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PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

CORPORATE EXECUTIVE BOARD

A meeting of the Board will be held on Wednesday 1 March 2000 at 12:30 in the Large Conference Room, Finchdean House

AGENDA

1. **Apologies for absence**

2. **Minutes of the last meeting**

   To agree the minutes of the previous meeting held on Wednesday 26 January 2000. — Attachment (white)

3. **Obstetric and Midwifery Workforce Planning**

   Presentation by John Bevan, David Davies and Joy Dillow

4. **Matters Arising**

   - **Service and Financial Framework**
   - **Creation of new Health Authority**
   - **Future health services for the residents of Gosport and south Fareham**
   - **Progress report on devolution of commissioning**
   - **Tackling teenage pregnancy**
   - **PCG to PCT and boundary review**

5. **High Cost Drug and other Contract Exclusions in 2000/2001**

   To receive a briefing note regarding high cost drugs and other contract exclusions in 2000/2001. — Attachment (green)

6. **Improving health in the South East**

   To receive the programme of work for the South East for the next three years. — Attachment (white)

7. **Any other urgent business**

8. **Date of next meeting**

   Wednesday 3 May 2000 in the Large Conference Room, Finchdean House at 12.30 pm.

Circulation List:

Ms P Humphris (Chair)
Dr J A Barton
Mr S Carr
Mrs S Clark
Mr J Henly
Dr J Hughes
Dr E Jorge
Mr J Kirtley
Dr C Lewis
Mr D Pugsley
Mrs S Robson
Dr G Sommerville
Mr B Ward

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PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

CORPORATE EXECUTIVE BOARD

Notes of the Meeting held on 26th January 2000 at 12.30 p.m. in the Large Conference Room, Finchdean House

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Present:	Ms P Humphris	Ms T Green for Mrs S Clark
	Mr J Henly	Mrs S Robson
	Mr D Pugsley	Mr J Kirtley
	Dr E Jorge	Dr G Sommerville
	Mr M Wagstaff for Mr B Ward	Dr J Hughes
		Dr C Lewis
In attendance:	Mr S Carr	

No	Discussion	Action

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1 **Apologies for Absence**

Dr J Barton, Mr B Ward, Mrs S Clark

2 **Minutes from the meeting held on 24 November 1999**

These were received and agreed as a correct record.

3 **Matters Arising**

There were no matters arising.

4 **Additions to 1999/2000 Allocations**

David Pugsley noted receipt of the additional non-recurrent allocation of £966k. Katie Hovenden has advised on the apportionment of this between PCG's. David has asked PCG's to review all year-end forecasts , and feed back to him by 31/1/00. PCG CEs

5 **Service and Financial Framework**

David Pugsley gave a brief progress report regarding the current position of the Service and Financial Framework. The Health Authority's Revenue Cash Limits for 2000/01 and the Exposition Book have now been received. The overall position for the Health Authority looks unpromising. First cut SAFF due on 28th January 2000.

The position regarding Modernisation Funds remains unclear although current indications would suggest that a significant proportion of the modernisation fund for 2000/01 has been distributed within individual health authority allocations.

6. 2000/01 Business and Performance Cycle

John Henly circulated a draft copy of the Health Authority Performance and Business Plan for 2000/01 (attached to minutes). It was envisaged that this plan would set out the implications for the work of the Authority for the coming year and would form the basis of the Health Authority's Accountability Agreements with Primary Care Groups. The plan includes information from the National Priorities Guidance and the HImP, as well as specific Health Authority responsibilities, key elements of national policy and local priorities.

It was noted that the document did not reflect the leadership responsibilities of Primary Care Groups around the key tasks. However, it was agreed that the Primary Care Groups would demonstrate their leadership responsibilities through their Accountability Agreements with the Health Authority as well as in their individual business plans

It was proposed to circulate the draft plan in order to obtain feedback from directorates and PCGs during March/April and present the finalised plan to the Health Authority in June.

It was agreed that members of the Board would feedback to John or Sharon on the appropriateness of the different programme areas, lead people and wording of tasks within two weeks. ALL

7. Isle of Wight Merger

Penny Humphris reported that work was progressing on the possible merger between a mainland health authority and the Isle of Wight HA. Clare Moriarty has now been appointed to project manage the merger on behalf of Region for two days per week.

A local event, to work through the implications for the local health economy and to plan programmes of work, has now been arranged for 10 February 2000. In addition to this, the Regional Office will be visiting the Island during the first week of February to assess the readiness of the Island primary care group for Trust status.

The Regional Office has agreed a set of criteria for a preferred partner for discussion with stakeholders on the Island, with a view to a decision being reached during February. The merger would be implemented by the dissolution of both authorities on 31 March 2001 and the formation of a new health authority covering both the Island and the mainland, on 1 April 2001. It is anticipated that the Primary Care Trust for the Island would be established at the same time.

8. Primary Care Groups: Taking the Next Steps

It was reported that East Hampshire Primary Care Group (PCG) was preparing an application for Trust status from April 2001. John Hughes informed the group that the PCG's OD group were currently driving the process but had

agreed that a PCT Development Group, consisting of representatives from all the key stakeholder organisations, should be established to oversee the development process and implementation of the primary care group's transition to Trust status.

It was agreed that discussions with stakeholders regarding the move to Trust status would need to incorporate the implications of the scenario planning exercise as this was an integral part of the plans for the local health economy.

Boundary Review

John Hughes reported that talks were currently taking place between the practices in the Cosham "cluster" regarding the proposals to review the boundary between East Hampshire PCG and Portsea Island PCG.

It was agreed that an independent review would be required in order to provide an objective analysis of the boundary position. The review would need to be timed carefully and conducted by an independent individual or organisation appointed through a tendering process. It was agreed to delay the tendering process in order to give Charles Lewis and John Hughes the opportunity to hold informal discussions with the practices involved in order to reach an agreement on the boundary issue. Penny offered to contribute to these talks if this was felt to be appropriate and helpful. JH / CL / PH

9. Disability Discrimination Act

The paper highlighting the work being undertaken by the Health Authority was received and the Board noted the good work that was being carried out on this issue.

10. Devolution of Commissioning

Sue Robson introduced the paper on the devolution of commissioning (attached to minutes).

The Board discussed whether the proposal for PCGs to take responsibility for commissioning from 1 April 2000, or as close to as reasonably possible, was deliverable – both operationally and strategically.

It was agreed that a number of issues would need to be taken into consideration before any changes to the existing system were implemented. These included:

- Human resource issues – manpower planning and changes
- Joint working arrangements between PCGs
- Co-ordinated commissioning between PCGs (to address needs of all PCGs)
- Economies of scale
- Co-ordination of "risk" sharing
- Ensuring mechanisms in place for effective delivery
- Performance monitoring mechanisms

It was agreed that: PCG

- These issues should be taken forward for discussion at the next PCG leads meeting on 11 February 2000. Leads

Any comments on paper to be passed back to Sue Robson before next meeting of the Board on 1 March 2000 ALL

11. Emergency/Winter Pressures

Mark Wagstaff introduced the paper summarising the Situation Report information for the Winter and Millennium period. He drew attention to the following points:

- above average incidence of emergency admissions (consistent pressure)
- peaks occurred in primary care before Christmas, Boxing Day and New Year's Day (reflected in A & E figures)
- medical outliers – record numbers in PHT and Haslar (at one stage 130)
- the need to manage emergency care rather than "winter pressures"
- the need to address the predictability of these trends for the future

Mark advised the Board that he was in the process of updating the information, validating and re-arranging it in a better format. Once this process was complete he would re-circulate the information to the members of the Board. MW

The Board was asked to let Mark have any comments on the paper as soon as possible. ALL

12. Future health services for the residents of Gosport and south Fareham

Penny reported that the consultation document had been launched and had generally been well received. Both Gosport and Fareham Borough Councils had voted unanimously to accept the proposals put forward in the document. A series of public meetings arranged by the Community Health Council was commencing the week beginning 9th February 2000.

13. Any other urgent business

Tackling Teenage Pregnancy

Elizabeth informed the Board that the Heath Authority was required to prepare a local profile on teenage pregnancy, showing areas of greatest need, before developing a comprehensive strategy by April 2001. Sarah Wild and Rachel Lennon were leading on this work and were currently preparing an outline bid for funds to support this work.

14. Date of Next Meeting

Wednesday 1st March 2000 at 12.30 p.m. in the Large Conference Room, Finchdean House.

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PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

BRIEFING NOTE

HIGH COST DRUG AND OTHER CONTRACT EXCLUSIONS IN 2000/2001

I would like to briefly bring an area of potential financial risk to the attention of the Health Authority that was not noted in the paper of 9 December 1999: 'Negotiation brief for service level agreements with non local providers.' Prior to 1999/2000 and the abolition of ECRs Portsmouth and South East Hampshire had many contracts with explicit contract exclusions for specific drugs; i.e. beta interferon and Taxol. With the introduction of OATs any money that had previously funded ECRs at those providers was rolled into the contract. The majority of Trusts no longer included specific contract exclusions and the 1999/2000 SLAs with the majority of our non-London Trusts did not contain contract exclusions or specific high cost drug charges.

During 1999 I have been asked to provide patient specific funding for high cost drugs on at least 6 occasions. These have originated from various Trusts' or their clinicians: notably Chichester, Guildford and Southampton. These have been for the provision of high cost cancer drugs and high cost neurological drugs.

In each case I have responded by saying that their SLA with this Health Authority has no contract exclusions and that their prices should reflect the average costs of the service. Consequently these must reflect the nature of the patients they see and include a provision to account for the occasional use of high cost drugs. I have also emphasized that this Health Authority and PCGs purchase clinical services and not individual patient treatments. This has of course led to concern from some Trusts and clinicians who say that their current budgets do not allow them to prescribe. To move away from this approach, which spreads financial risk equitably around the health economy, will allow Trusts and their clinicians to 'blame' purchasers for not funding individual specific patients, whilst removing their responsibility to look at the cost effectiveness of treatments and their overall use of resources within their department. The former situation is one that this Health Authority has experienced on a number of occasions in recent years.

Consequently I would anticipate that a number of Trusts will attempt to include a range of contract exclusions in their 2000/2001 SLAs. If contracts with exclusions for drug costs are agreed, or separate charging for drugs is agreed as part of the contract, then PCGs and the Health Authority may carry a substantial financial risk from these contracts. An example is appended below.

I am concerned that as PCGs are now leading many SLA negotiations for 2000/2001 that include an element of specialised services, they should recognise that the inclusion of a small number of contract exclusions could have a substantial financial risk either for the Health Authority or individual PCGs. My own view is that all high cost cancer drugs are part of PCG budgets, but that many high cost neurological drugs fall to the Health Authority specialised service budget.

I would propose that commissioning managers should not accept any contract exclusions being added to the SLAs that they manage, without confirming that the other PCGs and Health Authority Specialised Service Commissioning Team can accept the financial risk associated with the relevant exclusion.

Dr Nick Hicks
Consultant in Public Health
10 February 2000

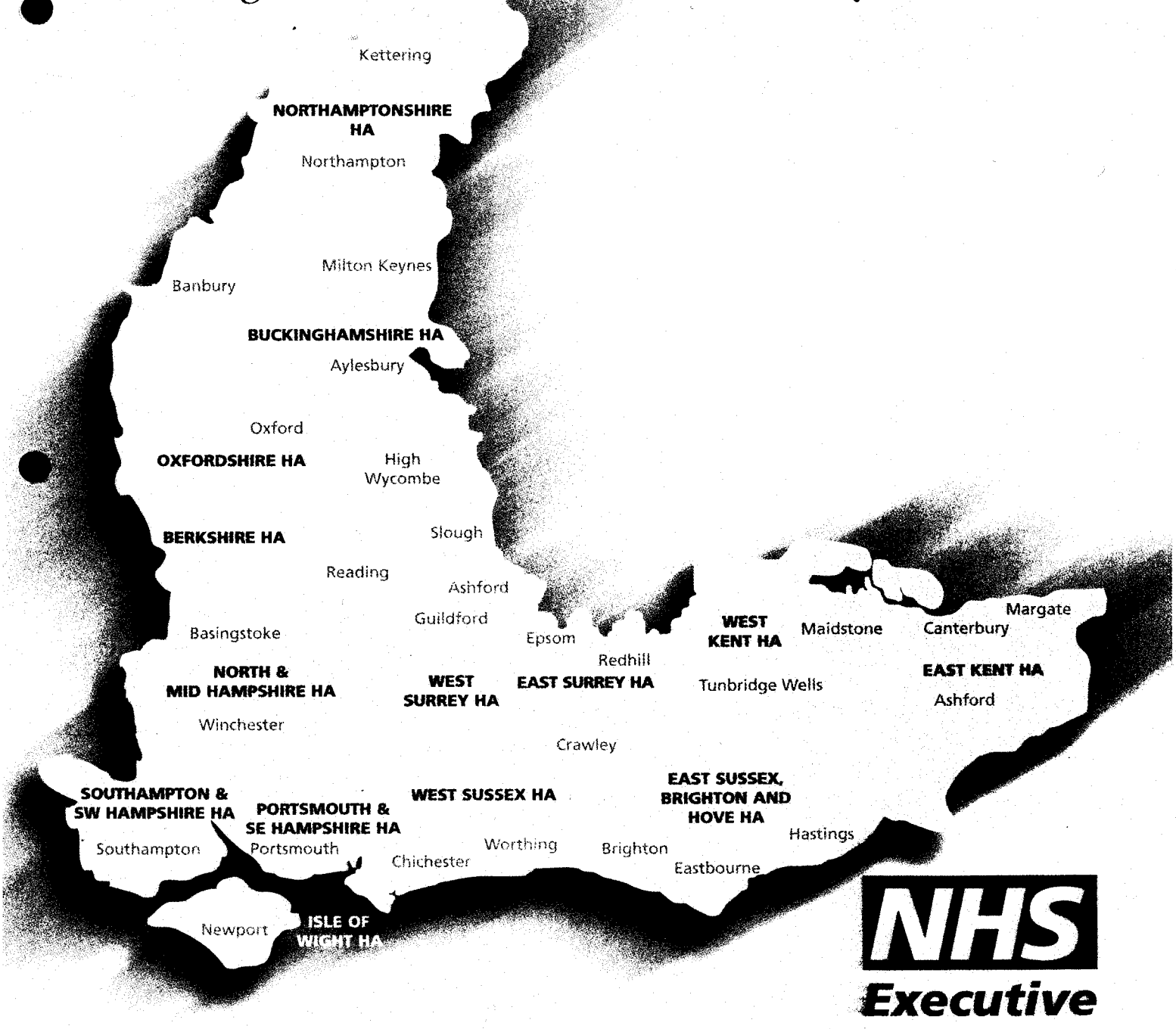
Example:

One Trust's view is that historically Beta Interferon was paid for as an ECR. They say that most purchasers carried forward this arrangement. However, because PSEHHA had no beta interferon ECR activity in the OATs baseline period, the Trust is of the view that no funding relating to Beta Interferon is contained in their baseline, hence it is appropriate to approach us on an individual patient basis. My view is that their prices for a service should reflect the average costs of the service. Consequently these must reflect the nature of the patients they see and include a provision to account for the occasional use of high cost drugs.

INFORMATION

Improving health in the South East

Programme of work for the next three years



NHS Executive

Purpose of this document

This document presents an overview of the main areas of work and developments facing the NHS in the South East region and the NHS Executive South East Regional Office for the next three years.

INFORMATION

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Date of issue	February 2000

Contents

This publication has four main sections, reflecting the key headings in *Modernising health and social services: national priorities guidance 2000/01- 2002/03*[1]. The headline narrative from this document is reproduced in each section, followed by a description of the work that needs to be done in this region over the next three years in support of that objective. The section on Developing Services combines the Saving Lives and Caring for Vulnerable People sections from the national priorities guidance document.

(1) Modernising health and social services: national priorities guidance 2000/01-2002/03.

Department of Health 1999

Working together to improve health

The Government has set out its agenda for improving health and for modernising the NHS. The detail of how this is to be done continues to be developed, but we have a clear enough picture for an overview of what we - the NHS and Regional Office together - need to deliver in the South East in the next three years.

We have a very strong base on which to build: a comparatively healthy and wealthy population and some very high quality services. But that must not make us complacent, because we have not yet developed an NHS which is of uniformly high quality, nor fast and convenient for patients.

Our health is better on average than in other regions, but that masks areas of very poor health where we need to make particular efforts. More generally while we compare well across the UK, we have a long way to go when we compare ourselves to our European neighbours.

We also have some particular challenges in the South East. Our population has high expectations of the NHS. They know what could be available to them. That must make us think about how we can deliver our services in different ways.

Our growing economy means that we have difficulties in recruiting and retaining staff. We will only be able to fully deliver what is needed to modernise the NHS if we use the skills of our staff imaginatively and across professional and organisational boundaries. We need to make working for the NHS as satisfying as we can by ensuring that jobs are "do-able" and that people are given the opportunity to grow, develop and feel able to contribute to improving services themselves.

This publication should not be seen as "just a list of targets". We have set out the key objectives, accompanied by brief descriptions of the development work which needs to take place to deliver these objectives in a sustainable way. To make delivery a reality we also must foster an openness to sharing and learning from each other across the region and beyond.

I hope this three year look forward will be helpful in giving people a context for their work, although it has to be an evolving plan which will change over time. It is not about working harder or faster; it involves a major development programme to reshape and modernise the NHS - including transforming the relationship between patients and the NHS.

We have much to do, but we also have enormous resources of enthusiasm, commitment and competence which can make it all possible.

Barbara Stocking
Regional Director
NHS Executive South East
February 2000

1. Improving health

The Government has a comprehensive programme to improve health and tackle health inequalities. Partnerships between the NHS, Local Authorities and other organisations are key to making our nation healthier, tackling social exclusion, and reducing inequalities.

Local action, including setting inequalities targets, should be agreed as part of the HImP development process. It should focus in particular on smoking, drugs, and teenage pregnancy.

(Modernising health and social services: national priorities guidance 2000/01-2002/03)

Establishing partnerships for health

Health is not something which the NHS alone can deliver. Throughout the region health organisations are working at all levels with partner agencies to set out in Health Improvement Programmes (HImPs) what needs to be done to improve the health of the people they serve and reduce inequalities.

In particular, health authorities must:

"link their agenda to that of their local authorities in practical and easily understood ways....[so that] the Health Improvement Programme will fit into the wider local public sector drive to improve services for local people"

Leadership for Health [1]

Over the next three years there needs to be evidence of changes in health status, in lifestyles and in the underlying determinants of health. Progress will be measured against the national targets in the public health White Paper *Saving Lives: Our Healthier Nation*[2] and by local targets for health improvement and for reducing inequalities. We can expect Primary Care Groups (PCGs) to be working at the heart of this and forging new links and new approaches to delivering care. Common ground and purpose between HImPs and community plans will be necessary. In turn, their assessment will become an increasingly joint effort between the Regional Office, the Social Care Region and the Government Office of the South East. There will also need to be a much better fit between local NHS initiatives and those of the South East Economic Development Agency.

Associated Health Action Zone programme

To facilitate the development of joint approaches to reducing inequalities in health, a partnership learning network, known as an associated Health Action Zone programme has been established. Initially it will focus on the following areas:

- Slough
- Brighton and Hove, and Hastings
- Corby
- Oxfordshire (focusing on rural issues)
- Portsmouth
- Southampton
- North Kent (Medway area)

(1) Leadership for health: the health authority role. NHS Executive. 1999.

(2) Saving lives: Our Healthier Nation. Department of Health. 1999.

The aims are to:

- Share learning and disseminate good practice on partnership approaches to health improvements, particularly in the development of HImPs.
- Accelerate good practice on partnership working by building on relevant work and by collaborating with other policy initiatives such as New Deal, Sure Start, New Deal for Communities, and the Single Regeneration Budget.
- Share the learning from the national Health Action Zone programme, since the South East is the only region which does not have a nationally designated Health Action Zone.

Target action towards those at particular risk of poor health

The relative prosperity of the South East in UK terms must not diminish the overriding importance of implementing policies aimed at reducing inequalities in health, both between the South East and the rest of the country, and within the region itself.

This will require differential investment, with some groups and some parts of the region receiving more than others. These different levels of investment will often occur within a health authority area, and across local authority boundaries.

Action needs to be targeted at protecting and improving the health of those at particular risk of poor health or premature death, for example those in prison, those in areas of social deprivation, and to focus on the specific needs of people from black and ethnic minorities.

Promoting and protecting health

Over the next three years all health systems should be able to demonstrate progress towards meeting the national targets in four key priority areas in *Saving Lives: Our Healthier Nation*. The areas and targets (by the year 2010) are:

- Cancer - to reduce the death rate by at least one fifth.
- Coronary heart disease - to reduce the death rate in people under 75 by at least two fifths.
- Mental illness - to reduce the death rate from suicide and undetermined injury by at least one fifth.
- Accidents - to reduce the death rate by at least one fifth and serious injury by at least one tenth.

The first three of these are the subject of national strategies. On accident mortality reduction, HImPs will need to be explicit on actions being taken to reduce risk, maximise the integration of initiatives across all sectors, and ensure access to effective treatment.

Specification will also be required to reduce the risks and effects of communicable disease.

Protecting health by:

Making the best use of antibiotics and controlling the spread of resistance
The target for the next three years is that at least 90 per cent of all trusts in the region are using well-presented and evidence-based policies to make the best use of antibiotics and to control the spread of resistance. The target will also be to see 90 per cent of health authorities using evidence-based policies compared to about 50 per cent at present.

The aim over the next three years is to reduce levels of antibiotic resistance. They currently run at between about 33 per cent in some hospitals in the South East to 5 per cent in others. These percentages relate to the amount of staph.aurius bacteraemia which is resistant to the antibiotic methicillin.

Increasing the take-up of childhood vaccination
The South East has 94 per cent cover for childhood vaccines which compares very well nationally. The aim for three years time will be to increase the regional average to 96 per cent and to have no health authority area with less than 95 per cent cover. On influenza vaccine policy, the target for three years time across the South East will be to achieve 80 per cent coverage of people who should have the vaccine compared to the current levels of 30 to 50 per cent.

Reversing the increase in TB and reducing the rate of new cases of HIV
Both TB and HIV are increasing at as fast a rate in the South East as in other regions apart from London. TB is currently increasing at a rate of between 1 per cent and 2 per cent, particularly among African population groups. The aim is to see TB declining. The three year target for HIV will be to see a reduction in the rate of new cases.

Strengthening hospital and community infection control
The aim over the next three years will be to see hospital and community control teams strengthened with at least half of NHS trusts in the region having at least one infection control nurse per 300 beds; an executive board member with clear responsibility for the infection control team; and effective electronic communications and databases.

Healthier lifestyles

Progress will be expected in four areas in particular:

Smoking
Nationally there should be 200,000 fewer adult smokers, 17,000 fewer child smokers and 9,000 fewer women who smoke during pregnancy by 2005.

By April 2000, every health authority in the South East should have a smoking cessation strategy. During 2000/01 and 2001/02, all health authorities in the region should:

- Implement local policy to tackle smoking, in partnership with local authorities and other agencies, with action focusing on disadvantaged adults, pregnant women, and young people, and on enforcing
  - legal requirements on tobacco sales to children
  - no smoking policies for all NHS and local authority premises.
- Ensure that smoking cessation is a priority in the HImP and in service level agreements.
- Use funding allocated to set up and monitor smoking cessation services; use nicotine replacement therapy to help people give up; and ensure that all staff recognise stopping smoking is a priority.

Misuse of drugs
All HImPs need to show progress towards implementing the Government's ten year strategy. The objectives are to:

- Help young people resist drugs. Targeted prevention activity should be provided for at least 30 per cent of young people most vulnerable to drug misuse by 2005.
- Protect communities from drug-related crime by reducing the levels of re-offending amongst drug misusing offenders by 25 per cent by 2005 and 50 per cent by 2008.
- Enable people with drug problems to overcome them and have healthy and crime free lives. The key performance target for this objective is to increase the proportion of problem drug misusers, including prisoners, in drug treatment programmes by 66 per cent by 2005 and 100 per cent by 2008. There are intermediate national targets for reduction in Class A drug use among 11-16 year olds.
- Stifle the availability of illegal drugs on the streets.

The programme to reduce drug misuse is being taken forward by local agencies through drug action teams. Their effectiveness and how best use will be made of current and future resources will need to be reflected in HImPs.

Sexual health and teenage pregnancy

Over the next three years integrated reproductive health services should be developed across the South East to meet the following national policy objectives:

- Improved access to services, with particular consideration to the possible benefits of integrating services for family planning and sexually transmitted diseases.
- Spreading good practice in service delivery, including developing strong links between health services, families and schools.
- Developing programmes of professional training in sexual health to move away from a segregated approach.
- Adding value to public health campaigns by adopting a broader sexual health focus and encouraging a more responsible attitude to sex.

Although this region has the second lowest rate of conceptions in teenagers under 18 in England, there are on average more than ten conceptions a week in this age group in every health authority area, and a more than twofold difference between the highest (Portsmouth and South East Hampshire) and the lowest (East Surrey).

On teenage pregnancy, there are two key goals:

- Reducing the rate of teenage conceptions, with the specific aim of halving the rate of conceptions among the under 18s by 2010.
- Getting more teenage parents into education, training or employment, to reduce their risk of long term social exclusion.

Local strategies for addressing these goals and agreeing local benchmarks for progress will be developed during this year.

A national sexual health strategy is due to be launched in the spring. In response to this, and as a first step to developing integrated sexual and reproductive health services, the NHS in the South East will review existing strategies during the next year.

Alcohol

A national alcohol misuse strategy will be published for consultation in 2000. Priority areas may include:

- Young people.
- Binge drinking.
- Safety in the community and at home.
- Services for misusers, their families and carers.

In particular there will be a priority to ensure a comprehensive health service response to alcohol misuse with all treatment services achieving the standards of the best NHS services.

Wider action

There are settings where particular progress needs to be made in the next three years:

1. *Schools*: all schools in the region will be participating in a 'healthy schools partnership' by 2004. A joint scheme between West Sussex Health Authority and West Sussex County Council is a national pilot for developing healthy schools partnerships. Other parts of the region making good progress include Hampshire, Surrey and Northamptonshire which have well developed healthy schools policies.

2. *Workplaces*: HImPs will need to show what local action is being taken to implement the Healthy Workplace initiative, in particular what contribution locally the NHS is making.

3. *Neighbourhoods*: In those areas not covered by the 'New Deal for Communities', HImPs will need to show what action is being taken to delineate, target attention, and, where appropriate, resources, to relatively deprived neighbourhoods. A good example in the South East is East Kent where a programme of work to educate women and young mothers has been built into the local HImP.

   All health authorities in the region are working with their local communities to co-ordinate healthy living centre bids. Whether or not health authorities secure national funding from the New Opportunities Fund, it is expected that over the next three years all health authorities will have explored the imaginative use of pooled budgets to develop local initiatives, tied in with HImP priorities. The second national healthy living centre award has gone to the South East with the Arden Rehabilitation Project, a drop-in centre near Dover for people with mental health needs.

Environment and housing

Local responses will continue to be developed in two other areas of Government policy, environment and housing. Local approaches to protecting and promoting the public health should be made on a sustainable basis. This will involve ensuring that the NHS plays a full part in the implementation of national strategies such as:

- 'A Better Quality of Life – a strategy for sustainable development in the UK'.
- New Deal for Transport
- National Air Quality strategy.

This will often be expressed through the contribution of the NHS to *Local Agenda 21* strategies.

HImPs will increasingly reflect the link between housing and health through the development of clear local targets in response to national policy initiatives such as the New Home Energy Efficiency Scheme, and grants to home improvement agencies.

Health assessment

Progress on all the fronts described above will be measured at local, regional and national level. As part of strengthening the availability and use of information about health at local level, a new South East public health observatory is being established this year. This will support local bodies by monitoring trends, drawing information together on new ways to improve health, giving early warning of future health problems, and advising on methods for health impact assessments.

In addition, acquisition and use of the skills required for health assessment locally will become increasingly important. Such assessments will be central to all local agencies planning investment in local services, buildings, or amenities.

2. Developing services: Saving lives and caring for vulnerable people

The Government is committed to modernising all aspects of care and treatment. But the priority is to deal with the biggest killers: cancer, coronary heart disease (CHD) and stroke. This will help tackle inequalities, as the burden of disease falls heavily on the most disadvantaged.

Effort needs to be focused on making services faster, stepping-up prevention work and improving primary and community as well as acute services.

The Government wants Health and Local Authorities to work together with a range of partners to improve care, support and independence for people with mental health problems and older people and to improve services for vulnerable children.

(Modernising health and social services: national priorities guidance 2000/01-2002/03)

Setting standards for consistent service delivery

To ensure consistency of service delivery across the country, a major programme of work is in place to set standards nationally and to ensure they are delivered locally.

National standards will be set through National Service Frameworks (NSFs) and the new National Institute for Clinical Excellence (NICE). NSFs will set out the best way to organise services for patients with particular conditions and the standards that should be met. NICE's role is to produce guidance about which treatments work best. It is also responsible for assessing new drugs, treatments and devices for their clinical and cost-effectiveness.

National Service Frameworks

Cancer services were a trailblazer of the NSF concept, and over the next three years the NHS will be expected to implement NSFs for:

- Coronary heart disease.
- Mental health.
- Older people.
- Diabetes.

Further NSFs will follow in later years.

Cancer services

The reshaping of cancer services has provided experience of how to implement an NSF. There has already been considerable change but specifically in the South East there is a need to:

- Develop managed cancer networks with strong links between health promotion, primary and secondary prevention and treatment sectors.

- Implement standards and targets for breast, colorectal and lung cancer (by March 2000) and required standards for other cancers; and ensure that monitoring arrangements for care of all cancers are included in routine performance assessment.
- Establish a peer review system to improve quality.
- Involve users and carers in service delivery, strategic planning and quality monitoring.
- Devise and evaluate innovative approaches to skill mix and deployment of workforce.
- Take forward a strategy for palliative care which includes access to specialist teams and enhances staff skills more generally.
- Develop a cancer information strategy which informs arrangements for audit and clinical governance and supports intelligence and patient information.

Achieving these objectives will depend upon health authority cancer leads working closely with the region-wide clinical reference group. At local level, clinicians, managers and users need to work together with effective contribution from education and training, and research and development specialists.

Coronary heart disease

The aim is to improve health in the population by reducing mortality and morbidity from coronary heart disease (CHD). The NSF for CHD has not yet been published, but priority areas are likely to include:

- Primary prevention by tackling risk factors and targeting deprived areas; treatment and rehabilitation.
- Improved equity of access to care.
- Meeting gaps and shortfalls in facilities and quality of care.

Early activity in implementing the NSF for CHD will include health mapping to ensure that services are targeted towards deprived communities and those most at risk of coronary heart disease. Health economies will then be in a position to:

- Develop and implement local prevention policies on CHD and stroke (by 2001).
- Secure an appropriate level of coronary revascularisation throughout the region in line with the national target increases, including the initial one of 3,000 more procedures by April 2002. This is likely to require a significant increase across the South East region in the medium term, which will need in addition to tackle the current sixfold difference between health authorities in revascularisation rates.
- Target investment in equipment and facilities to improve access to early diagnosis and assessment.

Mental health

The aim is for all health economies, in association with a local multi-agency team with user and carer representation, to ensure the achievement of national standards in five key areas:

- Health promotion and social inclusion of people with mental health problems.

- Access to services, including primary care, assessment and treatment and 24-hour access to local services.
- Services for people with severe mental illness including care programme approach, access to a hospital bed and improved discharge planning.
- Caring about carers.
- Preventing suicide.

Local action plans, together with an earlier stocktake, provide a regional map of key NSF service areas for attention over the next three years and beyond. Summary findings for key themes are:

Assertive outreach:

- Some health authorities have an assertive outreach service. All have plans for one, suggesting the NHS in the South East will achieve its contribution to the national target of an even distribution and full coverage of assertive outreach services by 2002.

Secure beds:

- Modernisation funds specifically for secure beds have been targeted at providing an additional 21 medium secure beds in the South East by March 2000. This will be the first stage of the region's contribution to a national target of 300 extra beds by April 2002. Regional targets thereafter will be determined by Local Specialist Commissioning Groups (LSCGs).

  A regional strategic approach will define and support the commissioning of all secure services by the three LSCGs on behalf of the Regional Specialist Commissioning Group.

24-hour staffed beds:

- Major variations between health economies arise from different local definitions of this service, though an absolute shortfall in excess of 100 beds across the region is probable. The equitable development of 24-hour staffed beds, as a key element in comprehensive local services, will be a priority for the period 2000 – 2003.

24-hour access:

- There is a critical shortfall across the region in 24-hour access to services. No health authority provides 24-hour access to services beyond that required for Mental Health Act admission assessments. Plans for evenly distributed crisis services, accessed through 24-hour NHS Direct-linked helplines, will therefore be a major priority over the next three years.

The three sub-regional development network project managers will:

- Establish local partnerships for disseminating and learning from best practice.
- Develop a single joint agency team responsible for implementation.
- Work closely with local education and training consortia to ensure future workforce reflects the service needs associated with the National Service Framework.

Older people

Care of older people is a significant issue in the South East region because of the high proportion of people aged over 65 and 85 living on the south coast and the Isle of Wight. The Island has the highest proportion of people over 65 (23 per cent) and over 75 years (11.7 per cent), and the second highest proportion of people over 85 years (3.3 per cent) of any health authority in England.

The Government has given a commitment to improve the health and well-being of older people. The key aims over the next three years are to:

- Ensure high quality services in all aspects of care.
- Support and maintain independence through choice.
- Provide care and treatment as close to home as possible and practicable.
- Provide an equitable system for long term care provision.

This will be achieved by:

- Health authorities, PCGs and social service departments working in partnership.
- The NHS locally designing and implementing (by June 2000), with housing and social services departments, local charters which will give people the information they need about the standard of care they can expect when they require long term care. (*Better Care, Higher Standards*)[1]
- Supporting the establishment of the National Care Standards Commission in its role to ensure high quality long term care.
- From April 2000 taking up the opportunities presented by Partnerships in Action which can support care and treatment across the health and social care interface.

Diabetes

The NSF is not yet available.

Children

Although there is unlikely be an NSF for children, reducing inequalities in the health and welfare of children is important, particularly for children in need and children looked after by local authorities.

The NHS in the South East will need to focus on:

- Ensuring that information is available to monitor the health targets in the Quality Protects programme for looked after children. Health authority chief executives will have responsibility with local authorities for signing off Quality Protects management action plans.

- Contributing to the Sure Start programme. Where appropriate, links should be established with associated Health Action Zones.

(1) Better care, higher standards: a charter for long term care: a guidance for local housing, health and social services.

Department of Health/Department of the Environment Transport, Regions 1999

- Contributing to the establishment of Youth Offending Teams and ensuring appropriate access of young offenders to treatment services likely to reduce offending.
- Ensuring that children's health services are planned and delivered within a coherent strategy.

Child and adolescent mental health services remain a national priority because of concerns about inconsistency in availability, accessibility and delivery of services. Service provision varies across the region. To tackle this the emphasis will be on:

- Continuing development of partnership arrangements between health and social services to commission and provide services on a consistent and equitable basis.
- Developing services to target identified service gaps. This will be demonstrated by clear progress against agreed development plans.
- Establishing a network of commissioners, providers and clinicians to develop and share best practice, and to work on areas of common concern.
- Developing shared health and social care performance indicators and outcome measures for services.

People with learning disabilities

While also not formally in an NSF, a national strategy for people with learning disabilities is being developed which gives this area a high priority.

Over the next three years the NHS in the South East will concentrate on:

- Partnership working to develop a region-wide strategic direction consistent with the developing national strategy.
- Identifying areas that need attention, change, development and areas of best practice and preparing a commissioning framework.
- The resettlement of all those in inappropriate accommodation, including those still living in long stay institutions.
- Developing appropriate specialist services for those who have specialist health needs.
- Developing performance indicators and outcome measures to improve equity, effectiveness and consistency of service provision.

Clinical governance

The Government will monitor the delivery of national standards through the newly established Commission for Health Improvement (CHI) as well as through management mechanisms. CHI will begin by monitoring cancer services development during 2000/01 and move on to other NSFs. It will also monitor the introduction of clinical governance.

Clinical governance provides a mechanism to ensure that organisations and the clinicians within them are delivering high quality services. Each organisation has already undertaken a baseline assessment. The immediate work is to:

- Ensure that those who have not yet got the minimum mechanisms and processes in place, achieve this by April 2000.
- Have a development plan in place for each organisation from April 2000.
- Develop minimum standards against which organisations will be further assessed during 2000/01.
- Work closely with CHI as it undertakes the first inspection visits for clinical governance of trusts in the region during 2000/01.

Region-wide development activity is likely to be needed as understanding in clinical governance develops. For example, there needs to be understanding of how to assess the patient's experience and of how to use measures such as the National Patient's Survey in clinical governance.

The main drive of clinical governance is to continue to raise standards. However, if public confidence in the NHS is to be improved, it is also essential that poor performance is tackled quickly and effectively.

This is true for all NHS staff but handling the poor performance of doctors is particularly complex and is likely to change. Partnership working with the General Medical Council, the Royal Colleges, and in future, CHI, and the new assessment and support centres proposed in *Supporting Doctors, Protecting Patients*[1]

Re-configuring health services for improved patient care

As services are reshaped, a balance needs to be struck between delivering the best health outcomes, which will sometimes mean grouping services into more specialised centres, and making services as local and easily accessible to patients as possible.

All health systems in the region are engaged in changes to the configuration of their services. These are shown in the Appendix at the end of this document. However we can expect over time that the opportunities presented from the formation of PCGs will give rise to further partnerships and approaches to services as yet just beginning to emerge.

For those systems at the beginning of major service changes it is expected that plans will be ready for public consultation by April 2000. The plans may need modification and then Ministerial approval before changes can begin to take place later in 2000. However, some changes are likely to take several years to complete, including the requirement for some capital funding.

(1) Supporting doctors, protecting patients: a consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England.

Department of Health, 1999

When health systems are planning reconfigurations they will be assessed against:

- Clarity of the purpose of the review.
- Evidence on which the proposed changes are founded, including a thorough look at alternative models of care and use of the most modern developments in information, for example telemedicine.
- Whether all relevant stakeholders in health and social care, including clinicians and the public (including community health councils) have been adequately involved in the process.
- Whether plans have been checked across geographical boundaries.
- Whether a whole system approach has been adopted.
- Whether plans are realistic in terms of the available workforce.

In support of this, there will be:

- A learning network for programme managers involved in delivering service reconfiguration.
- A reference guide of models of care and good practice.
- A series of workshops to explore the evidence and models in relation to particularly contentious issues in service configuration.

Commissioning specialised services

Currently three Local Specialist Commissioning Groups, each with responsibility for commissioning services for their populations, advise and report to the regional specialist commissioning group. The initial focus is on six national priorities: clinical genetics, rare cancers, renal services, paediatric intensive care, medium and high secure mental health services, and cleft lip and palate services. In addition, some specialist cardiac and mental health services need to be commissioned in support of their NSFs.

By March 2001 those variations in access to all these services which are unexplained by differences in need will have been identified. Action required to reduce these variations will have been agreed, set out in the annual report for 2000, and taken effect by 2002.

3. Fast and convenient services

The Government is committed to ensuring that people receive fast access to the care they need, delivered in a way that is responsive to their needs. Primary Care Groups and Trusts will play a key role in commissioning and providing fast and convenient services.

(Modernising health and social services: national priorities guidance 2000/01-2002/03)

Creating a culture of respect

Making services faster and more convenient is important if the relationship between the NHS and patients and the public is to be transformed. Equally essential is ensuring that patients and their carers are treated with dignity and respect. The NHS needs to create a culture of accessibility and respect.

A culture of respect means:

- Recognising the essential humanity of everyone.
- Looking beyond labels of 'patient' or 'carer' and seeing people as individuals.
- Listening to and respecting the concerns and values of users.
- Valuing diversity.
- Learning from mistakes.
- Delivering client-focused services with the individual's needs and convenience at heart.
- Empowering communities.

Even the best and most responsive practitioners can be let down by environments or institutions within which they work, making it difficult to provide personalised, high quality care. Developing client-focused services in every setting will inevitably take time as it requires profound cultural change.

The first steps should be to:

- Encourage all health authority, primary care groups/primary care trusts (PCGs/PCTs), and trust boards to step into patients' shoes on a regular basis, perhaps through shadowing patients, and learning from patient surveys.
- Ensure that the centrality of patient experience is reinforced in interviews for non-executive and executive appointments.
- Ensure that service changes and developments incorporate patients' perspectives.
- Engage and empower users and communities via HImPs, and make the most of the opportunities presented by associated Health Action Zones, Partnership In Action, and PCTs to build social inclusion and assess and address ethnic minority health needs.
- Learn from initiatives such as those at Dartford & Gravesham NHS Trust, Kent Cancer Collaborative, East Kent Community NHS Trust, Oxfordshire Mental Healthcare NHS Trust, Oxfordshire Community Health NHS Trust and Worthing Priority Care NHS Trust which are looking at engendering cultural change.

Creating a culture of accessibility

Faster, more convenient access to information, advice, diagnosis and treatment is a major priority for the Government, driving the development of NHS Direct and NHS Direct On Line, primary care walk-in centres, dental access centres, and the reduction of out-patient and in-patient waiting lists. At the heart of this is the transformation of the NHS into a modern, responsive service built around a culture of accessibility.

Access to information and advice

Information for Health[1] provides the framework and NHS Direct offers a major opportunity to share information with patients and public.

Key objectives include:

- Completing the roll out of NHS Direct across the South East region by October 2000, to include all of Sussex, Berkshire and the Isle of Wight and the remaining parts of Oxfordshire, Surrey and Kent.
- Integrating NHS Direct and walk-in centres with modernised primary care services, including pharmacy and out-of-hours services and local social services out-of-hours and information services.
- Increasing the availability of NHS Direct On Line and encouraging its use.

Some patients, particularly those with potentially serious or disabling conditions, will need more in-depth access to information, in partnership with clinical staff and carers.

A major development challenge will be to take forward the outcomes of the Chief Medical Officer's Task Force on expert patients, as well as the emerging lessons from the Kent Cancer Collaborative and patient partnership initiatives focusing on such conditions as chronic obstructive airways disease (at the Royal Berkshire & Battle Hospitals NHS Trust).

Access to consultation and treatment

Patients or their carers must be able to access appropriate services promptly and conveniently in every healthcare setting.

Key goals for faster primary care include:

- Improvement of up to 115 GP premises, and an increase in the number of primary care practice nurses employed, as well as more GPs.
- Continued roll-out of primary care walk-in centres, increasingly integrated with a broader range of primary and social care services. This will build on the South East region's first four front runners at Southampton, Weybridge, Woking and Slough.
- Establishing dental access centres (where there is a need) in all health economies by December 2001.

(1) Information for Health: Information strategy for the modern NHS 1998-2005.

A national strategy for local implementation.

NHS Executive 1998

The Government has challenging expectations for reducing the number of people waiting for treatment, and the length of time they wait for consultation and investigation. This means:

- The inpatient waiting list in the South East must not go above 176,099 from April 2000, contributing to achieving and sustaining the national 100,000 reduction in inpatient/day case waiting lists.
- A reduction in the number of patients waiting over 12 months for treatment in the South East by March 2001 with no patient waiting more than 18 months for treatment.
- The coronary heart disease NSF has yet to be published, but it is likely to include targets to substantially reduce waiting times for treatment for people with symptoms of angina.
- Reducing the number of patients waiting over 13 weeks for their first outpatient appointment, targeting ophthalmology, orthopaedics, ear, nose and throat (ENT), and dermatology to achieve an overall reduction of 55 per cent across the four specialties with at least a 50 per cent reduction in each individual specialty.
- All patients with any suspected cancer must (by December 2000) be offered an appointment within two weeks of their GP requesting an urgent appointment.
- Reducing the percentage of delayed discharges of over 75 year olds occupying an acute hospital bed to 11 per cent in 2000/01, 10 per cent in 2001/02 and nine per cent in 2002/03. At present delayed discharges of over 75s in the South East region are running at an average rate of 15.8 per cent. Given that to reach 11 per cent would only mean a reduction of about 55 delayed discharges - from 1,151 to 1,096 - the South East region could aim to do significantly better than that.

Related goals include:

- Improving the consistency and appropriateness of referrals from GPs.
- Substantially increasing the proportion of elective patients able to pre-book their appointment or treatment date, and reducing DNA (did not attend) rates to below 10 per cent of all scheduled appointments by March 2002.

How it can work: an example

Waiting times and day care rates vary greatly for cataract surgery, yet the operation can make real improvements to quality of life – and is highly cost effective. One person in twelve on an NHS waiting list is waiting for cataract surgery.

The best services are achieving now:

- Access rates of 300+ cases per 100,000 population per year.
- Integrated services.
- Good written/audio/video patient information.
- One stop diagnosis and pre-operative assessment, with booked admission dates.
- Office surgery – less than 90 minutes at hospital.
- Day case rates of 90 per cent plus.
- Treatment completed within four to six months of initial referral; second eye done within a further two to three months.

If this could become the norm throughout the South East, the impact would be huge – and the pattern could be repeated in orthopaedics, dermatology and ENT.

Ensuring sustainable improvements in accessibility and responsiveness

For the NHS in the South East to secure sustainable improvements in accessibility and responsiveness there needs to be:

Stepped increases in the efficiency and effectiveness of service delivery through:

- Out-patient improvement plans and best practice in managing waiting times.
- Re-design of care pathways and clinical support systems.
- Removing constraints in capacity (ranging from theatre scheduling and equipment availability to minimising the incidence and impact of delayed discharges and methicillin resistant staphylococcus aureus (MRSA) and hospital-acquired infections).
- Rolling out booked admissions – the South East already has 11 successful pilots, with more to follow – and partial booking schemes.
- Speeding up the adoption of effective clinical practice and innovation. The Breakthrough Programme aims to deliver this for common orthopaedic procedures.

Influencing the demand for investigation, opinion and treatment by:

- Developing local evidence-based referral protocols and proformas so the right patients get referred at the right time and their journey is streamlined.
- Improving the quality and consistency of referrals by providing comparative information and feedback.

- Providing alternative patterns of care, for example physiotherapist triage of lower back pain.
- Eliminating ineffective procedures.
- Encouraging effective patient partnership and easy access to high quality information and advice through NHS Direct and NHS Direct On Line.

Access to advice, support and care in an emergency

Traditional ways of responding in an emergency are becoming increasingly unsustainable and inappropriate. This is shown by:

- Rising levels of emergency admissions.
- High hospitalisation rates for medical admissions (often because there are few real alternatives to hospital).
- Increasingly severe "winter pressures", placing staff under unacceptable strain and potentially compromising the quality and responsiveness of care, and access to elective surgery.
- High levels of delayed discharges.
- Increasingly severe and chronic staffing shortages, making it difficult to sustain service quality.
- The widening gap between public and media expectations and the perceived quality of current services. The quality of emergency care has become a key test of public confidence in the NHS.

Principal objectives:

- Modernising those A&E services that need it.
- Minimising trolley waits and ensuring prompt admission to hospital.
- Reducing the rate of increase in emergency admissions for the over 75s and ensuring it is less than 3 per cent per annum by March 2003.
- 75 per cent of all category A emergency ambulance calls to be responded to within eight minutes irrespective of location (interim target) by March 2001.

To deliver such a whole systems approach in the South East, every health system needs a portfolio of services which provides a flexible, joint response to individuals and carers in crisis, and gives them genuine informed choice.

Plans need to be developed to ensure much of this is in place for winter 2000/01, if possible. The components will inevitably vary with local needs, but may include most of the elements shown in the diagram overleaf.

Options to avoid admission to and expedite discharge from hospital

PREVENTION

- immunisation and vaccination
- accessible advice (NHS on-line)
- winter chest clinics

TARGETED PREVENTION AND RISK MANAGEMENT

- targeted health promotion ("winter wise")
- effective management of chronic illness
- joint social care/practice register of vulnerable clients and carers
- pre-winter risk assessments
- home safety checks
- hip pads

RESPONSIVE PRIMARY CARE SERVICES

- walk-in centres
- minor injury units
- nurse triage
- NHS Direct

GP FAST ACCESS TO SPECIALIST ADVICE/INVESTIGATION

- fast GP access to diagnostic and investigative procedures
- telephone access to specialist advice

COMMUNITY RAPID RESPONSE/OUTREACH

- intensive community support
- hospital at home
- community and first responders
- home care/sitter
- outreach teams

EFFECTIVE ASSESSMENT

- senior advice at the front door
- medical admission units

ADMISSION TO HOSPITAL

EFFECTIVE DISCHARGE PLANNING

- discharge co-ordinators
- discharge planning on admission

STEP-DOWN/INTERMEDIATE CARE

- GP access to nursing homes
- hospital at home
- nurse-led units
- step-down facilities
- community assessment and rehabilitation teams
- active rehabilitation at home or in the community

The aim is to ensure that options are in place which avoid admission to, and expedite discharge from, hospitals and:

- Are evidence-based.
- Provide care in a modern, fit-for-purpose environment.
- Are integrated, providing, for example, one-stop access to health, social care and possibly housing advice and support.
- Engage primary care as an equal partner.
- Make the most of the opportunities provided by Partnership in Action, PCTs and associated Health Action Zones, generic workers and changes in practice and technology, especially telemedicine.
- Shift the balance from hospital, residential home and other institutional care to supporting and caring for people in their own homes and communities, sustaining their independence.
- Emphasise prevention and active rehabilitation, preferably at home or in the community.
- Are rooted in informed patient and carer partnership and choice, and have public confidence.

Access to critical care

Last year's stocktake highlighted the urgency of undertaking a complete review of critical care services, an objective set by the Government. It showed the scale of the structural and operational problems facing critical care services in the South East, which include:

- Insufficient general critical care capacity.
- An imbalance between intensive and high dependency care.
- Inappropriate configuration and lack of capacity of specialist critical care to support tertiary services.
- Configuration and accreditation of paediatric intensive care.
- Severe staffing shortages.

Recent "symptoms" have included:

- Cancellation of urgent surgery in many hospitals due to the lack of critical care beds.
- Transfers of patients to other hospitals for other than clinical reasons, or discharge inappropriately early from critical care to wards.
- High workloads for staff.

Key requirements to address these problems include:

By Autumn 2000:

- Strengthen inter-trust networks and collaboration to better manage peaks in demand.
- Clarify and develop more consistent admission and discharge criteria.
- Strengthen services and develop contingency plans for those health systems which experienced particularly severe difficulties during the winter of 1999/2000.

As soon as possible:

- Ensure sufficient general adult critical care provision within all health economies, including an appropriate balance between intensive, high dependency and step-down care.
- Maximise the flexible use of intensive care trained staff by improved recruitment, skill mix, training and development.
- Provide ward staff with more training and support so that they can look after patients who would otherwise need admission to a critical care bed.
- Improve the quality of information and facilities for relatives and carers.

Creating an environment fit for care

Healthcare estate

The Government has expressed a clear commitment to improving the fabric of the healthcare estate. This should be reflected in both new-build and investment in existing buildings. Not only must the buildings be 'fit for purpose' and efficient, the space should be flexible to respond to changing healthcare needs.

The key goals to make this a reality include ensuring expenditure is targeted to ensure compliance with:

- Fire safety: no patient areas to be in an unsafe condition within two years and full compliance within four years.
- Health and safety: 90 per cent compliance within three years.
- Meeting national standards for single sex accommodation.

To achieve the targets above will be a major challenge to the NHS in the South East.

Major Private Finance Initiative (PFI) schemes costing over £25 million are being undertaken at Darent Valley Hospital, Kent; High Wycombe and Amersham, Buckinghamshire; Fair Mile Hospital reprovision, Berkshire; Oxford Radcliffe Hospital and Portsmouth Hospitals. In addition, there is a major publicly funded scheme underway at the Royal Berkshire Hospital, Reading.

Alongside these are projects to modernise A&E, for example at Medway, Southampton and Heatherwood and Wexham Park. Major mental health reprovision schemes, such as Princess Marina Hospital, Northampton, St James Hospital, Portsmouth, Meadowfield at Worthing as well as Fair Mile will also improve the quality of accommodation for patients.

Healthcare technology

The NHS needs to create the underpinning infrastructure to provide integrated information systems to support new ways of providing care.

Key goals in local information strategies and HImPs should include:

- Moving from innovative pilots in minor injury and dermatology to telemedicine and telecare options considered in all HImPs and when developing plans to implement National Service Frameworks.
- All computerised GP practices to be covered by NHS net by March 2002.
- GP practices being able to book some hospital appointments electronically, and routinely exchange structured messages for referrals, discharge summaries, and diagnostic test requests and results by March 2002.
- 35 per cent of acute hospitals to have electronic patient record (EPR) facilities to at least Level Three[1], by March 2002, rising to include all acute hospitals by March 2005.
- Substantial progress towards implementing integrated primary care and community EPRs, and integration with secondary care to allow 24-hour emergency care access to patient records.
- Developing first generation electronic health records building on current experience in Winchester and other national pilots.
- Community prescribing linked electronically to GPs and the Prescription Pricing Authority.
- An effective health informatics service in each health economy by March 2000.
- The National Electronic Library for Health accessible through local Intranets in all NHS organisations.
- HR, training and development strategies which will help all staff develop and sustain the new skills and confidence to work effectively in this rapidly changing environment.

[1] Level Three EPR encompasses integrated master patient index and departmental systems plus electronic clinical orders and reporting, prescribing and multi-professional care pathways. Each health economy is currently being reviewed to assess how fast EPR can be implemented. Some acute hospitals are already at Level Three, with others following shortly.

4. Modernising strategies

People wherever they live should have access to high quality services and care. That means a focus on implementing new systems to deliver excellence, invest in staff and improve technology.

(Modernising health and social services national priorities 2000/01-2002/03)

The right people, in the right place, at the right time

In the South East, recruiting and keeping staff is probably the issue most likely to compromise the ability to deliver good care. Low unemployment in many areas, with a wide choice of other jobs, often better paid, and a high cost of living, makes it difficult for the NHS to compete for quality staff, even though the South East is an attractive region in which to live. That is why modernisation needs a sound strategy for recruiting, developing and retaining staff, and for using their skills to full effect.

Key goals include:

- Developing best practice in recruitment.
- Employing creative approaches to attracting and developing people from different groups.
- Treating staff well and encouraging development so that they want to stay within the NHS.
- Using skills flexibly and fully.

Working Together [1]

The national human resources strategy *Working Together* sets out the Government's strategic aims for staffing. It requires the NHS to:

- Have a quality workforce, in the right numbers, with the right skills and diversity, organised in the right way, to deliver the Government's service objectives for health and social care.
- Make real improvements in the quality of working life for staff.

Planning the workforce

During 2000, Local Workforce Advisory Groups (LWAGs) and local NHS organisations will be supported by a region-wide development programme to share skills and good practice in workforce planning. Work will also be needed on how the workforce can be used more flexibly and skills and knowledge developed for new requirements. LWAGs must:

- Use local HImPs as the basis for future planning. Each HImP will be supported by a comprehensive human resources and organisational development plan, signed up to by all participant organisations.

(1) **Working Together: securing a quality workforce for the NHS.**

Department of Health, 1999

- Help local NHS organisations plan their workforce (including skills mix) based on the current and likely future availability of professional and non-professional staff. By April 2000 each organisation should have in place an annual workforce plan.
- Integrate local workforce assumptions with data available nationally on trends and developments in the workforce, so that national planning is informed by local needs and local planning informed by wider trends.

The South East has a particular problem in recruiting and keeping nurses and midwives. On average, the three month vacancy rate for qualified nurses in this region is 3.7 per cent, compared with 2.7 per cent nationally. Three month vacancy rates for healthcare assistants average 6.4 per cent in the South East, compared with a national average of 3 per cent. The three month vacancy rate for medical consultants and professions allied to medicine is lower than the national average.

Professional education and training

In commissioning education and training for nurses, midwives and professions allied to medicine, local educational consortia must be concerned not only with the numbers trained but with the quality of the education and training process provided and with the "fitness for purpose" of the training.

Professional education needs to deliver both the necessary clinical skills but also the ability to continue to learn and develop, to work in teams and to work in partnership with patients and carers.

During the next three years it will be important for the NHS to work with its university partners to encourage education programmes which:

- Bring together people training for different professions for part of their basic training.
- Build in the patient's experience to all basic professional training.

The postgraduate deaneries will work with trusts, PCGs and GP practices to ensure that the correct number and quality of training programmes are available for doctors in training. Any changes to the distribution of doctors in training will be signalled well in advance so that trusts can plan for a different skill mix to maintain continuity of service delivery.

Imaginative approaches to recruitment

Imaginative approaches are needed to attract people to work in the health service:

- Consortia and educational providers should pay particular attention to access courses and approaches to developing basic skills in educationally disadvantaged groups.
- Equal opportunities should be a central part of recruitment processes, with data monitored on recruits to pre-registration training and consideration given to establishing programmes of positive action.

- All health systems need to be engaged with the local Learning Skills Councils so that health care is seen as a key sector for employment, including making full use of opportunities presented by the New Deal.
- The use of National Vocational Qualification pathways to recruit and develop staff should be maximised.
- Good practice in recruitment and retention needs to be shared.
- Work should be undertaken in 2000 on housing availability for staff and on good practice in relation to recruiting overseas staff.

Better working life

Beyond getting the basics right, staff need to be given the opportunity to develop. Everyone should take part in a proper appraisal process and each individual should have a personal development plan based on the need and aspirations of the individuals, the team, the client group served and the objectives of the organisation.

Each employer will provide the time and resources to complete realistic plans. Much of the development must be delivered through workplace training.

Improving the quality of working life

The NHS cannot afford to lose staff through poor employment practice. Getting it right in terms of pay, family friendly policies, protection from violence and racial harassment is essential.

The basic human resources agenda for the next three years is to:

- Implement the new pay system fairly and competently.
- Review and improve the operation of all HR policies including violence at work, racial harassment, family friendly policies, sickness absence, occupational health, etc. Each organisation should be able to demonstrate year on year improvement in retention and sickness absence.
- Take forward the work of the National Staff Involvement Task Force, including undertaking and acting on annual staff surveys. Each organisation should have published their local policy on staff involvement by April 2000.

Flexible staffing

The NHS in the South East will maximise the opportunities presented by the national nursing strategy, *Making a Difference*[1] starting with the nurse consultant role and apply the principles across other professional groups.

Good practice will be widely shared across the region, particularly on innovative approaches in the use of nurse consultants and nurse practitioners. Changes in the availability of junior

(1) Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare.

Department of Health, 1999

doctors should also encourage planned innovation, for example in maternity care and in a scheme with the Royal College of Physicians on the role of Senior House Officers (SHOs) in medicine.

Strong leadership and management

In the next three years there will be more organisational change to come:

- Year-by-year increase in the number of PCTs.
- As catalysts of real change in the modernisation agenda, PCTs and PCGs will have growing capability to commission services and to develop primary care.
- Reconfiguration of community, mental health and learning disability services.
- A relatively small number of structural changes in the acute sector but a major requirement for new ways of collaborative working across trusts and PCGs.
- Little change to the number of health authorities but continuing evolution of their role as strategic leaders of health care systems.
- Potential reconfiguration of ambulance services to enable them to deliver the new standards required, link effectively with NHS Direct and to integrate with other forms of access to health services.

These changes require strong development programmes, explicit timescales and processes, and a need for each health system to assess the implications for individuals affected by the changes. Scenario plans for each health system have been submitted.

By March 2000 the plans will have been peer reviewed and feedback given. They will provide an initial view of the scale of management change. Guidance will be prepared on what support individuals affected by change can expect. But it will be the responsibility of the local health economies in the first instance to plan for the consequences of change for senior individuals, particularly those displaced through organisational change.

Work will be commissioned on an internal consultancy scheme as an option for the continued employment and retention of skills of displaced executives. If this is a helpful model it will be established during 2000 in preparation for a significant number of changes in April 2001.

Each health authority needs to have in place development programmes for its PCGs, which build their capability and eventual movement to PCTs (as they come into being). Authorities will need to work through a specific plan for development and implementation with each PCG.

Leading and managing

Implicit in the modernisation agenda is the need for strong leadership and the most up-to-date management approaches. There are two national programmes for management development: the management training scheme (and alongside it the finance management training scheme and public health scheme) for those at the start of their career, and the chief executive development programme for new and established chief executives. Beyond these

programmes the responsibility for management development is up to individuals and their organisations.

The regional management and leadership development forum has agreed a set of recommendations around the needs of chief executives and, to some extent, executive directors. They are to:

- Establish a database of chief executives drawing on performance appraisal and career aspirations. This should be quickly extended to encompass individuals with the potential for chief executive roles.
- Provide appraisal training for chairmen.
- Encourage the use of the resources of the chief executive development programme and the region. The Regional Office should develop a similar database of providers of management development for executive directors.
- Ensure health authorities encourage PCG and PCT chief executives to take part in appropriate local or wider development programmes.
- Clarify the sharing of resources for management development and further devolve them to educational consortia.

The next step will be to establish a group to review leadership development needs at all levels, especially clinical leadership. Good leadership at service levels is a key to the recruitment and retention of staff.

Developing knowledge and sharing learning

The NHS aspires to be knowledge-based, with clinical and managerial practice based on sound evidence. This region encourages a climate where experiences are shared – the failures as well as the successes – and one in which everyone can learn quickly from mistakes and triumphs.

Knowledge encompasses scientific evidence but it also includes tacit, implicit knowledge or 'know-how'. Sharing knowledge requires formal mechanisms and can be greatly aided by information technology but it also requires informal conversations between people and through networks. The challenge is three-fold, to:

1. Nurture a culture of learning where people are prepared to share with each other and to seek out people with experience.

2. Develop systems and networks so that knowledge (including know-how) can be shared easily.

3. Take part in wider learning networks, contributing and learning from the NHS Learning Zone, beacon schemes and learning centres.

Much of the learning needs to be shared among people who are working on similar issues, for example, services for a specific client group. Each area of work needs to be backed by systems for learning, including the establishment of networks, visits, etc.

The national and regional research and development (R&D) programme and Information for Health are both underpinning strategies for a knowledge-based NHS. Each NHS organisation should develop strategies for assessing and using knowledge, including 'know-how.' NHS organisations can use the diagnostic organisational development tool designed with support from the Regional Office R&D directorate which can help them reflect on this capacity and help develop a strategy.

NHS organisations can contribute to the knowledge base by:

- Feeding issues and topics into national processes for identifying research needs.
- Being willing to host necessary research whether funded by the NHS or external partners such as the research councils or charities; this includes facilitating the recruitment of patients into high quality clinical trials.
- Taking part in research on the core work of the NHS through the regional project grant scheme.
- Developing research capacity through training fellowships and bursaries.
- Ensuring that service experiments are evaluated and the learning disseminated both formally and through learning networks.

Much of this will need to be done in collaboration with university partners.

Staff, and increasingly patients, must have easy access to sound information. Not all sources of knowledge are of high quality. The NHS should promote critical appraisal skills during training and at all levels of professional development.

A region-wide knowledge management for health programme has been established. This has two initial strands both of which are designed to experiment with more rigorous approaches to sharing knowledge:

- In Waverley, Surrey, a 'community of practice' approach will be used to share information across all those concerned with care and support for elderly people including those people themselves and their carers.
- A similar community of practice approach will be taken across the region to support improvement of outpatient services in NHS trusts.

The intention in both these schemes will be to understand how participants learn and use knowledge in order to improve learning networks more generally.

Sound stewardship of financial resources

The sound stewardship of resources is a vital part of the management of the NHS and a key Government priority.

Revenue resources
As a minimum each health system and its constituent bodies should be in recurrent balance or should be working towards it against recovery plans agreed with the Regional Office.

A key challenge in the next three years will be to address the significant inequity in resources at PCG level within the framework of a national capitation formula and Ministers' decisions on revenue allocation to health authorities. The impact of ring fenced funds for the modernisation agenda will also need to be taken into account.

Health systems will need to develop a more refined and sophisticated approach to their overall financial agenda encompassing the following:

- In year income and expenditure balance.
- Recurrent income and expenditure balance.
- Cash planning for self sufficiency.
- Recovery plans.
- Trust breakeven duty.
- Impact of accounting standards.
- Public sector payments policy.
- Overall balance sheet 'health' including restoration of working balances.
- Use of capital to revenue transfers as strategic change levers.

It is expected that an open-book approach will be taken within health systems in order to deliver this agenda.

Capital resources
The availability of capital for strategic investment over the next three years will be affected by the total public capital available nationally, sale of trust and Secretary of State owned assets, amounts of block capital to trusts and Ministers' priorities for its use, and access to private capital through PFI and the Public Private Partnership.

A closer fit will be necessary between likely availability of capital and the timing of consultation on service configuration.

Innovation schemes will be necessary to attract private capital and a substantial release of existing assets will be required in order to self fund new capital investment. Investment proposals which rely solely on public funding from the regional office capital programme are likely to face some level of disappointment.

Value for money/efficiency

As part of the wider financial and service agenda and in order to deliver the 3 per cent annual efficiency targets included in Public Service Agreements, it will be important to move away from a simple 'cash releasing efficiency savings approach' to a more refined mix of wider efficiency measures used differentially. For example:

- Benchmarking.
- Reference costs.
- High level performance indicators.
- Clinical indicators.
- National Audit Office and Audit Commission value for money studies.

All organisations need to be concerned about value for money, for example for PCGs, a key area is generic and repeat prescribing.

Corporate governance

In addition to sound financial management it is vital that organisations protect their resources through rigorous governance and stewardship arrangements. The constitutional arrangements for health organisations have been largely implemented during the 1990s following the recommendations of the Nolan Committee, although these will need to be rolled out as PCGs and PCTs develop. Two further strands of action will be progressed over the next three years:

Counter fraud services

National and regional infrastructures have been set up to help deliver the Government's strategy of an NHS which has zero tolerance for fraud.

Health organisations will need to respond to the revised arrangements and agree local approaches with the Directorate of Counter Fraud Services. Training of local staff will also need to take place within the ambit of the recently established national training centre.

Controls assurance

The framework for controls assurance has now moved beyond the financial controls area which has been implemented over the last few years into wider areas of risk management, organisational and environmental controls. HSC/1999/123 gives details of the 18 key areas which health bodies will need to review. All organisations need to:

- Have a designated lead officer at executive director level.
- Implement appropriate structures for controls assurance, including links with clinical governance.
- Complete a baseline assessment of compliance with risk management and organisational control standards.
- Formulate a prioritised action plan with designated leads.
- Provide an assurance statement in the annual report and have arrangements in place to verify the statement.

Work programme updates

Improving health in the South East: Programme of work for the next three years is a working reference document. As well as being printed, it has also been posted on the regional office website *www.doh.gov.uk/stheast/*. It will be updated on the website periodically with a major review annually. The NHS in the South East region will be notified of any major revisions.

Comments on the work programme and suggestions on how to take it forward would be welcome. Please send them to Barbara Stocking, Regional Director, NHS Executive South East, 40 Eastbourne Terrace, London W2 3QR.

Appendix: Reconfiguration of acute and community services

HOST HEALTH AUTHORITY	RECONFIGURATION
Northamptonshire	Northampton General Hospital NHS Trust/Kettering General Hospital NHS Trust
	Community Hospitals/Acute Hospitals
Buckinghamshire	Stoke Mandeville/South Buckinghamshire NHS Trust
	South Buckinghamshire NHS Trust
	Stoke Mandeville Hospital NHS Trust
Oxfordshire	Oxford Radcliffe Hospitals NHS Trust
	Oxfordshire Community NHS Trust
	Nuffield Orthopaedic Centre NHS Trust
Berkshire	Royal Berkshire and Battle Hospitals NHS Trust (RBBH)
	Redevelopment of Newbury Hospital (West Berkshire Priority Care Service NHS Trust)
	Heatherwood Hospital (Heatherwood & Wexham Park Hospitals NHS Trust)
Isle of Wight	Isle of Wight Healthcare NHS Trust
Portsmouth & South East Hampshire	Portsmouth Hospitals NHS Trust/Royal Hospital Haslar
	Portsmouth Hospitals NHS Trust/Portsmouth Healthcare NHS Trust
Southampton & South West Hampshire	Southampton Community Health Services NHS Trust (Lymington Hospital)
	Southampton University Hospitals NHS Trust
North & Mid Hampshire/Southampton & South West Hampshire	Winchester & Eastleigh Healthcare NHS Trust and Southampton University Hospitals NHS Trust
North & Mid Hampshire	Andover District Community Health Care NHS Trust
North & Mid Hampshire/West Surrey	North Hampshire Hospitals NHS Trust (Basingstoke) and Frimley Park Hospital NHS Trust (Frimley)
West Surrey	Ensuring a sustainable NHS - Phase 2 document
	Ashford & St Peter's Hospitals NHS Trust
East Sussex/West Sussex	Central Sussex Review (including: Surrey and Sussex Healthcare NHS Trust; Mid Sussex NHS Trust; Brighton Health Care NHS Trust; and as appropriate Worthing & Southlands Hospitals NHS Trust)
East Surrey/West Sussex	Review of services provided by Surrey and Sussex Healthcare NHS Trust
West Sussex	(see above Surrey and Sussex services review)
	Royal West Sussex Trust (St Richard's Hospital)
East Sussex	Hastings & Rother NHS Trust and Eastbourne Hospitals NHS Trust
West Kent	Mid Kent Healthcare NHS Trust/Kent & Sussex Weald NHS Trust
	Dartford & Gravesham NHS Trust
East Kent	East Kent Hospitals NHS Trust

CURRENT STATUS

Review of acute services and clinical linkages

Review of role and clinical links between community and acute hospitals in Kettering and Northampton areas

Bucks Partnership forging clinical links between hospitals and community services

South Bucks PFI scheme almost complete, improving acute service centralisation

Stoke Mandeville PFI, Outline Business Case complete. Invitation to negotiate now issued

Relocation of services from the Radcliffe Infirmary to the Oxford Radcliffe sites. Major PFI approval, Outline Business Case in preparation

Changes to the role, size and number of community hospitals now agreed by Secretary of State

Relocation of physical disability and creation of integrated specialist services

Redevelopment of RBBH and consequent closure of Battle Hospital underway

Replace an 'old' hospital to increase medical beds and enable increase in day case from RBBH

Heatherwood to take more medical emergencies and surgery to relieve pressure on RBBH & Wexham Park Hospital

Review of acute services on the Island and clinical links to the mainland.

Reprovision of services from RH Haslar which is due to close. Range of clinical collaboration, management and service relocation issues being discussed

Relocation of services at St Mary's to Queen Alexandra Hospital. Future role of community hospitals as part of these discussions

Planned redevelopment of community hospital to replace three current sites

Clinical collaboration schemes with Winchester and Eastleigh and Portsmouth. Review of accreditation of cancer centre underway

Development of clinical partnerships

Currently out to consultation on dissolution and assimilation with Winchester and Eastleigh Healthcare NHS Trust

Ongoing development of clinical partnerships

Public Document published in Dec 99 for consultation examining possible areas of reconfiguration of services as a prelude to further firm proposals being consulted upon later in the year

Consultation completed on reconfiguration of acute, maternity and paediatric services. Ministerial decision awaited

Review of acute services for Central Sussex

Consultation closed end Sept 99. Further work undertaken exploring the future role of Princess Royal Hospital, maternity services, and transportation issues

Ongoing clinical collaboration between St Richard's and Portsmouth Hospitals

Early discussions on acute services collaboration

Acute services review underway. Trust merger agreed for April 2000

New PFI hospital at Dartford due to open in Aug 2000. Working with health authority and PCG on strategy for community services

Merged from three trusts in April 99. Now implementing service changes following Secretary of State's decision

[redacted]

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PERFORMANCE AND BUSINESS PLAN
2000/2001

Draft 25th January 2000

	Programmes and Areas	Health Authority Lead Area	National Priorities Guidance	National Planning Guidance	HImP	National Policy	Key HA Functions	Local Issues
1	**Improving Health & Reducing Inequalities**							
1.1	Reducing Smoking	Director of Public Health	✓		✓			
1.2	Tackling drug misuse	Director of Public Health	✓		✓			
1.3	Reducing teenage pregnancies	Director of Public Health	✓		✓			
1.4	Reducing mortality rates for cancers and improving cancer services	Director of Public Health	✓		✓			
1.5	Reducing deaths and illnesses from coronary heart disease & stroke	Director of Public Health	✓		✓			
1.6	Improving mental health services, including implementation of NSF and CAMHs	Director of Public Health	✓		✓	✓		✓
1.7	Improving older people's services	Director of Public Health	✓		✓			
1.8	Reducing perinatal mortality	Director of Public Health			✓			
1.9	Development of Prison HImPs	Director of Public Health				✓		
1.10	Development and Implementation of Health Improvement Programme	Director of Public Health		✓		✓	✓	
1.11	AIDS Control Reports	Director of Public Health					✓	
1.12	Management of communicable diseases	Director of Public Health	✓					
1.13	Immunisation and vaccination programmes	Director of Public Health	✓					
1.14	Annual Report of the Director of Public Health	Director of Public Health					✓	
2	**Organisational Strategy**							
2.1	Roll out of NHS Direct and integration with local services	Director of Policy & Performance	✓					
2.2	Implementation of Disability Discrimination Act	Director of Finance & Corporate Services				✓		
2.3	'Partnership in Action' and management of unified budgets	Director of Strategic & Service Development				✓		
2.4	HR implications of the Health Improvement Programme, including workforce planning	Director of Finance & Corporate Services	✓		✓			
2.5	Emergency planning	Director of Policy & Performance				✓		
2.6	Management resources, inc access to information, for PCGs	Director of Finance & Corporate Services		✓				
2.7	Caldicott, including 'For the Record'	Directors of Public Health/ Policy & Performance				✓		
2.8	Implementation of the organisational development plan, Authority and PCGs	Chief Exec - Portsea Island PCG	✓	✓		✓		✓
2.9	Development of Primary Care Groups	Director of Policy & Performance	✓	✓		✓		
2.10	Implementation of 'Information for Health', and Local Implementation Strategy	Director of Finance & Corporate Services	✓			✓		
2.11	Implementation of 'Working Together', including improvement of working lives	Director of Finance & Corporate Services	✓			✓		
2.12	Review of Public Health capacity	Director of Public Health				✓		
2.13	Joint strategy for public involvement	Director of Public Health				✓		
2.15	Implementation of Controls Assurance and Risk Management	Director of Finance & Corporate Services				✓		
2.16	Merger with Isle of Wight Health Authority	Director of Policy & Performance						✓
2.17	Preparation of East Hants PCG for PCT status	Director of Policy & Performance			✓			✓
2.18	Boundary changes for Cosham Practices	Director of Policy & Performance						✓
2.19	Scenario Planning - organisational and service reconfiguration	Chief Exec - Health Authority						✓
2.20	Reprovision of Service to Gosport	Chief Exec - Health Authority						✓
3	**Strategic Service Planning**							
3.1	Waiting lists and waiting times	Director of Strategic & Service Development	✓		✓			
3.2	Booked admissions	Director of Strategic & Service Development	✓		✓			
3.3	A&E, emergency care and critical care services	Director of Strategic & Service Development	✓		✓			
3.4	Reducing delayed discharges	Director of Strategic & Service Development	✓		✓			
3.5	Collaborative commissioning (primary, secondary and regional specialised)	Director of Strategic & Service Development	✓			✓		
3.6	Service reviews and reconfiguration including rehab and diagnostics	Director of Strategic & Service Development						✓
3.7	Eliminating mixed-sex accommodation	Director of Strategic & Service Development	✓					
3.8	Promoting independence	Director of Strategic & Service Development			✓			
3.9	Development and implementation of Joint Investment Plans - Older People and Mental Health	Director of Strategic & Service Development		✓	✓	✓		
3.10	Preparation of Joint Investment Plan for Learning Disabilities, and Welfare to Work	Director of Strategic & Service Development		✓				
3.11	Management of winter pressures	Director of Strategic & Service Development				✓		
3.12	Development of long term service agreements, including integrated care pathways	Director of Strategic & Service Development		✓	✓	✓		
3.13	Devolution of commissioning	Director of Strategic & Service Development	✓	✓	✓	✓		
3.14	Ensuring partnership working across the health economy	Chief Exec - Health Authority				✓		
3.15	Development and implementation of Service & Financial Framework	Director of Finance & Corporate Services		✓		✓	✓	
3.16	Merger of services across PHT and RHH	Chief Exec - Health Authority						✓
3.17	Disinvestment	Director of Finance & Corporate Services						✓
3.18	Joint agendas with local authorities - Sure Start, Quality Protects, YOTs and Crime & Disorder, Early Years	Director of Strategic & Service Development	✓		✓			

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PERFORMANCE AND BUSINESS PLAN 2000/2001

Draft 25th January 2000

	Programmes and Areas	Health Authority Lead Area	National Priorities Guidance	National Planning Guidance	HimP	National Policy	Key HA Functions	Local Issues
4	**Quality & Clinical Governance**							
4.1	Implementation of new NHS Charter	Director of Public Health	✓					
4.2	Responding to National Surveys of NHS patients and management of complaints	Director of Public Health	✓					
4.3	Implementation of clinical governance action plans	Director of Public Health				✓		
4.4	Clinical governance agenda for GDPs, pharmacists and optometrists	Director of Public Health				✓		
4.5	Implementation of the local Quality Improvement Strategy	Director of Public Health				✓		
4.6	Annual Report of the Research Ethics Committee	Director of Public Health					✓	
4.7	Impact of NICE and CHI	Director of Public Health	✓	✓		✓		
4.8	Clinical Effectiveness	Director of Public Health				✓		
4.9	Implementation of 'Caring about Carers'	Director of Public Health	✓		✓	✓		
5	**Financial Control & Planning**							
5.1	Management of in-year financial allocations (modernisation funds)	Director of Finance & Corporate Services				✓		
5.2	Long term financial planning and stability	Director of Finance & Corporate Services	✓					
5.3	Financial allocations, including delegated budgets for PCGs	Director of Finance & Corporate Services					✓	
5.4	Annual Accounts of the Health Authority	Director of Finance & Corporate Services					✓	
5.5	Annual Report and Accounts for trust funds	Director of Finance & Corporate Services					✓	
5.6	Private Finance Initiative for Portsmouth Hospitals Trust	Chief Exec - Fareham & Gosport PCG						✓
5.7	Private Finance Initiative for Portsmouth HealthCare Trust	Chief Exec - Fareham & Gosport PCG						✓
5.8	Management of efficiency targets	Director of Finance & Corporate Services		✓				
5.9	'Countering Fraud'	Director of Finance & Corporate Services				✓		
5.10	Capital/ Asset strategy	Director of Finance & Corporate Services						✓
6	**Development of Primary Care Services**							
6.1	Improvement of practice premises, use of IT	Director of Finance & Corporate Services	✓		✓			
6.2	Continuing professional development	Director of Public Health				✓		
6.3	Primary Care Investment Plans	Director of Policy & Performance		✓		✓		
6.4	Prescribing	Director of Public Health	✓					
6.5	Improve access to NHS Dentistry, including Dental Access Centres (PDS)	Director of Finance & Corporate Services	✓		✓	✓		
7	**Business & Performance Management**							
7.1	Implementation with PCGs of Annual Accountability Agreements	Director of Policy & Performance		✓		✓		
7.2	Performance management for key activities	Director of Policy & Performance				✓		
7.3	Corporate Contract (Agreement with South East Regional Office)	Director of Policy & Performance					✓	
7.4	Health Authority business plan	Director of Policy & Performance					✓	
7.5	Annual Report of the Health Authority	Director of Policy & Performance					✓	
7.6	Assessment of performance (health economy and supporting agreements) across areas of the PAF	Director of Policy & Performance		✓		✓		

IN CONFIDENCE

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PROPOSED SERVICE COMMISSIONING ARRANGEMENTS FROM APRIL 2000

Background

'Leadership for Health' identifies the future responsibilities for Health Authorities to be providing strategic leadership and ensuring service improvements are coherently planned and delivered. It anticipates that operational management will no longer be the remit of the Health Authority. Commissioning will be undertaken by either PCGs/PCTs or a pan district consortium for specialised services. Given the Health Authority's current strategic agenda – RH Haslar, Portsmouth HealthCare Trust and Portsmouth Hospitals Trust Private Finance Initiatives, potential Health Authority mergers etc. It is proposed that PCGs should be equipped to take on all appropriate commissioning responsibilities as soon as possible – from April 2000.

This document sets out to:

- Propose commissioning arrangements
- Propose a respective split of commissioning responsibilities between PCGs and the Health Authority from April 2000.

Proposed commissioning arrangements and responsibilities

Service Commissioning

It is proposed that the commissioning responsibility for the following services are transferred from the Health Authority to PCGs:

Service	Rationale
Services for Vulnerable People • Adult Mental Health Services(Community Mental Health Teams including acute admissions but excluding specialist services i.e. eating disorders, medium and secure unit admissions and services for Mentally Disordered Offenders) • Mental Health Services for the elderly	In line with the recommendations from the recent strategic review of Adult Services
Substance Misuse Services (Locally provided not specialist services)	Co-ordination role will need to be held by the HA, DAT co-ordinator, but similar model to AMH with localised service commissioning
Dental Services • Community Dental Services • Oral Surgery • Orthodontics	PCGs now have links with LDC and district-wide Oral Health Strategy Group, both of which can provide expert

• Restorative Dentistry	advice.
Sexual Health Services • Family Planning Termination of pregnancy	These are not specialised services.
Urgent and Emergency Ambulances	This is not a specialised service.
'Old long stay' (Mental Health and Learning Disabilities)	Details to be determined following review

This would leave the Health Authority with residual commissioning responsibilities for:

Service	**Rationale**
Services for people with learning difficulties	Pending the outcome of the current strategic review
AIDs/HIV services	Nationally prescribed for HA commissioning
GUM services	Nationally prescribed for HA commissioning
Breast and Cervical Screening	Both nationally prescribed for HA commissioning
Immunisation and Vaccination	Purchased for the total population
All 'Specialised' services	'Wessex Consortium' to agree commissioning strategy. (Budgets/funding to be administered through PCGs)

Other Commissioning Responsibilities

In addition to the transfer of responsibility for the commissioning of additional services, it is proposed that additional commissioning responsibilities should be devolved to PCGs. This would reflect the principles set out in 'Leadership for Health'.

The Health Authority would continue to co-ordinate 'whole systems' initiatives e.g. waiting lists and times and winter pressures. It would also take responsibility for, facilitating and performance managing the commissioning process but with PCGs holding responsibility for all other components of commissioning.

It is proposed that the following Health Authority responsibilities will transfer to PCGs:

- Implementation of national policy for vulnerable care groups (Adult and Elderly Mental Health, Learning disabilities, older people and children and substance misuse) This would include National Service Frameworks and other best practice guidance from NICE, CHIMP or the Audit Commission for example.
- Provider service performance monitoring including Portsmouth Hospitals, Portsmouth HealthCare Trust and Hampshire Ambulance
- Service performance monitoring and management for vulnerable care groups
- Care Group Priority Setting and the development of Joint Investment Plans
- Review of continuing care criteria and negotiation with Local Authorities
- Service review/evaluation and disinvestment or reconfiguration.

- Development of Long Term Service Agreements and Care Pathways

Whilst there will not be any formalised co-ordination for services or care groups between PCGs, there will need to be agreement between PCGs, identifying on an ongoing basis, those services or care groups that may require collective action.

The Health Authority will retain a role in the following areas:

Information provision - data receipt and manipulation (subject to outcome of JISG work)
Specialist Service Commissioning – strategy planning and negotiation arrangements for specialised services
Performance Management – Performance reporting to SERO (CIC returns), corporate reporting to the HA, provision of performance information to PCGs (HLPIs)
Strategic Planning – Interpretation of national policy. Lead on HIMP Development and SFF, co-ordinate district-wide joint planning arrangements and Joint Finance
Health system co-ordination – particularly around political imperatives such as waiting lists and winter pressures

In areas such as quality, patient and public involvement and public health medicine it is recognised that the Health Authority and PCGs have complementary responsibilities. The resources to fulfil these are within the Health Authority with staff providing their expertise in PCGs on an informal basis. It is proposed that the PCG time commitment and work programme should be formalised with annual objective set between PCG Chief Executives individual members of staff; Consultants in Public Health Medicine, Quality Manager, Clinical Effectiveness Manager, Patient and Public Participation Manager.

Resources

Work is in hand to identify the resource necessary to undertake the revised responsibilities set out above.

Consideration will need to be taken of existing staff skills and expereience which will need to transfer into PCGs to ensure that the skills and resources are acquired before the extension of their responsibilities.

The financial implications of the above shifts in responsibility need to be affordable within the overall management cost target for the Health Auhthority for 2000/01.

Consideration will also need to be given to revised accommodation requirements of each part of the Health Authority.

It has been assumed that managerial resource shifts will be mirrored by admin and secretarial support shifts.