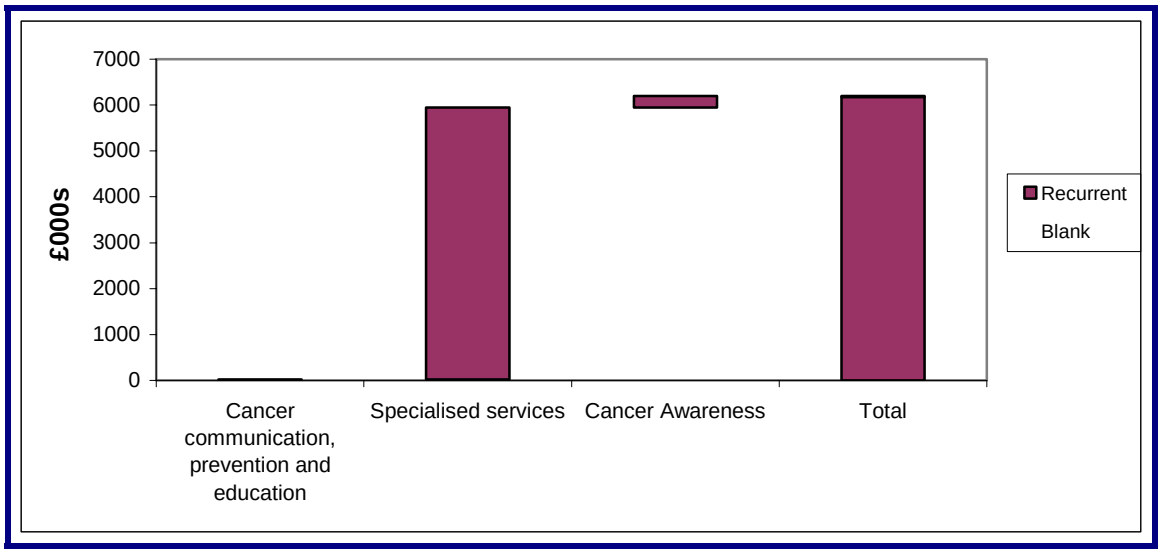
2. Evidence of need: Lung cancer is the biggest cancer killer in the Bassetlaw locality in men and women. In Bassetlaw the mortality rate for cancer is 21% higher than the national average. In 2007, 163 people died from cancer in Bassetlaw. A priority is to understand the reasons for this inequality, possible reasons for this relate to later stage of disease at presentation/diagnosis, poorer access to diagnosis/screening/treatment, delayed initiation of treatment, presence of co-morbidities and variations in effectiveness and quality of treatment.

3. Health impact: This initiative aims to reduce mortality rates and over time incidence if prevention is effective over next 20 yrs.

4. Impact on health inequalities: Bassetlaw has significant health inequalities with a quarter living in the 20% most deprived areas in England. Deprivation is linked to certain cancers –i.e. lung. Cancer accounts for the second most common cause of death after

cardiovascular. 30% of cancer deaths are due to tobacco, 30% diet and 40% due to other factors. For cancer Inequalities in the East Midlands (2007), Bassetlaw ranks significantly high for lung cancer incidence in males and females and high for lung cancer mortality in males and females.

5. Cost and cost effectiveness: The cancer initiative will require a strategic investment over the 5 year period of £6.1m.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	435	835	1,235	1,635	2,035	**6,175**
Non-recurrent Cost	20	-	-	-	-	**20**
Disinvestment	-	-	-	-	-	**-**
Net Cost	455	835	1,235	1,635	2,035	**6,195**

This initiative will reduce the cancer mortality rate within Bassetlaw from 129.4 per 100,000 to 112.5 per 100,000 by 2013/14. This would save 20 lives in 2014, and 81 over five years.

6. Affordability and timing: Bassetlaw's spend is currently in line with that of its peers and the national average for the programme budgeting category of cancers and tumours. In 2007/08 Bassetlaw spent £71 per head of population (unified weighting) on cancers and tumours compared to £62 nationally and £61 amongst Bassetlaw's peers. The costs associated with this initiative may further increase this gap. The key benefit associated with this initiative reduction in cancer mortality is likely to be realised quite quickly once the investments have been made in establishing the services.

7. Patient demand: Patients want information to help them make informed decisions. Lung cancer pathway improvements also need to be completed to meet expected demand in cancer referrals.

8. QIPP

Quality: The lung cancer pathway review will support better quality service for patients via more measured quality and experience metrics. It will reduce 31 day and 62 day waiting times along specific parts of the pathway, enable more treatment to be available at Bassetlaw hospital, result in less travelling for patients to Sheffield, be cheaper for local patients to access with easier parking and support standardised treatment across the three sites in DBHFT.

9. Delivery - Ongoing

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Decrease the cancer mortality rate (indirectly age and sex standardised rate) by 4.2% from 119 to 114	▪ Reduced cancer mortality ▪ Increased quality of care for cancer patients in Bassetlaw
Year 5 (2013/14)	Decrease the cancer mortality rate (indirectly age and sex standardised rate) per 100,000 by 1.3% from 114 to 112.5	

Key Milestones	Delivery Date	Slippage
Cancer specialist services – compliance with national best practice and the North Trent Cancer Network	Ongoing	No
Early diagnosis and awareness lung cancer campaign launched	Jan 2010	Yes - Awaiting public health data since July 2009 to inform planning of campaign and the lung cancer pathway review.
Improved lung cancer pathway - all actions completed	March 2010	No
Evaluation of campaign	May 2010	Yes (planned to be April 2010)

Risk to delivery	Impact	Likelihood	Mitigation
Risk of not starting in 2009/10 financial yr if pathway work slips or data analysis is not made available.	Medium	Medium	Chasing data from Notts County Public Health. Progress on DBHFT pathway action plan being monitored and performance managed closely.

Organisations engaged in the initiative: DBHT, Primary Care and STH

NHS Bassetlaw capability and capacity: There is currently no awareness campaign. The Cancer Pathway is in place but is currently being improved.

Provider Implications: An expected increase in demand for DBHT and Primary care - plus impact on STH for patients diagnosed with lung cancer.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of success: Decrease in the cancer mortality rate of 5.4% per 100,000 over the 5 year plan, supporting NHS Bassetlaw's improved performance against the CQC and LOP vital sign VSB03, Cancer Mortality. In addition the cancer initiative should aim to ensure the continued strong performance against VSA11, 12 and 13 national cancer specific vital signs.

4.4.11 G3B) Stroke

Lead: Commissioning Manager Stroke Services **Director:** Director of Commissioning

Our Stroke success story

The Situation	It was clear that implementing the national stroke strategy locally would require a co-ordinated and multi-agency response.
What we did in 2009	In March 2009, NHS Bassetlaw set up the multi agency, Bassetlaw Stroke Strategy Implementation Group (BSSIG) chaired by NHS Bassetlaw's Director of Commissioning. The group meets bi-monthly and has representation from NHS Bassetlaw, DBH, Social Services, a local GP provider and a stroke survivor and his carer. Its purpose is to be a steering group to drive actions to deliver the strategy. The first activity has been to organise the stakeholder workshop in June with 50 attendees comprising stroke survivors and staff from many agencies. Including stroke survivors and carers. Two project groups were set up to review to review aspects of the pathway in greater detail (acute, and post discharge). A framework for user involvement and engagement for stroke survivors has also been produced.
The impact and ongoing delivery	The acute sub group, whose membership includes the lead consultant from DBH, a nurse manager, and GP have made detailed recommendations on improvements to the acute pathway such as GPs using ABCD 2 tool, increase availability of TIA clinics locally, and joining Doncaster and Bassetlaw clinics into a single process such that if there are no clinics in Bassetlaw, patients with suspected TIAs will be offered an appointment in Doncaster. We are now commissioning this service and patients who have a TIA will be offered appointments in Doncaster. The post diagnosis subgroup has a rolling consultation programme (started April 2009) This is a monthly meeting to review quality markers in the stroke strategy and get feedback from stroke survivors on how things could be made better. Comments about post hospital experience have been used to build a user specification for what the community service should provide. This will be used to work with the provider arm to improve services.
WCC Competency	1,3,4,6

Initiative Focus: To reduce the physical, emotional and economic damage of Stroke through a radical transformation of the whole Stroke Pathway in line the National Stroke Strategy, the National Clinical Guidelines for Stroke, NICE Guidance CG68 Stroke, and NICE Guidance on Thrombolysis. The Initiative is comprised of four strands: (1) TIA Pathway; (2) Hyper Acute Stroke Pathway; (3) Long Term Support and (4) Stroke Awareness & the national social marketing campaign.

Progress over the last year: The Initiative is at an early planning stage. Infrastructure to support the transformation project is in place, comprising a PCT commissioning manager, a North Trent Network service improvement facilitator, a strategy steering group and associated project teams and, crucially, all partners are signed up to the need for improvement and are actively engaged in improvement processes.

All partners have a common understanding of the issues and challenges in developing stroke services, and have better knowledge about how the current system works.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Fit with improving quality and length of life for the people of Bassetlaw

Vision: Bassetlaw's commitment to improved clinical quality of services

Strategic Goal: Improved clinical quality for our population

Outcomes: Stroke deaths within 30 days, Life Expectancy and Average All Age All Cause Mortality

National Fit: Stroke is a major national priority. UK Stroke services are poor and lag behind not only other countries but have also not received the same investment or organisational priority as other similar conditions e.g. cancer, CHD. The National Stroke Strategy (2007) calls for a "revolution, not an evolution" in standards. Implementing the NSS is now one of the DH's main priorities.

Regional Fit: The County Council have appointed two Stroke Commissioning Managers which is evidence that Stroke is a priority for them.

Local Fit: Local services are patchy, with some areas of good practice but generally the organisation and quality of services meet few of the NSS Quality Markers. Stroke is identified as a priority area for action in our JSNA.

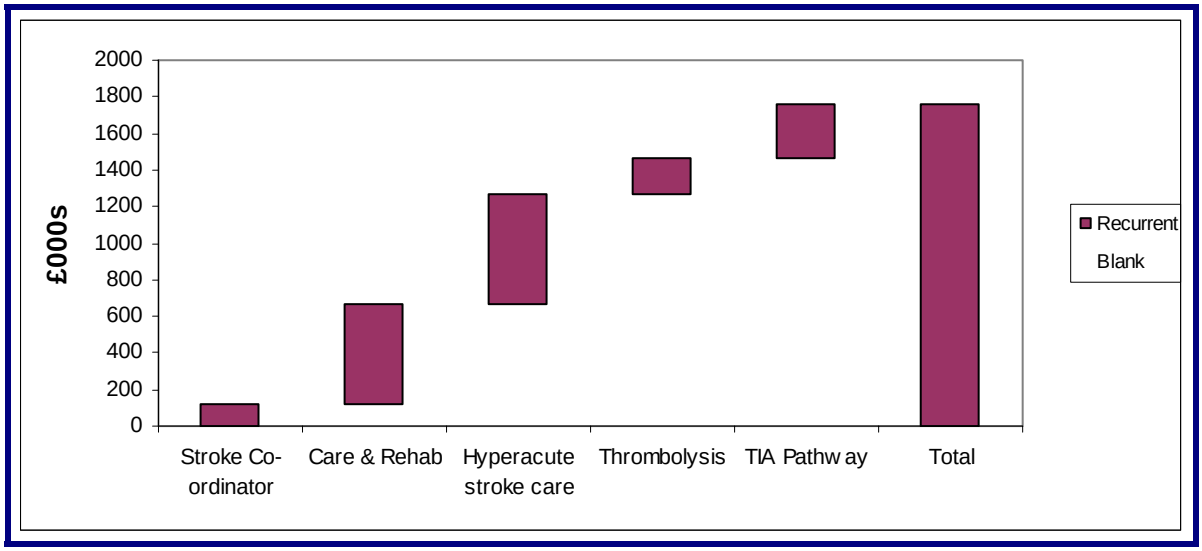
2. Evidence of need: Bassetlaw is currently failing on both the Vital Signs for Stroke (that patients should spend at least 90% of their hospital stay on a Stroke Unit, and that High Risk TIA patients are assessed and treated within 24 hours). Bassetlaw has the worst performance in Nottinghamshire for Stroke mortality within 30 days of admission, and is worse than the SHA and England average. Locally death rates from Stroke have been reducing in Nottinghamshire but increasing in Bassetlaw. Bassetlaw therefore needs to improve its performance against local peers. In Bassetlaw on average around 150 people have strokes annually, and there are over 2,000 stroke survivors living with varying degrees of disability caused by their strokes.

3. Health impact

- Reduction in the number of people who have strokes after having a TIA
- Reduction in the percentage of people who die from their stroke
- Reduction of the burden of disability from stroke
- Reduction in the number of people who have strokes will be achieved by actions already in progress outside this specific investment plan

4. Impact on health inequalities: The initiative is designed to move services in Bassetlaw, and the outcomes for the people of Bassetlaw, from poor to excellent when compared to national or regional benchmarks on all Indicators. The Initiative is not explicitly aimed at reducing Inequalities; however it is evidenced that economically disadvantaged people are three times more likely than affluent people to have a stroke (Stroke Association/British Heart Foundation, August 2009).

5. Cost and cost effectiveness: The stroke initiative will require a strategic investment over the 5 year period of £1.6m.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	30	196	511	511	511	**1,759**
Non-recurrent Cost	-	-	-	-	-	**-**
Disinvestment	-	- 25	- 25	- 25	- 25	**- 98**
Net Cost	30	171	486	486	486	**1,661**

The initiative is expected to reduce stroke mortality rates (within 30 days) from 31,000 per 100,000 of the people having strokes in 2005/06 to 24,000 per 100,000 in 2013/14. This equates approximately to saving 10 lives in 2013/14 and 30 during the period of the strategic plan. This will be partly achieved by the introduction of Thrombolysis within the hyper-acute pathway and partly by an improvement in stroke care. The initiative will also reduce the amount of long term disability for stroke survivors, improve the quality of life of those people suffering a stroke and their carers with improved long term support, and prevent 6 people per year having a stroke through better TIA management. The prevention of strokes through better TIA management will also result in a cost saving for the PCT; this is estimated at £25,000 pa in emergency admissions alone.

There are existing programmes of work around reducing obesity, increasing exercise and reducing smoking rates which will help to reduce the number of people who have strokes, and further initiatives are planned within this strategy on stopping smoking, reducing obesity and alcohol abuse and early identification of people at risk through the vascular checks programme. These pieces of work will help to reduce the prevalence of heart disease, strokes and diabetes.

6. Affordability and timing: Bassetlaw currently spends more than both the average of its peers and the national average on neurological problems. In 2007/08 Bassetlaw spent £89 per head of population (unified weighting) on neurological problems to £89 nationally and £90 amongst Bassetlaw's peers. The costs associated with this initiative may increase this gap, however many aspects of the initiative are nationally driven and so many PCTs are likely to also be investing in this area. It is expected that once the pathway changes have been funded and enacted the benefits will begin to accrue quickly.

7. Patient demand: There is clear evidence of public support from responses to the North Trent consultation on stroke, from comments at the stakeholder event held in June 2009, and from ongoing consultation with users.

8. QIPP

Quality: The investment in Hyper-acute services and in Long Term services will improve quality of care and improve outcomes, in terms of reductions in the percentage of people who die from their stroke, and reductions in the degree of disability which will enhance the quality of life of people who have had a stoke, and their families.

Innovation: Imaginative use of staff resources to provide a consistent quality of care between Doncaster RI and Bassetlaw Hospital.

Productivity: The Economic Impact Assessment for the NSS showed that investments to improve quality will have a long term impact. The number of TIA patients presenting for treatment is likely to increase due to awareness raising and social marketing, and earlier treatment will produce a positive cost/benefit by reducing the number of future strokes. By commissioning Thrombolysis, lives will be saved and long term disability will be reduced. **Prevention:** Preventing some people who have had TIAs going on to subsequently have Strokes.

9. Delivery

Start date: 2009 **End date: 2013/14**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Decrease the rate of stroke deaths within 30 days per 100,000 by 9% from 29315 to 26669	▪ Reduction in the rate of stroke deaths within 30 days ▪ Improved quality of stroke care for the people of Bassetlaw
Year 5 (2013/14)	Decrease the rate of stroke deaths within 30 days per 100,000 by 10% from 26669 to 24020	

Delivery Item	Key Milestones	Delivery Date	Slippage
Stroke Commissioning Manager	Appoint to new post to implement National Strategy	Summer 2009	n/a
Hyper acute stroke pathway	Agree service model, pathway, and funding for commencement of DBH hyper acute stroke pathway implementation.	Nov 2009 – Jan 2010	2009/10 spend plan has slipped due to significant work with DBH on agreeing service model not starting until summer 2009. The scale of the transformation required is far greater than initially thought.
	Commission a thrombolysis service in conjunction with North Trent Network , involving negotiations with surrounding Trusts and PCTs	Apr 2010	No
	DBH complete Implementation of the hyper-acute pathway	Aug 2010	
TIA Pathway	Agree service model, pathway, and potential funding issues between NHS Bassetlaw and DBH	Nov 09	

	Publicise and implement new pathway, including changes to referral process and DBH operational arrangements	Mar 2010
Long term support for Stroke patients	Assess current service provision against standards	Dec 2009
	Agree Bassetlaw Pathway to include psychological support and covering period from admission to end of care and support for stroke survivors	Mar 2010
	Redesign pathway	Apr-Oct 2010
	Start Clinical Psychology service	Apr 2010
	Start other new elements	Sept 2010
	New service in place	Mar 2011
Social Marketing	Specify service required from external provider	Dec 09
	Procure service	Jan 2010
	Implement the FAST campaign (National stroke campaign)	Jan 2010

Delivery Item	Risk to delivery	Impact	Likelihood	Mitigation
Hyper acute stroke pathway	Inability of DBH to recruit staff	High	Medium	Negotiate risk sharing strategy with DBH over financial pressures and fluctuations in income and cost.
	Inability to agree funding levels with DBH			
TIA Pathway	Ability to influence GPs to adopt new Pathway		Low	Carry out publicity and awareness exercise

Organisations engaged in the initiative:

- For Stroke pathways - DBH, EMAS, and GPs
- For Stroke long term care: NHS Bassetlaw Provider, Social Care, Voluntary Organisations, DBH, and mental health service providers

NHS Bassetlaw capability and capacity: A self-assessment by Bassetlaw Hospital shows that it does not meet any of the NSS Quality Markers. Bassetlaw Hospital was within the middle half of hospitals nationally in the 2008 Royal College of Physicians Sentinel Audit; however data gives an over-optimistic view of reality.

Provider Implications:

- **Hyper Acute Stroke Pathway:** DBH will need to make major internal process changes as well as recruiting significant extra staff. EMAS need changes to protocol and travel patterns. Other Acute Trusts will be impacted by NHS Bassetlaw's thrombolysis pathway.

- **TIA Pathway:** GPs will adopt the TIA pathway.
- **Long term care:** Providers including NHS Bassetlaw Provider, Social Care, Voluntary Organisations, DBH, and mental health service providers will see an increase in demand for their services over the next five years.
- **Stroke awareness:** The public and external stakeholder organisations should be more aware of stroke and the consequences of having a stroke.

The improved clinical quality driving stroke care in Bassetlaw should increase the choice and plurality of provision for people of Bassetlaw at risk of, or have experienced a stroke.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measures of success:

- Completed service transformations to meet NSS Quality Markers
- Positive feedback from service users that their quality of life has improved
- Improved performance against the national stroke vital sign (VSA14), implementation of the national stroke strategy
- Decrease the number of stroke deaths in 30 days per 100,000 by 18% over the 5 year plan

4.4.12 G4A) Access

Lead: Director of Commissioning **Director:** Director of Primary Care

Initiative Focus: To commission accessible acute, primary and community care for the people of Bassetlaw.

Progress over the last year:

- PPCI was made available to all Bassetlaw patients from Oct 26th 2009
- Improving access to psychological therapies is currently out to tender
- The new GP-Led Health (Westwood 8 to 8 Primary Care Centre) became fully operational on the 1st December 2009. The centre provides increased choice for patients to primary care medical services, as well as providing a "walk-in" facility.
- 9 of our 12 practices offer extended hours, which is 75% (this meets the requirement of this part of the initiative)
- Dental procurement in progress

NHS Bassetlaw has achieved marked improvements in access for acute, primary and community care over the last year. This will continue over the next five years.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Improved access to acute, primary and community services.
Vision: Supporting end to end patient experience in Bassetlaw.
Strategic Goal: Improved patient experience from access to the end of life
Outcomes: Life expectancy and Average All Age All Cause Mortality

National Fit: All are national 'must be dones'.

Regional Fit: Evidence to Excellence supports improved access to acute, primary and community care.

Local Fit: PPCI is a NORCOM protocol, primary care access aligns to our Bassetlaw primary care strategy and IAPT is supported in the LSP.

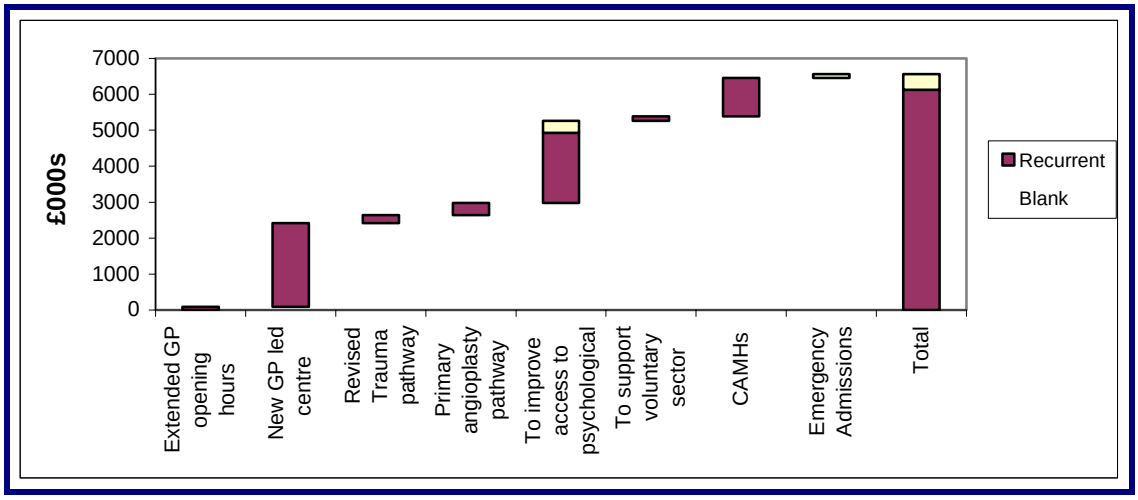
2. Evidence of need: There are high levels of unmet need in the population regarding access. PPCI access requires improvements for all our population – being driven by a NORCOM protocol. Primary care dental access decreased from 64% in 1993 to 55% in March 2009, whilst routine GP consultations were below the threshold for referral to secondary care. In addition, Bassetlaw lags behind its regional counterparts on IAPT implementation.

3. Health impact: PPCI will lead to better health outcomes for recovery from heart attacks. Increased access to NHS primary care dental services will enable NHS Bassetlaw to maintain and further improve the level of oral health of its population. Effective management of mental health in the community will support people to stay in work, consequently supporting the local economy.

4. Impact on health inequalities: PPCI will tackle deprivation associated with CHD in particular. Primary care access needs to meet the needs our entire population. IAPT will support people to stay in work leading to reduced deprivation levels.

5. Cost and cost effectiveness: The access initiative will cost £6.1m to implement over the period of the strategic plan. Much of this cost is recurring cost associated with

increasing access to services such as dental, GPs, GP led health centre and psychological therapies.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	594	839	1,564	1,564	1,564	**6,125**
Non-recurrent Cost	100	335	-	-	-	**435**
Disinvestment	-	-	- 100	- 200	- 200	**- 500**
Net Cost	694	1,174	1,464	1,364	1,364	**6,060**

Potential cost savings from a reduction in prescribing as a result of IAPT have been considered, however no substantive evidence of this could be found. Considering NHS Bassetlaw's focus on prescribing as part of the efficiency agenda no further savings are being pursued in this area via IAPT.

6. Affordability and Timing: The access initiative covers a wide range of activities and programme budgeting areas. The majority of spend is in three areas:

- Mental health where Bassetlaw's expenditure per head lags the national average and its peers
- GP health centre and extended hours, Bassetlaw's expenditure per head on GMS/PMS is higher than that of its peers
- Dental where Bassetlaw's spend per head also lags that of its peers

7. Patient demand: Without access adequate access to primary care services patients are caught between 2 stages - e.g. needing more than a GP but not 'ill enough' for secondary care. Feedback from the public has identified the need for additional access to NHS primary care dental services. NHS Bassetlaw undertook a 3 month statutory public consultation in relation to the location of the GP-Led Health Centre. In relation to extended hours, feedback was received via the National GP Patient Survey.

8. QIPP

Quality: PPCI is a higher quality intervention, reduction in stroke deaths – improved health outcomes.

The GP-Led Health Centre offers increased choice for patients in relation to accessing medical care. The provision of additional NHS primary care dental services will also enable increased access to services and will be available for all Bassetlaw residents.

Innovation: The GP-Led Health Centre is the first provider to offer a "walk-in service" in Bassetlaw and the dental procurement service specification includes the requirement to provide extended opening hours.

Productivity: GP extended hours increases the number of patients having access to extended hours appointments.

Prevention: IAPT offer earlier interventions reducing the likelihood of referral to secondary care, with another aim to keep people in work. Evidence reports that a high number of working days are lost through Mental Health. The APMS (Alternative Providers Medical Services) contract for the GP-Led Health Centre and the contract for the provision of additional NHS primary care dental services include a number of Key Performance Indicators, aimed at improving public health and oral health priorities.

9. Delivery - Ongoing

Key Milestones	Delivery Date
PPCI implementation	Ongoing
Acute Services Review	2010/11
Dental Contract Award	Feb 2010
Commencement of Dental service	June 2010
IAPT Implementation	Apr 2010

Risk to delivery	Impact	Likelihood	Mitigation
PPCI process went wrong - patients taken to the wrong place.	Medium	Medium	Comply with correct clinical procedure
Dental Services - Unsuccessful procurement process	High	Low	If current process is unsuccessful, undertake retender exercise

Organisations engaged in the initiative: Nottinghamshire County Council, Nottinghamshire Healthcare Trust, BCVS, NHS Bassetlaw, DBH, STH, EMAS, and NORCOM.

NHS Bassetlaw capability and capacity

- Contract management APMS contract (Current vacancy within primary care team)
- IAPT is required to shift the focus from secondary care

Provider implications: The ongoing development of a commissioning strategy for acute services and exploring opportunities for improved models of care integration to support the delivery of our strategic goals will have implications for our providers that we cannot currently determine. We are carrying out this work in 2010/11 with our main commissioning partner NHS Doncaster.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measures of success:

- Seamless PPCI implementation for the benefit of local residents
- Completion of the acute services review to define the strategic direction of acute services for the people of Bassetlaw
- Strong performance against national vital sign VSA06, patient reported measure of GP access and VSA07, practices offering extended opening hours

4.4.13 G4B) End of Life

Lead: Commissioning Development Manager **Director:** Director of Commissioning

Initiative Focus: To implement an End of Life pathway, integrating services and supporting individuals to die in a place of their choice at the end of their life.

Progress over the last year:

- Development of a Nottinghamshire End of Life care pathway (2008) for all diagnoses via countywide stakeholder involvement
- Development of a draft Bassetlaw strategy building on existing local work through a End of Life partnership group established in November 2008
- An implementation plan for End of Life care in Bassetlaw (conducted by Bassetlaw End of Life Partnership group, underpinned by a communication strategy and joint working with the Nottinghamshire End of Life Next Stage Review Programme)
- A piece of work to understand the local needs of all patients, regardless of their disease, at the End of Life conducted again by the Bassetlaw End of Life Partnership group

The progress over the last year has enabled a strong collaborative relationship across the locality and with partners, with some real improvement and transformational opportunities identified to implement the pathway. A GP practice data quality project and the public engagement have been significantly beneficial, and will continue to be central to the implementation.

Initiative Strategy aligned to Bassetlaw's Prioritisation Framework

1. Fit with strategy

Mission: Link to improving quality of life for the people of Bassetlaw at the end of life.

Vision: Supporting end to end patient experience in Bassetlaw. The end of life is a major issue for patients and their carers and has been previously overlooked.

Strategic Goal: Patient Experience

Outcomes: Percentage of all deaths that occur at home and Average All Age All Cause Mortality

National Fit: The National Strategy for Improving End of Life Care and the NICE Supportive and Palliative Care Improving Outcomes Guidance underpin the pathway and local strategy development. The End of Life Care strategy (2008) recommends a care pathway approach both for commissioning services and for the delivery of integrated care. This should include care after death and support for carers, both during a person's illness and after their death.

Regional Fit: End of life care was identified as a clinical priority by the East Midlands SHA in a 'Picture of Health'. The Nottinghamshire End of Life care pathway for all diagnoses is also representative of National Strategy. This is further enhanced by the release and alignment with the National Quality Markers for End of Life (2009) as the best practice implementation mechanism for achieving the proxy VSC15 indicator (the proportion of deaths at home).

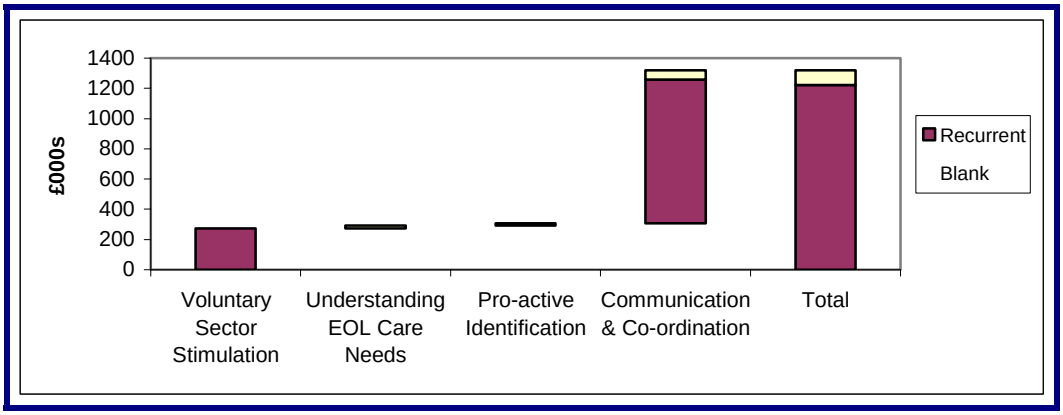
Local Fit: The proportion of deaths at home is a local priority Vital Sign. An End of Life Care Public Health Report (2008) and Health Needs Assessment (2009) have been completed confirming the local requirements and scale of need. NHS Bassetlaw Board have also agreed that health services are cradle to grave and that end of life care is as important as prevention and treatment. End of Life development has been driven through under the Professional Executive Committee, with leadership provided by Dr Foster.

2. Evidence of need: Approximately 1200 patients die in Bassetlaw every year, and it is anticipated that as many as 70% of these could be identified in advance and benefit from the implementation of the end of life care pathway. Carers, patient's families and the health and social care professionals working with patients at the end of life would benefit from improved integration and development in end of life care. The rate of deaths at home in Bassetlaw is lower than other areas and the National average as Bassetlaw has a significantly higher number of residential and nursing homes. The deaths in residential care homes do not contribute to the deaths at home proportion; such deaths are coded as a communal establishment. Other areas have significantly higher rates of deaths at home following substantial investment within co-ordination models such as Marie Curie's Delivering Choice. However, evaluation and cost/benefit analysis is still outstanding and analysis needs to consider the whole cost to the system (e.g. continuing care budget implications).

3. Health impact: The key health outcome for the end of life care initiative is to improve the quality, choice and experience of the end of life care. This will be achieved by increasing the proportion of deaths at home. Benefits realisation work through the Nottinghamshire Next Stage Review highlighted such an initiative significantly benefits both adults and their carers/families at the End of Life. Patients will have a greater awareness of and confidence in the services available for them and their families at the end of their lives.

4. Impact on health inequalities: The significant impact on inequalities is for patients receiving the same level of input regardless of their disease. It is considerably more difficult and less traditional to make a terminal prognosis for patients with long term and chronic conditions, as opposed to patients with cancer. This is partly due to other diseases such as heart disease or COPD deteriorating at varying rates where, for example, patients can get better. In addition, it is even more difficult to diagnose patients with dementia as their dementia affects their mental capacity to be involved in advanced care planning. The frail and elderly may also benefit from the pathway, although it is anticipated that there will be a cultural reluctance to enter into conversations or advanced care planning even though an individual may wish to do so.

5. Cost and cost effectiveness: End of Life Care will require a strategic investment over the 5 year period of £1.3m, some of this funding is being sought from the regional innovation fund.



	2009/10	2010/11	2011/12	2012/13	2013/14	Total
	£k	£k	£k	£k	£k	£k
Recurrent Cost	-	236	322	332	332	**1,222**
Non-recurrent Cost	35	13	10	40	-	**98**
Disinvestment	-	- 41	- 74	- 107	- 125	**- 346**
Net Cost	35	208	258	265	207	**974**

This will increase the proportion of deaths occurring at home from 16.8% to 25%, this is equivalent to an additional 100 patients a year being able to die at home if they wish to do so. There will also be an associated cost saving with those patients dying at home not requiring admission to hospital; this has been estimate to be worth £0.4m over the 5 year period. The End of Life Care project would therefore have a net cost to NHS Bassetlaw (excluding other funding sources) of less than £1m over the 5 year period.

6. Affordability and timing: End of Life Care spans several disease groups and so also several programme budgeting categories and so it is difficult to benchmark the affordability of the project based on programme budgeting spend by disease type. However NHS Bassetlaw's spend is typically low in areas of social and community care. This project has also received some external funding improving its affordability.

The benefits of the project will be immediate once implemented with patients, carers and relatives all benefiting from the choice of being able to die at home.

7. Patient demand: We compiled a 'Listening to You' – Patient and Public survey on End of Life Care for inclusion within the local press (Retford Times, Worksop Guardian, Worksop Trader and Retford and Bawtry Trader). This was also forwarded to the lay representatives on our Readers Panel, Modernisation Board, Maternity Services Liaison Committee (MSLC), the Bassetlaw Vascular Partnership Programme (BVPP) User Group and also posted on our website. We had 29 responses to the survey. 75% of respondent's felt that having access to a multi-disciplinary team who knows all about you is the most important factor for adults at the end of life. In addition, 52% of respondents said that they would like to receive information as early as possible following their diagnosis at the end of life. We also held two stakeholder events during August 2009, within which all attendees found the event interesting or very interesting, supporting the demand for more effective end of life care services for people in Bassetlaw at the end of life. Ongoing involvement is invaluable and central to the further development of plans, and it is clear that there is an appetite for this.

8. QIPP

Quality: The implementation of the best practice End of Life care tools is core to the pathway, and equality in access to EoLC services is the overarching objective, to ensure all patients have confidence in the health system.

Innovation: An innovation fund application has been made to take forward the work undertaken in Larwood & Village surgeries to proactively identify patients at the EoL, diffuse this across practices, and to integrate local solutions to improved communication using the Gold Standards Framework approach to End of Life care management in Primary care.

Productivity: Improved communication and co-ordination across community services to support patients to be cared for at the End of Life across settings. Integrated co-ordination and a centralised but local approach will ensure generalists are supported to care for patients at the end of life with confidence.

Prevention: Avoidable admissions related to general end of life care (i.e. not acute exacerbation of disease or symptom control) should be prevented as currently the last few days of life are treated as a crisis stage which can result in admission to hospital, whereas effective planning and communication can prevent this in line with the patients wishes.

9. Delivery

Start date: 2009 **End date: 2013/14**

Year	Health outcomes realised	Benefits
Year3 (2011/12)	Increase the proportion of deaths at home by increasing choice over place of death for people at the end of life by 4% from 18% to 22%.	▪ Cost saving of reduced hospital admissions of £0.1m by year 3 ▪ Increased choice over place of death for people at the end of life ▪ Improved patient experience
Year 5 (2013/14)	Increase the proportion of deaths at home by increasing choice over place of death for people at the end of life by 3% from 22% to 25%.	▪ Cost saving of reduced hospital admissions of £0.3m by year 5 ▪ Increased choice over place of death for people at the end of life ▪ Improved patient experience

Key Milestones	Delivery Date	Slippage
1. Understanding End of Life Care Needs	31/10/2009	Yes - Discovery interview process will be completed by March 2010 to include in-service action planning. Public consultation has more widely influenced the strategy development and was completed in Sept 09.
2. Pro-active identification of adults at the End of Life in Primary Care	Start 2012/13	No
3. Integrated Communication & Co-ordination service across all settings	Start July 2010	
4. Joint commissioning of carer support and voluntary sector stimulation, including counselling and bereavement services	Start April 2010	
5. Promotion of End of Life care services and pathway, including health promotion	March 2010 - 2012	

Delivery Item	Risk to delivery	Impact	Likelihood	Mitigation
2. Pro-active identification of adults at the End of Life in Primary Care	Practices overwhelmed with increasing demands	High	High	Financial incentives identified in budget request to pump prime activity rather than an enhanced service agreement.
3. Integrated Communication & Co-ordination service across all settings	Inability to agree funding levels with Provider or market management approach	High	Medium	Negotiation strategy to include requirement for ongoing productivity assessment, via productive series tools
4. Joint commissioning of carer support and voluntary sector	No interest from local 3rd sector	High	Low	Immediate engagement and widening of scope

stimulation				
5. Promotion of End of Life care services and pathway, including health promotion	Service model and information on new service enhancements or referral criteria's are not completed	Medium	Medium	Segment clinical detail and universal provision to provide clarity to patients.

Organisations engaged in the initiative: Primary Care/Local GP Practices, NHS Bassetlaw Provider services, Social Care, Voluntary Organisations, DBH, and Mental Health service providers.

NHS Bassetlaw capability and capacity: Opportunity to expand on existing end of life care projects in the Larwood practice. Significant commissioning capacity required to support the implementation of the end of life care pathway. The input and quality of services for patients known to the services are reported as being very good, receiving positive patient experience reports. The Integrated Pathway of Care (IPOC equivalent to Liverpool Care Pathway) has been implemented and used well, although this is not widespread. There is reported unmet need for specialised care in the community (potentially due to vacancies).

Provider Implications: Greater choice and plurality for patients will need to be offered by providers across the Bassetlaw community. Providers will be required to establish a locality register for patients at the end of life. Local voluntary sector providers are also necessary to implement the initiative in terms of their interest and engagement in the end of life care agenda. Providers will need to work with NHS Bassetlaw to develop clear and agreed service models and referral criteria for patients at the end of life.

OD: Ongoing partnership working with the organisations engaged in the initiative is required to initiative delivery. In addition, ongoing initiative delivery will be supported by Bassetlaw's OD programme management, Board Leadership, commissioning competence and staff training initiatives.

Measure of Success: Increase the proportion of deaths at home by 7%, enabled by increasing the % of people offered choice over place of death. To increase the proportion of deaths at home for the local vital sign (VSC15) - however this measure does not include residential care settings.

5 Finance

5.1 Financial Baseline

NHS Bassetlaw has a good track record of delivery and has annually met its statutory financial duties. We have ended every financial year in surplus since our inception (ranging from £0.1m to £2.7m), cash has been managed each year within our allocation, and we have consistently achieved Better Practice Payment Code targets over recent years.

Whilst still being 'below target' in terms of its Resource Limit funding, NHS Bassetlaw has received significant growth over recent years. As a result we have been able to deliver significant improvements to the delivery of healthcare to our population.

Financially NHS Bassetlaw ended 2008/09 with a surplus of £2.7m (hitting the SHA Control Total) and in recurrent balance. This sum has been carried forward to 2009/10 with a reduced, but reasonable surplus being planned for the end of the financial year.

We will use the surplus from 2009/10 during 2010/11 and subsequent years as we move to a period of potentially lower growth rates. The surplus will help us to deliver our initiatives identified within this document, directed at improving the quality and length of life for the people of Bassetlaw. The resource and other key assumptions utilised in the financing of this Strategic Plan for 2010/11 onwards in addition to the costs of our Strategic Initiatives and financial risks are described later in this section.

5.2 2009/10 Position Statement

NHS Bassetlaw Board approved our financial plan for 2009/10 at its meeting in March 2009. The plan demonstrated how we will meet our financial duties, deliver the requirements of the 2009/10 Operating Framework, progress our strategic initiatives, hold a contingency to meet in-year pressures and end the year with a surplus to carry forward to 2010/11. The plan incorporated the following assumptions:

Assumption	Value
Resource Limit Uplift	7.90%
National Tariff Uplift (incl. CQUINS)	2.20%
Primary Care Contractor Uplift	2.00%
Prescribing Uplift	4.00%
Efficiency Saving Target	2.00%
Contingency Reserve	0.75%
Utilisation of 2008/09 Surplus	£2.7m
Change in Strategic Reserve Investment	£1.0m
Planned Year End Surplus	£1.4m

We are on target to deliver our year end surplus for 2009/10, and are managing downside risks (around secondary care activity and prescribing) to its delivery.

5.3 Revenue Resource Limit

The 2007 Comprehensive Spending Review (CSR) confirmed the overall spending limits for the NHS for the period 2008/09 through to 2010/11. Changes (in the latter years of this period) to the allocation formula have had a material impact on NHS Bassetlaw's funding level. The review of the formula by the Advisory Committee on Resource Allocation improved the previous formula by introducing:

- A separate, transparent formula targeting funds at areas with the worst health outcomes;
- A new needs formula which enables need according to age and other factors to be assessed together for the first time; and
- A new market forces factor (MFF), which reduces the variation in the MFF for neighbouring PCTs and secondary care providers.

To ensure that by the end of 2010/11 no PCT is further than 6.2% away from its target allocation the Department of Health revised its Pace of Change policy. The resulting impact is that NHS Bassetlaw will receive 17.1% additional growth (around £27m) over the 2009/10 and 2010/11 financial years (against a minimum uplift of 10.6%), the highest in the country. We will however still end the period at 6.2% away from the target allocation.

5.4 Framework and Assumptions for 2010/11 Onwards

The Operating Frameworks for 2008/09 and 2009/10 set out the basic framework for the management of NHS finances, in talking about the need for 'transparency, consistency, independence and fairness', alongside the requirement to plan to deliver a reasonable level of surplus each year, whilst providing flexibility within the plan to manage risk and allow for further investment. In addition the latter recognises the changing outlook for public finances related to the economic recession.

NHS Bassetlaw has utilised a model incorporating secondary care activity and costs to develop its financial plans. The model works from the current baseline, utilising a series of assumptions, combined with the proposed Strategic Initiatives and other anticipated expenditure to formulate year on year plans through to 2013/14.

5.5 Key Assumptions

Our plans have been redeveloped against a backdrop of worldwide recession which followed the collapse of the financial sector in the Autumn 2008. Whilst there is a time delay before the full impact of this is felt by the public sector within the United Kingdom, the era of unprecedented levels of growth is now over, and the NHS must plan accordingly for what will most likely be a period of "little" or "no" growth.

The rapidly changing financial backdrop means that there is less certainty as we move from a period of "investing with growth" to one of "investing with savings". These savings however, have to be delivered from a review of the totality of our expenditure portfolio to ensure we are delivering best value, not just a review of our intended strategic initiatives. This review has been undertaken and is outlined in later sections of the Plan. We have therefore redeveloped more than one financial plan, to account for different potential scenarios. As such our strategic plan incorporates three financial scenarios redeveloped in conjunction with the East Midlands Strategic Health Authority.

We have redeveloped a common set of assumptions across the Nottinghamshire health community as part of the 'Productive Nottinghamshire' programme of work in the summer of 2009. This has allowed us to consistently model of the likely scale of pressures in the local health economy at an early stage and develop a collaborative response.

Following further work undertaken across the East Midlands Strategic Health Authority and nationally, an updated set of assumptions have been issued for financial modelling purposes. The scenarios each contain the same set of assumptions for 2010/11 with the variability being between 2011/12 and 2013/14, affecting the resource limit increase (between the base and worse case) and the level of efficiency retained from providers (across all three scenarios). These have been fully incorporated into our plans and are outlined in the following paragraphs.

Resource Limit Assumptions: No change is anticipated to the Resource Limt uplift announced for 2010/11. Resource Limit growth for the remaining three years of the strategic plan is based on the SHA assumption across the three scenarios. The Resource Limit assumptions for the duration of the Plan are tabulated below:

Resource Limit Uplift /Year	2010/11	2011/12	2012/13	2013/14
Base Case (%)	8.6	0.0	0.0	0.0
Worst Case (%)	8.6	0.0	0.0	0.0
Best Case (%)	8.6	2.5	2.5	2.5

We have included a small number of additional assumptions in each scenario:

- Each year's surplus is available in the following year
- The return of the residual funds currently lodged within the SHA Strategic Reserve in 2010/11

Inflation/Cost Pressure Uplifts Assumptions: Inflation and cost pressure uplifts that will be applied to Legally Binding Contracts and Service Level Agreements for Hospital, Community Services and Private providers are based around projected uplifts to the National Tariff, net of efficiency savings. These are set out below across the three different scenarios:

Base Case

Year	2010/11	2011/12	2012/13	2013/14
Gross Tariff Uplift (%)	3.5	2.5	2.5	2.5
Efficiency Rate (%)	-3.5	-4.5	-4.5	-4.5
Net Uplift (%)	0.0	-2.0	-2.0	-2.0

Worst Case

Year	2010/11	2011/12	2012/13	2013/14
Gross Tariff Uplift (%)	3.5	2.5	2.5	2.5
Efficiency Rate (%)	-3.5	-4.0	-4.0	-4.0
Net Uplift (%)	0.0	-1.5	-1.5	-1.5

Best Case

Year	2010/11	2011/12	2012/13	2013/14
Gross Tariff Uplift (%)	3.5	2.5	2.5	2.5
Efficiency Rate (%)	-3.5	-3.5	-3.5	-3.5
Net Uplift (%)	0.0	-1.0	-1.0	-1.0

In addition it is anticipated that 1.5% will be available under the CQUINS scheme non-recurrently each year for the relevant providers.

In respect of Primary Care, differential rates are required for uplifts to contracts and GP Prescribing. The percentage uplifts are tabulated below (net of efficiency savings) and are consistent across the three scenarios:

Sector/Year	2010/11	2011/12	2012/13	2013/14
GP and Pharmacy Contracts (%)	1.0	1.0	1.0	1.0
Dental Contracts (%)	0.2	0.2	0.2	0.2
GP Prescribing (%)	4.0	5.0	5.0	5.0

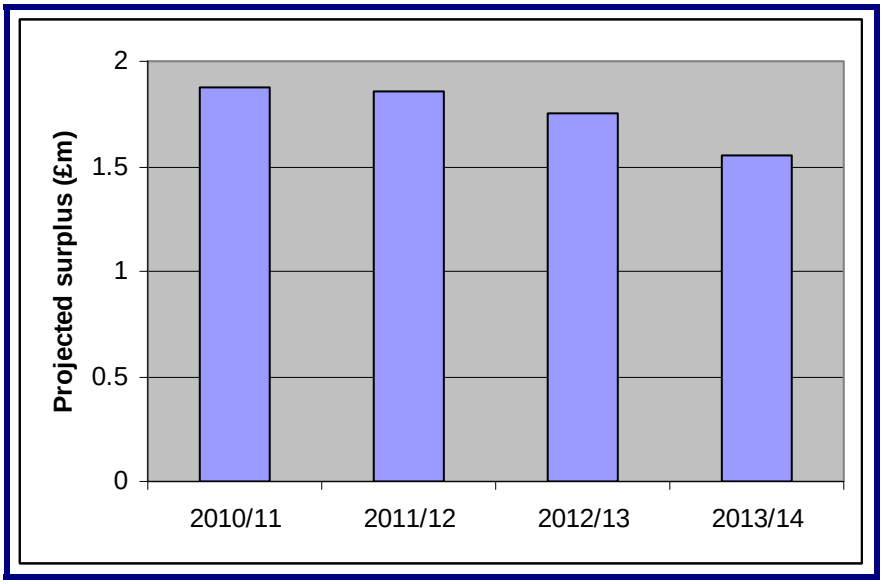
Contingency: NHS Bassetlaw has included a contingency reserve of 0.5% within the plans for each year.

Population Changes: The Plans incorporate anticipated increases to the population of Bassetlaw over the duration of the plan. These increases are based on projections provided by the Office of National Statistics, adjusted to reflect the changing age structure of the population and the size of historical rises compared to previous projections. The increases have been applied to our healthcare spend and are as follows:

Year	2010/11	2011/12	2012/13	2013/14
Population Increase (%)	0.91	1.22	1.06	0.65

Acute care demand: Whilst demand for acute services has increased in excess of population growth during 2009/10 it is at a lower rate than in 2008/09. The plans for 2010/11 onwards assume that growth is limited to population growth only. Practice Based Commissioning groups will manage this position as part of the initiative to ensure best value and movement to upper quartile performance in referrals for elective care, with urgent care growth being contained by the investment in strategic initiatives and the outcome of the review of acute care at our main provider.

Year End Surplus: The proposed surplus of £1.4m for the end of 2009/10 equates to around 0.8% of our resource limit for that year. We plan to deliver a surplus of 1.0% (c.£1.9m) in 2010/11 in line with Operating Framework requirements, with annual surpluses for 2011/12 through to 2013/14 falling slightly each year to around 0.83% (c.£1.6m) of our resource limit by 2013/14. The annual surpluses are shown in the following graph:



Recurrent Balance: The plans accord with the requirement in the 2010/11 Operating Framework to end each financial year with 2% of the Resource Limit recurrently uncommitted.

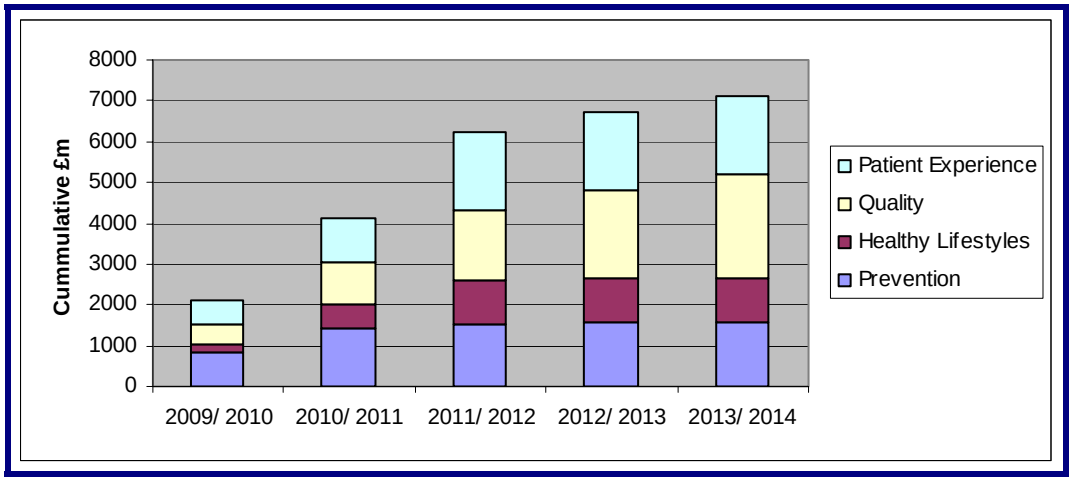
5.6 Investments

Pre-commitments/Non-Initiative Expenditure: The early years of our plan contain the costs of commissioning decisions made in previous years, the balance to full year effect of schemes that we have already commenced and the costs of the increased demand for services during 2009/10 in our main acute, ambulance and specialised services contracts. In addition our financial plans recognise that while the strategic initiatives form the backbone of our spending plans for the duration of the strategic plan, NHS Bassetlaw will be required to commit resources to other areas of its wide investment portfolio. In summary these investments cover the following issues:

Year (k' 000s)	2010/11	2011/12	2012/13	2013/14
Acute Contracts	3,177	3,727	4,177	4,427
Ambulance Service	772	1,016	1,016	1,016
Specialised Services	474	774	1,074	1,374
Continuing Care	1,500	2,200	2,800	3,400
Secure Services	285	470	655	840
Other	291	401	591	691
Total	6,499	8,588	10,313	11,748

Strategic Initiative Investment: All of our strategic initiatives have been fully costed and included within our financial planning, the details of these costs can be found within the strategy and delivery section of the strategic plan. The following tables outline the additional recurrent investment being made each year within the "Base Case":

Recurrent Initiative investment by our 4 strategic goals



Recurrent Initiative Investment (£000's)	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014
G1A – Older People (Falls)	40	213	213	213	213
G1B – Infant Health	614	721	721	721	721
G1C – Obesity	65	235	325	400	400
G1D – Vascular	109	249	249	249	249
G2A – Smoking	10	35	142	142	142
G2B – Long Term Conditions	68	264	632	632	632
G2C – Alcohol	95	267	267	267	267
G3A – Cancer	435	835	1,235	1,635	2,035
G3B – Stroke	30	196	511	511	511
G4A – Access	594	839	1,564	1,564	1,564
G4B – End of Life Care	0	236	322	332	332
Children and Young People (Complete 2009/10)	35	35	35	35	35
Total Investment	**2,095**	**4,125**	**6,216**	**6,701**	**7,101**

Non Recurrent Initiative Investment (£000's)	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014
G1B – Infant Health		10	5	5	5
G1C – Obesity		20			
G2A – Smoking	15	10			
G2B – Long Term Conditions		92	50		
G3A – Cancer	20				
G4A – Access	100	335			
G4B – End of Life Care	35	13	10	40	
Cross cutting	40	240	200	200	200
Children and Young People (Complete 2009/10)	44				
Total Investment	**254**	**720**	**265**	**245**	**205**

5.7 Efficiency (QIPP) Programme

Reference has already been made earlier to the impact of the recession on public sector finances, and the move to a period of "investing from savings". Dis-investing from current services, re-engineering pathways, moving to upper-quartile performance, driving out inefficiencies and tightening up bureaucratic processes will form the backbone of an integrated Efficiency Programme under the Quality, Innovation, Productivity and

Prevention (QIPP) initiative. Our delivery of this efficiency programme is key to providing the finances required by NHS Bassetlaw to drive forward its investment programme.

Details of NHS Bassetlaw's approach to the QIPP process focussing on governance arrangements, collaboration, scheme identification and delivery plans can be found in the next section. This section outlines the (Base Case) financial plans around those funds that will be disinvested via Strategic Initiatives and those that have been identified for disinvestment through benchmarking.

Via Strategic Initiatives -

Initiative/Disinvestment (£000's)	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014
G1A – Older People (Falls)	-149	-387	-622	-867
G1D – Vascular		-61	-61	-61
G2B – Long Term Conditions		-277	-554	-554
G2C – Alcohol	-333	-467	-604	-743
G3B – Stroke	-25	-25	-25	-25
G4A – Access (Psychological Therapies)		-100	-200	-200
G4B – End of Life Care	-41	-74	-107	-125
Total Disinvestment	**-548**	**-1,391**	**-2,173**	**-2,575**

Via Benchmarking -

Area/Disinvestment (£000s)	2010/2011	2011/2012	2012/2013	2013/2014
Outpatients	-488	-1,325	-2,050	-2,613
Prescribing	-788	-2,088	-2,919	-3,453
Elective	-400	-1,200	-1,600	-1,600
Urgent Care	-200	-336	-336	-336
Mental	-131	-325	-425	-481
Extended Primary Care		-200	-300	-400
Management Costs/Back Office	-166	-716	-716	-716
Total Disinvestment	**-2,173**	**-6,190**	**-8,346**	**-9,599**

Overall plan -

Area/Disinvestment (£000s)	2010/2011	2011/2012	2012/2013	2013/2014
Total Disinvestment	**-2,721**	**-7,581**	**-10,519**	**-12,174**

Transformational Change: Disinvestment on such a scale is unlikely to happen without incurring one-off costs in both the planning and delivery stages. To enable the delivery of the efficiency programme, we have set aside a non-recurrent (Transformational Change) budget each year for the duration of the plan. Initial focus will be on supporting Practice Based Commissioners to deliver savings on those schemes which have their 'start point' in Primary Care (e.g. prescribing and outpatient referrals). This sum will also be available

to support change emanating from the Review of Acute Services (predominantly affecting the contract with Doncaster and Bassetlaw Hospitals NHS Foundation Trust) referred to elsewhere in the document. The proposed funding level in each year is £2.8m.

5.8 Capital

Excluding LIFT Buildings, NHS Bassetlaw has a relatively small fixed asset base (£7.7m as at 31st March 2008). In addition our proposed strategic initiatives are not capital intensive (the GP Led Health Centre premises are the responsibility of the provider and reimbursement will be dealt with through revenue funding).

We will therefore require a low level of capital allocation through to 2013/14 to meet statutory requirements, upkeep of the estate, equipment and IT investment totalling around £500,000 pa to £750,000 pa. This requirement may change dependent on the outcome of the review of acute services.

5.9 Financial Plan under Multiple Funding Scenarios

The financial plans have been developed in line with the assumptions outlined earlier in this chapter. The plan for 2010/11 remains constant across all scenarios with the variable assumptions (Resource Limit growth and Tariff efficiency) impacting on 2011/12 to 2013/14. All plans are considered to be realistic and capable of delivery.

The Board have been involved in handling the "Trade-offs" required under the "Worst Case" scenario and their opinions sought on additional investment under the "Best Case" scenario. Further prioritisation under the latter scenario will take place if additional funding becomes available.

Base Case

Assumes 0.0% increase in Resource Limit and 2.0% efficiency (above gross tariff costs) withdrawn from providers from 2011/12.

Source and Application of Funds (£m)	2010/11	2011/12	2012/13	2013/14
Recurrent				
Recurrent Uplift	14.4	0.0	0.0	0.0
Recurrent surplus/deficit (-) b/fwd	-1.0	3.8	3.7	3.9
Efficiency Programme	2.7	4.9	3.0	1.6
Total Funds Available	**16.1**	**8.7**	**6.7**	**5.5**
Inflationary Uplifts to Budgets	-2.3	1.3	1.2	1.1
Population Growth	-1.5	-2.1	-1.8	-1.1
Investment	-8.5	-4.2	-2.2	-1.8
Recurrent Surplus	**3.8**	**3.7**	**3.9**	**3.7**

Non Recurrent				
Previous Year Surplus	1.4	1.9	1.8	1.8
Change in SHA Reserve	0.8	0.0	0.0	0.0
Other Income/Resource Limit Changes	0.3	0.2	0.0	0.0
Investment	-0.7	-0.3	-0.2	-0.2
Contingency	-0.9	-0.9	-0.9	-0.9
Transformational Change	-2.8	-2.8	-2.8	-2.8
Non Recurrent Surplus/Deficit (-)	**-1.9**	**-1.9**	**-2.1**	**-2.1**
Total Surplus	**1.9**	**1.8**	**1.8**	**1.6**

Worst Case

Assumes 0.0% increase in Resource Limit and 1.5% efficiency (above gross tariff costs) withdrawn from providers from 2011/12.

Delivery of financial targets has been maintained under this scenario by identifying areas of potential investment, which can be reduced, slowed-down or delayed, and further productivity and efficiency opportunities. Examples of the former are a reduction in Social Marketing spend and scaling back investment in the smoking and long term conditions initiatives. Examples of the latter are productivity opportunities identified through Programme Budgeting and increasing the target savings for prescribing, management costs and urgent care (through tighter management of the outcomes of the Acute Services Review). Detailed changes are included within the financial templates.

Source and Application of Funds (£m)	2010/11	2011/12	2012/13	2013/14
Recurrent				
Recurrent Uplift	14.4	0.0	0.0	0.0
Recurrent surplus/deficit (-) b/fwd	-1.0	3.8	3.6	3.8
Efficiency Programme	2.7	5.3	3.6	2.2
Total Funds Available	**16.1**	**9.1**	**7.2**	**6.0**
Inflationary Uplifts to Budgets	-2.3	0.7	0.6	0.5
Population Growth	-1.5	-2.1	-1.8	-1.1
Investment	-8.5	-4.1	-2.2	-1.8
Recurrent Surplus	**3.8**	**3.6**	**3.8**	**3.6**

Non Recurrent				
Previous Year Surplus	1.4	1.9	1.8	1.8
Change in SHA Reserve	0.8	0.0	0.0	0.0
Other Income/Resource Limit Changes	0.3	0.2	0.0	0.0
Investment	-0.7	-0.2	-0.1	-0.1
Contingency	-0.9	-0.9	-0.9	-0.9
Transformational Change	-2.8	-2.8	-2.8	-2.8
Non Recurrent Surplus	**-1.9**	**-1.8**	**-2.0**	**-2.0**
Total Surplus	**1.9**	**1.8**	**1.8**	**1.6**

Best Case

Assumes 2.5% increase in Resource Limit and 1.0% efficiency (above gross tariff costs) withdrawn from providers from 2011/12.

This scenario affords us the opportunity to invest further across a number of important areas, including neighbourhood management, lifestyle change, children and young people and care in the community. Examples of these would be extending the obesity initiative, home based intensive care, commissioning joint services with adult social care, development of "non-medical" Primary Care and community diagnostics.

Detailed changes are included within the financial templates.

Prioritisation of these issues will take place once there is more clarity on the timing and scale of funding over and above the Base Case.

Source and Application of Funds (£m)	2010/11	2011/12	2012/13	2013/14
Recurrent				
Recurrent Uplift	14.4	4.6	4.7	4.8
Recurrent surplus/deficit (-) b/fwd	-1.0	3.8	3.7	3.9
Efficiency Programme	2.7	3.9	3.0	1.6
Total Funds Available	**16.1**	**12.3**	**11.4**	**10.3**
Inflationary Uplifts to Budgets	-2.3	0.0	0.0	-0.1
Population Growth	-1.5	-2.1	-1.8	-1.1
Investment	-8.5	-6.5	-5.7	-5.4
Recurrent Surplus	**3.8**	**3.7**	**3.9**	**3.7**
Non Recurrent				
Previous Year Surplus	1.4	1.9	1.8	1.8
Change in SHA Reserve	0.8	0.0	0.0	0.0
Other Income/Resource Limit Changes	0.3	0.2	0.0	0.0
Investment	-0.7	-0.3	-0.2	-0.2
Contingency	-0.9	-0.9	-0.9	-0.9
Transformational Change	-2.8	-2.8	-2.8	-2.8
Non Recurrent Surplus	**-1.9**	**-1.9**	**-2.1**	**-2.1**
Total Surplus	**1.9**	**1.8**	**1.8**	**1.6**

Sensitivity Analysis: We have used the scenarios agreed with the SHA as the basis of our sensitivity analysis, and feel that the assumptions around resource limits and inflation uplifts are generally robust. NHS services are however in the majority of areas, demand led. We are therefore aware of the risks and drivers that could affect the financial performance of NHS Bassetlaw, and the organisation has assessed these potential impacts and has a strategy in place to deal with them should the need arise. The following issues could influence the delivery of this plan.

- Variation in anticipated resource limits growth levels
- Growth in acute sector cannot be contained
- National tariff uplift and other inflation assumptions vary from projection
- Levels of required disinvestment cannot be delivered
- Changes to the Payment by Results process are not revenue neutral
- Growth in high cost case numbers (Continuing Care/Secure Services) higher than projection.
- Unanticipated growth in registered population.
- In-year cost pressures exceed planning assumptions and cannot be managed down to affordable levels.
- Impact of unpredictable costs, such as the impact of new technologies cannot be afforded within current assumptions.

The table below takes forward a number of the above risks, and outlines the potential effect on NHS Bassetlaw's overall financial position of these risks:

Risk	Each %	Value £m
Variation in Resource Limit growth level	1.0	1.80
Variation in prescribing costs	1.0	0.20
Variation in National Tariff	1.0	1.20
Efficiency savings not delivered (average across plan)	10.0	0.30
Movement in Continuing Care Costs	10.0	0.50
Increase in acute sector activity	1.0	0.80

Where there is downside risk this will be mitigated by utilisation of the contingency reserve, a reprioritisation of investments, identifying and delivering additional efficiency opportunities and the planned surplus. Upside risk will allow NHS Bassetlaw to bring forward schemes planned for future years or invest in further initiatives, which benefit the health of the population of Bassetlaw.

NHS Bassetlaw will ensure that its internal processes of budgetary management, monitoring and forecasting are reviewed and enhanced where appropriate, to reduce the impact of the types of variation outlined above on the finances of the PCT.

6 Quality and Productivity

6.1 Context

Reference has already been made earlier to the impact of the recession on public sector finances, and the move to a period of "investing from savings". Dis-investing from current services, re-engineering pathways, moving to upper-quartile performance, driving out inefficiencies and tightening up bureaucratic processes will form the backbone of an integrated Efficiency Programme under the Quality, Innovation Productivity and Prevention (QIPP) initiative. Our delivery of this efficiency programme is key to providing the finances we require to drive forward our investment, and failure to deliver the programme is the major risk we face.

Our plans (under the base case) require the need to identify and deliver significant efficiency savings over the next four years:

Year	2010/11	2011/12	2012/13	2013/14
Cumulative Savings (£m)	2.7	7.6	10.5	12.2

The disinvestment opportunities have been identified through two sources:

- Those associated with our strategic initiatives, and
- Those identified through detailed benchmarking using a range of national and local data such as the NHS Institute (e.g. Better Care Better Value and Opportunity Locator toolkits), programme budgeting and Dr Foster.

In addition the plans reflect the 2010/11 Operating Framework requirement to reduce the cost of management within PCTs, and savings from the urgent care workstreams currently underway.

Unsurprisingly given the high level of spend on acute services the majority of the opportunities identified are attributable to that sector. It is anticipated that there will (at this point) be no additional cash releasing impact on the PCT's provider function other than its contribution to the overall reduction in management costs and handling the implications of a zero uplift or reduction to tariff. Additional productivity will however form part of our commissioning intentions for the provider function.

The delivery of plans requires close collaboration with the wider health communities in both Doncaster and Nottinghamshire. In line with other organisations within the Nottinghamshire Health Community plans have been developed around aspiring to top quartile performance.

6.2 Savings Opportunities from Strategic Initiatives

All of our strategic initiatives have been tested to determine whether they will deliver efficiency savings within the duration of this Strategic Plan. A number of them (e.g. Smoking and Obesity) are likely to deliver economic benefits through reduced care costs in years to come, but not before 2013/14 and therefore no financial benefit has been assumed.

Seven of the initiatives however will deliver benefits, by reducing non-elective admissions (or in the case of Access to Psychological Therapies, prescribing costs) within the timescale of the plan. These savings totalling around £2.6m have been incorporated into our plans, and where applicable for 2010/11, contracts with providers will be reduced accordingly in anticipation of the savings being delivered. These savings are tabulated below:

Initiative/Disinvestment (£000's)	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014
G1A – Older People (Falls)	-149	-387	-622	-867
G1D – Vascular		-61	-61	-61
G2B – Long Term Conditions		-277	-554	-554
G2C – Alcohol	-333	-467	-604	-743
G3B – Stroke	-25	-25	-25	-25
G4A – Psychological Therapies		-100	-200	-200
G4B – End of Life Care	-41	-74	-107	-125
Total Disinvestment	**-548**	**-1,391**	**-2,173**	**-2,575**

6.3 Savings Opportunities from Benchmarking

The detailed benchmarking undertaken using a range of national and local data, has identified a range of areas where significant opportunity is available to reduce cost to top quartile performance. This must of course be delivered whilst maintaining quality of care for the population and this will be achieved by taking on-board best practice from elsewhere and developing and implementing plans in conjunction with the clinical community.

The main areas of opportunity come from:

- High levels of outpatient appointments where we are in the top quartile for highest referral rates, are well above average for the percentage of outpatients discharged at first appointment and have a higher than average follow-up rate.

- Prescribing, where we are in the top quartile for prescribing rates nationally and have significant variation between practices

- Elective admissions, where we are currently performing in excess of national average, are in the lowest quartile relating to the day case to inpatient ratio, have lower surgical threshold rates than Doncaster PCT who share the same main acute provider and carry out some interventions of limited clinical benefit.

- Mental Health where we have a high admission rate, and are in the top quartile nationally and within peer group for first attendance outpatient appointments

- Extending Primary Care due to having a number of practices still in receipt of a high level (or estimated high level for PMS practices) of funding in respect of the Minimum Protected Income Guarantee

Workstreams currently underway with our main acute provider, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, enable us to set a savings target for reductions in urgent care activity and costs in addition to those savings identified through the strategic initiatives. These workstreams are focussed on the admissions process through (and use of) A&E, the role of assessment beds, and the discharge process.

In addition our plans incorporate the savings that will derive from the 2010/11 Operating Framework requirement to reduce management costs and back office functions. These savings will also include projected savings from the reduced management costs of the Provider Function following a decision on its future form.

6.4 Savings Plans

Savings plans to deliver the savings opportunities are being finalised for each of the areas identified above. Examples of initiatives currently being considered in a number of the areas are listed below:

Outpatients: Peer review of referrals within practice, a PCT owned/led referral management centre for all or specific speciality referrals, alternative community based services across a range of topics, increasing direct access to diagnostics, results via GPs, setting tight targets/ratios for follow-up attendances, a comprehensive PCT led referral audit and practice elective referral reduction targets by speciality

Prescribing: Continuous review of those areas covered by Better Care, Better Value indicators, improving generic prescribing performance, concentrating on "high-spend" practices, implementing a PCT-wide incentive scheme, providing on-site support to practices, reviewing repeat dispensing processes, ensuring linkage between pharmacies and practices around Medicines Use Reviews and increasing their usage, and reviewing and monitoring the Excessive and Inappropriate Prescribing Policy.

Elective Care: Ensuring consistent application of surgical thresholds within the main acute provider, investigating and ensuring application of the thresholds associated with procedures of limited clinical benefit, and improving the day case to inpatient elective ratio.

Mental Health: Building on a pilot scheme to site Crisis Resolution and Home Treatment staff within the A&E Department at Bassetlaw Hospital to provide appropriate and timely assessment for patients without the need for admission to Hospital.

Extended Primary Care: Delegating 100% of the commissioned healthcare budget to practices to ensure delivery of additional services for those practices with a "high" Minimum Protected Income Guarantee.

Management Costs: Scrutiny of all management budgets for immediate savings (including vacancy control), review of partnership processes, and estates review.

Target savings have been identified for each area and are tabulated below:

Year/Cumulative Savings (£000s)	2010/11	2011/12	2012/13	2013/14
Outpatient Appointments	-488	-1,325	-2,050	-2,613
Prescribing	-788	-2,088	-2,919	-3,453
Elective Care	-400	-1,200	-1,600	-1,600
Urgent Care	-200	-336	-336	-336
Mental Health	-131	-325	-425	-481
Extended Primary Care		-200	-300	-400
Management Costs/Back Office	-166	-716	-716	-716
Total	**-2,173**	**-6,190**	**-8,346**	**-9,599**

6.5 Clinical Engagement

Clinical engagement is key to the delivery of the savings and the future Quality and Productivity agenda. To deliver our QIPP ambitions we must leverage the impact and pace of change of practice based commissioning, ensuring that the clinical leadership infrastructure is not held back by bureaucratic procedures, which stifle the innovation that could come from primary care.

Effective clinical leadership and engagement with PBC at the forefront is the key vehicle for change both in secondary and primary care. This must be underpinned by a clear

understanding of commissioning and practice based commissioning; the divide between commissioning and provision and the infrastructure, accountability process and outcomes measures/incentives to create the level and quality of engagement that is needed to achieve for all participants.

6.6 Transformational Change

Disinvestment on such a scale is unlikely to happen without incurring one-off costs in both the planning and delivery stages. To enable the delivery of the efficiency programme, we have set aside a non-recurrent (Transformational Change) budget each year for the duration of the plan. Initial focus will be on supporting Practice Based Commissioners to deliver savings on those schemes, which have their 'start-point' in Primary Care (e.g. prescribing and outpatient referrals). This sum will also be available to support change emanating from the Review of Acute Services (predominantly affecting the contract with Doncaster and Bassetlaw Hospitals NHS Foundation Trust) referred to elsewhere in the document. The proposed funding level in each year is £2.8m.

6.7 Approach and Governance

A Bassetlaw Health Economy QIPP Delivery Group has been established to support the local NHS organisations in setting and delivering the QIPP agenda across both commissioners and providers. It will give strategic input and direction to the QIPP agenda, a consistent and coordinated approach across functions and organisations, be a cross organisation performance management function and provide a mechanism to help maintain financial stability.

In addition it will provide assurance of delivery to the constituent organisation's Boards, support the continuation of high quality services whilst delivering the necessary savings, and commission specific pieces of work from task and finish groups. Its membership covers all NHS organisations within the Bassetlaw Health Economy, NHS Doncaster and Nottinghamshire County Council.

The Group will also link into the equivalent structures within Doncaster and Nottinghamshire, as it is recognised that the volume of savings required cannot be achieved by organisations working in isolation. The Productive Nottinghamshire Health Community approach (which is equally applicable to our cross-border working) is based on the following set of principles:

- Health community's board level commitment to the collaborative approach
- A shared financial approach and growth assumptions
- A collective approach to assessing the impact of change
- Agreed community wide priorities for increasing productivity
- A process for driving this major agenda forward

Internally we will use our Performance and Delivery Group chaired by the Director of Commissioning to oversee delivery of our plans and improve our performance in delivering Competency 11 (Ensuring Efficiency and Effectiveness of Spend). Board assurance will be delivered via the Audit Committee.

7 Board Approval

NHS Bassetlaw Board in conjunction with staff and key stakeholders has supported the redevelopment of our 5 year strategic ambition – 'to improve the quality and length of life for the people of Bassetlaw'. The Board has been fully engaged in our strategic plan redevelopment as part of our WCC assurance process.

Throughout the redevelopment of our strategic plan the Board has championed the plan's development. This has been achieved by Board involvement in a number of key sessions. These include a Board mission, vision and strategic goals session, a large stakeholder event (which members of our Board attended), a number of Board confirm and challenge sessions, continuous Board review and feedback, and final Board sign off of our redeveloped plan.

Our Board participated in debates about quality and productivity of our 5 year strategic plan during Board confirm and challenge sessions. In particular discussion and debate took place around prioritisation, quality and productivity of our strategic initiatives, informed by NHS Bassetlaw's productivity report and ongoing QIPP agenda. Our productivity report highlighted benchmarking and productivity opportunities relating to our strategic initiatives and wider productivity gains for NHS Bassetlaw over the course of our 5 year plan.

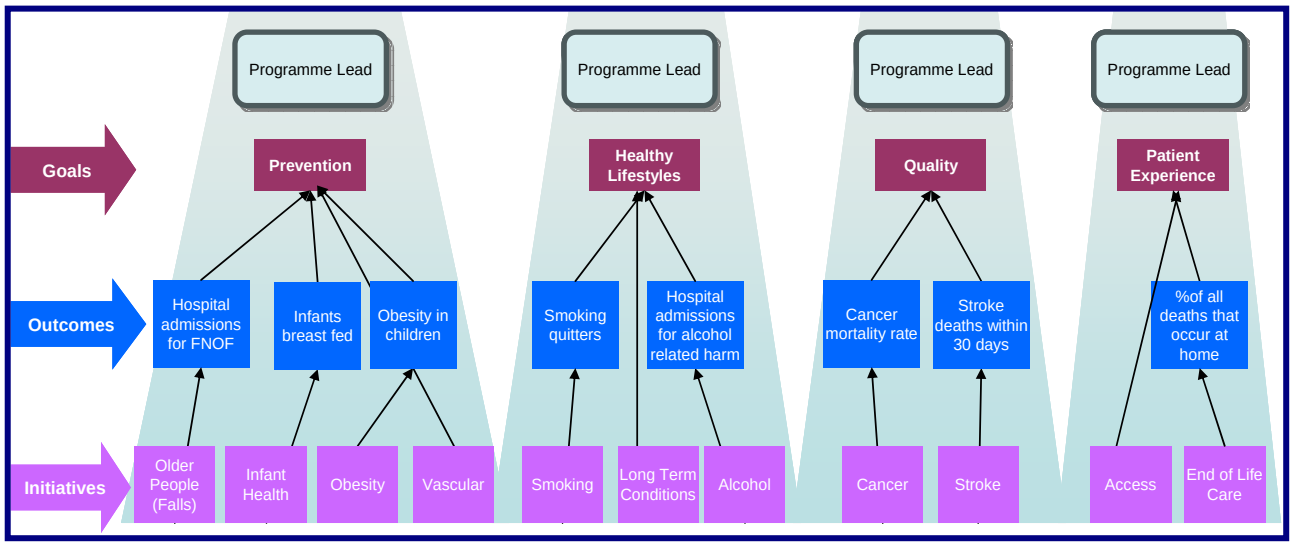
The Board have also strengthened the assurance process for 2010/11 building on the 2009/10 approach where throughout the year our Board have received quarterly WCC monitoring reports on our strategic initiative progress. To build on this within our redeveloped strategic plan we are pursing a programme management approach to deliver our strategic ambition with Board Sponsorship through its assurance processes. The box below defines the principles of our programme management approach which has been endorsed by our Board.

Programme management -

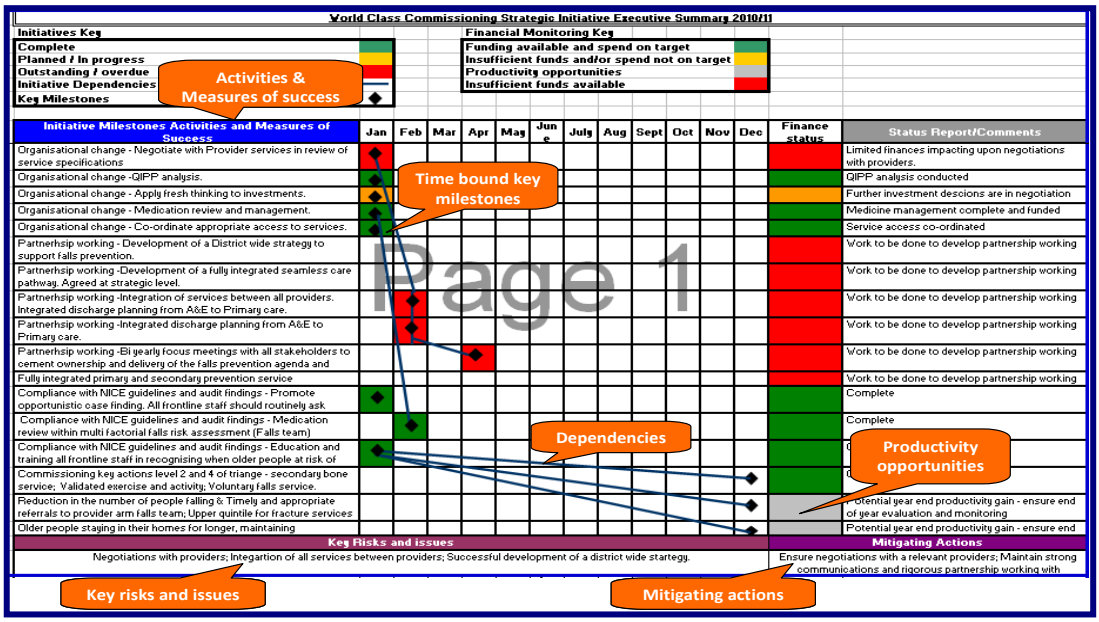
- ……provides assurance that outcomes in the strategic plan are being delivered
- …… supports the application of WCC competencies throughout the commissioning cycle
- ……provides greater accountability for the delivery of outputs and outcomes
- ……supports staff by clarifying roles and managing workloads
- ……enables risks and issues to be proactively managed
- …. gains visibility and control of initiatives through improved reporting and communications
- …….builds understanding of dependencies between initiatives and programmes of work
- …….facilitates time-bound monitoring of key strategic milestones supporting effective milestone delivery

To proceed with a programme management approach (as defined above) our four strategic initiatives (prevention, healthy lifestyles, quality and patient experience) all have a named director programme lead. In addition, our non-executive directors (NEDS) have agreed the process of aligning the chairs of board subcommittees to the strategic plan by sponsoring one of our four strategic programmes. This was seen by the Board as an

opportunity to provide further Board challenge throughout the delivery of our redeveloped strategic plan. Our four programmes are illustrated in the diagram below.



We already have the foundations of initiative based performance management in place. To support the successful delivery of our redeveloped strategic plan we are also enhancing our existing WCC monitoring report which is reviewed by our Board (see below).



The report will now include clear time bound key milestones, measures of success and initiative activities as defined within our 5 year plan, key initiative dependencies, risks, issues and mitigating actions, and productivity opportunities. Our ongoing QIPP work will be monitored through our Audit Committee as a subgroup of the Board. Risks to the delivery of our strategic plan will be included in our risk register and Board Assurance Framework. Contingency plans i.e. the triggers for best and worst case scenarios, will also be reviewed, monitored and brought into effect by the Board.

Our Board approves the content and strategic direction of Bassetlaw's redeveloped 5 year plan and the programme management approach to ensure successful delivery of our strategic ambition for the people of Bassetlaw.