A16

CARLISLE CITY COUNCIL

REPORT TO EXECUTIVE

PORTFOLIO AREA: HEALTH & WELL BEING

Date of Meeting: 18 February 2002

Public

Key Decision: No **Recorded in Forward Plan:** No

Inside Policy Framework

Title: NORTH CUMBRIA HEALTH IMPROVEMENT AND MODERNISATION PLAN, 2002-2005

Report of: Director of Housing

Report reference: H016/02

Summary:

The purpose of this report is to provide the Council's views on the draft Health Improvement and Modernisation Plan (2002-2005).

Recommendations:

Members of the Executive are requested to:

1. Note the evolution of the Carlisle Local Health Group in seeking to address health inequalities and well-being as set out in section 7 of this report and approve.
2. The responses set out in section 8 to consultation on the Health Improvement and Modernisation Plan.
3. Delegate responsibility to the Director of Housing to relay Carlisle City Council's views on the HIMP document by 28 February 2002.
4. Approve the approach to identify a health and well-being strategy for the district in partnership with the Primary Care Trusts, as set out in 8.3.

Contact Officer: Laurie Brewis **Ext:** 7301

Note: in compliance with section 100d of the Local Government (Access to Information) Act 1985 the report has been prepared in part from the following papers: None

NORTH CUMBRIA

HEALTH IMPROVEMENT AND MODERNISATION PLAN, 2002-2005.

1. Introduction

1.1. As part of the evolving partnership approach being pursued in the Health economy, the authority has been requested to provide comments on the *HIMP 2002-2005* draft proposals.

The document (full version available in the Members room) highlights questions on which we are encouraged to respond by 28th February 2002.

1.2. For the purpose of this report the main aspects of the document have been extracted and are set out below for information and comment, with the relevant information on the Primary Care Trusts (PCT's) and Local Health Groups (LHG's) being appended to this report.

2. The Scope and Coverage of the Plan

2.1. The Health Improvement and Modernisation Plan (HIMP) for North Cumbria sets out the joint proposals of partners to improve health in North Cumbria and meet the targets and standards in the National Health Service Plan and associated national guidance.

2.2. The process has involved the three Primary Care Trusts (PCTs), three NHS Trusts and five Local Authorities, together with voluntary sector involvement.

2.3. It sets out the policies and strategies on which the detailed action planning will be based. for each of the programmes, with more specific implementation plans or business plans will be drawn up, based on the targets and strategies set out in the document.

2.4. North Cumbria is substantially a single health economy and the constituent organisations work closely together in planning, commissioning and managing services, risk sharing in both finance and performance, and increasingly in pooling

budgets between health and social services. It is also a very large and diverse area geographically, with major variations in standards of health, reflecting a need for local action and investment to address these problems.

2.5. This HIMP sets out the proposals for tackling problems of health over the period 2002-5 in a manner which combines the strengths of joint working across North Cumbria with the locally based management of each PCT.

3. The National Priorities

3.1. The HIMP is concerned with achieving results in terms of better health and services. Inevitably decisions have to be taken on priorities. The national priorities have been set out by the Department of Health, and are threefold:

- Improving emergency services -their availability, quality, comprehensiveness and speed.
- Reducing waiting times generally, and in particular for consultations in primary care and hospital, and admissions to hospital.
- Continuing to implement the national cancer strategy and the national service frameworks for coronary heart disease, mental health and services for older people.

3.2. The priority targets in these areas are set out in various sections of the document, together with the strategies to meet them. Although separate planning documents give more detail for each of the National Service Frameworks (NSF's).

4. North Cumbria - A Local Perspective

4.1. The HIMP also addresses additional local priorities, where there is evidence of particular health problems. These include children, diabetes, learning disability and mobility and sensory impairment. There are relationships between the high levels of need in these areas and national priorities for health and wellbeing. For example, improved child health can prevent social exclusion, and improved diabetes care can prevent heart disease.

4.2. Additionally in North Cumbria with its areas of poor health there is a particular need to address health inequalities and this is recognised both in individual plans and in funding levels for North Cumbria.

5. Meeting Health Needs

5.1. Health in North Cumbria, as measured by standardised mortality ratios (SMR's)

- is slightly worse than would be expected if national rates were applied with all cause SMR for men covered in the period 1997-99 is 103, and for women 107.
- Mortality from heart disease and stroke is raised in women much more than men.
- Cancer mortality in men is more or less as expected, and slightly raised (SMR 105) in women.
- Deaths from accidents and suicides are very significantly increased in men, and are up to 50% more than expected. In women these rates are not increased above the expectation.
- North Cumbria has higher than average incidence of certain cancers as expressed by Standardised Registration Ratios (SRR's) particularly for stomach, colo-rectal and non- melanoma skin cancers. Mortality ratios are also higher than the national average, particularly for men.
- The early neo-natal death rate (mortality in the first week of life) is increased in Carlisle, Copeland and Allerdale, and decreased in Eden. Mortality in the first year of life is Increased in all four local authority districts, but is lowest in Eden, where it is nevertheless still 25% above the expectation.

5.2. There are quite noticeable inequalities in health between and within the local authority districts making up North Cumbria. Life expectancy in Carlisle, Copeland and Allerdale in both men and women is shorter than the national figure, but for Eden District both men and women live longer than in England and Wales as a whole. In Carlisle, for example, men live less long by 1.07 years and females live less long by 0.9 years. In Eden the men live 1.61 years and females 1.39 years longer than expected.

5.3. Nationally, there are targets to be met aimed at reducing inequalities in health. These targets concern the reduction of inequalities in infant mortality and in life expectancy. These have been identified as "high risk" target areas and therefore policies and plans are being established to tackle them.

6. Health Inequalities Programme

6.1. The Partnership for Health Structure introduced early in 2001 has provided the strategic framework in which action to address the inequalities agenda has become more targeted. A key focus at a more local level has been the establishment of ***Local Health Groups*** along boundaries that align to the emerging Local Strategic Partnerships (LSPs). These arrangements should ensure that there is coherence between the HIMP, Community Strategies and other major plans.

6.2. The Partnership includes wide representation with key staff from the health and other statutory sectors, together with Voluntary and lay representatives.

Key National Targets

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in infant mortality between manual groups and the population as a whole.

- Starting with Health Authorities, by 2010 it is expected to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

- To make substantial progress towards the eradication of child poverty by reducing the number of children living in child poverty by a quarter (25%) by 2004.

- To reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010. (Also see Cancer programme).

- By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter.

These five targets form the major drivers for action on health inequalities at all levels.

7. Carlisle Local Health Group

7.1. To take the partnership agenda forward in a health context, Local Health Groups have been established. These are based on District Council boundaries as the key geographical unit to take forward the proposed functions of:-

- Acting as a multi-agency focus for partnership working
- Health needs assessment in its widest sense
- Providing the framework to develop a partnership approach to strategy
- Act as the focus for combining resources to address health needs
- Commissioning services to meet identified needs
- Monitoring and evaluating

7.2. Aims and Objectives of the CLHG

Primarily the focus of work being considered by the newly formed group has been that of actively promoting the "Partnership" concept and the identification of broad criteria to address health inequalities.

The focus of the group in the future is anticipated to be:

- The compilation of a Health & Well-Being Strategy for the district
- Identification of inequalities among areas and groups in determinants of health
- Recognition of the wider determinants of health, e.g. housing, environmental health, employment and household income
- Assessment of health in relation to education, leisure, transport, and other health supporting services

- Addressing inequalities in access to services e.g. rurality

7.3. Of these issues, a key area of work for the group is the development of a Health & Well-Being strategy and that of seeking to identify mechanisms to map and determine "needs" on a geographical basis, including:

- Ward Profiling
- Rurality Issues
- Neighbourhood based

(N.B. This will cover all 21 wards in Carlisle, including the 5 wards designated as priority areas, Belle Vue, Morton, Arthuret, Botcherby and Petteril Bank.

7.4. The Partnership structure, membership and operational arrangements reflect the underpinning principles of Health Action Zones and provides a spring board for developing strategies for Economic, Social & Environmental Well-Being at a Local Authority level.

- Achieving Equity
- Engaging Communities
- Working in Partnership
- Engaging Front Line Staff
- Taking an Evidence Based Approach
- Taking a person centred approach to service delivery
- Taking a whole systems approach

8. The Consultation Process

8.1. As part of the consultation process a number of specific questions have been set where responses are encouraged. For clarity the questions where applicable to this Authority have been set out in a series of italic bullet points with the proposed response being in regular format.

These questions cover a range of issues including and request views on:

- ***The priorities of the Local Health Group as set out in Appendices 3 & 4.***
  Response:
  Nominated representatives of the authority have taken a proactive role in the LHG and have endeavoured to promote the concepts set out in section 7.2 and 7.3 in the interests of the citizens of Carlisle.

- ***Redesigning services around the needs of patients. (HIMP – Page 7)***
  Response:
  The emphasis on patient/person centred care/support needs is seen as an integral aspect of modernising care services with the priority from an authority perspective being related to sharing of information on health and utilisation of the workforce to complement health and social care provision.

- ***Development of Primary Care and its integration with all aspects of Health and Social Care. (HIMP – Page 7)***
  Response:
  In furtherance of this development process, a range of initiatives are already in experimental stages, including the utilisation of Careline Community Alarm Services, the Housing Visitor Scheme and Sheltered Housing Schemes. It is recommended that the complimentary role of these and other services provided by this authority are progressed as priorities in the future within the Partnership for Health framework.

- ***Develop priorities and determine health based needs on smaller "natural communities". (HIMP – Page 9)***
  Response:
  The authority is keen to develop Geographic Information Systems (GIS) to map existing service provision and determine health "needs" in natural communities utilising statistical information based on a wide range of health and well-being indicators. Initial consideration is focused on the five HAZ wards, including Belle

Vue, Morton, Arthuret, Botcherby and Petteril Bank:

- Ward profiling
- Rural communities
- Neighbourhood based

It is recommended that discussions with the Public Health Department, and Eden Council which have already commenced to determine the effectiveness of such a system be approved to further this approach.

- ***Developing partnership working at 'Locality Levels' to commission and deliver care in partnership. (HIMP – Page 10)***

  Response:

  Initial proposals to introduce "locality level" commissioning, in the interim for older people's services within locality boundaries as set out in Appendix 5 is welcomed in principle, subject to further detailed consultation. (NB: It is intended that a paper detailing these specific proposals will be tabled at a future meeting of the Executive).

- ***Developing the workforce. (HIMP – Pages 10/11)***

  Response:

  The Authority supports the concept of community based integrated working, which utilises the generic skills of front line Council staff working in partnership with health and social care professionals, including the sharing of information and including the single assessment process.

- ***Cost effective measures to increase capacity of health and social care to meet demand. (HIMP – Page 12)***

  Response:

  Development of a range of alternative community based facilities to reduce the need for acute hospital care and support hospital discharge, is supported by the Council as an area where some valuable contributions by this authority can be made.

8.2. Other general comments on the HIMP document are set out below for Members consideration and approval.

- The absence of any reference to work in relation to the Drug Action Team (DAT) is seen as a profound weakness in the document in consideration of the implications of drug and alcohol abuse on the fabric of health and social well-being.

- It is suggested that the document continues to evolve to include other relevant issues/services which have a health impact, and may include under the heading of Health and Well-Being sections on:

  - ❖ Environment & Transport
  - ❖ Leisure & Culture
  - ❖ Learning & Health
  - ❖ Carers
  - ❖ Housing
  - ❖ Community Safety

- Further consideration of this issue could be pursued through the LHG for forthcoming years.

  In addition it is recommended that the two local PCT's that cover the Carlisle district be engaged to jointly consider how best to exercise the authority's new powers to promote social, economic and environmental well-being of local communities as part of a health and well-being strategy for the district.

8.3. The contents of the HIMP document have been discussed in detail within the Partnership for Health structure, with ongoing consultation being planned within the authorities internal Officers Health Group.

9. **Comments of City Treasurer**

There are no direct financial implications arising from this issues set out in this report.

10. **Access to Services Implications**

There are no direct implications to access to services within this report, however the furtherance of specific issues will have a direct impact and will need to be addressed when such services are pursued in detail.

11. **Environmental Implications**

Similar to the above, no direct impact in foreseen, however some positive influences are anticipated on the Council's LA21 when some of the initiatives set out in the HIMP are further pursued.

12. **Consultative Arrangements**

The contents of the HIMP document have been discussed in detail within the Partnership for Health structure, with ongoing consultation being planned within the authorities internal Officers Health Group.

13. **Conclusion & Recommendations**

13.1. Members of the Executive are requested to:

13.1.1. Note the evolution of the Carlisle Local Health Group in seeking to address health inequalities and well-being as set out in section 7 of this report

13.1.2. Approve the responses set out in section 8 to consultation on the Health Improvement and Modernisation Plan.

13.1.3. Approve the approach to identify a health and well-being strategy for the district in partnership with the Primary Care Trusts, as set out in 8.3.

13.1.4. Delegate responsibility to the Director of Housing to relay Carlisle City Council's views on the HIMP document by 28 February 2002.

Tony Bramley

Director of Housing

APPENDIX 1

CARLISLE AND DISTRICT PCT

HEALTH IMPROVEMENT PROGRAMME 2002-05

1. PCT PROFILE

Extract from PCT application to include
- population
- practice details
- provider functions
- commissioning responsibilities

2. COMMISSIONING OF SERVICES

The PCT commissions services on behalf of its population from:-

(i) Primary Care Contractors
(ii) Secondary Care Providers

The North Cumbria Health Improvement Programme details the strategic changes and improvements in North Cumbria programmes which have been jointly agreed with Eden Valley PCT and West Cumbria PCT and in close liaison with NCHA, North Cumbria Acute Hospitals NHS Trust, North Cumbria Mental Health and Learning Disability NHS Trust. Cumbria Ambulance Service and Social Services. The following represent local initiatives/proposals in respect of primary care services.

2.1 Primary Care Collaborative

Carlisle & District Primary Care Group joined Wave 2 of the Primary Care Collaborative Project in October 2001. Five practices have been actively involved in the first year of this two year initiative; progress in the three main project areas is summarised below.

All practices have undertaken a range of initiatives around improving access. Demonstrable improvements in access have been achieved, with four out of the five practices routinely achieving a 3rd available appointment measure of 2 or less, which is the access target within the NHS plan. Three practices have an appointment system that reflects the key concepts of advanced access, although it is recognised there is still progress to be made in certain areas. Developing skill mix within the primary healthcare team is an additional area identified for further work during Year Two.

Involvement in the Collaborative Project provided additional focus on Coronary Heart Disease, which had already become a priority for practices with the publication of the National Service Framework. Collaborative techniques were used to facilitate progress towards NSF milestones, including validation of CHD registers and implementation of nurse led clinics. Practices have achieved improvements in their management of patients by developing nurse led clinics, or by specifically targeting patients using the monthly audit figures, which have proved a useful tool for improving care. Involvement in the national PRIMIS project has facilitated development of standardised read codes and templates for disease management. The PCT CHD subgroup is now meeting regularly to ensure that developments within practices are consistent with local and national priorities. The development of services

is also supported by the initiatives instigated by the local Programme Board for CHD, which has the remit for delivering the all NSF targets within North Cumbria.

Initiatives relating to improving demand and capacity management across primary and secondary care include the development of referral information to inform clinical and management decision making within the PCT and constituent practices, an audit of GP specialist interests and a waiting list validation exercise. The local Access Programme Board acts as the steering group for the Collaborative Project, and have identified key areas of work for Year Two. The PCT has been involved in existing process mapping exercises, including cardiology services. Organisational and personnel changes have had some impact on progress however, there is now an established network of key personnel with a responsibility for capacity and/or demand management initiatives which will facilitate progress towards project milestones.

Year Two of the project will see the five initial practices addressing access issues which remain unsolved, whilst sharing their experiences with their colleagues within and across neighbouring PCTs. Progression of the capacity and demand management work, particularly in the area of care pathway development, will be a key area of work for Year Two.

SPREAD STRATEGY

Aim: To spread learning and experiences of the Primary Care Collaborative Project within Carlisle & District PCT and across North Cumbria.

Spread within Carlisle & District PCT

Initial spread phase

The table below summarises the key stages of spread within the PCT. The NPDT milestones have been moved from July 2001 & October 2001 to October 2001 & January 2002.

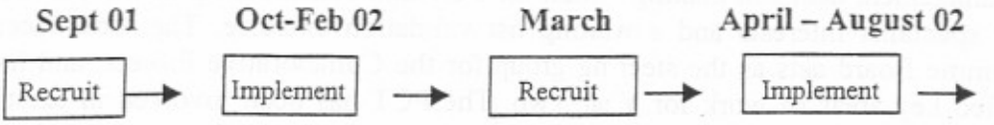
Table . *Spread within PCT*

Aug/Sept 01 **Practice Recruitment**	**Oct 01** **Implement** ***Prepare practices***	**November 01** **Implement** ***Prepare practices***	**Dec – Feb 02** **Implement** ***Active work in areas***
Newsletter to practices Follow up newsletter with contact with practices not involved in any projects Negotiate involvement of PMS practice	Collect baseline data Establish reporting arrangements Develop information pack/terms of involvement Plan local spread event	Local spread event to cover: - Collab. Principles - PDSA basics - Local and national examples Attendance at National Spread event (22nd Nov) Presentation to non-principals*	Practices looking at access and CHD management within context of the NPDT milestones **Support/resources** 'Buddy' with phase 1 Collaborative individuals Project manager support PDSA resource pack (local/national) NPDT Website Meeting/support network established

Two practices have been recruited to the initial spread phase with another 3 being actively encouraged to participate.

Subsequent roll out

There are 21 practices in Carlisle & District PCT. Following initial roll out (target 5 practices) the programme of events will be repeated for remaining spread practices.



Spread: between PCTs

There are three PCTs within North Cumbria. Eden Valley PCT are a fourth wave Collaborative Site, West Cumbria PCT are not involved in any of the initial phases. The plan for linking with the two neighbouring PCTs is as follows:

- *West Cumbria PCT*. Project Manager has already had initial discussions with Medical Director and Clinical Governance lead from PCT who are keen to roll out a similar project. West Cumbria PCT will be invited to attend the national Spread event in November.

- *Eden Valley PCT*. Main area of joint working for this fourth wave site relates to the capacity and demand management component of the project. Looking to involve Eden Valley practices in relevant capacity management initiatives as both relate to same Acute Trust.

2.2 GMS/PMS

2.3 G.P PRESCRIBING

3. SERVICES PROVIDED BY THE PCT

Profile

CARLISLE & DISTRICT PRIMARY CARE TRUST – HIMP 2002 – 2003

SERVICE	HIMP OBJECTIVES	KEY SERVICES	ACTION	MEASURE OF OBJECTIVES
District Nursing + Community Support Team	Quality & Patient Satisfaction – Improving clinical quality across primary and secondary care	To implement the Essence of Care document as part of Clinical Governance	To produce an implementation plan which identifies areas to benchmark and key staff to carry out the benchmarking process	All areas identified in the Essence of Care document to be benchmarked – All appropriate staff to be informed of the importance of the initiative and the process for implementing – benchmarking completed
All Services	Quality & Patient Satisfaction – Clinical Governance	To implement the Carlisle & District PCT Supervision for all document		All staff to be aware and understand the value of supervision All staff to be receiving regular supervision as defined in the Trust guidelines.
Community Support Service	Older People – reduce preventable hospitalisation of older people	To develop a rapid response service within the CST		1. Introduction of a rapid response service 2. A decrease in the number of acute hospital admissions 3. An increase in the number of supported hospital discharges 4. Improved use of existing intermediate care beds
Community Support Service		To increase the CST in the Wigton/Solway plain area		1. An increase in the number of clients accepted by the service 2. A decrease in the number of actue hospital admissions 3. An increase in the number of assisted hospital discharges
Community Support Services	Quality & Patient Satisfaction	To implement a programme for monitoring the quality of care given	Implement the use of the North Cumbria Intermediate Care evaluation questionnaire	1. Clients within the CSR will give positive feedback on care received 2. Responses to the questionnaires will be reviewed monthly 3. Benchmarking will identify areas in need of improvement
Continence Services	Older People – Promote independence	To supply pads to self funding residents in Nursing Homes from October and to all residents from April 2003	Undertake an audit project in three care homes to identify cost savings which can be made to implement service developments	Audit completed – service changes made.

SERVICE	HIMP OBJECTIVES	KEY SERVICES	ACTION	MEASURE OF OBJECTIVES
Continence Services (contd)			Dependent upon the audit results – Appoint an RGN with continence and training qualifications at an E grade for 15 hours per week to carry out assessments and re-assessments within care homes. This standardisation of assessment has been shown to significantly improve the quality of care and reduce costs to the NHS (Pomfret 1997)	
Continence Service	Older People – Integrated Continence Services	In line with Government document "Best Practice in Continence Services" guidelines need to be established to integrate services to identify and treat people with a continence problem. Plan to begin discussions to form group with Acute Trust, Social Services and other providers in 2002.		
Liaison Service	Older People – reduce preventable hospitalisation – develop links between Health & Social Services	To develop the education role of the Liaison Service.	To organise and present "roadshows" in hospital and community settings aimed at promoting new Discharge Policy, Community Hospital Transfer Policy and Transfer Documentation	
Liaison Service			To organise workshops involving staff from different settings/disciplines to increase communication and promote awareness of discharge/transfer issues (as requested in feedback from study day June 2001)	
Liaison Service			Continue discussions regarding involvement in student nurse training programme as combined placement with Community Support Team.	
Liaision Service			Determine potential for input to CIC staff nurse. Preceptorship programme, to new doctor induction programme.	
Liaison Service			Produce quarterly newsletter specific to discharge/transfer issues for circulation to hospital and community settings	
Liaison Service	Older People – reduce pre-hospitalisation – develop links between Health & Social Services	Continue to develop links with and promote integration/communication between all agencies involved in discharge/transfer process	Continue regular attendance at multidisciplinary ward meetings, District Nurse Team meetings, Social Services Panel meetings and meetings with Bed Management and Social Services/Intermediate Care representatives.	
			Pilot new role in facilitating case conferences as agreed with Social Services	
			Continue input at strategic level to Disharge Planning Group, Penrith & Eden PCT Reference Group, Continuing Care Group, Single Assessment Review Process, NSF Falls Group & Essence of Care Group	
			Meet with staff from elderly care wards to explore potential role for liaison nurses in facilitating communication between community nursing teams, social services and elderly care wards.	
Wigton Hospital	Quality & Patient Satisfaction – Better Hospital Food	To implement the guidelines for improving the quality of patients meal		Patients to be given choice of meals – refreshments available 24 hours

SERVICE	HIMP OBJECTIVES	KEY SERVICES	ACTION	MEASURE OF OBJECTIVES
			To carry out a patient satisfaction survey	Survey completed
Wigton Hospital	Workforce – Modernised education, training and development	To ensure that all staff receive training and education appropriate to their role	To produce and implement a training plan for continuing professional development	Each member of staff has a training plan
Wigton Hospital	Quality & Patient Satisfaction – Better Quality Environment	To improve the status from amber to red	To implement the guidelines for 'Cleanliness in Hospitals'	Red Status achieved
Community Support Team	Workforce – Modernised education, training and development	To introduce an 'in-house' training package based on the rehabilitation model	All Community Support workers will receive regular training and up-dating in the rehabilitation of clients	
Health Visiting	Coronary Heart Disease – Improving outcomes	Develop working strategies to extend CHD prevention as set out in NSF guidelines	Implement CHD prevention training for those not yet trained.	
Health Visiting		Link up with local health groups, HAZ, develop local partnerships to work together to improve health of local communities	Work alongside practice staff to ensure service appropriate – deliverable. Collaborate with Practice Nurse and GP's to complement existing services.	
Family Planning	Public Health and Reducing Health Inequalities	To develop the service to meet the aims of the national strategy for sexual health	Review location and opening hours of young peoples service – involve users and signpost services effectively. Develop outreach contraceptive service	Audit attendances to show evidence of wider access to services.
Family Planning	Workforce – Modernised education, training and development	Improve the service towards Level 3 in the Strategy	Improve S.T.D detection and management, through continued training to update staff in recent contraceptive advances	Improve chlamydia detection – Monitor training levels – personal development plans for staff
Family Planning	Quality & Clinical Governance	To improve Clinical Governance activity	Create some hous for team doctor/nurse to work together on clinical governance	Quality audits undertaken

SERVICE	STRATEGIC OBJECTIVES	KEY SERVICE OBJECTIVES	MEASURE OF OBJECTIVES	BY WHEN?	LEAD AGENT	ADDITIONAL FINANCIAL IMPLICATIONS
District Nursing Service	To implement the revised District Nursing Strategy	To produce and implement an action plan to deliver the strategy across the service	Action plan produced	March 2002	Senior Clinical Nurse	
District Nursing Service	To develop a Specialist Diabetic Service	Explore options for the Development of Specialist Diabetic Service	Option appraisal undertaken and action plan produced	June 2002	Senior Clinical Nurse	
District Nursing Service	To implement skill mix	Employ "D" grade to provide additional cover – therefore reduce overspend by reduction of higher grade staff cover in Wigton Team	Monitoring Budgets		Senior Clinical Nurse	
		Enhance Relief Nursing Team in Wigton to reduce current necessity to use high grade staff				
Continence Service	To arrange Dry Bed Clinics across the Trust	To assess and treat children from the age of seven with primary or secondary enuresis with no other disabling condition	Identified nurses – school nurses or health visitors receive training. Clinic sessions in operation	March 2003	Continence Nurse Specialist	This will require: Training for nurses, clinic facilities, cover for clinics during school holidays, supply of alarms costing £40 approx plus replacement sensors at £20 each.
District Nursing Service	To change the skill mix within weekend Carlisle District Nursing Team to reflect the changing health needs and service requirements	To observe the District nursing Weekend Team. Explore and clarify the individual roles of staff. Set up a working group. Involve all weekend staff in the process. Facilitate skill mix change as required.		Feb 2002	Chris Fell, Acting Senior Clinical Nurse Working Group	
District Nursing Service	To respond to the National Guidance of Free Nursing Home Care for self funders	To carry out determination on all self funders in Carlisle Nursing Homes		Dec 2001	Chris Fell	
District Nursing Service		To incroporate the follow up determinations into main stream District Nursing Services		March 2003	Senior Clinical Manager	
Wigton Hospital	To implement the business case for the development of Wigton Hospital	To produce and implement a project plan for the development of Wigton Hospital and its services			Fraser Cant	
Wigton Hospital	To establish a culture of risk awareness and health and safety	To establish a Risk Management Group within the hospital	Group operational. Risk assessments undertaken and actions implemented	March 2002	Modern Matron	

SERVICE	STRATEGIC OBJECTIVES	KEY SERVICE OBJECTIVES	MEASURE OF OBJECTIVES	BY WHEN?	LEAD AGENT	ADDITIONAL FINANCIAL IMPLICATIONS
School Nursing	To develop the child centred public health role	1. Continue to develop corporate caseloads in practices 2. Encourage team working & skill mix throughout HV team 3. Collaborative working with other PHCT colleagues & other statutory and non-statutory agencies	Audit and development plan	July 2003	Senior Nurse	
School Nursing	Implementation of Hall Report v 4 in line with locally agreed policies	Participate in North Cumbria agreement of core programme of screening of school age children	Implementation of agreed core programme with support from management and stakeholders	July 2002	Senior Nurse	
School Nursing	Implement School Nurse Strategy – using locally agreed strategy & development resource pack (Dept of Health 2001)	1. Roll out Action Plan: Child centred public health role 2. Identifying and responding to health needs 3. Working towards evidence based practice 4. Developing skills to respond to health needs 5. Delivering on health priorities	Implement public health skills and audit tool	July 2002	Senior Clinical Nurse	
Health Visiting	To implement the Health Visitor Strategy	Rollout the action plan incorporating family centred public health role increasing community based & targeted public health initiatives. Achievable by working in collaboration with colleagues, managers & other local stakeholders to agree plan for change. Local Health Needs Assessment & systematic assessment of community needs should identify where services should be focused.	Audit of public health initiatives using Public Health skills audit tool & development plan in Health Visitor Practice. Development Pack Audit of public health initiatives using publis health skills audit tool & development plan in Health Visitor Practice Development Pack	June 2003	Senior Clinical Nurse	Local Levy
Health Visiting	Continue to develop corporate caseloads in practices, encourage team working & skill mix throughout	Continue to improve communication between staff, access to e-mail and training on IT. Continue to assess & improve office environments for HV's.	Corporate working established – audit through staff if corporate working effective, assess how improvements can	June 2003	Senior Nurse	Improve office furniture, shelving, filing, storage etc.

SERVICE	STRATEGIC OBJECTIVES	KEY SERVICE OBJECTIVES	MEASURE OF OBJECTIVES	BY WHEN?	LEAD AGENT	ADDITIONAL FINANCIAL IMPLICATIONS
Health Visiting (contd)	HV team. Collaborative working together with other PHCT colleagues & other statutory and non-statutory agencies.		be made.			
Liaison Team	To improve the quality, timeliness and relevance of information needs to support service delivery	To rationalise and optimise information gathering systems within Liaison Team	Meet with key personnel to review current information gathering systems and plan improvements. Future action as determined at initial meeting in consultation with stakeholders	Initial meeting October 2001	Discharge co-ordination team Julie Edge, Paediatric Liaison Nurse Lyn Armstrong A&E Manager Chris Fell and Lin Kendal	
Wigton Hospital	To participate in a multi-centre research project	To network with other community hospitals to improve standards of care		March 2003	Dr George	DOH funded
Family Planning	To improve staffing levels and continuity of clinics	Creation of a nursing team leader post across clinics 20-22 hours per week G Grade	Post created	Dr Brock	Dec 2002	15 hours increment F to G grade + 4 new hours at G Grade

APPENDIX 8

Eden Valley Primary Care Trust HIMP

Programme & Action	Timescale	*Key Partners*	*Named Lead*	*HR Implications*	*Information Implications*	*Funding Implications*
Access Young Peoples Health rural access	Ongoing	Cross	Ailsa Dinning	To be		Currently supported by teenage pregnancy strategy
Primary Care Collaborative. Reduce GP workloads and ensure people have access to a healthcare practitioner within 24 hours	2004	All GP Practices	Alex Herries	Increased Nurse Led Services and multi-skilled roles will require practices to identify practice specific training requirements	Data collection in practices	To be identified once training & development needs are assessed
Cancer Palliative Day Hospice Services	Start April 2002	North Lakeland Hospice at home, Voluntary agencies	Palliative Day Hospice manager	Training needs identified	Under review	Pre commitment pick up form SAFF
Coronary Heart Disease Implementation of standards in NSF. Each practice will have a CHD register with clinical audit data and will actively manage those identified as at risk.	March 2003	GP's & Practice Nurses	Angela George	Workforce training needs to be identified in each practice	Practice base data collection Introduction of computerised data system in some practices	Training & development needs Computer systems
Family Services Paediatric OT service East Cumbria	To start April 2002	SSD, Education, Acute Trust	Kerry Burton	Senior OT 0.5	Information Base	SAFF priority bid 2002 £14,000 + on costs

Mental Health Redesigning of Mental Health Services, (NSF, LMR, Best Value Review, Sainsbury)	March 2003	HA, Northern Centre for MH NSF lead, SSD, MH & LDT, Voluntary, Users & Carers group	Muriel Nixon	Workforce & training needs to be identified	Data collection from health information	Possible bridging costs & pooled fund
Mental Health primary care awareness training (NSF) benchmarking from North Cumbria Survey of 19 topic areas	March 2003	MH & LDT, SSD, Service Users & Carers, Independent & Voluntary Services, St Martins College	Venetia Young Muriel Nixon	Produce training plan & programme following practice survey	Establish effective training audit system	Training & Development leads across all sectors
To improve the uptake of Carers Assessment of people on enhanced CPA. ***Also covers older people with mental health problems***	March 2003	NSF carers task team & Carer Strategy Group	Muriel Nixon & Venetia Young	Carers assessment training	Social Services database format agreed	Dedicated family worker support time
Drug & Alcohol Shared Care for substance misuse in general practice.	Nov-2002	PCT's & MH & LDT, Public Health	Venetia Young & Muriel Nixon	Training & Development leads in Primary Care	To be identified	Training & Development leads in Primary Care
Substance misuse protocol fully implemented & audit in General Practice (NSF)	March 2003	NSF lead, PCT's & MH & LDT	Venetia Young & Muriel Nixon	Training & Development leads in Primary Care	Clinical audit to monitor compliance	Training & Development leads in Primary Care

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Learning Disabilities Maximising opportunities for people with Disabilities as identified in JIP for Leaning Disabilities, Highlighting the 11 objectives to be implemented locally (Valuing People, Disabilities White Paper, Best Value review & NSF)	March 2003	PCT,s, SSD, Employment Services, MH & LDT, Voluntary Services	Muriel Nixon & Venetia Young	Within existing frameworks	Objectives to provide a series of performance indicators against which local plans will be evaluated	To be identified though the JIP's & Learning Disability Partnership Board
Older People Intimidate Care continued Development	Ongoing	SSD & Voluntary agencies	Heather Burton	Workforce & training needs to be identified	Single Assessment to Identify Current Situation Further requirements Priorities for action	Developments when resources become available
Older peoples NSF 8 standards implementation	10 Year programme	North Cumbria LIT all agencies	Heather Burton & Muriel Nixon	Common information system across primary & secondary care	Information strategy is being developed as past of older peoples NSF	To be identified,
Older People with Mental Health Problems Review the role & scope of day & hospital provision	March 2003	NSF lead, SSD, MH & LDT, Voluntary, Users & Carers group	Muriel Nixon	Workforce & training needs to be identified	Data collection from health information	To be identified following review
Improve awareness in Primary Care of early identification & diagnosis of dementia	March 2003	NSF older people Task team	Muriel Nixon & Venetia Young	Produce training plan & programme following practice survey	Establish effective training audit system	To be identified

Diabetes Primary Care incentive Diabetes Scheme	*Ongoing*	General Practice & Diabetic Sub Group	Sarah Mills	Diabetic manager & admin support	Development of North Cumbria Diabetic register	£45,000 for North Cumbria, existing SAFF bid
Mobility & Sensory Impairment Development of a Joint Equipment Store, identify services within organisational structure	March 2003	Cross agency	Michael Smillie & Muriel Nixon	To be identified	To be identified	Capital & revenue to be identified 24
Medicines Management (based on 10-point Prescribing Plan and inclusive of Prescribing Incentive scheme)	Ongoing	GP practices	Gillian Johnson	Ongoing training/ updating for practice pharmacists, prescribers, practice nurses & dispensers	Prescribing data from PPA Reports from GP practices	Dependent on development of Prescribing support activities £5k initially, plus £15k if MMS collaborative bid is successful Impact on prescribing budget dependent on MMG recommendations on drug therapy
North Cumbria Medicines Management Group	Ongoing	PCTs, Acute Trust and MH & LD Trust	Dr Peter Weaving & Gillian Johnson		MMG Newletter	

CARLISLE LOCAL HEALTH GROUP
ACTION PLAN

Communities

- To work with local communities to identify local health need and ways of addressing them effectively.
- To support measures which seek to ensure the social inclusion of all citizens.
- To link in with local partnerships including Carlisle South SureStart, Longtown SureStart, the Travellers Sure Start, Crime and Disorder Strategy, Carlisle City Vision, Market Town Initiative for Longtown
- To establish support mechanisms to encourage participation at a local level through local health partnerships and neighbourhood forums.
- To support the development of a Healthy Living Initiative in Botcherby
- To support the development of good practice throughout the Carlisle area-
- To promote mental health for all by working with individuals and communities

Information

- To explore opportunities for obtaining GIS based data in association with Eden LHG.
- To pursue community approaches to inform and raise awareness of key health issues for young people in particular linking with local schools

Drug and Alcohol Misuse

- To work with the Drug Reference Group to prevent and reduce the incidence of misuse.

Teenage Pregnancy

- To identify measures to reduce conception rates of under l8s particularly in wards demonstrating high levels, linking in with the East Cumbria Teenage Pregnancy Strategy Implementation Group.

Smoking Cessation

- To work with the Smoking Cessation Co-ordinator to reduce the prevalence of smoking.
- To ensure wide coverage and information about the available service.
- To promote locally accessible services.

Healthy Eating and Physical Activity

- To target healthy food initiatives working with the Food Development Steering Group.
- To promote increased physical activity rates, particularly for the obese and inactive in disadvantaged communities.
- To develop exercise on referral beyond the pilot phase
- To ensure accessible information about sport and physical activity options.

Supporting Individuals

- To maximise the delivery of advice services through seeking a co-ordinated partnership approach.
- To promote locally accessible advice and information appropriate to need.
- To support measures which will assist young people to live independently

Injury Prevention

- To reduce the incidence of accidents through safer cycling.
- To support the development of initiatives which will help create a safer environment for older people, in particular reducing accidents in the home.

EDEN LOCAL HEALTH GROUP

ACTION PLAN

Communities

- To work with local communities to meet their health needs, linking in also with the Market Towns Initiative and Vital Villages Programme.
- To support mechanisms to encourage participation at a local level.

Information

- To explore opportunities for obtaining GIS based data in association with Carlisle LHG.

Drug and Alcohol Misuse

- To work with the Drug Reference Group to prevent and reduce the incidence of misuse.

Teenage Pregnancy

- To identify measures to reduce conception rates of under 18s particularly in wards demonstrating high levels, linking in with the East Cumbria Teenage Pregnancy Strategy Implementation Group.

Smoking Cessation

- To work with the Smoking Cessation Co-ordinator to reduce the prevalence of smoking.
- To ensure wide coverage and information about the available service-
- To promote locally accessible services.

Healthy Eating and Physical Activity

- To work with the Food Development Steering Group to target healthy food initiatives at parents with young children and the disadvantaged
- To promote increased physical activity rates, particularly for the obese and inactive in disadvantaged communities.
- To develop a pilot exercise on referral scheme.
- To ensure accessible information about sport and physical activity options.
- To work with Eden LA21 on specific projects.

Supporting Individuals

- Promote locally accessible advice and information appropriate to need.
- Work with Eden LA21 on a scheme to identify need and address fuel poverty.

Accidents

- To reduce the incidence of accidents through safer cycling.

APPENDIX 5


North Cumbria Health Authority
Local Communities
Carlisle DC
Allerdale DC
Carlisle North
Brampton & Area
Carlisle West
Carlisle East
Wigton & Solway
Penrith & Lower Eden
Alston & Area
Maryport
Cockermouth
Workington
Keswick & Area
Upper Eden Valley
Clesler & Egremont
Copeland DC
Eden DC
Millom & Area
Public Health Medicine
Carlisle & District PCT
29.1.02