

Trafford PCT

Business Plan 2008/09: Organising the Next Step

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Executive Summary

This business plan presents an account of the business context for Trafford PCT in 2008/09 and the work we propose to undertake to improve services and outcomes for patients.

In summary, it highlights eight main priorities for this year, which range from delivering significant improvements to our performance to embarking on a newly ambitious public and clinical engagement strategy to laying the foundations for our three year strategy.

By way of explaining the particular emphasis for this year, it also provides an outline account of the thinking that will inform our three year strategy, due for publication in October.

It then goes on to argue that for reasons of focus and flexibility the PCT is proposing adopting a 6 month objective setting and business planning cycle and presents an outline account of the financial implications and some of the risks associated with the plan.

Finally, in its Part II, it presents a detailed series of objectives that describe the areas of investment, efficiency savings and management actions that will take place through the first half of the business year.

2. Introduction

When we look back over the past five years, we see a period characterised by a high level of external change – from having two PCTs in Trafford borough, to having two PCT boards but only one management team and finally to the single Trafford PCT we have today.

In response to this, we spent a lot of time last year getting the foundations right within the new PCT and we are now confident that we have the right senior management team to move ahead and the right strategy to begin making – in partnership with others – a real difference to healthcare services and health outcomes for the Trafford population.

In fact, the shift to health outcomes, and the formal performance management of these, is one of the most welcome developments in the national policy framework. The PCT's commitment to its public health agenda, and a renewed focus on delivering systematic programmes to deliver tangible improvements to the health of the population form a core part of our work in the next 12 months and have informed our thinking for our three year strategy. Our 'flagship' programme around this is our proposal to adopt a new approach to managing programmes using the registered list as a key part of our enabling infrastructure and the first test of this approach will be our work this year on developing a new, Trafford-wide risk register for cardio-vascular disease.

One of the biggest changes that will make 2008/09 very different from other years for the PCT is the new separation between our functions as a commissioner and our role as a provider of services. The Department of Health has required all PCTs to put into place arrangements to ensure that their provider units operate at 'arms length' from the commissioning function. For us, this means that the PCT will consist of an increasingly autonomous provider unit on the one hand, and increasingly autonomous practice based commissioners on the other. Developing the 'glue' to hold the economy together in a way that is strategically coherent will become the key systems management challenge for the PCT.

Another big change will be in the way the PCT relates to patients and the public. We have invested a considerable amount of time and resource to develop a new approach to this essential engagement. As well as fully supporting the emerging 'LINKS' process, we will also be adopting a much more transparent system of clinical engagement and communication. This will incorporate new techniques of social marketing to ensure our messages stand the best chance of being received by those most likely to be affected by them and that our services reflect what our population requires. We will also develop elements of our engagement strategy specifically at carers to ensure that their voice is heard with increasing clarity as we develop our strategic framework.

The internal relationship between commissioning and provision, and our approach to communication will inform all of our work in 2008/09 and from now on. This business plan has been designed to enable us to describe as clearly

as possible what we intend to do to transform services and outcomes for people in Trafford.

The acid test of our success in doing this will come in our performance as measured by independent, external bodies. There are three important external frameworks that will publicly measure our success – the Annual Health Check, the World Class Commissioning Assurance Framework and the Auditor's Local Evaluation. Because of the importance of these, we begin this business plan outline each of these frameworks, showing very clearly both where we want to be by March 2009 but also keeping a weather eye on where we want to be in three years time. This answers the question about 'why' our business plan looks the way it does.

This focus on the three year 'horizon' matters, because 2008/09 is also an important year in that it represents the beginning of a new strategic direction for the NHS. Through its new performance management regime and its new approach to developing 'World Class Commissioning', the Department of Health is now requiring PCTs to focus their efforts much more on health outcomes. Alongside this, the SHA-wide Advancing Quality programme is changing the focus and context of services. To succeed in the future we will have to achieve highly responsive access times for all services *as a minimum* standard. We do not underestimate the challenge that this represents and we are aware that there are some areas of our healthcare system that require a continued and sustained effort, such as the opening of all GP lists within the borough.

Notwithstanding this, the emphasis in our strategic thinking needs to shift decisively to quality.

We have acknowledged internally that the new focus on quality and outcomes requires us to think differently about how we do things. Because of this shift, the next section of the business plan provides a brief outline of the three year strategy and answers the question about 'what' we want to achieve.

We think it is important that our strategic work is not just about improving performance and delivering against the priorities set for us in our public accountabilities. It is also about developing capabilities that will deliver benefits into the future for the people of Trafford and the professionals who work hard to support and care for them. We have used the term 'enabling infrastructure' to describe the things we are planning to do develop these capabilities and the next section of the business plan will discuss these in some more detail. These seven 'pillars' of our strategy represent our answer to 'how' things will be different.

A disciplined approach to the way we think through our plans and the way we execute them is essential. Developing this discipline is the basis for producing within the PCT a strong performance culture. The next section of the business plan describes how we are going to develop our approach to performance management and means we can be constantly clear about 'when' things are moving in the right direction, at the right pace.

Finally, we acknowledge that we are managing within a complex context. Because of this we need to stay both highly focused and highly flexible. To answer this demand, we have adopted an approach to planning that develops detailed objectives 6 months at a time. The next section of the business plan describes this process and a series of objectives are presented in Part II of the plan, focused on the period from now to September 2008. This answers the final question of 'who' is responsible for delivering the main developments this year.

The final two sections deal with financial implications and risks. This shows on the one hand where we intend to place our main investments this year, and on the other hand our view about the things that could slow us down or force us to change direction. It remains a key priority of the PCT to change the balance of investment away from reactive care and towards more integrated and preventive models of care.

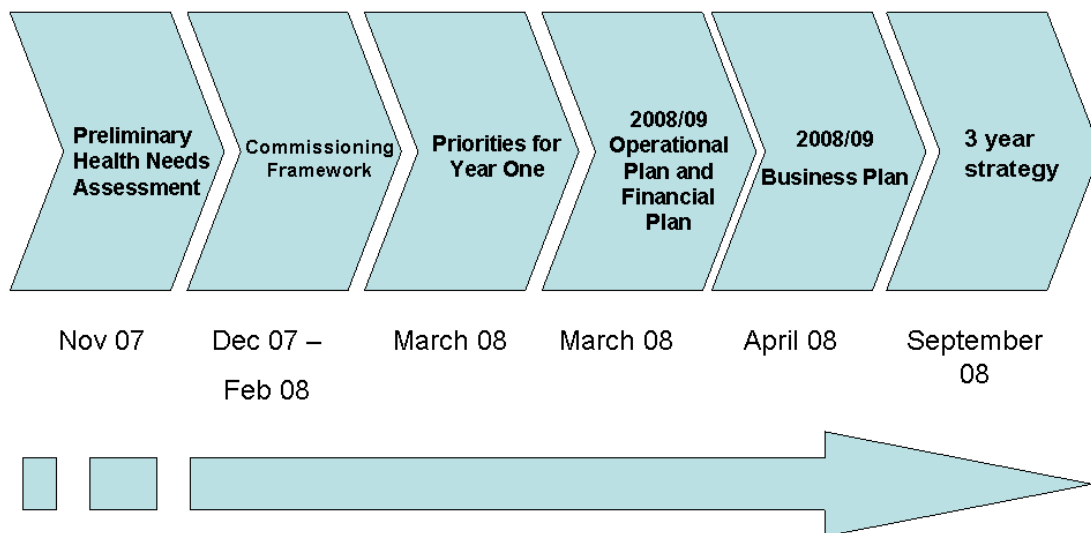
So for us, 2008/09 is a critical year, during which we will pursue six main priorities:

- 1) Deliver significant improvements to our performance, shifting the focus of our performance systems to manage outcomes;
- 2) Introduce a new emphasis on quality, enshrining this in our contracts whenever possible;
- 3) Lay the foundations for our new enabling infrastructure to improve the health of the population and transform services;
- 4) Accelerate the development of our practice based commissioners;
- 5) Support the development of an increasingly autonomous provider;
- 6) Continue our programme of engagement and partnership working with staff, clinicians, carers, patients and the public, but move it to a more ambitious level.

3. Description of Key Priorities

It is important to state at the outset that this business plan takes its place as part of a larger planning process. Some parts of this have been set by the Department of Health, and some parts of it we have developed ourselves to ensure that our plans are in keeping with local needs. We can summarise this planning process as follows:

THE PLANNING PROCESS



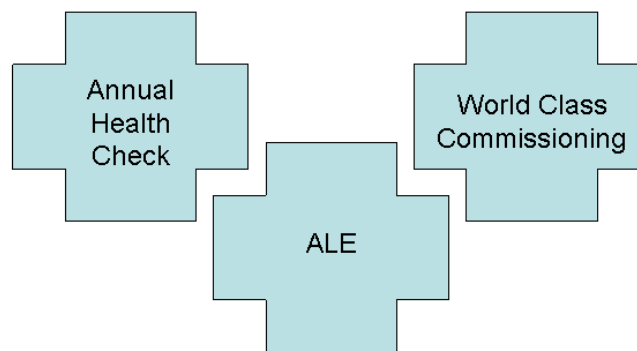
As this diagram shows, we are on a journey that is about clarifying our ideas and developing plans for their execution that will lead to us publishing a clear three year strategy by September 2008.

In the context of this business plan, the PCT has seven clear priorities for 2008/09:

- 1) ***Deliver significant improvements to our performance, shifting the focus of our performance systems to manage outcomes***

Our performance is measured by three main external frameworks:

Core Domains for key priorities



Of these, the best known is the 'Annual Health Check', which measures our achievements across a wide range of indicators. The ratings scale for this goes from 'poor' to 'excellent' and at the moment the PCT is rated as 'fair'. The strongest test of whether we have delivered 'significant improvement' to our performance will come from the Annual Health Check rating, which we are determined will be at least 'good' for 2008/09, moving to 'excellent' in 2009/10 at the latest.

The Auditor's Local Evaluation is used in determining the rating for the Annual Health Check but is a framework in its own right looking at our use of resources and our internal business processes. Its rating scale is similar to the Annual Health Check but on a number scale of 1 (poor) to 4 (excellent). We are presently rated as '2' and 'significant improvement' means being rated as '3' in 2008/09, moving to '4' in 2009/10.

The new evaluation framework is 'World Class Commissioning'. The Department of Health is presently completing the details of how this will operate and will publish its 'Assurance System' by the end of May. We know already that there will be three components to the system – Outcomes, Competencies and Governance. We also know that there will be a four stage ratings scale ranging from 'Below baseline' to 'World Class'. We believe the standard will be

set very high for organisations to achieve a rating of 'Baseline' in the first assessment that will take place between September and Christmas 2008. Because of this, we are aiming to be at baseline level this year, moving to World Class by 2011.

We can summarise our performance improvement goals both for 2008/09 and for the three year period as follows:

PERFORMANCE IMPROVEMENT GOALS

External framework	Performance Goal 2008/09	Performance Goal over 3 years
Annual Health Check	Good	Excellent
Auditors Local Evaluation	3	4
World Class Commissioning	Baseline	World Class

2) Introduce a new emphasis on quality, enshrining this in our contracts whenever possible

From now on, the development of systems to ensure quality needs to become the focus of everything the PCT does. We have made a start on this by incorporating for the first time a schedule of quality indicators into our contract with Trafford Healthcare Trust. These indicators come with quantified thresholds and are linked to financial incentives.

As well as this, we are beginning Trafford's formal involvement in the SHA-led 'Advancing Quality' programme which will ensure that hospital providers begin to manage whole pathways for patients. We intend to become enthusiastic participants in phase one of this programme, and to develop and pilot new approaches for future phases of the work.

3) *Lay the foundations for our new enabling infrastructure to improve the health of the population and transform services*

The 'enabling infrastructure' referred to here has seven 'pillars':

- 1) A recommissioned 'Caretnet' model
- 2) GP registers linked through a data sharing agreement and the development of a register based 'population health status monitor'
- 3) The development of a network of new primary care centres/SMH
- 4) The development of a web-based systems management function supported by very high frequency patient level monitoring
- 5) A new public engagement strategy
- 6) Establishment of new integrated care provision
- 7) New PCT teams and organisation

Explaining what each of these means will take up the next section of the business plan.

4) *Accelerate the development of our practice based commissioners*

The capacity and capability of our practice based commissioners to take on increasing levels of responsibility for commissioning services is a critical success factor for the PCT. This is not only so that the voice of primary care clinicians can better inform our commissioning decisions, but also so that we can develop a more effective demand management infrastructure. The way we are making this a priority in 2008/09 is by:

- a) Developing the management infrastructure and governance arrangements to support the PBC consortia;
- b) Investing in information systems to ensure that contract information is accurate, timely and more readily available at cluster and practice level;
- c) Developing a clear incentive structure for PBC, extending the good work already underway as a result of the prescribing incentive scheme;
- d) Building a 'Business Hub' within the commissioning directorate, specifically resourced to support the development of business cases indicated by PBC;
- e) Involving PBC directly in contract management by having GPs attending our formal contract monitoring meetings;
- f) Involving PBC directly in the work to deliver the 2008/09 contract, with particular reference to reducing outpatient follow ups; and

- g) Securing a 'place at the table' for the formal renegotiation of contracts for 2009/10.

5) Support the development of an increasingly autonomous provider

The appointment of our new Director of Provider Services has given a strong impetus to the development of increased autonomy for our provider unit. We are making this a priority in 2008/09 by:

- a) Providing dedicated financial support and personnel to the provider unit;
- b) Providing dedicated clinical leadership in the form of a new 'Medical Director' post and strengthened nursing leadership;
- c) Providing dedicated communications and marketing support to develop a new, stronger brand identity and dedicated channels of communication; and
- d) Exploring the possibilities for changing the legal form of the provider unit to determine its most appropriate relationship to the PCT.

6) Continue our programme of engagement with patients and the public but move it to a more ambitious level

The PCT will continue to work towards delivering an organisational culture and structure that places Patient, Public and Community Engagement and involvement at the heart of decision-making. This will require a systematic and structured approach across Trafford PCT, which ensures that: our population is informed and engaged; and our commissioning is always informed by patient and population experiences and outcomes.

To achieve this, we will:

- Establish clear routes into the PCT for the public, patients, staff and colleagues from partner organisations and clarify community links.
- Ensure that the PCT has the structures to involve people in service developments and delivery, including front line staff and other agencies.
- Facilitate the progression of Trafford PCT towards excellence in its delivery of stakeholder engagement.
- Investigate ways to jointly promote and undertake patient, public and community engagement initiatives with our partner organisations.
- Be open and transparent about our decision-making processes and have clear lines of accountability and responsibility for this work.
- Be clear about how we process all communication (both formal and informal) and document how we involve patients and communities.

- Ensure that our policies support and promote patient, public and community engagement and local priorities are informed and influenced by the community.
- Ensure that the PCT adheres to national standards and directives in relation to involving patients and the public in its work.
- Ensure the best use of the resources available.
- Be proactive in reaching out to different parts of our community and in supporting those who want to be involved in developing initiatives and solutions that lead to health improvements.
- Deliver services that empower individuals and communities and promote health.

7) Develop even closer working with our partners

We are well aware that our ambitions to improve outcomes cannot be achieved alone. We intend to improve our partnership working in 2008/09 in four specific ways:

- a) Through the successful implementation of the Children and Young People's Service with Trafford Metropolitan Borough Council (TMBC). This innovative service will provide the opportunity for integrated working between health, education and social care teams to deliver the best possible services for children and young people in Trafford.
- b) Through new partnerships with the voluntary sector. We have excellent relationships with many parts of the voluntary sector and we would like to see these continue and grow. We have also started to increase the overall value of our contracts with the voluntary sector and we are exploring opportunities to continue this trend, particularly in mental health. We will commence work this year to develop a new framework for contracting with the voluntary sector and also explore the possibility of developing target rates for the proportion of our contract value assigned to voluntary sector providers.
- c) Through new arrangements with adult social services. We have agreed to begin a process in May to systematically explore the potential for closer working between the PCT and adult social services, including the potential for joint commissioning where this will add value.
- d) Through our active engagement in the Local Strategic Partnership so that the PCT can contribute effectively to borough-wide strategies to improve the effectiveness of the public sector and change health and health-related outcomes for the people of Trafford.

8) *Develop further our approach to clinical engagement*

We recognise the need to develop further our approach to clinical engagement. We are exploring the possibility of holding a “Clinical congress” with GPs and consultants who serve the population in Trafford on the theme of ‘Service Integration’.

We are also expanding the number of clinical sessions that will be used by the PCT to provide expert strategic and issue-specific advice from practising clinicians. This will partly be delivered through PBC, partly through proposals for new clinical leadership roles within the provider unit and partly through new adviser posts within commissioning.

We are also planning to extend our formal networks, to ensure that clinical representatives feed in to our policy development and implementation. Early in the year we will establish new networks for urgent care and 18 weeks implementation.

The PCT also recognises the importance of training and maintaining the competencies of healthcare professionals. It will continue to develop a programme for primary care staff offering multi-professional educational events and support the growth in capacity to train staff building on the work to increase the numbers of practices training medical students and FY2 doctors.

These priorities, taken together, will do two things. First, they will deliver some immediate and tangible benefits for our population in the form of improved healthcare systems. Secondly, they will lay the foundations for our three year strategy and begin the process of transformational change.

4. Outline of the Three Year Strategy

It is important to keep our three year 'planning horizon' in mind so that our work during 2008/09 forms part of a cumulative programme to transform services and outcomes. This section will briefly outline the three year strategy by characterising each year's work.

Year One – laying the foundations

This business plan is focussed on building the capacity of the PCT, ensuring our governance arrangements are appropriate regarding our provider services, becoming fully engaged with our population, developing the core capabilities of the system and planning the large changes for the future.

Year Two – making the change

It is during 2009/10 that any large structural alterations to contracts and systems will take place. Obviously, we need explore the possibilities and risks of each of these changes but we cannot move to more integrated, technology led care processes without anticipating some significant shifts in the nature and value of our contracts.

Year Three – realising the benefits

Experience tells us that enacting major change requires careful follow-through if the main benefits are to be realised. 2010/11 will be the year where these benefits will materialise and also the time when we will be fine tuning our performance systems to ensure that the work we have done is acknowledged within our external frameworks as we move to becoming a validated 'excellent' and 'world class' health economy.

5. Developing the Enabling Infrastructure

The 'enabling infrastructure' that we think is necessary to deliver transformed health outcomes and healthcare services has seven 'pillars'.

1) A recommissioned 'Caretnet' model

At present, we are running a highly reactive system and largely disjointed system that we describe as 'unscheduled care'. This language is unfortunate, as it perpetuates that idea that we must always be taken by surprise by people 'suddenly' needing 'emergency' treatment.

Of course, we need to have facilities in place for true emergencies, and there will always be the need for the NHS to react quickly in a crisis. But what we need to do is redefine what counts as a crisis. Road traffic accidents, other forms of trauma and the sudden onset of acute disease legitimately fall into this category. However, there are a large number of users of our 'unscheduled' care systems that do not fall into any of these categories, but are best thought of in a different way, as suffering from exacerbations.

Exacerbations are moments in the progress of a disease, often associated with long term conditions, which signify either a change in status in terms of the well being of a patient, or where some other cause has made the main condition more difficult to live with.

The traditional way to manage exacerbations beyond a certain level of severity has been to hospitalise. This is a perfectly valid approach, since it places the patient in an environment where the appropriate support and expertise is readily available.

The issue for us is whether this is the *best* way to manage our most vulnerable patients, many of whom will have more than one long term condition. In the most developed and holistic healthcare systems, every episode of hospitalisation is considered to be a systems failure. From a whole population point of view, quite apart from the risks of hospital acquired infections, it is an expensive way to manage what are often foreseeable events.

The concept of the 'Caretnet' is to develop a commissioning approach that will exploit new technologies – specifically remote monitoring – to place patients who can benefit under a care system that watches very closely for signs of an approaching exacerbation and intervenes before hospitalisation is necessary.

The development of this element of the infrastructure has two components. The first is a review of present services to ensure that they are capable of acting in a systematic way to support an integrated model. The second is to review the market possibilities and build the business case to identify a strategic partner to deliver the remote monitoring as the core of the new system.

As we undertake this development, we will pay particular attention to the needs of carers, and explore ways we can offer new levels of support to those who help to look after some of our more vulnerable patients. In doing this, we are acknowledging both the enormous contribution carers make to the well being of the population and also our responsibility to do more to support them.

- 2) GP registers linked through a data sharing agreement and the development of a register based 'population health status monitor'

The board of Trafford PCT approved in March the concept of the 'primacy of the GP registered list'. Part of the thinking behind this is that the information contained within the GP list could be the keystone upon which we could build a new approach to delivering public health benefits.

GP practices are the only places – according to simple systems logic – where we can build a system that will enshrine the virtues of continuity of care, patient confidentiality and population health improvement.

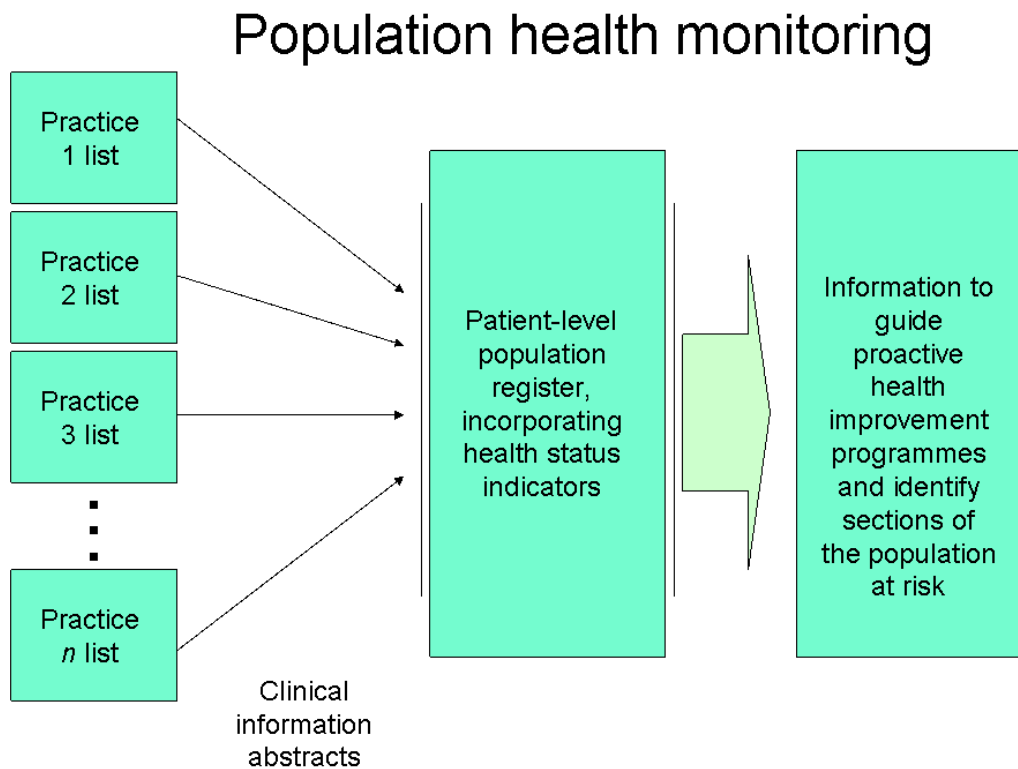
By building a system in which the future integrated care record is founded on the GP register we can develop a stronger continuity than is at present possible.

By ensuring that, other than for direct care processes, patient identifiable information is only viewable from within the practice we can guarantee confidentiality.

By using pseudonymised data shared from within practices, we can develop programmes that guarantee our health improvement programmes are acting effectively for all our patients, including those that are presently hard to reach by conventional general practice.

The development of this element of the infrastructure has two components. First is the negotiation of a data sharing agreement to operate between practices, practice based commissioning consortia and the PCT. This will enshrine and enforce appropriate safeguards for patients and practices whilst facilitating the new approach to continuity and population health improvement. Second is the development of the appropriate software and hardware environment to exploit the potential of integrated, shared care.

This idea can be illustrated as follows:



3) The development of a network of new primary care centres

We know that a number of our practices are operating out of premises that are unsuitable for a 21st century healthcare service. We also know that there are a range of services presently being provided in a hospital setting because there is no realistic alternative.

We intend to look at both of these issues in tandem with a view to developing a strategy by September that will identify the priorities for capital investment to renew key parts of our estate and develop the clinical spaces to provide a broader range of services in primary care.

The development of this element of the infrastructure consists of us convening a new 'Primary Care Strategy Group' within the PCT to bring together the main stakeholders. We will then develop:

- a set of principles which will guide the strategic development
- a clear financial policy to support the revenue consequences of schemes which will show us how quickly we can move
- a set of criteria against which we will judge business cases

Our intention is to develop an infrastructure for new groups of practices to operate within an environment conducive to taking on extra work in integrated services.

4) The development of a web-based systems management function supported by very high frequency patient level monitoring

At the moment many of our data flows are infrequent and only analysed at an aggregate level. This makes it almost impossible for us to correctly diagnose where there are problems emerging in the system, and how we might act to correct them.

Web-based systems offer us a new approach in two ways. First, we can develop our own 'business logic' that can be formalised into automated reports. Second, we can access this information from anywhere within our internal network, meaning that both managers and clinicians from across the PCT can begin to operate within an information-rich environment.

Very high frequency patient level monitoring is an important principle to extract the most value from a web-based system. What we mean by very high frequency will change over time. At present, it would be an achievement for us to see and analyse patient level detail for hospital activity within a month after the end of the month within which the activity takes place. In contrast, our early work in this regard has led us to be able to receive daily reports on A&E performance, though not at patient level.

Developing this element of the infrastructure will have two components. First, we will build a preliminary web based performance system to manage our corporate and public accountability performance. Second, we will start to undertake 'systems management reviews' to identify and establish new data flows to improve the frequency of our reporting. We intend to develop this approach first with respect to primary care mental health access and access to orthodontic services.

5) A new public engagement strategy

Patient, public and community engagement (PPCE) will underpin our approach to improving health services and the health of the people of Trafford. More specifically:

- we will take a strong lead in the buying of services for our population from local providers to meet demand;
- we will make a real impact on improving health in the borough by providing both treatment and prevention programmes; and
- we will act as a guide for the people of Trafford to ensure that they have all the knowledge to be able to choose the right treatment.

Our approach to it will be open and systematic and put people at the heart of what we do. The basic principle will be to carry out PPCE across two levels:

The **individual**: The involvement of patients / service users in discussions and decisions concerning their own individual care and treatment.

The **collective**: The involvement of patients / service users **and** the wider public in decisions concerning the delivery and planning of services.

At both the individual and collective levels there are different degrees of involvement which reflect a spectrum of engagement that ranges from provision of **information**, through **feedback** to **influence** over the decision making process.

The PCT will make the best and most effective use of key existing frameworks including Overview and Scrutiny and LINKs. However, it will also need to establish its own frameworks and techniques to engage as a means of complementing and supplementing these existing frameworks.

We will, this year, start the process of developing and embedding systematic patient experience metrics into the performance framework of the PCT. This will include (but not be limited to) access and patient satisfaction, and will underpin our contracting and commissioning processes. This will be informed by an inclusive approach to involving patients, the public and other stakeholders in commissioning.

A key challenge in our role as the lead NHS commissioning organisation in Trafford will be to strengthen and develop existing partnerships with NHS partners, the local community, statutory agencies and voluntary organisations in order to work towards a seamless approach to patient, public and community involvement. It will be important that the Board is assured that the PCT is performing its duties and accountabilities to involve patients and the public.

6) Establishment of new integrated care provision

Alongside the 'Caretel' suggestion, there are further areas of the healthcare system that we believe can benefit from a new approach to provision.

There is a whole stage of the healthcare process that does not require a sterile environment and which could be delivered with improved quality and reduced cost by the introduction of cost-effective new technologies.

Broadly speaking, this stage relates to what is presently organised and funded under the 'outpatients' model. The PCT is keen to explore the potential to re-think the concept of outpatients to see if there are different ways to deliver this stage of care that would result in better services for patients, better support to GPs in practice and a better use of consultant time.

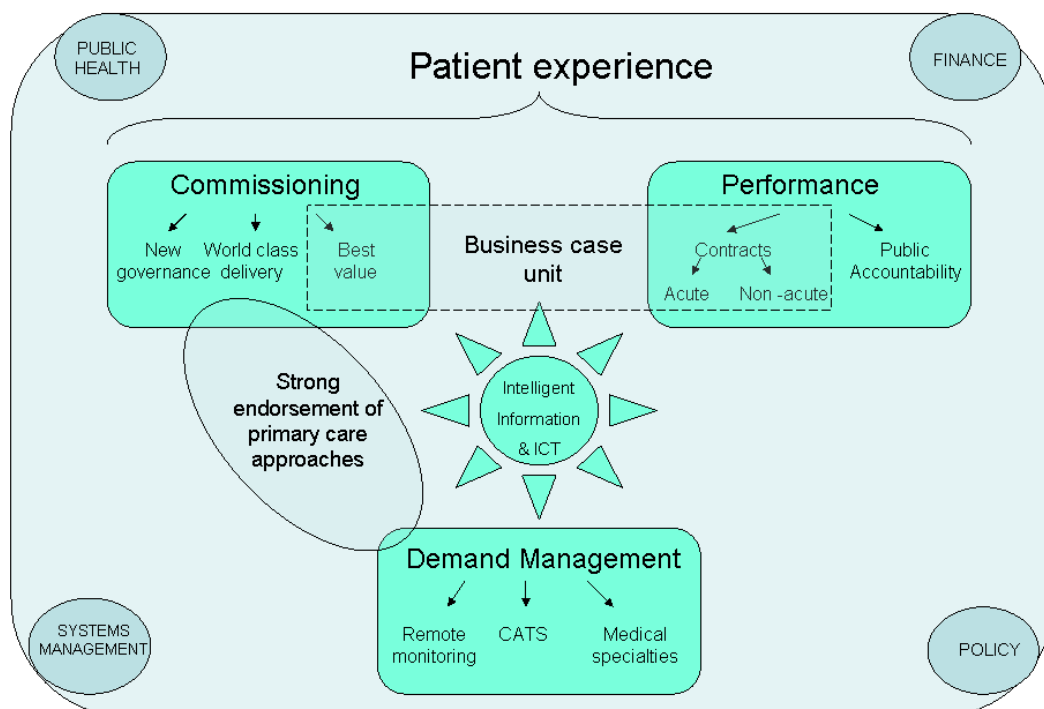
The key for us is to explore with GPs, consultants and other clinicians the *optimum* range of services that could be delivered in different settings, taking full account of each professional point of view. It is imperative that we begin this conversation in the right spirit, since one of the bigger strategic challenges the NHS faces as a whole is how to incentivise the introduction of cost-effective new technologies into our models of care. Health economies that produce a better answer to this question are likely to deliver better services to patients and better value overall.

The development of this component of the infrastructure has two components. The first is a series of business models we will build to establish the potential for bringing existing contracted services under a single, integrated banner. The second is a process of engagement with providers and clinicians about the extent to which the delivery of integrated services is achievable and desirable.

7) New PCT teams and organisation

The PCT is developing its capacity and capability to deliver against this challenging new agenda. The most significant changes will occur within the provider unit – where a consultation is presently underway – and within the commissioning and performance directorate, where a new team structure is being developed. The key functional components of the commissioning and performance directorate can be illustrated as follows:

PERFORMANCE AND COMMISSIONING DIRECTORATE: FUNCTIONAL DESCRIPTION



6. The Principles of Performance Management

The development of a strong, information-based performance culture is essential to the success of the PCT. We are proposing achieving this through the implementation of two core business cycles – performance monitoring and performance improvement.

The *performance monitoring cycle* relates to each individual performance line and its dominant KPI. As such, it is ad hoc and not linked to a specific timeframe since it is dependent on the state of the starting position with respect to the data flows. It is obviously critical, however, to ensure that the monitoring systems are effective early in the year since without effective monitoring we will be ‘flying blind’ with respect to our performance. The most important issue here is the difference between a *leading* and a *lagging* indicator.

A *lagging* indicator is one that we see after the performance period has passed. Almost all of our central reporting uses lagging indicators. A moment’s reflection reveals that if we only use lagging indicators for our performance management system we will be doomed to fail since we will not be able to intervene in the system in a timely fashion to prevent performance failures.

A *leading* indicator, on the other hand, is one we see in the course of the performance period. It is often a challenge to establish data flows to provide leading indicators since commissioning organisations have often not required them. However, with the exception of board reports and central returns, almost the entire focus of the performance monitoring cycle needs to be on developing effective leading indicators. If we do this well, the lagging indicators will look after themselves.

We need to treat our leading indicators as small works of art. They require some imagination, crafting and a great deal of attention. The most important thing of all is that we need to get our information systems to the point where when we look at the data we are not seeing numbers but a real (albeit aggregate) representation of our patients’ experiences.

Once we have our systems working like this, our performance improvement process becomes about high-level patient advocacy rather than just number crunching or the dry ‘meeting of the targets’. The concept of the ‘moral force’ of our performance system is very important, but can only be invoked once the information flows are strong enough.

We can see the development of leading indicators for each line of our core performance in three stages – definition, refining and automation.

Definition

The definition stage has two important parts to it. The first is a very clear grasp of what the construction of the target says with respect to its component parts, either a flat number or a ratio with respect to its numerator and denominator.

The second is to fully understand how these parts are collected and reported locally.

The standard rubric we will apply to our leading indicators relates to *frequency, quality and time lag*.

The frequency relates to how often we receive the report, quality relates to how well the number represents the state of affairs it is supposed to describe and time lag indicates the lapse between the period the number relates to and the time when we first see the report.

Refining

It is often the case that information flows are not right first time. Sometime it is only when we see the first draft of the performance charts that we know how they need to change. This is where we require patience and sustained management focus. The refining of the indicators will require close co-operation between the Policy and Information Team and the Systems Management Team.

This is because establishing the leading indicators correctly and securely will be an iterative process, and can require visits to provider sites or clinical teams and meetings with providers to ensure we have the appropriate properties of the information system in place.

It is only once we have a rounded view of what the information is telling us that we can develop the right set of interventions to drive performance improvement.

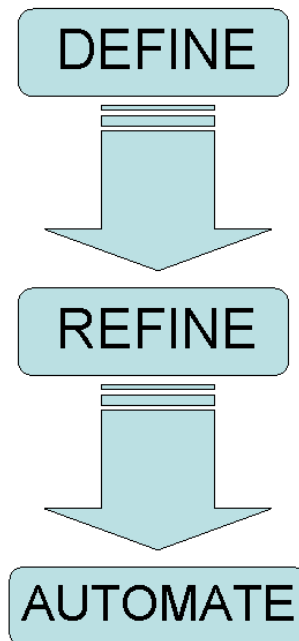
Automation

Even when we have our flows established, and appropriate leading indicators in place, this will not be sufficient. For an efficient as well as an effective system, we need to keep the process of automation constantly in mind.

The engine for automation will be the web, and we will resource a team to develop a comprehensive, web-based performance management system that will accommodate corporate performance as well as the Annual Health Check indicators.

We can summarise the monitoring cycle process as follows:

KPI development process



The *performance improvement cycle* relates to the set of actions we take, or require others to take, on the basis of the monitoring system. There are four stages to a systematic approach to performance improvement that link escalation and accountability to the monitoring system:

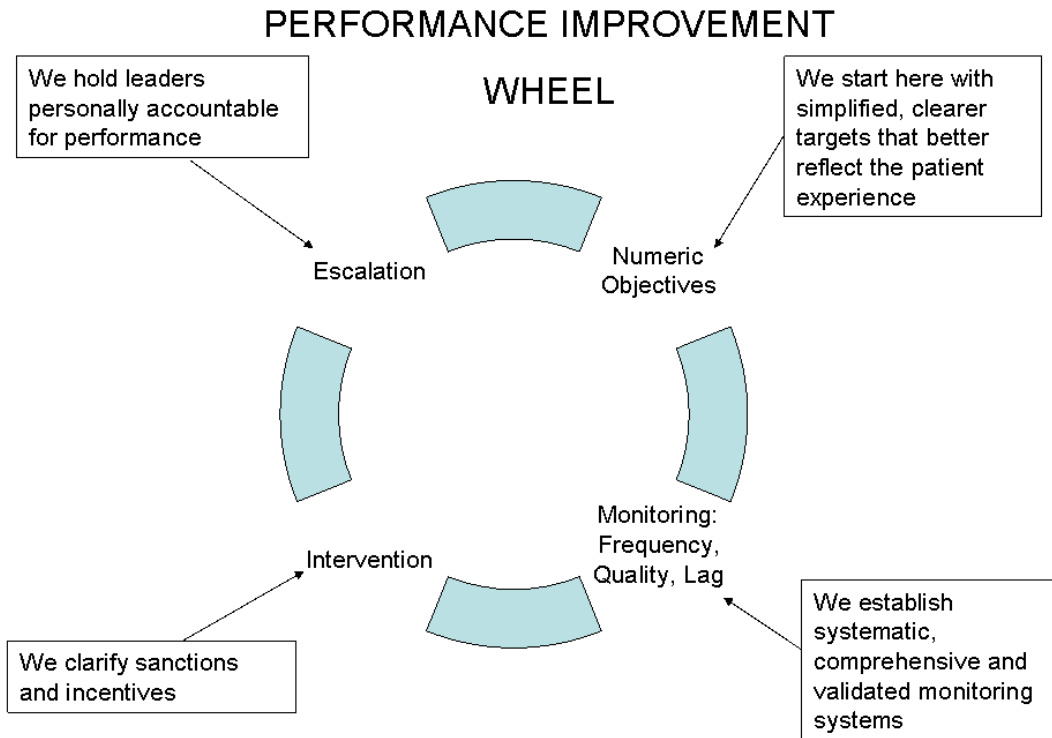
- 1) Simplify the targets through clearly expressed definitions
- 2) Establish weekly data flows
- 3) Clarify sanctions and incentives
- 4) Hold people personally accountable for performance

Each of these are very important, and need to be thought through with the greatest care – especially with respect to sanctions and incentives. There will be large parts of our performance requirement that will relate to tasks others will need to perform that are outside our direct management control. We will need to decide on a case by case basis how to use our various powers of influence to develop an intervention and accountability system. This will include internal escalation, contracting and ultimately the reprovision or recommissioning of services.

The commissioning and performance directorate policy will undertake a systematic analysis of the three external frameworks and interpret them for the board to ensure that there are ‘no surprises’. This means that if we need to

change something to improve our core performance, we have sufficient notice to do so before it is too late in any performance period.

The approach to performance improvement, then, can be shown in the following 'performance wheel':



7. Half-Year Outcomes

We are suggesting in this business plan that the detailed objectives we set that will be our main guides to action should be focussed on half-year outcomes. This is for a number of reasons.

First, it is impossible to predict at the outset of the year which areas of work will go better than expected and which will struggle against unforeseeable obstacles. An explicit part of setting objectives over six months is that we can formally review progress in September as a whole board, and determine those areas we need to refocus around and those areas we can celebrate success and accelerate progress. This discipline of continuous review will pay us dividends time and again as we move through our strategic implementation and should also build a more effective engagement about the work of the PCT between non-executive and executive directors.

Second, the more disaggregated an objective is, the easier it is to focus on the immediate management actions required to carry it out. There is a danger with annual objectives that they are not specific enough to act as a guide to action.

Third, six-monthly objectives engender a sense of urgency. We should think of the present three year strategic period in terms of 'twelve quarters' and define our work as appropriate to these periods.

Fourth, six-monthly objectives with reviews should enable us to see much more clearly the work programme being proposed, and enable us to hold each other to account more clearly. It is for this reason that the format of the tasks includes a statement of 'objectively verifiable indicators' so we can show definitively where we are making progress and where we need more focus.

With a view to attempting to move to this system, we have been pulling together our proposals for the first six months of 2008/09 and these are included as Part II.

8. Financial Implications

In October 2007, the Government published the latest Comprehensive Spending Review (CSR), which signalled a 4% real terms annual increase over the three years 2008/09, 2009/10 and 2010/11, starting with a cash uplift of 5.5% in 2008/09.

For Trafford PCT this equates to £15.9 million additional resources available in 2008/09. Of this £9.6 million is immediately taken by inflation and tariff-related adjustments, leaving £6.3 million available for investment.

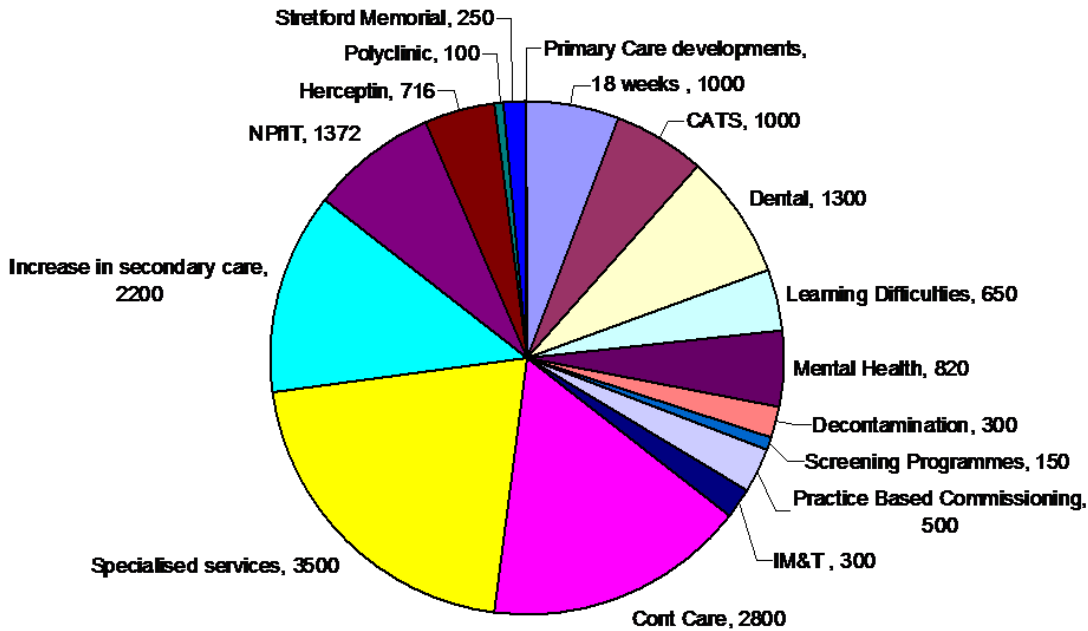
Through its Commissioning Framework, the PCT has set itself the challenge that in three years' time there will have been a significant reduction in expenditure in secondary care and prescribing and to have increased expenditure in primary care.

The Financial Plan for 2008/09 strives to begin this reprofiling of investment in prescribing and primary care but recognises a further year of growth in activity in secondary and tertiary care before the downturn can begin.

For the balance of growth funds to meet the resource implications of the objectives for 2008/09, it will be necessary to target some of this downturn during the coming year and deliver £2.8 million of savings against initial contracts values. During the early part of the year it will therefore be necessary to create the performance management infrastructure to deliver this or some areas of planned investment will have to slip into 2009/10.

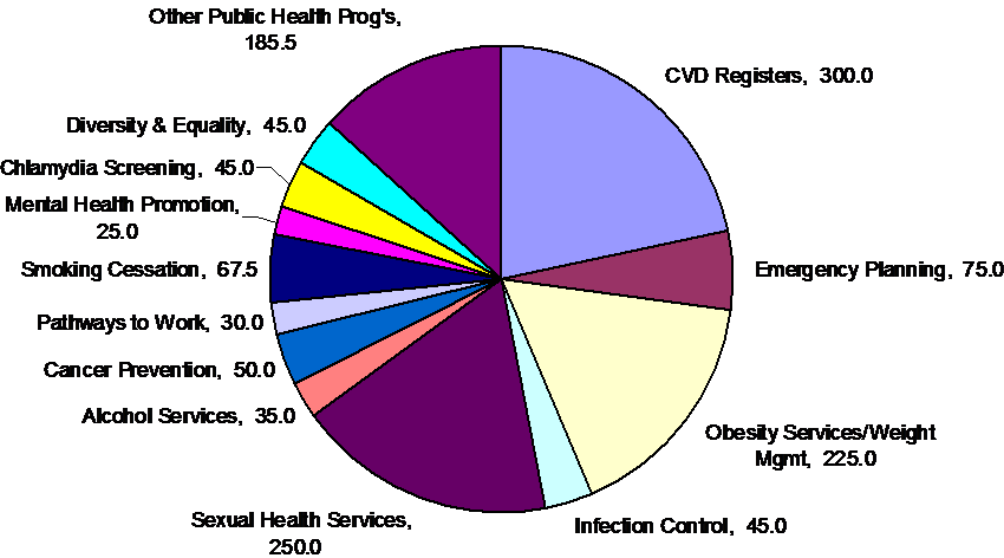
The main areas of financial investment planned in healthcare programmes are shown in the pie chart below:

Principal Investments (000s) 2008/09



And our key public health investments can be summarised as follows:

Principal Public Health investments (000s) 2008/09



We are continuing to develop our financial and service models to demonstrate the proposed shift in resources from hospital services to primary and community care. In part, this is dependent on the feasibility of the enabling infrastructure outlined above. We will have a detailed account of our three year intentions in this regard when we publish our detailed three year strategy in October 2008.

9. Risks

We believe that delivering on the eight key priorities for 2008/09 is manageable and largely within our control. The area where we have the greatest risks is in five of the areas concerned with the development of the enabling infrastructure. These risks are highlighted as follows:

Infrastructure area	Key risk	Contingency
1. Developing the 'Care net'	Failure to secure agreements on implementation of remote monitoring	Plan B – investigate establishment of ambulatory conditions centre
2. Population health status monitor	Failure to negotiate data sharing agreement	Need to adopt new approach
3. New health centres	Failure to develop business process, or to meet criteria for approval	Revisit process
4. Integrated care provision	Failure to reach agreements on business and clinical model	Adjust existing contracts
5. New PCT teams and organisation	Failure to recruit sufficient people at calibre required	Deploy interim managers

10. Conclusion

This business plan for 2008/09 attempts to describe where the main priorities of the PCT will lie, and the main actions we will be carrying out to deliver these priorities.

If it is approved and enacted we believe it will make the PCT a stronger and more accountable organisation, more in tune with the needs and preferences of the people of Trafford and better able to participate in meaningful partnership working.

As well as delivering these benefits in 2008/09, we will also have laid the foundations for a secure strategy to transform services and outcomes through to 2011.