Herefordshire Council

NHS Herefordshire

HEALTH SCRUTINY COMMITTEE MEETING
18 MARCH 2011

CHIEF EXECUTIVE'S UPDATE REPORT
NHS HEREFORDSHIRE

1. Health Improvement

1.1 Introduction

As part of its current programme of work, the Health Scrutiny Committee has looked at work aimed at improving population health with a particular focus on Smoking and Alcohol, and Diet and Physical Activity.

This report is intended to provide an update report to the Health Scrutiny Committee. It looks at progress and achievements to date in relation to improving the health of local people, and the development and implementation of strategic plans for population health improvement, focusing on Smoking, Alcohol, Diet and Physical Activity. It identifies areas where work is continuing including areas where more work is needed and looks forward to the next steps that need to be taken in future years in order to achieve real improvements in population health and to reduce health inequalities affecting local people.

1.2 Background

In general, people in Herefordshire enjoy relatively good health. However, despite this, too many people suffer avoidable ill health or die prematurely from preventable conditions. In addition to the resulting unnecessary suffering for individuals and their families and carers, this also leads to unnecessary time off school or work and avoidable costs for society (for example, spending on health and social care, benefits payments, lost productivity for businesses).

During 2010/11 the Public Health Directorate has led on the development of a new Population Health Improvement Plan (HIP) for Herefordshire. At the beginning of this process there were no existing strategic population health improvement plans in place locally from which the 2010/11 HIP could be developed. The process of developing a local HIP therefore had to start from scratch.

1.3 Overview of the 2010/11 Population Health Improvement Plan

The aim of the HIP is to create a single strategic plan for improving population health and preventing avoidable illness and early death in Herefordshire. The HIP identifies, and brings together into a single plan, nine priority areas which influence the main causes of avoidable illness and premature death in Herefordshire, namely:

- Smoking;
- Alcohol;
- Diet;

- Physical activity;
- Oral health;
- Infectious diseases;
- Sexual health, including teenage pregnancy;
- Accidents and injuries;
- Mental wellbeing.

Each section is structured to include the wide range of actions required to improve health using the following framework:

- Encouraging a healthy start in life;
- Reducing exposure to risk factors;
- Enforcement and ensuring a supportive environment;
- Inequalities;
- Advocacy;
- Early diagnosis and treatment.

1.3.1 The importance of the underlying wider determinants of health

Because of the fundamental influence of wider determinants such as socio-economic and environmental factors on population health, the 2010/11 HIP is not limited to health services and attempts to capture existing and proposed activity across a wide range of partner organisations. Where possible, the HIP also identifies how existing work is funded and sources of funding for new and proposed activities.

It is important to recognise that both the development and the implementation of the HIP has involved, and continues to require, joint working across a wide range of partners. Health is about much more than expecting individuals to adopt a more healthy lifestyle by giving them information or education. Whilst this has a role, we also need to make sure that people are encouraged and supported towards better health by the community, their surroundings and environment in which they live and work. Crucially, it is important to recognise the role of the wider socio-economic and environmental determinants (the "causes of the causes") which underpin health and to work with partners who have influence over these determinants in order that action is taken to address them.

1.4 Progress to date

Section 1.4.1 looks at recent achievements in population health improvement as a whole. The rest of section 4 reviews progress in relation to developing and implementing the 2010/11 HIP, looking in turn at what we have achieved to date, areas that we are still working on and areas where work hasn't progressed as much as we would have liked, but which are still priorities.

This section focuses on the topic areas within the the HIP that the Health Scrutiny Committee has looked at over the past year ie: smoking, alcohol, diet and physical activity. However, a short update on oral health has also been included here following the Committee's recent consideration of access to services which included some discussion of both access to dental services and population oral health.

1.4.1 Recent key population outcome achievements

All Cause Mortality
Males: all cause mortality has dropped by 8.5% from baseline rate of 656.4 per 100,000 population (2006-08) to 600.8 per 100,000 population in 2009.

Females: all cause mortality has dropped by 3.8% from baseline rate of 430.3 per 100,000 population (2006-08) to 413.9 per 100,000 population in 2009.

Coronary Heart Disease
Coronary Heart Disease mortality has dropped by 7.8% from baseline rate of 79.2 per 100,000 population (2006-08) to 73.0 per 100,000 population in 2009.

Circulatory Diseases
Circulatory Diseases mortality has dropped by 3.9% from baseline rate of 61.8 per 100,000 population (2006-08) to 59.4 per 100,000 population in 2009.

Cancer
Cancer mortality has dropped by 0.6 % from baseline rate of 103.7 per 100,000 population (2006-08) to 103.1 per 100,000 population in 2009.

Land Transport Accidents
Land Transport Accidents mortality has dropped by 17.1% from baseline rate of 11.7 per 100,000 population (2006-08) to 9.7% per 100,000 population in 2009.

(NB; the rates are based on very small numbers, therefore significant drop should be interpreted cautiously. It may not be sustainable as only a few fatal accidents can avert the course of success.)

Life Expectancy at Birth
Male: Life Expectancy has increased by 0.6% from baseline of 78.1 years (2005-07) to 78.6 years in 2006-08.

Females: Life Expectancy has increased by 0.5% from baseline of 83 years (2005-07) to 83.4 years in 2006-08.

MMR Uptake
MMR Uptake rate has increased by 6.4% from 73.9% (in 2007-08) to 81.3% (in 2009-10).

Chlamydia Screening
Chlamydia screening uptake rate has increased by more than fivefold from 4.3% (in 2007-08) to 23.2% (in 2009-10).

1.4.2 Overall progress

During 2010/11 a "baseline" HIP was completed as planned. This has been an iterative process resulting in a "live" HIP document which will form a sound basis for future plans. This process has brought together existing initiatives and new ideas for action together into a structured plan covering the nine priority areas listed above.

A prioritisation process has also been undertaken to identify priority areas for action within each section of the HIP. This identified 'best buys' and key target groups where efforts should be focused in order to achieve maximum population health gain including the regional QIPP priorities on alcohol and tobacco.

Work to develop and implement the HIP has involved and engaged a range of local partners. This process has helped to foster a greater shared understanding locally that

health is everyone's business and that everyone has a part to play in working towards achieving good health and wellbeing for the whole population.

1.4.3 Smoking

Achievements to date

- Implementation of a new hub and spoke model for the Stop Smoking Service. This has involved a changed role for the Stop Smoking Team (Specialist Stop Smoking Service) which now focuses primarily on providing training and support for a network of Stop Smoking providers across the county along with specialist stop smoking advice for smokers with more complex needs and for groups of quitters.
- New management arrangements have been put in place for the Specialist Stop Smoking Team.
- A Service Specification for the Specialist Stop Smoking Service has been developed.
- Continued development of a network of trained Stop Smoking advisers across the county in GPs practices, pharmacies, HALO leisure centres.
- Implementation of stop smoking database within the "hub".
- Stop Smoking providers trained in HALO leisure centres across the county.
- Service Level Agreements agreed with HALO and pharmacies.
- Inclusion of briefing intervention for smoking within 2011/12 CQUIN.
- Pilot completed for provision of Stop Smoking advice in a local dental practice and development of an SLA for this new service provider.
- Development of a workplace-based stop smoking pilot scheme with local employer Amey Herefordshire, as part of the national Healthy Places, Healthy Lives programme.
- Training provided for staff in brief intervention, including HHT and community health staff as part of 2010/11 CQUIN.
- Established a multi-agency Smoking Strategy (Tobacco Alliance) Group.

Ongoing areas of work

- Continuing development of a network of trained Stop Smoking advisers across the county in GPs practices, pharmacies, HALO leisure centres.
- Roll-out of database to "spoke" providers.
- Promotion of new "hub and spoke" model.
- Develop and implement local communications/social marketing plans based on national campaigns eg Quit Kit, No Smoking Day.
- Further roll-out of workplace-based stop smoking.
- Implement a Local Enhanced Service to increase provision of smoking cessation services in primary care (GP LES).
- Further movement towards formal commissioner/provider relationship with Specialist Stop Smoking Service.
- Development of further capacity in brief intervention in range of settings/providers including secondary care.
- Implementation PGD and staff training for varenicline.

Priority areas where progress has not yet been made

- Develop further workplace-based smoking cessation activities, building on the Healthy Places, Healthy Lives pilot including within NHSH and HC.
- Delivery of smoking prevention and cessation interventions in schools.

1.4.4 Alcohol-related harm to health

Achievements to date

- Inclusion of IBA (brief intervention for alcohol) in 2011/12 CQUIN.
- Training programme established for IBA.

Ongoing areas of work

- Develop primary care LES for alcohol services and service model for Level 2 primary care based alcohol service.
- Increase capacity and provision of structured brief interventions (IBA) on alcohol in primary and secondary care and in locality settings.
- Provision of advice and treatment for harmful alcohol consumption, ensuring adequate capacity within existing specialist alcohol services to meet additional demand resulting from the structured brief interventions.
- Case management of frequent admissions due to alcohol.
- Undertake a needs assessment/service review of specialist alcohol services.
- Alcohol liaison nurse to identify and manage patients frequently admitted to hospital due to alcohol (including providing family support) – supported by new alcohol admissions database.

Priority areas where progress has not yet been made

- Develop a service specification for the delivery of IBA in secondary care.
- Building on existing good practice in the delivery of social marketing interventions for young people.
- Evaluate the impact of existing social marketing campaigns and look to identify future funding opportunities.

1.4.5 Healthy diet and physical activity

Achievements to date

- Launch of local Change for Life programme.
- Pilot of NHS Health Checks programme in local GP practices implemented.
- Local implementation of national Healthy Start programme.
- Completion of a number of MEND and post-MEND programmes for overweight children.

Ongoing areas of work

- Continued promotion and roll-out of Healthy Start.
- Implementation of Start4Life and the Unicef Baby Friendly initiative.
- Build on local Change4Life programme including promoting of Ten Top Tips.
- Evaluation of interventions to manage and support children who are overweight and obese to lose weight, including MEND programme.
- Increase opportunities for physical activity including opportunities for walking, cycling and dancing.
- Increase the provision of lifestyle coaching support through development and implementation of a new Health Trainer service specification.
- Development of obesity care pathway to identify, manage and support people who are overweight or obese.
- Development of a children's obesity care pathway.
- Evaluation of pilot of NHS Health Checks programme.
- Roll-out of NHS Health Checks (depending on outcome of evaluation.

Priority areas where progress has not yet been made

- Launch the middle-age strand of Change4Life.
- Increase workforce capacity to deliver healthy lifestyle advice and support.
- Develop further local social marketing plans based on C4L.
- Develop care pathways to increase physical activity for those identified as at low/medium or high risk of cardiovascular disease from the NHS Health Checks programme, based on the Let's Get Moving programme.

1.4.6 Oral Health

Achievements to date

- Implementation of Herefordshire "Brushing for Life" programme (fluoride toothpaste/toothbrush distribution to pre-school children, delivered by Health Visitors).
- Implementation started of school-based supervised toothbrushing programme for nursery and reception children.
- Work with local dental practices to increase the use of fluoride varnish
- Completion of training programme in oral health and the application of fluoride varnish for a cohort of local dental nurses.
- Provision of educational update for dental team staff as part of the local post-graduate programme.

Ongoing areas of work

- Further roll-out of the school-based supervised toothbrushing programme for nursery and reception children.
- Continue work with local dental practices to increase the use of fluoride varnish.
- Establish mechanism for ongoing provision of Brushing for Life programme and supervised school-based toothbrushing programmes.

Priority areas where progress has not yet been made

- Establish mechanism for ongoing monitoring of prevention in practice including provision of fluoride varnish as part of routine contract monitoring.
- Promote key oral health messages via communication/social marketing campaigns.
- Increase awareness of oral cancer.
- Explore options for provision of general health improvement, eg stop smoking within dental practices.

1.5 What priorities have we identified for 2011/12 – 2012/13?

It is important that local plans for health improvement are updated in line with local needs and in the context of local and national policy.

1.5.1 Priorities

The following key issues are highlighted in the 2010 JSNA and remain priorities for 2011/12 onwards:

- smoking remains the single most important cause of avoidable ill-heath and premature death;
- rates of alcohol-related hospital admissions are increasing;

- obesity is emerging as a major contributing factor to poor health, disability and premature death. Herefordshire has a higher rate of obesity amongst adults than England generally and it is particularly concerning that more than one in four 11 year-old children are overweight or obese.

These priorities need to continue to be reflected in the updated plans for 2011/12 onwards. In addition, since the 2010/11 HIP was developed, fundamental changes to public services, including to the delivery of health services, local services and public health have been introduced including the NHS and the Public Health White Papers.[1, 2] Some of the funding streams identified in the 2010/11 HIP have been reduced or withdrawn. The impact of these changes and the current financial challenges will need to be considered in the development of the future HIP.

1.5.2 Herefordshire localities

Future plans for health improvement need to be closely aligned to localities agenda in Herefordshire, both in terms of identifying the health needs of local communities and in implementing initiatives to address these needs.

1.5.3 Economic climate

The potential of preventative health approaches to deliver significant cost-savings to both the NHS and wider public services is increasingly being recognised There will, however, continue to be a need to keep this under review and to ensure that the system as a whole delivers the most clinically and cost-effective interventions to ensure we are maximising value for money, and making real progress in reducing the burden of preventable disease in the Herefordshire population.

1.6. Summary and next steps

Most of the major causes of ill-health and mortality in Herefordshire are influenced by lifestyle behaviours including smoking, diet and physical activity. A range of simple, affordable and cost-effective interventions have the potential to improve population health in Herefordshire significantly and include:

- identifying and treating hypertension, high cholesterol levels and diabetes at an early stage for example via NHS Health Checks programme;
- supporting smokers to quit;
- supporting people who are overweight or obese to lose weight and
- reducing tooth decay in children by promoting appropriate use of fluoride toothpaste and professionally-applied fluoride varnish.

It will be important that these (and other) simple measures continue to feature in our plans for population health improvement and that these are implemented on an "industrial scale" if we are to have the greatest impact on population health and great potential for saving future health and social care costs.

The 2010/11 HIP has provided a foundation for the development of future health improvement plans. In order to build on the current HIP and develop comprehensive plans for health improvement during 2011/12-2012/13, the priorities identified in sections 4.1 and 4.2 will need to be reviewed in the light of local needs as identified, for example, in the JSNA. The updated plans will also need to take account of emerging new structures for the delivery of services across the public, private and third sectors,

[1] Equity and excellence: liberating the NHS
[2] Healthy lives, healthy people: our strategy for public health in England

including new structures within local government (including the introduction of a Health and Wellbeing Board), the NHS and new arrangements for the delivery of public health. A life-course approach is recommended as this would build on the conceptual framework used in the 2010/11 HIP and be aligned to the national approach to health improvement and reducing health inequalities outlined in the Marmot Review.[3]

2. Finance

2.1 In year financial position 2010/11

A verbal update on the February financial position will be given to the Health scrutiny committee as the date for submission of this paper was prior to the February financial position being available. The January financial position of the PCT reported a £2.9m over performance on the Hereford Hospitals NHS Trust contract. This over spend was attributable to the high levels of usage of the A&E department, the number of emergency admissions and expenditure on high cost drugs.

Other cost pressures at month 10 are primarily a result of an increase in the level of continuing health care packages which results in a forecast overspend of £3.4m. This is despite an additional £2m investment in 2010/11 and cumulatively c£6.8m additional investment since 2007/08. However it is important to note NHSH is ranked 11th highest in terms of activity nationally and 5th highest per 10,000 population. Despite significant cost pressures NHSH will have delivered its cost improvement target and anticipates achieving all of its statutory financial duties by 31st March 2011.

2.2 2011/12 Budget

Historically, NHSH has had a sound history of financial management achieving all statutory targets and delivering planned surpluses. However the limited level of growth in NHS budgets combined with a growth in service demand and the key local issue of an aging population will mean that Health and Social Care resources will be constrained in Herefordshire for the next 4-5 years. Sound financial management will be essential for enabling Herefordshire Public Services to improve and maintain services for patients, service users, carers and communities.

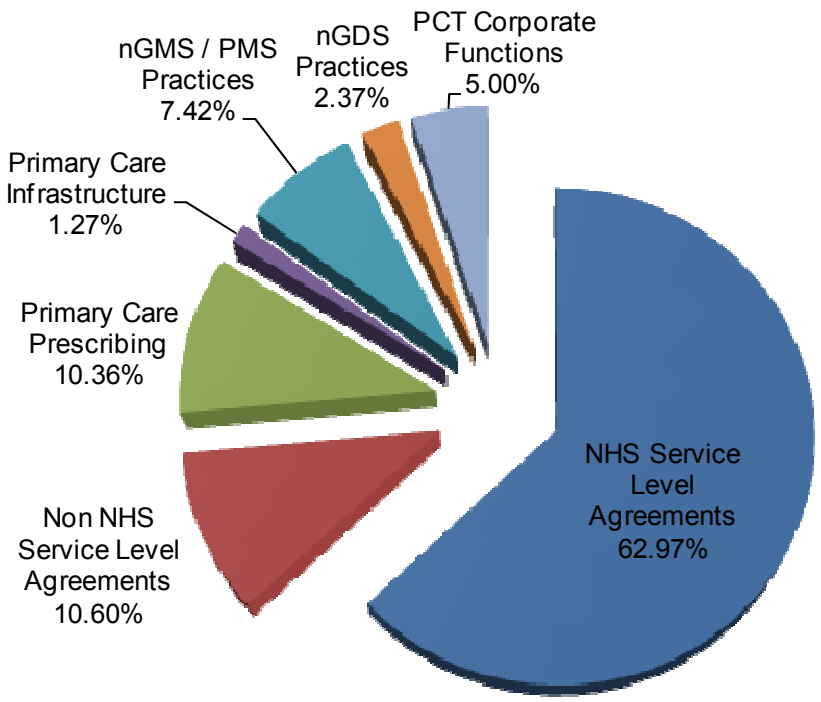
In 2011/12 NHSH will receive an uplift of 3.1% which equates to an £8.6m increase making the NHSH total accountable spend for next year £290m. In 2011/12 there will be no automatic capital allocation for PCTs, with necessary capital funding for PCTs being granted on a case by case basis. This represents a fundamental change in funding which previously was consisted of both a block capital allocation and bidding process. Figure 1 shows the makeup of Herefordshire 2011/12 allocation with figure 2 outlining the distribution of financial resources across the Herefordshire Health and Social Care Economy.

[3] The Marmot Review: Fair Society, Healthy Lives.

Figure 1.NHS Herefordshire Resource Allocation 2011/12:

Total 2011/12 Revenue Allocation			Composition of Total Allocation			Growth in Recurrent Allocations Plus Growth in Non Recurrent Allocations £000's	Recurrent Allocations		
Total Revenue Allocation £000's	Growth in Total Revenue Allocation £000's	Growth in Total Revenue Allocation %	Recurrent Allocation £000's	Non Recurrent Allocation £000's	Support for Joint Working Between Health and Social Care £000's		Growth in Recurrent Allocations %	Distance from Target %	Distance from target £000's
289,677	8,614	3.1%	274,490	12,280	2,368	6,246	2.2%	-2.8%	-8,000

Figure 2. Percentage distribution of NHSH Resource Allocation:



The West Midlands Strategic Health Authority will top slice 2% or £5.3m from this allocation to create financial flexibility and to create headroom to support change. Provision for a 2% non recurrent top slice was made recurrently in 2010/11. NHSH will be required to submit business cases to the SHA in order to release our funding. It is envisaged that the top slice will be used to support restructuring costs. Additionally NHSH is required by the SHA to plan for a surplus of £250k and set aside a 1% contingency fund of £2.7m.

In 2011/12 £2.3m of non recurrent funding will support joint working between Health and Social Care. This £2.3m will be transferred to Herefordshire Council to invest in Social Care services that will benefit Health and improve overall Health gain. A joint plan will be developed that outlines appropriate areas for Social Care investment and the

outcomes that will be expected from this investment. An extra £4.8m is also being invested in continuing care, special placements and free nursing care to close the current funding gap at current activity levels.

Finally it is anticipated that growth in service demand will mean that there will be financial pressures on NHS contracts of £10.9m with other factors, such as inflation uplift, Practice Based Commissioning savings liability, cancer drugs fund and GP consortia development adding further pressure of £3.1m.

Overall this means that NHSH is facing costs pressures of £14.35 in 2011/12. A base budget contribution and the return of the contingency will give NHSH a funding gap of £11.0m in 2011/12. Quality, Innovation, Productivity and Prevention (QIPP) plans have been developed to deliver £10.8m have been developed to, in conjunction with management of the year end, close this funding gap. Figure 3 summarises this position.

Figure 3. Summary of factors contributing to NHSH funding gap:

Source	**Amount £m**
3.1% Uplift in total revenue allocation	8.6
Application	**Amount £m**
Transfer of Health Budgets to Social Care	-2.3
1% Contingency	-2.7
Delivery of in year surplus	-0.25
Demand Pressure on NHS Contracts	-10.9
Investment in continuing care, special placements and free nursing care	-4.8
Other	-2.0
Cost Pressure	**-14.35**
Base budget contribution	0.6
Add back contingency	2.7
Funding Gap	**11.0**
Planned QIPP Savings	10.8
Year end management	0.25
Funding Gap to be closed	**0**

It can be seen from figure 3 that the delivery of the Quality, Innovation, Productivity and Prevention (QIPP) savings, realised through the implementation of the transformation programme outlined in this strategy, will be critical for maintaining the financial sustainability of the Herefordshire Health and Social Care Economy. Figure 4 shows the NHSH Quality, Innovation, Productivity and Prevention (QIPP) savings Schedule for 2011/12 through to 2014/15

Figure 4 NHSH Quality, Innovation, Productivity and Prevention (QIPP) Schedule for 2011/12 through to 2014/15:

QIPP Initiative	Amount £m
Planned Care	1.64
Care Pathways	1.77
Management Costs	1.30
Urgent Care	0.27
Medicines use and procurement	1.40
Right Care	1.37
Intermediate care and reablement	1.20
Mental Health	1.00
Other	0.90
Total QIPP Savings	**10.8**

Ultimately, if efficiencies cannot be driven out of the health and social care system and demand continues to increase then investment in those interventions which have the least health benefit will have to be further reduced so that resources can be diverted to increase the capacity of essential services.

3. Performance

NHS Herefordshire currently monitors 79 performance indicators on a regular basis to provide assurance that the care delivered in the county is of the highest quality. In 2010/11 these indicators highlighted a number of areas for improvement, these included:

- Stroke Care
- Ambulance response times
- Cancer diagnostics waits
- Immunisation
- Chlamydia screening

Action plans have been put in place to rectify these issues and in many areas improvements against performance targets are being delivered. Additionally in a number of areas NHS Herefordshire is performing better than target these include:

- 18 week waits for elective care
- Cancer referral to treatment waiting times
- Access to maternity services
- People supported to live independently
- Breast feeding coverage

4. NHS Clusters

NHS Clusters have been developed to maintain the strength of the commissioning system in light of the significant financial challenges ahead. NHS Herefordshire is part of the West Mercia Cluster which also includes Worcestershire and Shropshire PCTs. The primary aim of Clusters is to maintain and improve the quality and safety of services across their areas through the commissioning and contracting process. The key developments in this area will be:

- Work with Cluster colleagues to design a regional planning process which supports GP Consortia in their commissioning role
- Establish a methodology for coordinating initiatives aimed at managing the supply and demand for health care services across the Cluster
- Develop local quality, innovation, prevention and productivity (QIPP) plans and integrate these into a cluster wide approach to securing quality improvement and delivering cost improvements
- Explore opportunities for centralising some functions
- Design and implement a Cluster wide plan for the closedown of PCT's in 2013
- Work with West Midlands Specialist Commissioning Group in supporting the transition of specialised services to the NHS Commissioning Board

5. GP-Led Commissioning Consortium - Herefordshire

- All 25 Herefordshire practices (including the Walk In Centre) are expected to join a single county-wide Consortium, which has been granted national first wave Pathfinder status, the aim of which is to empower pioneering groups of GP practices.

- A Transition Steering Group has been established to complete the necessary background work, e.g. communication with key partners, Terms of Reference, testing design concepts and participation in learning networks.

- A Vision Event took place in January 2011 to begin the process of formulating the Consortium's commissioning strategy and priorities.

- Elections have taken place for GP and Practice Manager colleagues to take up key posts within the Consortium, i.e. Chair, Deputy Chair, GP leads for finance/contracting and GP lead for governance/clinical, Practice Manager representative. Results are expected to be announced during March 2011.

- The elected leads will as a first priority work with the PCT Board to align key staff to the Consortium. Further national HR guidance is awaited.

- From April 2013 GP Consortia will take full responsibility and PCTs will be abolished. However, from April 2011 the Herefordshire GP-led Commissioning Consortium will be a subcommittee of the Herefordshire PCT Board, with a scheme of delegation and work plan towards full establishment by April 2013.

- For 2011/12 it is proposed that the Consortium take delegated responsibility from 1 April for the primary care prescribing budget, high cost drugs budget and contract with the Integrated Care Organisation. From 1 October 2011 it is proposed that the Consortium would take delegated responsibility for the contact with the new mental health provider.

- The Consortium will be a member of the proposed health and social care community QIPP delivery mechanism.

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