

PCT Operating Plan 2009/10 Commentary Template

PCT Name: City & Hackney tPCT

Date: 27th Feb 2009

NHS

London

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PCT details

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1. Vital Signs Tier 1 and 2 Delivery plans for 2009/10

1.1 18 Weeks - VSA04

Objective/Aim (inc. maintenance of the standards, striving to achieve the standards across all services and specialties and appropriate online operational management of outpatient referrals)

A&E Services

Current YTD A&E performance (A&E/PUCC combined) is 98.4%. Local health economy-wide performance (including WiCs) is 98.7%.

The PCT capacity plan assumes 1% population of growth, in line with GOL assumptions. Contract plans for 09/10 have incorporated the requirement to “de-host” A&E services in terms of payment for activity at PBR tariff.

2009/10 projected out-turn in A&E remains within commissioned levels of activity. The contract plan assumes a target of 35% diversion of all attenders at A&E into the Primary Care led Urgent Care Centre (current performance 33%).

The Homerton FT is actively engaged in the PCT-led, local urgent care network. We have recently reviewed arrangements for patient flows through the Homerton FT (Alan Bedford) review in support of the 4-hour wait target and are implementing recommendations.

We have commissioned the minimum requirement of 98% achievement in 2010/11 and are seeking to incentivise A&E performance to 99%.

Hospital Services

The requirement for PCT's to ensure that 90% of admitted patients and 95% of non-admitted patients do not wait more than 18 weeks for treatment at all hospitals remains a major priority. There has already been significant progress made towards the achievement of this target. City & Hackney PCT and its local acute Trust, the Homerton FT, is the only 'Early Achiever' health economy in London. Processes for agreement on hospital capacity plans for 09/10 are underway. These include the activity required to meet the targets. As host for the Homerton University Hospital FT we will agree the overall capacity requirement and trajectory for 09/10. Within the capacity plan we have set a local standard of an average of 2 weeks for outpatients and 3 weeks for inpatients with a local maximum wait of 4 weeks for outpatients and 6 weeks for inpatients. We are active as Associate in all other contract negotiations. Again, the capacity plan and PCT financial plans include the volumes of activity required to meet the target.

Community Services Consultant and non-consultant led outpatients

Contract plans for the PCT provider arm include trajectories to achieve < 5 week waits in 2009/10 and the requirement for 18 weeks by March 2010.

Latest Performance and forecast outturn

December (monthly) data shows
Admitted patients 94.43% against a plan of 90.0%
Non admitted patients 96.74% against a plan of 95.0%

Action to Improve Performance

Data Quality

Whilst overall performance on 18 weeks is within target, there have been breaches in the absolute 13/26 week wait standards for inpatients and outpatients at our second largest provider, i.e. Barts and the London Trust, for whom Tower Hamlets PCT is the lead commissioner and City and Hackney is Associate (see section 3.2). 18 week reporting at BLT has been suspended as at January 2009. The breaches are a result of system and operational failures at BLT during 08/09. An action plan to support recovery is detailed in Section 3.1, The plan is supported by NHSL and the DoH recovery team.

Management of Service Delivery (inc. agreement of robust demand and activity assumptions with key providers, and that finance, activity and workforce assumptions are reconciled, and are incorporated in contracts)

See above, our robust capacity planning methodology incorporates assumptions in relation to population growth, changes in patterns of demand arising from practice based commissioning and the volumes of activity required to meet and exceed the overall 18-week target. It includes assumptions in relation to average and maximum wait times (Outpatients average wait 2 weeks, max wait 4 weeks, Inpatients average wait 3 weeks, max wait 5 weeks).

The capacity plan is segmented to speciality level and negotiated with provider Trusts. It is summarised below:-

Growth Assumptions (as per Mckinsey hfl model):

1. Population growth :

Sex:	Age band	Growth	Sex:	Age band	Growth	Grand Total
Male	0-16	0.9%	Female	0-16	0.8%	
	17-39	0.3%		17-39	0.6%	
	40-64	1.8%		40-64	1.6%	
	65-84	0.0%		65-84	0.4%	
	85+	4.0%		85+	0.7%	
	Total	0.8%		Total	0.9%	

2. Prevalence factor : 0.3% each year for regular attender

3. Residual growth :

Inpatient admissions	Growth rate per year
Medicine	2.7%
Surgery	0.5%
Obstetrics	2.0%
Outpatients attendance	0.1%
A&E attendance	4.0%

4. Impact of Olympics :

Year	Growth
2009/10	0.25%
2010/11	0.5%
2011/12	0.75%
2012/13	1%

Additional impact on year 2012/13

	Cost	Activity
A&E	£ 2,015,208	13333
Emergency admission	£ 2,85,433	23

5. Waiting list assumptions :

	Maximum wait	Average wait
Inpatient WL	6	3
Outpatient WL	4	2

HFL assumption of activity provided at different setting of care after 10 years:

	Major Acute	Polyclinic	Home	Not done
	%	%	%	%
Elective medicine				
• Complex	100			
• Non-complex	76	23		
• LTC*	100			
• Under 17s	90	10		
Emergency medicine				
• Complex	100			
• Non-complex	89	11		
• LTC*	80	20		
• Under 17s	96	4		
Elective surgery				
• Complex	92			7
• High-throughput	95			5
• Minor procedures	32	59		8
• Under 17s	92			8
Emergency surgery				
• Complex	100			
• Non-complex	100			
• Minor procedures		100		
• Under 17s	96	4		
Paediatrics				
• Paediatrics	94	7		
• Neonatology	100			
Obstetrics	94		6	
Regular attenders	68	32		
A&E	40	50		10
Outpatients	40	40		20

Proportion of the shift over five years :

year 1	08/09	0%
year 2	09/10	0%
year 3	10/11	5%
year 4	11/12	20%
year 5	12/13	36%

Polyclinic implementation phasing over years :

	0910	1011	1112	1213	1314	1415	1516	1617	1718
SERC		33%	66%	100%	100%	100%	100%	100%	100%
SWRC		10%	20%	40%	70%	100%	100%	100%	100%
NERC		10%	15%	30%	50%	75%	100%	100%	100%
NWRC		10%	15%	30%	50%	75%	100%	100%	100%
		5%	20%	36%	56%	74%	92%	100%	100%

Action/Initiatives/ New Services Commissioned in 2009/10

Capacity plan as above.

In addition to the above we are also working on the re-profiling of outpatient services and plan to develop one stop shops in urology, cardiology and radiology in 09/10 reducing the need for follow up visits for tests or further consultation and thereby improving patient experience and access.

Community Health Services – 18 week assumptions and max 5 week wait built into contract plans for non-consultant led services including AHPS.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£4,219,000	£90,000	£4,219,000	£90,000

Risks to Delivery with Mitigating Actions Planned

The achievement of the overall target is relatively secure within the local health economy. We have also built into our capacity/contract plans for community services sufficient volumes of activity to match the outpatient/18 week target, in order to avoid referrals to acute hospital as alternative to poor access in community based services such as foot health, locomotor, therapies, dermatology and child health.

Risks remain around the poor performance of Barts and the London and we are working with Tower Hamlets PCT as lead commissioner to monitor progress against the recovery plan.

1.2 HCAI's (C.diff and MRSA) - VSA01 & VSA03

Objective/Aim (across all HCAs, inc. MRSA local stretch targets and the rollout of MRSA screening)

The Trust is committed and aims to ensure that there is a facilitative partnership approach to the reduction of HCAI across the health economy. At the same time, the PCT needs to be assured that its population is protected by robust performance management, quality assurance and a succinct escalation process to ensure a year-on-year reduction in Health Care Associated Infection (HCAI).

The term "Health Care Associated Infection" (HCAI) encompasses any infection by any infectious agent acquired as a consequence of a person's treatment by the NHS or which is acquired by a health care worker in the course of their NHS duties.

Methicillin Resistant Staphylococcus Aureus (MRSA), *Clostridium Difficile Infection* (CDI) and other HCAs are a significant cause of harm in the NHS and can result in patient suffering, unnecessary pain, anxiety and possible death. Many HCAI are avoidable and everyone can contribute to reducing their burden. HCAs also impact on the efficiency of health care services by increasing costs and reducing productivity. In total it is estimated health care acquired infections cost the NHS around £1billion per year.

In recognition that HCAI does not recognise organisational boundaries and that the Trust cannot impact on infection rates in isolation from its partner organisations, therefore a cohesive and co-ordinated approach to the prevention and management of HCAI across the local health economy is promoted.

The recommended approach to reduce the spread of HCAs has been to identify what factors are influencing the increase in such infections. Structures and processes across the Trust support the increase in surveillance of HCAI. The Health Act, 2006 and Board to Ward (DoH, 2008) documents both underpin the direction of changes as the philosophy adopted is that that the prevention of health care associated infections requires commitment from everyone, not just specialists in infection control. Better strategic management, leadership and accountability, education and training and monitoring of performance and progress are all crucial to bringing about these changes.

Targets for Achieving year on year Reduction in HCAs.

In line with the National Public Service Agreement target and the Operating Framework for the NHS in England, close partnership working with our host Trust the Homerton Foundation and Bart's and the London Trust, is undertaken to achieve year- on- year reduction in MRSA levels and to achieve a 30% reduction in the number of CDI infections by 2010/11 compared to a 2007/08 baseline.

Targets for CDI – 2009/10 and 2010/11

Number of Homerton University Hospital Trust (HUH) patients aged 2 years and over tested positive for CDI should not exceed 55 cases per annum. This is an extremely ambitious target for the Homerton and is based on a 10.3% reduction on the baseline outturn figure for 08/09 of 58 cases. The target for 2010/11 is not to exceed 52 cases.

Target for MRSA – 2009/10

The Homerton's MRSA target has been set at no more than 12 cases per annum for the last two years. This year we will be setting the Homerton a stretch target to reduce cases to 11 as a final out turn position of 09/10.

Table 1: MRSA target plan for 2008-2011 (Homerton Hospital)

This is a local stretch target.

2008-9	2009-10	2010-11
12	11	10

Trajectory for 2009/10 (C. diff.) - annual only, taking account of revised baseline

Baseline CDI	124
Population aged 2+	209,224
Baseline Rate	5.93
Target Rate or 10% reduction	112
Maximum Target	112
Percentage reduction	10%
Attributed as Lead PCO	10

Details from HPA HCAI data Capture System

2010/11 (C. diff.) - annual only, taking account of revised baseline (N.B. this will be set by DH for each organisation)

Baseline CDI	124
Population aged 2+	209,224
Baseline Rate	5.93
Target Rate or 10% reduction	101
Maximum Target	101
Percentage reduction	10%
Attributed as Lead PCO	10

Details from HPA HCAI data Capture System

Latest Performance and forecast outturn

HCAI Performances for the Homerton

HCAI's	Plan YTD as of December 08	Actual YTD as of December 08	Forecast Outturn
Cdiff	84	75	
MRSA	9	9	

Action to Improve Performance

Data Quality

Performance Monitoring

The reduction and control of HCAI depends on a number of key interventions being used consistently at all times.

For MRSA these are as follows:

Screening and decolonisation of appropriate patients.

Strict hand-hygiene procedures by clinical staff.

Use of care bundles for high risk interventions; particularly central lines, renal dialysis catheters, urinary catheters and surgical wound care.

Restricted use of antibiotics.

For CDI the key interventions are as follows:

Strict hand-hygiene procedures undertaken by clinical staff

Community approach to isolation of infected patients who are symptomatic

Restricted use of antibiotics

The PCT and NHS London will monitor performance of all local providers in relation to prevention and control of HCAI through the above.

In addition:

Concerns around HCAI will be fed to the bi-monthly control and prevention of infection working group (CPIWIG) meeting.

The PCT will continue to undertake local visits to all provider organisations, starting with the most challenged areas. The PCT will assess the use of the key interventions in local providers and will intervene where these are not systematically in place. Each provider will be asked to produce an action plan following each visit. The PCT will carry out a follow-up visit to monitor progress with local action plans. The action plan needs to provide clear measures/outcome against each action and each action must be owned by a named individual.

The PCT will monitor training standards across the PCT area and examine competency frameworks for all clinical and non-clinical staff ensuring compliance with infection control standards identified through the hygiene code through quarterly updates and reports from all provider services. The PCT will carry out regular analysis of RCA reports of all cases of MRSA bacteraemia and deaths due to CDI across the health economy and consistent poor performance will be brought to the attention of relevant parties and assurance will be sought from the provider.

The PCT Board will monitor the infection control programme by:

Board performance report on national targets for HCAI

Declaration of achieving the infection control core standard as part of the healthcare Commission Standards for Better Health

Receipt of the DIPC annual report

Compliance with infection control aspects of NHS Litigation Authority Standards for PCT.

The PCT will monitor progress against agreed annual trajectories. Providers that are at risk of failing to meet agreed trajectories will be notified and will be requested to submit a full recovery plan within a week of notification by the PCT.

While local rates of HCAI are within expected levels of performance, the Homerton University Hospital University Foundation Trust has received a performance notice from the HCC in relation to hygiene measures which support infection control. An action plan has been developed. Progress against the action plan will be monitored via the CPIWIG and contract review processes. The Homerton FT has revisited by the HCC team in February and the results of their findings are expected imminently.

Quality Indicators for Reducing HCAs in 2009/10

Proposed quality indicators:

The following indicators have been developed to be used to ensure that infection control practice is in accordance with best practice for that particular environment and nature of care.

These indicators are additional to the centrally set trajectories for reducing the incidence of MRSA bacteraemia and CDI.

Clinical Quality Performance Indicator	Method of Measurement
Infection Prevention & Control in the Trust will be managed in accordance with the Health Care Commission HCAI Self-assessment Tool	Annual reporting against the self-assessment tool
<p>MRSA & Clostridium difficile:</p> <p>Practice when and wherever appropriate will be in accordance with the 'High Impact Interventions' care bundles for infection control as outlined by the Department of Health</p>	<p>Clinical audit of the use of 'High Impact Interventions' compliance tools</p> <p>Audits will be conducted on a rolling programme agreed as part of the annual programme in line with Saving Lives. Data at the first Quarter will determine the baseline for further performance measurement. At subsequent review in quarter 2 the Trust will demonstrate either sustained or incremental improvement</p> <p>Appropriate action plans developed and monitored</p>
<p>CDI: antibiotic prescribing will be in accordance with CDI prescribing policy and subject to audit involving pharmacist and microbiologist/infection control specialists</p>	<p>Audit of antibiotic prescribing in CDI cases & action plan</p> <p>Audits will be conducted on a rolling programme at quarterly intervals. Data at Quarter 1 will provide the baseline for further performance measurement. At subsequent review in quarter 2 the Trust will demonstrate either sustained or incremental improvement</p>
<p>Cases of C. Diff Associated Disease (CDAD) and MRSA bacteraemias will be subject individually to root cause analysis (RCA) and collectively to trend analysis to enable lessons to be learnt and shared across the Trust</p>	<p>RCA reports & action plans</p> <p>Trend analysis reports & action plans</p> <p>Breakdown of incidence in specialities/patient groups with supporting commentary to indicate hotspots and action undertaken with evidence of shared learning</p>

<p>Clinical practice will be in accordance with best practice principles to minimise the risk of MRSA bacteraemia and blood borne viruses in all service users.</p> <p>Audit criteria will include the following: - Staff hand hygiene Decolonisation of MRSA</p>	<p>PEAT inspections, reports and action planning</p> <p>Essence of care clinical benchmarking on infection control</p> <p>Cleaning score on National specifications</p> <p>Robust outbreak management procedures</p> <p>Infection rate surveillance reports</p>
<p>Community hospitals/ Trusts are suitable for implementing effective infection control measures</p>	<p>Reports from HPU on visits to all local sites and relevant action plan from CHO</p>
<p>Information and local policy on infection prevention and control are accessible to all clinical and non-clinical staff</p>	<p>Direct observation through programme of local visits</p>
<p>Appropriate action is taken to minimise the spread of HCAI within Primary Care Commissioned Services.</p>	<p>Annual audit of GP practices using the Essential Steps tool for GPs,</p> <p>QOF visits and intervention when infection control concerns arise.</p> <p>Annual audit of Dental Practices.</p> <p>Annual audit of Optometry Practices as necessary.</p> <p>Use of professional tools when available (Dentistry)</p> <p>All Primary Care Commissioned services must comply with the National Decontamination Strategy</p>

Management of Service Delivery

Achieving year on year reductions in Health Care Associated Infections through Local Surveillance and Reporting.

It has been recognised that effective local surveillance is essential in reducing healthcare associated infection rates and associated costs locally. The PCT therefore, expect all providers to take action to improve data quality for HCAI surveillance including ensuring consistency in CDI case reporting, reporting of CDI deaths and distinguishing between hospital-acquired and community-acquired infections.

Acute Trusts and community providers are expected to develop a clear protocol for allocation of cases to the relevant provider. The protocol must be agreed and signed off by both providers by April 2009 and a copy should be submitted to the PCT by May 2009.

All providers must comply with the reporting requirement of the PCT and NHS London in relation to all healthcare associated infections.

To undertake a Root Cause Analysis for all cases of MRSA Bacteraemias and CDI. The RCA should be undertaken within 5 days (7 days maximum) of identification of the infection. The RCA is to be undertaken by clinical teams, with the assistance of the PCT Health Protection Team. A copy of the RCA for all hospital acquired episodes, together with an action plan must be sent to the PCT and the SHA through the Strategic Executive Information System (STIES) within 7days. The action taken must address and correct any deficiencies and may involve various strategies including education, policies, audits, new technology etc. A copy of the action plan should be forwarded to the PCT within a week of RCA completion.

The Service Level Agreement (SLA) between City & Hackney PCT and Tower Hamlets Community Infection Control Team (THCICT) has been in place for a number of years. Under this agreement the team provides infection prevention and control services to the PCT including the mechanisms by which the Board intends to ensure adequate resources are available to secure effectively prevent and control HCAI. In addition,

As a provider, the Trust does not manage any inpatient facilities but has a fully established Control & Prevention of Infection Working Group (CPWIG) which oversees the management of all HCAIs. Its primary aim and objectives are to ensure the safety and quality of healthcare commissioned services across the Trust. As part of this responsibility the Working Group monitors progress against implementation of local policies and plans in relation to HCAI by the receipt of regular reports from Primary Care Commissioning, Health Protection Agency, Tower Hamlets Community Infection Control Team, Occupational Health and Community Health Services (CHS).

The Homerton University Hospital reports all cases where CDI is mentioned on any part of the death certificate to the PCT and update the London SHA Strategic Executive Information System (STEIS). It is expected that a case review meeting should be held within 24 hours to review the case with the Infection Control Team and the clinical team responsible for the care of the patient. These meetings are chaired by the Trust DIPC or delegated deputy. An RCA would be expected within maximum of 7 days of the incident. A final report should be produced and forwarded to the PCT within 30 days of the incident.

- Education is key to ensuring compliance with infection control interventions.

The Homerton has already begun pre-48 hour screening of elective patients during the financial year 2008/09. The PCT will be working with the Homerton during 09/10 to take forward plans to extend screening to cover emergency admissions. This will be implemented before the deadline of March 2011. The progress on the implementation will be monitored through the quarterly clinical quality review meetings with the Homerton.

Providers:

1. Must ensure that Managers, supervisors and staff are sufficiently trained to enable them to carry out their duties and responsibilities relating to infection control.
2. Must demonstrate year-on-year increase in percentage of people trained in infection control.
3. Develop a training register with information on number of participants and content of training programme.
4. Ensure that Infection control is included in the induction training for new staff.
5. Must include reference to infection prevention and control in all job descriptions and assess this via staff appraisal/personal development plans on an annual basis.
6. Will be expected to provide evidence to the PCT on request.

Action/Initiatives/ New Services Commissioned in 2009/10

Further investment for 2009/10

The PCT has secured funding for 2.0 WTE clinical posts for 2009/10 and is committed to further funding to ensure clinical focus on infection control in the Operating Plan until 2011 is fully addressed.

An **Infection Control Nurse (1 WTE)** has been appointed to ensure that we will continue, in collaboration with Primary Care Commissioned Services, to ensure that infection control audits are undertaken systematically, and that all new building specifications comply with infection control procedures.

In addition we have secured funding for a **Specialist Infection Control Nurse (1 WTE)** whose remit would include working proactively with colleagues in the Health Protection Agency to support staff working in residential and nursing homes to prevent and control infections occurring.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£137,000		£137,000	£0

Risks to Delivery with Mitigating Actions Planned

Risk	Consequences (1-5)	Likelihood (1-5)	Overall Rating	Mitigation
Failure to engage with key stakeholders	5	2	10	Ensure existing networks/partnerships are fully utilised.
Unable to recruit to Specialist Infection Control Nurse Vacancy	5	3	15	Network with neighbouring PCT. Work closer with Workforce team.
Failure to monitor trajectories from Homerton and Barts	5	1	5	Ensure relevant data is captured and monitored.
Lack of robust monitoring of HCAI data (community acquired)	5	4	20	Ensure system and processes are firmly in place to capture data.

1.3 Patient Satisfaction with Access to Primary Care - VSA06 (including out-of-hours)

Objective/Aim (inc. ensuring that opening hours reflect patient needs, implementation of HfL, newly procured services, including polyclinics, other planned increases in capacity, improvements in quality, reviewing service provision of urgent care)

Patient reported measure of GP Access:

The PCT has a lower level of satisfaction than the national average on all of the 5 key indicators of patient reported measures of GP access. Whilst the level of satisfaction is in line with the experience in PCTs in north-east London they continue at an unacceptably low level and the PCT is committed to improving both the level of response to the national survey and the levels of satisfaction reported. It should be noted however that local in-depth surveys conducted by IPSOS-MORI have show high levels of satisfaction with local GP services, as do individual QOF practice surveys, however these do not focus on the specific key areas.

In 2007 we developed an action plan in relation to improving access to GPs. We have continued to work through this. Our target is to improve levels of satisfaction to the national average as reflected in the 2006-07 survey. The actions to achieve this are set out below.

1. Telephone Access

The PCT has identified those practices where telephone access is a problem and has increased investment through improvement grants and PCT capital spending programme to address these concerns. We are seeking to further target our investments in telecoms infrastructure to address this as an area of concern and to target the issue as part of our approach to contract compliance. We are working with individual practices to ensure that they developing specific action plans in relation to the concerns that have been raised by their patients, and looking at ways of incentivising further improvements via enhanced services and other investment routes. We are planning to pilot systems that allow remote booking of appointments with a number of practices, with a view to increasing investment in this area and rolling it out.

2. 48 Hour Access

A process for ensuring that follow-up of practices that fail to achieve this target without the support of the urgent care centre has been implemented. On-going failure of the target is followed up by the PCT with a plan agreed for compliance This will continue, though the incidence of practice failure of the target is very limited. The increase in numbers of practices undertaking extended hours has helped with the achievement of this target at practice level. The PCT has two Walk in Centres, one in NE Hackney and one, mainly providing services to commuters in the City that provide extra capacity in the system. Further more the Primary and Urgent care Centre based alongside the ED at Homerton Hospital provides extra capacity for patients unable to access their GP in a timely manner. Furthermore the PCT has a well developed Pharmacy First programme, which has in excess of 30k consultations per annum.

3. Booking Ahead

This measure is supported by the continued roll out of the extended hours DES and LES, which requires all practices participating to offer four week booking in advance and a review of the numbers of appointments of all types offered by practices. Currently the proportion of practices delivering extended hours is at 64.9% in January 2009 and continues to rise.

4. Opening Times

The PCT has exceeded the trajectory set for 08/09, and continues to build on this. 08/09 has seen the marketing of information about specific practices and the hours they undertake to the local population. The PCT will continue to drive engagement from practices into the delivery of this target, reviewing processes to enable us to continue to outperform the trajectories. The recent marketing campaign will be followed up with further work to ensure that all patients have a realistic choice of practices offering extended opening times.

5. The proportion of people satisfied with their overall experience of their GP

It assumed that this measure will be an amalgamation of all elements of the target. However, the PCT will also monitor patient satisfaction levels through a number of routes, (MORI survey, Picker survey, patient satisfaction surveys) continue to monitor information from practices and challenge any slip in performance against this target. Our monitoring will also include polling on a quarterly basis to check progress.

Number and staffing of new GP practice

CHPCT is not an under-doctored area. The National Equitable Access programme, means that over the course on 09/10 we are progressing the procurement of a GP led health centre and will sign a new contract for a zero list practice which meets all the criteria of the scheme, including seeing unregistered patients with primary care needs

The Unregistered Population

We will continue to develop an understanding of some of the barriers to registration for some of our practices. We are also running a project involving the PUCG and the A&E department to support the registration of attendees who do not have a GP.

New Health Centres and development of Polyclinics

One new health centre was opened in Autumn 2008, with two practices relocating from unsuitable premises to new purpose built premises. The South East Resource Centre, is expected to receive planning permission from LB Hackney in March 2009 and is expected to be approved and be on line for completion by June 2010. This will provide a hub for the South East Hackney polyclinic linked to the Primary and Urgent Care Centre at the Homerton Hospital. The St Leonard's Outline Business Case has had stage one approval from NHS London and it is expected that work will commence on site in early 2010. This will provide primary care with a large facility, into which a number of GP lists will relocate. The building will form the hub of services for the SW polyclinic and in 09/10 the PCT are working with local stakeholders to develop a new model for an urgent care centre in South West Hackney as part of the St Leonard's redevelopment.

Trajectory for 2009/10 (for each question and average)		2010/11 (for each question and average)	
VSA06_01	11,118	VSA06_01	11,491
VSA06_02	12928	VSA06_02	13,058
VSA06_03	86%	VSA06_03	88%
VSA06_04	10,860	VSA06_04	11,230
VSA06_05	12,928	VSA06_05	13,085
VSA06_06	84%	VSA06_06	86%
VSA06_07	9,696	VSA06_07	10,055
VSA06_08	12,928	VSA06_08	13,058
VSA06_09	75%	VSA06_09	77%
VSA06_10	10,860	VSA06_10	11,230
VSA06_11	12,928	VSA06_11	13,058
VSA06_12	84%	VSA06_12	86%
VSA06_13	10,860	VSA06_13	11,230
VSA06_14	12,928	VSA06_14	13,058
VSA06_15	84%	VSA06_15	86%
VSA06_16	83%	VSA06_16	85%

Latest Performance	
VSA06_01	8227
VSA06_02	10066
VSA06_03	82%
VSA06_04	5832
VSA06_05	7420
VSA06_06	78%
VSA06_07	4023
VSA06_08	5732
VSA06_09	70%
VSA06_10	4630
VSA06_11	5825
VSA06_12	79%
VSA06_13	9854
VSA06_14	12314
VSA06_15	80%
VSA06_16	79%

Action to Improve Performance

Data Quality

The PCT are working with practices to promote the importance of returning the survey to their patients, low returns have the potential to skew results to the dissatisfied.

Management of Service Delivery

In 09/10 the PCT will undertake a review of PMS contracts for VFM, list size and access. We will also:

- Revise contract compliance systems through Annual contract reviews
- Take steps to end inefficient contracts and non-compliant contracts
- Incentivise practices engagement with the access and customer care agenda
- Increase public awareness of service improvements through a social marketing approach.

Action/Initiatives/ New Services Commissioned in 2009/10

The PCT is taking a number actions as outlined above, which include increasing capacity through new contracts

Equitable Access to Primary Care new contract to be agreed by Dec 2009

Procurement of services to manage the South East Resource Centre, to enable an effective approach to the delivery of service innovations in a primary care setting

Work on Long-Term Conditions i.e. diabetes and raised blood pressure to increase detection and control. This will have a knock on effect in ensuring planned use of primary care services for patients with those conditions. The development of a comprehensive vascular screening programme will involve commissioning screening from General Practice.

Reduction in the variation of performance of Primary Medical services (PMS) contractors, through implementation of a balanced score card approach, containing agreed Performance Indicators for Primary Medical Services, including:

- Patient reported access
- Extended opening
- Adult BMI recorded in GP practices
- Prescribing NIC per STAR-PU for CV system
- HbA1C control

The balanced score card will be a fundamental tool in the PCT's overall process of assuring contract compliance, and we will deliver effective clinical input to assessment of service delivery to ensure that we have the evidence required to performance managing contracts efficiently.

Reviewing current PMS capacity building on information relating to access and assessing the need for further investment, linking this to the assumptions underpinning our services and estates strategy

Delivering the South East Resource Centre, and closing the business planning process for SW Resource Centre

There a number of major premises developments in development, as outlined in the PCTs Bigger Brighter Better, Services and Estates strategy, the costs for which are factored into the overall financial plan for the PCT. All developments are linked via their business plans to providing

increased capacity for patients to register. One large extensions on the St Leonard's site will be delivered in 09/10. a further third party developer rebuild is currently delayed due to the economic climate and its impact on borrowing.

Work with practices to ensure better information is provided by practices on their profile & services on NHS Choices to facilitate patients choosing a GP practice.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£865,000	£6,086,000	£865,000	£6,086,000

Risks to Delivery with Mitigating Actions Planned

Equitable access to Primary Care (GP led Health Centre) – Premises issues with SE Resource centre delivery being delayed. Mitigation via a review of the model for delivery, with NHS London. An alternative site has been identified to add a second centre into the procurement.

Procurement of management services for SE Resource centre – Premises Issues with SE Resource Centre delivery being delayed. Managed through contract commencement dates.

LTC programme – take up by population and service providers, mitigated through pump priming work in 08/09, with QMUL

Implementation of balanced score card and increased contract compliance – staff to develop paperwork and implement process, resistance with contractors. Mitigated through interim project managers and clinical engagement in KPIs

Delivery of non-Lift premises – availability of loans to developers and to contractors. Mitigated through a review of business plans and close working with the DV and other financial advisers, regarding the impact of the economic environment.

1.4 Cancer - 2 Week maximum wait for all referrals for breast symptoms - VSA08

(i.e. not just urgent referrals)

Objective/Aim

That all patients referred to a specialist for investigation of breast symptoms should be seen within 14 calendar days (excluding those referred urgently for suspected breast cancer under existing standard).

Trajectory for 2009/10 (confirmation of plan for 100% by January 2010)	2010/11
100%	100%

Latest Performance (local estimate if no robust data)

Following delays in national data definitions, providers have commenced submitting PTL data. Trusts have been submitting to Open Exeter. January data will be reported mid March with Q4 in mid May.

Data definitions were late and systems are in the process of being updated to allow data submission, so information may be initially incomplete. Outpatient data has been run through the "new rules" as an indication of likely performance. Currently this shows variation across providers with Homerton FT performance at below London average. This is being investigated, and will be pursued through local contract processes as well as cancer network arrangements.

Action to Improve Performance

Data Quality

North East London PCTs well developed cancer network arrangements
Implementation and performance management of Cancer Waiting Time Standards is led by the Cancer Taskforce which is the operational level group reporting to the Cancer Network Board. Chaired by the Network Director, all providers and PCTs are represented. Clear pathways for data collection are being developed and the detailed data work stream is lead by a Data Subgroup, involving all providers, chaired by the Network Data and Information Manager. The Network has also facilitated and funded the agreed implementation of a common cancer data collection system that will be key to the successful implementation of this standard and which will feed Open Exeter. The network has agreed with provider and PCT leads to investigate the potential to integrate data collection for cancer waiting times more closely with the 18 Week processes.

Management of Service Delivery

Service delivery will be led by provider breast cancer services supported by existing and well established trust cancer waiting times offices. Providers will monitor performance through the PTL and through extending the current waiting times performance management reports that will be monitored within the Trust, by the PCT Cancer Locality Board and by the Network's Cancer Taskforce.

Action/Initiatives/ New Services Commissioned in 2009/10

The Cancer Network manages a NHS Improvement programme that includes a Service Improvement Facilitator in each provider/PCT locality with Cancer Waiting Times compliance on their work plan and including the understanding of demand and capacity for breast referrals. An existing network service improvement priority, 'Care after Breast Cancer' is moving forward in all localities [except for BLT] and this will seek to reduce the current levels of ongoing routine follow up of breast cancer patients, in line with NICE Guidance, freeing up outpatient capacity.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In cancer mortality	In cancer mortality	In cancer mortality	In cancer mortality

Risks to Delivery with Mitigating Actions Planned

Risk: that there is inadequate outpatient capacity. Mitigating actions will be through the Service Improvement programme lead and funded by the Network – including technical assessment of capacity and demand and the rationalisation of follow up for breast cancer highlighted above.

1.5 Breast screening

age extension (trajectory submission deferred but action plan summary for new age extension required and recovery plan where needed to achieve coverage target and round length for existing age range)

Objective/Aim

Our aims for 2009/10 are:

1. Ensure that the Central and East London breast Screening Service introduces an agreed programme of new initiatives to improve uptake, including the offer of a second timed appointment
2. Strengthen service commissioning arrangements- through introduction of a new service specification and performance management arrangements
3. Plan for the further age extension and introduction of full-field digital mammography by 2010/11- led by the Breast screening commissioner based at Tower Hamlets PCT
4. Deliver evidence-based local screening promotion programmes, tailored to the diverse needs of local women
5. Develop local governance and clinical leadership arrangements, following substantive appointment of a Public Health Consultant and a Strategist to lead on cancer and with accountability to the City and Hackney Cancer Board.

Trajectory for 2009/10	2010/11
62%	67%

Latest Performance (current age range) and forecast outturn

Breast screening coverage rates in City and Hackney remain low. City and Hackney is not a pilot site for the breast screening extension to provide nine screening rounds between 47 and 73 years.

Target for 2008/9 = 58%

Data available 6 months in arrears. Current performance 56%

April to June 2008 = Uptake 55% for the Central and East London

Forecast outturn = 50%

Action to Improve Performance

Data Quality

City and Hackney is half way through a GP list cleansing project which will enable us to be more confident about the denominator and impact of population mobility on the performance of our screening programme. The first phase, focused on reviewing patients who registered for the first time on the Exeter system (immigration flag) is nearly complete. Phase two will focus on patient confirmation of registration with a practice across the whole practice list.

Management of Service Delivery

There have been changes in the senior management team at CELBSS, including appointment of a new Service Manager and Service Director, and involvement of the service commissioner in the job descriptions and sitting on the appointments panel. CELBSS has also designated a new lead surgeon for the service.

A major service review was commissioned from McKinsey & Co by the sector. Recommendations are being implemented and current service developments include:

Move provision of the call-recall service to CELBSS

Reduce the number of missed calls to CELBSS appointment booking number through increased telephone capacity and improved call management

Offer of a second timed appointment for women who do not attend the first scheduled appointment
Development of GP involvement in promoting screening, including use of GP letterheads on invite letters, advance notice of screening rounds

Reduce the national 36 month round length standard to 33 months, to build flexibility into the invitation process

Programme-wide health promotion initiatives led by the CELBSS health promotion lead e.g. adverts in Muslim Weekly

In City and Hackney we have commissioned a catch up programme for women who DNA'd in the screening round before last, offering first and second timed appointments at the mobile screening unit in Mile End. We will be reviewing the current primary care LES to strengthen the role of practices in encouraging women to attend their second timed appointment offer if they DNA, building on the good practice guide developed by Tower Hamlets PCT. We will also be exploring whether there is any benefit to smoothing out the invite schedule over the 3 year period, to maintain the profile of breast screening locally, particularly in primary care.

Building on Best Practice Guidance on Collaborative Commissioning of National Cancer Screening Programmes (DH December 2007), considerable progress has been made over 2008 in developing more effective commissioning arrangements for the Central and East London Breast Screening Service, covering 7 PCTs and based at Barts and the London. This includes development of a new service specification and performance management arrangements which will introduce an incentive for CELBSS to improve uptake by introducing payment per women screened. It will also set a framework for commissioners to work with the provider to develop a 5 year breast screening strategy, and annual plans. Lead commissioner arrangements at Tower Hamlets PCT remain.

Implementation will be prioritised in the context of the programme to improve survival from breast cancer in NEL, including the breast cancer inequalities project which suggests that the relatively poor 5 year survival rate may be largely explained by relatively poor survival at one year and be associated with both late presentation and deprivation.

Action/Initiatives/ New Services Commissioned in 2009/10

The new contract/service specification for CELBSS will come into place in April (including the changes to the service specified in the management of service delivery section). These changes to the specification allow more flexibility within the service to allow for the increased capacity the age extension requires. The plan for the age extension has been developed by CELBSS In partnership with the lead commissioner and the commissioning PCTs and the new specification also includes details of this. Also included are the specifications for the call/recall services, the QA standards and that there are processes in place for vulnerable women/groups.

The breast screening round for City and Hackney will run from April to January and involves 35 practices and nearly 13,000 women. To coincide with this screening round, we are planning a local health promotion campaign to increase awareness of the screening programme and highlight the benefits of screening. We are also offering an enhanced service for primary care to incentivise the promotion of screening within GP practices and running a variety of training events for practice staff prior to their screening round. We are also looking to increase our work with community and voluntary groups, to increase awareness and improve uptake levels.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£75,000	£0	£75,000	£0

Risks to Delivery with Mitigating Actions Planned

Delay in implementing new SLA with CELBSS due to need for revised financial agreements between each programme area and the lead commissioning PCT: Tower Hamlets currently working out a way of smoothing out financial flows over the round length.

Limited engagement from local GPs in the programme: we will be continuing the current LES, and looking to develop local clinical leads/champions for the breast screening programme.

1.6 Bowel screening

(trajectory submission deferred but action plan summary required)

Objective/Aim
<p>Bowel cancer screening was rolled out for men and women aged 60-69 years across Hackney and the City of London in 2007. In the first year uptake has been approximately half that achieved in research/pilots elsewhere.</p> <p>Aims for 2009/10:</p> <p>Develop local bowel cancer screening promotion plans</p> <p>Plan to extend screening to cover 70 – 75 year olds, including assessment of the increased demand on treatment services.</p> <p>Consolidate corporate and clinical governance arrangements for the service, through the City and Hackney Cancer Board.</p>

Trajectory for 2009/10	2010/11
Deferred	Deferred

Latest Performance
31%

Action to Improve Performance
<p>Data Quality</p> <p>At present data is collected by the national programme, making real time local performance management challenging.</p> <p>Data on ethnicity would be helpful in understanding whether there are inequalities in uptake and inform health promotion/social marketing but this is not currently collected by the national programme.</p>
<p>Management of Service Delivery</p> <p>Screening promotion plans for 2009/10 include:</p> <ul style="list-style-type: none">Bus campaign on 100 bus routes, scheduled for March and September 2009 and focused on a. understanding of risk and b. benefits of being screenedFour adverts addressing different stages of screening to be posted in local papers, based on case studiesContinuation of radio advertsPerformance of a play addressing bowel cancer screening, to be performed by the Pyramid Theatre Company at different community venuesScoping and development of local resources to promote screening by April 2009

In City and Hackney we plan to:

Review the potential for voluntary and community organisations to promote bowel cancer screening, e.g. through our new health trainers programme

Develop a process through which our GPs can endorse and support the bowel cancer screening invite

A bowel cancer screening researcher has been appointed and will develop the monitoring and evaluation framework for these and other initiatives.

Action/Initiatives/ New Services Commissioned in 2009/10

The Department of Health currently commission the bowel cancer screening programme directly from the screening 'Hubs' (Northwick Park for City and Hackney), but commissioning of the programme will be devolved to the PCT 3 years after the start of the screening programme which for North East London is early 2010. We are planning for this in terms of funding and service specifications.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£10,000		£10,000	£0

Risks to Delivery with Mitigating Actions Planned

We currently have a relatively poor understanding of the barriers to bowel cancer screening amongst City and Hackney residents. This will be addressed through the appointment of bowel cancer screening researcher, and possibly undertaking a health equity audit of bowel cancer screening uptake once the programme is embedded, probably across the whole screening programme area.

The North East London Bowel Cancer screening service has temporarily closed the Homerton Hospital screening centre due to QA concerns re small numbers of investigations undertaken in the unit. City and Hackney residents therefore have to travel to the Royal London which may provide a further barrier to completion of treatment if required. This is being kept under review.

1.7 31 day maximum wait for all cancer treatments – VSA12 (i.e. second and subsequent) for radiotherapy

Objective/Aim (inc. ensuring that sufficient radiotherapy capacity is commissioned)

That all patients requiring radiotherapy as a second or subsequent treatment for their cancer receive it within 31 days of the cancer treatment period start date.

Trajectory for 2009/10 (March 2010 figure)	2010/11 (confirmation of plan for 100% by January 2011)
100%	100%

Latest Performance (estimate if no robust data available)

Following delays in national data definitions, providers have commenced submitting PTL data and the available data is not yet robust enough to measure performance. Nevertheless, waiting times data collected for the Royal College of Radiologists audit, and assessed as part of the London Cancer Networks Board review of the implications of the National Radiotherapy Advisory Board report, suggest the majority of patients are treated within 31 days.

Action to Improve Performance

Data Quality

Implementation and performance management of Cancer Waiting Time Standards is led by the Cancer Taskforce which is the operational level group reporting to the Cancer Network Board. Chaired by the Network Director, all providers and PCTs are represented. Clear pathways for data collection are being developed and the detailed data work stream is lead by a Data Subgroup, involving all providers, chaired by the Network Data and Information Manager. The Network has also facilitated and funded the agreed implementation of a common cancer data collection system that will be key to the successful implementation of this standard and which will feed Open Exeter. Further work is planned to ensure that radiotherapy department data systems, linked to treatment machines, are fully integrated with overall cancer data flows. The network has agreed with provider and PCT leads to investigate the potential to integrate data collection for cancer waiting times more closely with the 18 Week processes.

Management of Service Delivery

Service delivery will be led by the radiotherapy departments at Queen's Hospital Romford and St Bartholomew's Hospital and supported by existing and well established trust cancer waiting times offices. Providers will monitor performance through the PTL and through extending the current waiting times performance management reports that will be monitored within the Trust, by the PCT Cancer Locality Board and by the Network's Cancer Taskforce.

Action/Initiatives/ New Services Commissioned in 2009/10

The extended waiting times standard for radiotherapy is related to the requirement included in the Operating Framework (Chapter 2 para 39) to increase radiotherapy capacity to the level of 40,000 fractions per million by 2010 as recommended by the National Radiotherapy Advisory Group (NRAG). Further increases are recommended by 2016.

The London Cancer Networks are working together to develop a strategy for the implementation of the NRAG report and a baseline assessment (November 2008) has been undertaken. North East London is currently both significantly below the 40,000 fractions per million level and has a lower percentage of cancer patients receiving radiotherapy (42%) than the level identified by NRAG (52%). The baseline assessment suggests that physical capacity in NEL and London as a whole is probably adequate but that there will be a need for significant increases in the radiotherapy workforce in NEL.

The NRAG report also included recommendations on efficiency of equipment utilisation. The Cancer Network manages a NHS Improvement programme that includes a Service Improvement Facilitator in each provider/PCT locality with Cancer Waiting Times compliance on their work plan. Additionally, the network is prioritising Service Improvement input to the radiotherapy service and is seeking, as part of this, the sessional input of a radiotherapy clinical lead.

Radiotherapy is outside the current scope of Payment By Results and the Network investment priorities approved by PCTs included radiotherapy workforce pump priming (£500,000 for sector) for 2009/10 with the need for further increases in future years.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£185,000		£185,000	£0

Risks to Delivery with Mitigating Actions Planned

Risk: That physical capacity proves to be inadequate. Action: The London baseline assessment suggests that this will not be the case but the emerging strategy will assume that, if necessary, flows can be commissioned across providers to optimise available capacity. Service improvement to be prioritised.

Risk: That workforce capacity proves to be inadequate. Whilst the waiting times standards may well be achieved in the short run, the Operating Framework makes it clear that both waiting times and the numerical standard for the population should be met. Action: The funding included in CSPs should be released to Cancer Centres early to allow recruitment to proceed at an early stage both to meet the challenging timescales and secure scarce workforce resources at a time when other providers may also be recruiting.

1.8 Implementation of the national stroke strategy - VSA14

Objective/Aim (inc. implementation of the National Stroke Strategy and HfL)

Improving stroke care and preventing stroke is a key priority for the PCT and therefore from 2009 all patients who are admitted to the Homerton with a primary diagnosis of stroke will spend at least 90% of their time being treated and cared for in a specialist stroke facility, and people who have had a TIA and who are classified as high risk will be assessed and treated within 24 hours of presenting to local health services.

In terms of prevention of Stroke we aim to improve the detection and prevention of high blood pressure, leading to a reduction in premature death from Heart disease and Stroke (13% increase by 2013). The Vascular Risk Assessment programme will be a key part of this prevention initiative.

Resources have been identified which allow services for local people to meet the standards set out by Healthcare for London and in the National Stroke Strategy.

Trajectory for stroke care 2009/10 (Q4 figure, sign-off criteria is 70%)	2010/11 (Q4 figure, sign-off criteria is 80%)
73.0%	89.0%

Trajectory for TIA cases 2009/10 (Q4 figure, sign-off criteria is 45%)	2010/11 (Q4 figure, sign-off criteria is 60%)
60.0%	73.0%

Latest Performance and forecast outturn

Acute stroke
Q2
Actual = 59.2%
Target = 69.0%
FO = 73.0%

TIA
Q2
Actual = 0.0%
Target = 44.0%
FO = 60.0%

Action to Improve Performance

Data Quality

TIA data collection system in place to begin reporting as of start of Jan 09

Management of Service Delivery

2008/9 saw the largest ever financial investment in stroke and TIA services in City and Hackney (£0.75m; £1m recurrently). As a consequence we now have 3 acute beds and 20 rehabilitation beds. 2 additional stroke beds were planned to be opened during Jan 09, however due to recruitment problems we are due to open in Apr 09.

Action/Initiatives/ New Services Commissioned in 2009/10

The Homerton came out well in the Healthcare for London's designation process, and was chosen as a potential provider of acute stroke care and TIA assessment for the Capital. The designation process continues and this will undoubtedly have longer-term consequences for the service the Homerton currently provides.

The PCT will work closely with providers and the North East London Cardiac and Stroke Network to ensure that local residents continue to have access to high quality care in accordance with the model defined by the designation process, including the proportion of patients who have a brain scan within 24hrs of admission. Across North East London, seven PCTs have come together to establish priorities for collaborative work. This work builds on the success of existing clinical networks. The priorities reflect Healthcare for London themes and areas of particular significance to North East London. The Collaborative Commissioning Initiatives (CCI's) include stroke. The PCT will be an active partner in the consultation across London for stroke services and the designation of hyper-acute centres.

The PCT plans to continue to ensure equitable use and access to its services through its audit programme and routinely monitor against recognised standards for all components of the pathway.

The PCT together with the London Borough of Hackney has invested £97k recurrently for the next three years in expanding community provision, notably a monitoring hub, access to sport and leisure and specific support to the Orthodox Jewish Community. The development and impact of these services will be monitored.

Investment in 09/10 relate to the full year effect of developments commissioned in 08/09.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£361,000		£361,000	£0

Risks to Delivery with Mitigating Actions Planned

Homerton not selected as a provider of services for stroke. Mitigated by strong bid, highly performing hospital, support from the PCT. Delay in designation and consultation re hyper acute stroke services mitigated by active engagement in stroke CCI and HFL consultation.

1.9 Cervical screening test results to be received within 2 weeks - VSA15

(trajectory submission deferred but action plan summary required)

Objective/Aim

City and Hackney PCT is a partner in the North East London cervical cancer screening improvement programme, led by NHS improvement.

The project aims to develop understanding, agreement and implementation of a timed clinically effective pathway to reduce the time from screening to notification of results to two weeks, in line with the cancer reform strategy.

Trajectory for 2009/10

Deferred

2010/11

Deferred

Latest Performance

Provisional quality improvement data applicable to the whole programme population is available for October and November 2008.

Action to Improve Performance

Data Quality

Considerable effort is being put into data collection, quality and reliability. Delays are being quantified across the pathway i.e. from GP practice to lab, from receipt in the lab to registration, from registration to screening; from screening to review, to letter being printed. One early finding is the considerable variation in the delay in sending screening samples to the lab by GP practice (range 0 to 21 days).

The project team is being trained in LEAN methodology (workshop planned for 5th Feb)

Management of Service Delivery

LEAN methodology has been applied to lab process, reducing processing time in the lab from 14 days to 4 days. Changes have also been made to the FHS letter production process.

We are working with primary care to review transportation arrangements of the sample to the lab, and monitoring individual practice performance.

At the end of January, 99% of samples were within the 14 day turnaround time target.

Action/Initiatives/ New Services Commissioned in 2009/10

We are planning various initiatives to increase our cervical screening coverage including a health promotion campaign and working with primary care and community groups.

NHS Shared Business Services (SBS) have taken over the call/recall service as of February 2009. They are moving to transfer data via the Open Exeter programme. However, this should not change the way in which call/recall is run and so this service should still meet QA requirements.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£110,000		£110,000	£0

Risks to Delivery with Mitigating Actions Planned

Engaging GPs to ensure timely transfer of screening samples to the lab: we will develop a local monitoring process, and ensure this is reinforced through contractual mechanisms where possible.

1.10 All-age all-cause mortality - VSB01

Objective/Aim (inc. improving life expectancy, tackling high infant mortality rates, tackling health inequalities, comprehensive prevention services, the Prevention Package for Older People, personalised care plans for people with long term conditions)

Whilst the inequalities gap between Hackney and the rest of the country is narrowing, levels of avoidable death remain high. All age all cause mortality is a top priority in the Hackney LAA.

We will be improving outcomes by improved access to primary care, improved prevention of and treatment for cancer, including smoking cessation, improved management of diabetes, improved identification of and treatment for cardiovascular disease, reductions in levels of obesity, mainstreaming of parts of Reducing Infant Mortality Programme and introducing Health Trainers.

Trajectory for males 2009	2010	2011
770	754	738

Trajectory for females 2009	2010	2011
469	458	447

Latest Performance and forecast outturn

798 for men
492 for women

Action to Improve Performance

Data Quality

Not applicable

Management of Service Delivery

See below

Action/Initiatives/ New Services Commissioned in 2009/10

A number of key objectives in the operating plan support improvements in this area. They include:

Improved access to primary care (see section 1.3)

Improved prevention, treatment and outcomes in cancer, including smoking cessation (see sections 1.4, 1.5, 1.6, 1.7, 1.9, 1.12, 1.13)

Improved identification, treatment and outcomes in diabetes (see section 2.2.2)

Improved identification, treatment and outcomes in cardiovascular disease (see sections 1.8, 1.11, 2.2.1)

Reductions in levels of obesity (see section 1.16)

Reduced infant mortality, including mainstreaming of parts of Reducing Infant Mortality Programme (see section 1.14)

In addition to these initiatives we will have in place a comprehensive programme of Health Trainers, based on the most deprived housing estates, with the aim of improving health for the most disadvantaged people in Hackney and the City.

The spend detailed below includes:-

Specialist commissioning

De-hosting A&E GUM

Hub and London commissioning specialist group

Strengthening commissioning

Social marketing

Telehealth

ISTC

Joint care with social services

Contingency

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£10,820,000	£64,000	£10,820,000	£64,000

Risks to Delivery with Mitigating Actions Planned

Difficulty managing performance in primary care being mitigated through clinical performance committee

Difficulty recruiting to key posts, for example midwives and Health Trainers, mitigated through wide advertising and work on reputation of NHS locally as a good employer

Poor performance on breast screening, being mitigated through new contract with Bart's and the London

Difficulty improving control of blood glucose, blood pressure and cholesterol for diabetic patients, being mitigated against by refresh of the local LES

1.11 Cardiovascular mortality - VSB02

Objective/Aim

Cardiovascular disease remains a major cause of early and avoidable death in City and Hackney. Heart attack, heart failure, hypertension and stroke contribute to high levels of morbidity and poor quality of life associated with long term disability, as well as high service utilisation rates. We want to achieve a significant increase in the early intervention, diagnostic investigation and active management of these diseases. We will work preventatively with those at risk, including targeting men and people who are in higher risk groups due to their race, as well as improving access to secondary prevention.

The PCT has ambitious plans to improve all aspects of local cardiovascular disease detection and management throughout 2009/10. In this category we are including heart disease, stroke and kidney disease.

Trajectory for 2009	2010	2011
98	93	90

Latest Performance and forecast outturn

Calendar year
 2005 = 103.5
 2006 = 117.5
 2007 = 108.9

Action to Improve Performance

Data Quality

2 yr lag so slow to reflect impact of recent interventions, change in population structure, etc

Management of Service Delivery

Action/Initiatives/ New Services Commissioned in 2009/10

The PCT will implement a programme to deliver the Government's plan to offer a vascular check for everyone aged 40-74 once every 5-years, as outlined in the paper "Putting Prevention First", at an annual cost of £1.2m. The introduction of this vascular screening programme will have a significant impact on the local detection rate for hypertension, diabetes and pre-diabetic states, other co-morbidities, and on cardiovascular morbidity and mortality.

The programme requires a systematic call and recall framework in order to ensure that we do not increase local inequalities and we have taken the decision that primary care is best placed to deliver this. There will however be a plurality of providers offering the initial vascular screen, including in the first instance community pharmacists.

The first group of residents to be invited for a screen is a joint targeting of people who are already at significant risk, as defined by their QRISK score (the PCT's risk engine of choice) and those who are already identified as having hypertension (last recorded blood pressure >140/85) but who are not on a hypertension register. This cohort will be identified through a rigorous search of pre-existing patient-level data practice by practice. Additional questions will be asked during the assessment in addition to calculating the QRISK, for example on physical activity and alcohol consumption, and appropriate referrals will be made.

The PCT is commissioning additional capacity within smoking cessation, weight management and exercise on referral services to meet the predicted increased demand generated by the screening. The screening programme will make a positive contribution to our local smoking quit rate.

The programme will be evaluated in partnership with Queen Mary College, University of London. The vascular programme excludes patients with pre-existing cardiovascular disease on the basis that this cohort of patients already receives a structured programme of care, including annual review, etc.

The PCT has identified that there is further scope to improve control of risk factors, such as blood pressure and cholesterol, in hypertensive, cardiac and diabetic patients. The PCT will do this by commissioning a trial primary care based education programme called "HiLo", from Queen Mary College, University of London and through introducing tighter targets on BP and cholesterol control through a new Local Enhanced Service (a "super-QOF").

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£1,520,000	£50,000	£1,520,000	£50,000

Risks to Delivery with Mitigating Actions Planned
The PCT's VRA plan is based on the DH guidance but this is very much work in progress and could well change during the year; the VRA plan is complex and requires recruiting significant numbers of new staff who may not be available due to competing demand from elsewhere in London

1.12 Cancer mortality - VSB03

Objective/Aim

We will continue to take a five pronged approach to reduce premature deaths from cancer:

- Increasing access to and uptake of screening services
- Ensuring timely access to cancer diagnosis and treatment services
- Improving public awareness of symptoms
- Empowering people to present early if they are concerned
- Improving lifestyle choices and supporting behaviour change

Trajectory for 2009	2010	2011
112/ 100,000	107/ 100,000	100/100,000

Latest Performance

130/ 100,000 (data from 2004-2006)

Action to Improve Performance

Data Quality

Not Applicable, ONS Data.

Management of Service Delivery

The PCT remains an active member of the North east London Cancer network, which is chaired by our Chief Executive, and recently appointed both a Public Health Consultant and a Public Health Strategist, who will lead on cancer. An early priority is to develop local clinical leadership and engagement for cancer prevention, screening and treatment services.

Increasing access to and uptake of screening services
See sections on breast, cervical and bowel cancer screening.

Ensuring timely access to cancer diagnosis and treatment services
See sections on cancer waits

We will also be developing links with the Cancer Network's breast cancer inequalities project, currently focusing on reasons for poor survival rates.

Improving public awareness of symptoms and Empowering people to present early if they are concerned

Promotional activities will focus on increasing awareness of the symptoms of cancer and encouraging people to present to their GP if they are concerned. This will be informed by learning from the National Awareness and Early Diagnosis Initiative (DOH), the North East London Cancer Network, and local research.

Improving lifestyle choices and supporting behaviour change

Our health trainer programme will be key to achievement of higher screening rates and cancer prevention. By focusing on the most deprived housing estates health trainers will be able to support

individuals to register with a GP practice, access quit smoking services, take up the offer of screening, and present early with concerns. They will also be able to offer support to communities in achieving a balanced diet and healthy weight.

See sections on smoking and obesity for further detail.

Action/Initiatives/ New Services Commissioned in 2009/10

Please refer to initiatives outlined in other sections of this document.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£277,000	£0	£277,000	£0

Risks to Delivery with Mitigating Actions Planned

Hackney residents may not be registered with a GP, and population turnover on GP lists is also high (25%). Residents may therefore miss out on screening or early signs of cancer: we are currently in the early stages of a project that aims to understand the reasons why people do not register with a GP practice, and establish access through the Homerton, local walk in/urgent care centres and other services.

1.13 Smoking prevalence (indicator is 4-week quitters) - VSB05

Objective/Aim

Our plans for tackling smoking are in four main areas: smoking cessation, smoke free legislation, smoking during pregnancy, working with young people to prevent them starting smoking and GP recording of smoking status.

Smoking cessation forms part of the Team Hackney Local Area Agreement and the City Together Strategy, with the PCT as the lead partner. In partnership, our plans include further extending local stop smoking advice and support in order to reach the 2009/2010 quitters target of 2020.

This will be achieved through further development of the local enhanced service for local pharmacies, commissioning 'Quit' to deliver specialist training sessions for mental health patients and pregnant women who smoke and further targeting of NHS staff and staff of other major local employers and through introducing new initiatives such as text messages to smokers. Smoking cessation is included in the City of London Corporation LAA with a stretch target of helping 1500 additional people to quit by 2010.

We are developing a new publicity strategy that includes undertaking social marketing and focus groups to develop and improve aspects of the delivery of the service. We also plan to increase the number of schools participating in the Hoops for Health Project and smoking awareness training. Working with the Homerton Hospital we aim to encourage 100 people to "Stop before the Op" annually.

Following on from the implementation of the smoke free legislation through the development of a Smoke Free Action Plan for City and Hackney in partnership with London Borough of Hackney and City of London Corporation we plan to set up a Tobacco Alliance to develop on tobacco control strategy for the area. We plan to recruit a co-ordinator specifically to set up the alliance and develop the strategy.

In 2009/10 we will be putting a greater emphasis on working with young people delivering innovative programmes in schools and youth services looking at behavioural interventions to prevent smoking amongst young people working closely with the Healthy Schools team.

Trajectory for 2009/10 (sign-off criteria remains unchanged)	2010/11
2020	2024

Latest Performance and forecast outturn

2008/09 performance quarters 1 & 2 - 431 four week quitters

Forecast outturn – 1500 by 31 March 2009

Action to Improve Performance

Data Quality

Implementation of a web based monitoring system for all Pharmacy practices & GP surgeries so information will be live and can be monitored more regularly

Management of Service Delivery

City & Hackney Tobacco Control Team will manage service delivery. The team includes:
Tobacco Control Programme Manager
2 x Health Improvement Practitioners

Seven key areas of work have been identified:

Supporting GP surgeries to ensure they are targeting smokers on the practice lists particularly those with chronic diseases and referring them into the service.

Increasing referrals into the services through working with partners who provide frontline services such as libraries and leisure centres, the voluntary and community sector as well as other health professionals.

Include information on smoking cessation services in council mail outs to residents

Expanding specialist service provision to GP surgeries and workplaces

Increasing provision of specialist clinics within the community

Implementing an incentive scheme for pregnant mothers

New years and no smoking day campaigns

Action/Initiatives/ New Services Commissioned in 2009/10

In 2009/10 the tobacco control team will broaden the focus from just smoking cessation to include tobacco control. The work programme will include the following new areas of work:

- Development of a tobacco control alliance
- Recruitment of a tobacco control co-ordinator
- Recruitment of a young person lead for tobacco control and smoking cessation and development of a young persons action plan
- Increasing community provision targeting communities identified with a high smoking prevalence
- Increasing provision within mental health settings, working closely with East London Foundation Trust
- Developing a communication and social marketing strategy
- Commissioning of research to increase intelligence on local communities, including smoking prevalence by BME group.
- Developing a smoke free homes programme

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£308,000	£30,000	£308,000	£30,000

Risks to Delivery with Mitigating Actions Planned
<p>As smoking prevalence reduces services are required to work with more dependant smokers making it harder to support people to quit and may mean a slower take up of the service. The proposed research will help inform service development ensuring services are appropriate and suitably targeted. In addition the marketing campaigns run through out the year will increase awareness. Currently work is being carried out to forge stronger partnerships with the Community and Voluntary Sector to ensure they are referring clients where appropriate.</p> <p>Poor engagement from key partners in the development of the Tobacco Alliance Paper recently taken to the Thriving Health Communities Partnership Board for agreement of a local Tobacco Alliance</p> <p>Lack of resources made available for the Tobacco Alliance in the past, so now interventions can be progressed Partner engagement will be key to the success of the Alliance to ensure a range of funding can be sought including mainstream funding as well as external. A key part of the co-ordinators role will be to identify pools of funding.</p>

1.14 Maternity 12-week assessment - VSB06

Objective/Aim (inc. implementation of HfL, service quality, responsiveness and choices of type and place of care, taking account of the need for sufficient workforce)

The aim is to increase the proportion of women needing antenatal care who are assessed before the end of the 12th week.

This is part of our overall developing maternity strategy to improve continuity of care, market services to local women so that they know what is available and can choose what is best for them, assess women's individual needs early, provide more services outside of the hospital setting near to where women live, provide one to one care during labour, provide 60 hours of obstetrician cover on the labour ward at the Homerton, maintain our low rates of infant mortality and excellent performance on smoking at time of delivery and breastfeeding initiation and improve long term maintenance of breastfeeding. We will also deliver the requirements of Maternity Matters in terms of choice, through our emerging Maternity Strategy.

Trajectory for 2009/10	2010/11
80% as of QTR4	90% as of QTR4

Latest Performance and forecast outturn (using new DH denominator: number of women seeing a midwife or maternity professional for assessment of needs at any time in their pregnancy)

Since January 2006, gestational age at booking has been recorded on the discharge form (i.e. post natal) Performance for the latest quarter at the Homerton was 59%. We believe we are on track for 55% at the end of Q4 (green) across all providers.

Action to Improve Performance

Data Quality

Data on this indicator is made available by the Homerton Hospital on a monthly basis. Homerton Hospital account for 80% of deliveries for City and Hackney women with the remaining 20% predominantly occurring at the Royal London, UCLH, Whittington, Guys and St Thomas's and North Middlesex. Data will need to be obtained from each of these providers as is currently the case for breastfeeding initiation and smoking at time of delivery.

Management of Service Delivery

The locality has already put in place a system of providing information about maternity services when people purchase pregnancy tests from pharmacies.

In 09/10 we will improve our marketing of maternity services through a website with information about how to improve health during pregnancy, where services can be accessed including antenatal care, parenting classes, choice of place to deliver and postnatal care and breastfeeding support, in addition to other publicity.

In 08/9 the PCT funded an additional eight community midwives and a system of a named midwife for every GP practice was introduced. The midwives working in community were also organised into teams covering specific geographical areas, making it clear who would be covering each GP practice when the named midwife was away.

A telephone helpline has been introduced allowing women to speak directly to a midwife for advice. This has been well evaluated and there has been a reduction in N12 admissions, to which this is thought to have contributed.

The LES with primary care is supporting early booking and therefore health and social care assessment at an early stage of pregnancy. A new assessment of need of individual women has also been devised locally as part of a review of community maternity system and this will be implemented during 09/10. Every GP practice now has a named midwife to improve continuity of care.

A comprehensive maternity strategy is being developed in collaboration between the PCT, practice based commissioners and through work with the Homerton Hospital.

Homerton hospital has an antenatal screening coordinator in post. They are undertaking audits including on communicable diseases. A steering group oversees the work, there is also a guideline in place for bloodspot screening and a steering group is working on meeting the new standards. Six monthly training takes place for health visitors and midwives.

Action/Initiatives/ New Services Commissioned in 2009/10

Significant additional investment has been planned in 09/10 and 10/11 to support the delivery of 'Maternity Matters' standards. The impact of HRG4 (published in February) is being modelled through as part of the contract negotiation process with providers. The PCT planned financial commitment will be maintained within the overall financial envelope.

In 09/10 we will be commissioning, 11 additional midwives, three administrators to relieve midwives of some of the administrative duties which they are currently undertaking, an additional obstetrician, a specialist midwife for mental health issues and administrative support for this post and to facilitate smooth referral processes, a community maternity centre to provide a wider range of services outside of the Homerton Hospital and a programme of marketing of maternity services, including the website detailed above. We will also be addressing standards for 1-1 care in labour and 24hr consultant obstetric cover.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£2,112,000	£0	£2,112,000	£0

Risks to Delivery with Mitigating Actions Planned

Inability to recruit suitable staff, will be mitigated against by wide advertising of posts.

1.15 Teenage conceptions - VSB08

Objective/Aim

The Teenage Pregnancy Partnership has achieved a great deal of progress in reducing teenage conceptions; however, it is important to consolidate these achievements and to strengthen and refine the local strategy in order to maintain low teenage pregnancy rates and to better target interventions to reach high risk groups to be able to achieve the ambitious stretched target.

Trajectory for 2009	2010 (PCTs have set targets)	2011
37	31	31

Latest Performance

The anticipated performance relating to the year 2007 is 52/1000. The rolling average (calculated as the average of the latest 4 quarters) helps to see the underlying trend by smoothing out fluctuations which are likely to occur when looking at relatively small numbers; Hackney's conception rate for quarter 3 of 2006 was unusually low (lower in fact, than the national rate for that quarter) and it was followed by an unusually high spike in quarter 4. Consequently the current (2007) Q3 rolling average has taken a sharper upward turn (62.6), since it doesn't include the exceptionally low rate of Q3 in 2006 but includes the exceptionally high rate of Q4. If we assume that the exceptionally high rate of 2006 Q4 is linked in some way to the very low rate in the preceding Q3, we do not anticipate such an atypically high spike in Q4 of 2007. If this assumption is correct we would expect the rolling average to come down again in Q4. The latest data shows the PCT has achieved a 27.7% reduction against the 1998 baseline.

Action to Improve Performance

Data Quality

The data regarding teenage conception rates is produced by the Office for National Statistics (ONS), released around 14 months **after** the period to which they relate. In other words, the current data that will be released by ONS in Feb-March 2009, relates to the **calendar year** (as opposed to fiscal year) of 2007. Thus, paradoxically all current teenage pregnancy strategy and performance are framed in historical data, not real-time data.

To address this gap, a predictive tool is being developed with support from the CHtPCT Health Intelligence Unit, to provide an indication of the likely current teenage conception rates for the current calendar year, to mitigate the effects of the 14 month time-lag, while addressing current measures.

Management of Service Delivery

The Teenage Pregnancy Partnership will run a partners' away day in February 09 to assess progress so far and to benchmark the programme against the recommendations from DCFS as to what constitutes an effective local programme (see key headings below). The away day will also allow us to identify opportunities to maximise impact at all levels considering synergies and elements of economy, efficiency and effectiveness. We will also conduct a health equity audit of teenage conceptions early in 2009. This work will influence the commissioning of the local teenage pregnancy programme for 09/10 as part of the Local Area Agreement arrangements, led by Team Hackney and supported by the Teenage Pregnancy Coordinator based in the PCT.

Engagement of delivery partners Committed to actively engage all the key mainstream delivery partners who have a role in reducing teenage pregnancies (health, education, social services, youth support services, and the voluntary sector) and encourage collaboration and participation.

Selection of a senior champion The CHPCT TP Partnership has strong senior leadership from the Learning Trust and the PCT who are champions for the local strategy and take the lead in implementing it.

Effective sexual health advice service The TP coordinator works closely with the local Sexual Health Management Group to ensure the availability of well-publicised contraceptive and sexual health advice services centred on young people. We will continue to support the work towards reducing second terminations and promoting LARC uptake through, in particular, contract performance relationships with community sexual health services for adults and adolescents. The development of the SHO-me (Sexual Health Online) website and the SHO-me bus have supported health promotion work, as well as delivering reactive services.

Prioritisation of sex and relationships education The inclusion of PSHE in the school's curricula will help us intensify sex and relationships education (SRE) provision in all schools, with support from the local authority to develop comprehensive programmes.

Focus on targeted interventions In order to further reduce TP rates we will have a strong focus on targeted interventions with young people at greatest risk such as looked-after children.

Training on SRE for partner organisations We also support SRE training for professionals in partner organisations who work with vulnerable young people, such as Connexions personal advisers, youth workers and social workers.

Well-resourced youth service Collaboration with the local authority in providing young people with things to do and places to go, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

Action/Initiatives/ New Services Commissioned in 2009/10

The launch of the SHO-me website (Sexual Health Online for North East London) in Dec 08 aimed at improving access to up to date information on sexual health and local services including sexual health, support and family planning services, condom distribution and pharmacies providing emergency contraception.

SHO-me mobile unit toured City and Hackney during Nov/Dec 08, providing information on sexual health and family planning services to more than 3,300 people. The unit also provided Chlamydia and HIV testing, condom distribution and outreach services. We targeted local Colleges and at risk groups. The mobile unit will be visiting colleges again in Feb 09.
Evaluation of the Teenage Pregnancy Partnership.

Teenage Pregnancy equity audit.

Targeted interventions. Our local teenage health service will continue providing outreach services to the Youth Offending Team, including sexual health services. After termination of pregnancy more than 30% of women will take up LARC. Our primary care LES for contraception will also be used to increase LARC uptake and a target is being negotiated with the community sexual health provider.

Financial planning includes sufficient investment in 0809, no new additional spend in 0910 other than activity requirements (capacity plan).

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
No Funding Allocated	No Funding Allocated	No Funding Allocated	No Funding Allocated

Risks to Delivery with Mitigating Actions Planned
<p>Competing commissioning priorities within LAA process - the TP Partnership has already started discussion with LAA to ensure continuing support.</p> <p>The CHPCT stretched target for TP is very ambitious – it is therefore relevant to consolidate achievements to maintain low rates and better target future interventions to further reduce the TP rates.</p>

1.16 Childhood obesity - VSB09

Objective/Aim

The 2008 Joint Strategic Needs Assessment shows that local children are some of the most overweight in the country. This is disturbing because being overweight can limit their fun as children and can be the start of long term health problems as they get older. Hackney also has a higher than average number of overweight adults. Helping residents reach a healthy weight is a priority for the NHS, Hackney Council and other local agencies and we are currently refreshing the current City and Hackney Obesity Strategy.

City and Hackney Primary care Trust, Hackney Council and Corporation of London provides and commissions numerous services which seek to promote healthy weight, including the provision of information as well as leisure and cultural opportunities for local people to be more active. In addition, local health services provide dietary advice and support for overweight individuals. There is huge potential in capturing local enthusiasm about the 2012 games.

Our aim is to reduce childhood obesity in line with government's aims – halting the year on year rise.

Trajectory for reception year 2009/10 (DH issued guidance in Feb. '08 on target setting, requiring an increase of less than 0.5%, no increase, or a reduction in obesity, for each PCT) (with % completeness, which should be at least 85%)	2010/11 (DH issued guidance in Feb. '08 on target setting, requiring an increase of less than 0.5%, no increase, or a reduction in obesity, for each PCT) (with % completeness, which should be at least 85%)
Percentage recorded 90% Percentage who are obese 15%	Percentage recorded 90% Percentage who are obese 15%

Trajectory for year 6 2009/10 (DH issued guidance in Feb. '08 on target setting, requiring an increase of less than 0.5%, no increase, or a reduction in obesity, for each PCT) (with % completeness, which should be at least 85%)	2010/11 (DH issued guidance in Feb. '08 on target setting, requiring an increase of less than 0.5%, no increase, or a reduction in obesity, for each PCT) (with % completeness, which should be at least 85%)
Percentage recorded 90.0% Percentage who are obese 24.2%	Percentage recorded 90.0% Percentage who are obese 24%

Latest Performance

In 2008/2009 we have taken numerous steps to improve our performance. These have included:

Promoting opportunities for healthy living. Healthy Lifestyles, a family based multidisciplinary intervention to support 7-13 year olds to lose weight was mainstreamed and expanded to increase capacity and accessibility. Exit routes for this service were commissioned to support ongoing physical activity among families graduating from the scheme. A service for under-7's was delivered through children centres supporting prevention and reduction in obesity among pre-school children. We also saw developments in relation to support relating to maternal and infant nutrition, principally through the development of HENRY programme. We are also working jointly with the adolescent health service.

Services supporting obesity prevention have been funded. These include Fitness Fun which provides low cost physical activity opportunities to parents and their children linked to schools, and Hoops4Health which offers introductory basketball sessions and key health messages linked to diet and exercise and smoking. Additional services with psychology, dietetic and paediatric input, based in Children and Families, have also been funded.

Social marketing. Also linked to prevention the social marketing campaign – *fit chance* - started in 2007/08 and continued and in addition to the web resource events and promotional were delivered throughout the year supporting behaviour change linked to improved diet and physical activity. This work is being reviewed in line with recommendations from department of health and the new national campaign. The website will incorporate the Change4life marketing initiative.

Healthy lifestyles. Keeping healthy has many aspects, important are eating foods that are good for you and exercising regularly, but does everyone in Hackney know where to go to get these foods and be active? We are creating maps of a selection of Hackney neighbourhoods to help people discover local opportunities to get active and eat well. Each map will contain short descriptions of opportunities in easy walking distance from home. The Shoreditch Trust is helping us develop these maps; they have considerable experience of making similar resources.

Parks and green spaces. We have funded a large scale consultation about the use of parks and green spaces locally. Hackney has more parks and open green spaces than any other London borough. Parks are places to get fit, play games, spend time with your family, connect with friends or just escape to walk alone. We are curious about the impact of our parks on local people and curious about the reasons why some people in City and Hackney are not using our parks more regularly. We want to find out what Hackney Council, the NHS, the police and other local partners can do to improve the parks, and what would attract more people. The consultation is also focusing on playgrounds.

Engaging local people. We know that there are people who live locally who are keen to work with their neighbours to help them attain a healthy weight. We have commissioned the Shoreditch Spa to work on a pilot project to train local enthusiasts to work with their neighbours to be active and eat well! This might include organising football matches for young people or initiating walks for older residents. We will watch closely to see if these local enthusiasts are able to motivate people. We will be working on the Woodberry Down and Fellowes Court Estates in Hackney. If the initiative works we will make the case for future investment in other areas.

Capital investment in local estates. Some of our most deprived estates have halls with community kitchens and spaces where people can meet and be active. We have had a look at them and decided they need a makeover. We have refurbished 10 halls in 2008/9 – a further ten will be refurbished in 2009/10 - so that people can be trained to cook well and have opportunities to be active, such as tai chi or tea dancing. This work is being managed by the Shoreditch Trust and is an innovative partnership between Hackney Homes, City and Hackney Primary Care Trust and local Tenants' and Residents' Associations. Our Health Trainers who will support people to be more active will work in these halls to motivate local residents.

Healthy eating. We value the diversity of the population in Hackney and recognise that the food that various communities bring is part of our local heritage. We have commissioned a number of organisations to work with local communities, including African Caribbean older people and the Charedi community, to understand how we can make appropriate interventions to promote their health. The consultations will build relationships with these communities.

Community consultation. City and Hackney Primary Care Trust and Hackney Council will host a community consultation event on Saturday 31st January 2009 to hear local people's views about what needs to happen to help them attain a healthy weight.

Action to Improve Performance

Data Quality

Childhood height/weight monitoring - Data has been collected for the past two years. However performance in 2005/06 was poor with only 28% of reception and year 6 children being measured, therefore baseline data from 2005/06 is not reliable. The performance for this target in 2006/07 was excellent – 95% of children were measured, exceeding the 80% target; City & Hackney PCT was the highest performer in London for Year 6 and the 3rd highest performer for Reception last year.

2007/8, Prevalence figures suggested that City & Hackney PCT has one of the highest prevalence of obesity in London; 16% of reception year children and 24% of children in year 6 were found to be obese in 2006/07.

Coverage fell slightly in 2007-8. According to data collection based on current school rolls, coverage for reception was 93% and for Year 6 was 91%. However, these changed to 95% and 82% respectively according to the DH data base. (Target was 88%) This change in Year 6 appears to be due to a falsely inflated denominator on the DH list.

The Learning Trust is working closely with the PCT to inform trajectory setting to 2020. School nurses will continue to be supported to ensure City & Hackney PCT maintains high levels of height and weight monitoring. (See data tables above).

We are fortunate that the Health in Hackney Scrutiny Commission, under the leadership of Cllr Jonathon McShane, is undertaking a significant piece of work scrutinising childhood obesity services, which will provide crucial intelligence for the refreshed City and Hackney Healthy Weight Strategy.

Management of Service Delivery

We are currently reviewing the City and Hackney Obesity strategy. The new strategy which addresses healthy weight in a comprehensive way will be completed by 04/2009. It will include maternal obesity and breastfeeding initiatives. Its purpose is to identify what parts of the system, including the NHS and each directorate of the two local authorities will do to reduce childhood obesity. The PCT is providing leadership in this regard.

Proposals are being finalised to change the governance of implementing the refreshed strategy. Notably, the PCT is establishing a multi agency partnership to address childhood obesity. Its first task will be to define a care pathway for the management of childhood obesity which will focus on prevention through to management of weight related conditions as well as to review and co-ordinate existing and proposed initiatives. The Childhood Obesity Group will feed in to the Child Health Board and the Children and Young People's Partnership boards, ensuring a wholly systematic and integrated approach.

Action/Initiatives/ New Services Commissioned in 2009/10

Building strategy. Before we begin to set ambitious plans for the future, we need to stop and look at what we have achieved to date, test out what has worked and what has not, and decide how we will measure success in the future. We will develop a list of what is going on and where opportunities are for future developments. University of East London and Continuum Leisure will help us with this work. Both organisations have a wealth of experience in this regard.

Securing leadership. In May 2008, the childhood Obesity National Support Team visited City and Hackney and noted that whilst there were lots of projects underway, there was little sustained leadership from across the system. We have enlisted the support of senior figures from across the

NHS, Hackney Council, the Corporation of London and the local voluntary and community sector to take ownership of the new strategy and ensure implementation. Through a series of events a set of key priorities for action are being established. Hackney Councilors Nargis Khan, Rita Krishna and Sharron Patrick are engaged in the process and are shaping the forthcoming Strategy, providing political leadership.

Clinical interventions to manage obesity. Resources are secured to expand clinical interventions to manage obesity, including the provision of specialist professional input, for example psychologists, nurses, dietetics and OT support. The work will have educational and psychological support elements. The choice of provider will depend on how the proposals fit in the care pathway that will be developed early in 2009. Work to develop the care pathways which will be completed in February 2009 will determine the exact form of the interventions - a competitive process will determine the provider.

Under 18s free swimming. Currently London Borough of Hackney provides free swimming facilities for all under 16s. It is proposed this scheme be extended to encompass the 16-18 years age group. This will be an important initiative in widening participation in physical activity, especially for local young people who find cost a barrier. It will become an important aspect of our programme to achieve healthy weight.

Personal Best programme. Team Hackney, in collaboration with the Hackney 2012 unit, currently funds a Personal Best programme in 10 primary and 3 special schools throughout Hackney, with plans to extend this substantially. The programme facilitates increased physical activity in schools, as a part of which it provides prizes to those children most successful in achieving their own personal bests. We wish to fund the expansion of this scheme. It rewards pupils who have made improvements in relation to their own abilities, and does not reward the highest performing, but the most improved. Each year the Mayor hosts an award ceremony to mark local sporting achievements for young people. There are prizes given from other agencies in addition to the mayor's categories, including the Learning Trust and the Schools Sports Partnership, and it is proposed, as part of this, that the PCT provide funding for an additional prize to link to the personal best programme.

Nursery Fruit Scheme. Currently funded by Team Hackney, this scheme provides free fruit to 9 children's centres across Hackney, representing a total of 583 children daily, with plans to increase this to 12 centres in the near future. In addition, it provides healthy eating and oral health sessions for children aged 3-5 years, receiving excellent feedback from nursery staff and parents. Team Hackney's funding of the project is due to come to an end and funding is secured for the continuation of this valuable scheme. We are confident that it makes an important contribution to improving the diet of local children.

Healthy Weight Volunteers. In 2008/9 a Healthy Weight Volunteer pilot programme is established, provided by Shoreditch Spa. They recruit local residents as volunteers to act as trainers for other local residents in aspects of physical activity and healthy eating. In addition to the more obvious obesity-related health benefits, this provides training opportunities for the volunteers, thereby facilitating potential pathways to employment. Funding is secured to extend this programme beyond the initial pilot period. It will have considerable benefits for local people and be an important piece of our programme to develop estate based health improvement programmes.

Inclusive sports activities. We are reviewing our current commissioning of numerous healthy lifestyle related projects provided by voluntary sector providers. In 2009/10 several initiatives are proposed to promote inclusive sports activities for diverse communities, including working with existing providers such as Sunshine club, Shel, Hoop La Las, a school based hoola hooping project, New Age Games, an older people's sports programme, and the development of a wheelchair basketball club in partnership with Hackney Sparrows. This will play an important role in ensuring inclusive physical activity initiatives for all members of City and Hackney's population.

Hackney Marshes Sports Development. Funding is secured for much needed refurbishment of changing facilities at the Hackney Marshes Sports Development in order to promote their use, and

thus participation of the local community in physical activity. This is to complement investment by the London Borough of Hackney and the Football Association, to develop the sports and physical activity potential of the area. The provision will be a hub for health trainer activity, so investment will be beneficial to the PCT in many ways.

Free school meals for primary schools. We have secured funding to contribute to a universal free school meals scheme for primary schools. However, the exact nature of this scheme is yet to be defined because of operational issues to be resolved with the learning trust and schools.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£1,051,000	£610,000	£1,051,000	£610,000

Risks to Delivery with Mitigating Actions Planned

The Refreshed strategy will be complete in April; this assumes that its recommendations are adopted by partners. As the process of strategy development has been highly participatory it is unlikely that this will arise.

Being able to secure joint funding from the Learning Trust and successfully engage schools are crucial in delivering our plans for providing free school meals for all primary school children. Constant dialogue is addressing this issue.

Parents deciding to opt out of the healthy weight monitoring programme.

1.17 Immunisation – VSB10

Objective/Aim

Increasing immunisation uptake is a high priority in CHPCT. We will continue to seek a solution to the difficulties with our child health information system and seek alternative way for reporting more accurate COVER statistics. We will also benchmark ourselves against other London PCTs to ensure we are able to identify any example of good practice and will work closely with Local Authority services such as libraries to continue to publicise widely the availability of childhood immunization. The Human Papilloma Virus (HPV) immunisation school based programme for 12-13 year old girls commenced on the 30th September 08; by December 08 a total of 808 girls had received the 1st HPV dose (out of 1350 girls). All LEA schools gave consent for the programme to be conducted on the school premises, while the only independent school who agreed for the programme to go ahead was City of London Girls school. No girls have been immunised from the remaining 10 independent schools. A school nurse to support immunisation in Orthodox Jewish schools was appointed in Dec 08.

Trajectories for 2009/10

(good performance is 95% for 3 doses for diphtheria, tetanus, polio and pertussis at year 1, 95% for first dose for MMR at year 2, 90% for the tetanus, diphtheria and polio booster between ages 13-18. For the HPV vaccine 90% of girls aged 12-13)

VSB10_03 - 80%
 VSB10_09 - 80%
 VSB10_10 - 80%
 VSB10_14 - 80%
 VSB10_15 - 80%
 VSB10_18 - 70%
 VSB10_21 - 75%

2010/11

(good performance is 95% for 3 doses for diphtheria, tetanus, polio and pertussis at year 1, 95% for first dose for MMR at year 2, 90% for the tetanus, diphtheria and polio booster between ages 13-18. For the HPV vaccine 90% of girls aged 12-13)

VSB10_03 - 90%
 VSB10_09 - 85%
 VSB10_10 - 90%
 VSB10_14 - 90%
 VSB10_15 - 90%
 VSB10_18 - 75%
 VSB10_21 - 85%

Latest Performance and forecast outturn

A concerted exercise to clean data derived from CHIA allowed us to identify a more accurate picture of the immunisation situation in Q2; the uptake of diphtheria, pertussis, tetanus, polio and Hib at year 5 was 80%, MenC was 83% and MMR was 68%; MMR uptake at 24 months was 66%; the data is still not reliable and it is likely to under-represent actual figures.

Action to Improve Performance

Data Quality

City and Hackney PCT continue experiencing difficulties in the availability and accuracy of childhood immunisation data from the Child health interim application (CHIA) system. CHIA is still unable to provide accurate data, produce up to date target lists or to support appointing children for immunisations at practice level. We are now able to clean data from CHIA and have been producing a defaulters list by practice since November 08. These lists are not completely accurate due to the problems with CHIA; however, we aim to support practices to write letters to parents of un-immunised children inviting them to attend primary care. We are also working with primary care to ensure all

practices use standardised READ codes in order to improve the quality of immunisation data available from primary care. The roll out of the RiO programme is being delayed and it is not clear if RiO will have all the functions required to support childhood immunisations. Issues related to GP access to the HPI (Health Protection Informatics) system for collecting data from Primary Care on immunisations of 17 year olds.

Management of Service Delivery

Immunisations in City and Hackney are provided in most GP surgeries, child health clinics, Children Centres, nurseries and schools and in some community settings such as Hackney Family Centre. Many healthcare professionals (health visitors, community nursing teams, school nurses, GPs and paediatricians) provide advice and information to parents about immunisation; a range of written materials in many different languages is also available.

The development of six children's centres will support integrated services for children offering universal services as well as targeted support, including for looked after and gypsy and traveller children. The Hackney ARK children's centre opened in March 08 supporting children with disability. This centre will improve integration of multi agency support for disabled children and we are further increasing services to improve life chances of disabled children.

All parents receive a personal child health record which includes information on the immunisation programme. Health visitors and community nurses visit all new families within 21 days of birth and parents are reminded about immunisation and advised on where this can be given. Where GPs are able to use electronic databases to call children for immunisation they are encouraged to do so. Immunisation status is checked at every contact with a health professional, including through the use of questionnaires sent to parents when their child enters school.

The Measles outbreak (May to Dec 07) has been contained and weekly figures in the second half of 2008 have remained similar or lower than the average for NEL PCTs. The awareness and publicity campaigns as well as offering opportunistic immunisation have continued.

Action/Initiatives/ New Services Commissioned in 2009/10

Monthly reports from the CHIA system are being cleaned and data on children missing immunisations by GP practice is sent to GPs monthly to support primary care calling in children who have missed their immunisations; GPs are also requested to provide data on already immunised children not included in CHIA to improve the quality of the data;
 Standardisation of READ codes for immunisations in primary care;
 Primary care LES to support MMR catch up and 17 year olds HPV immunisation;
 School Nurse for the Orthodox Jewish community to support immunisations in general and also HPV in this group.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£125,000		£125,000	£0

Risks to Delivery with Mitigating Actions Planned

Failure to engage the Rabbinate to endorse HPV administration to Orthodox Jewish girls
 Further delays in the implementation of RiO

1.18 Breastfeeding at 6-8 weeks - VSB11

Objective/Aim

Increase the proportion of women who are breastfeeding at 6-8 weeks, this will contribute to improving the life chances of children by improving maternity services and achieving a 2% reduction in childhood obesity by 2013.

Breastfeeding is prioritised within the CSP and includes specific support for continuation of breastfeeding. Health visiting teams and GPs are aware of the requirement to collect these data and will continue to do so using the Red Book forms.

Trajectory for 2009/10	2010/11
55% as of QTR4	60% as of QTR4

Trajectory for 2009/10 (inc. % data coverage, which should be at least 90%)	2010/11 (inc. % data coverage, which should be at least 95%)
90%	95%

Latest Performance and forecast for Q4

City and Hackney is not a pilot site for the breast screening extension to provide nine screening rounds between 47 and 73 years.

Our coverage target for 2008/9 is 58%, which we plan to achieve. Data from the last screening round in City and Hackney (summer 2008) is not yet available, and we hope that screening coverage will be further improved through a DNA project recalling women from the South of the Borough to mobile screening unit in Mile End. 47% coverage. FOT 85%

Action to Improve Performance

Data Quality

Data is recorded manually by Health Visitors in the Red Book and a tear-out page is sent to Child Health which includes breastfeeding info (breastfeeding totally/partially/not at all at time of review). Some 6-8 week checks are carried out by GPs, however key pieces of information such as date of birth, postcode, name and NHS number are missing on a significant number of the tear-out pages and delays in returns of the pages are significant. To increase returns of the tear-out pages from the Red Book, GPs and Health Visitors are contacted and reminded about the importance of this target. Data is being entered into CHIA by the Child Health Team but there is a constant backlog of this information as the priority for Child Health is focusing on immunisation data entry and cleansing in preparation for migration to RiO. In addition, data cannot be extracted from CHIA as it does not have a working reporting function, so it is not possible to establish baseline figures or estimate data quality. To ensure data for this PSA target is collated and submitted for each quarter, a Children Centre Information Assistant is currently tasked with the manual entering of data into a separate database. Although the database is up and running there is a current backlog of forms to be entered. A new staff member from the Child Health Team is therefore helping the Children Centre Information Assistant with the data entry and extraction.

Management of Service Delivery

A Breastfeeding Coordinator for CHPCT has been in post since September 2008. The Breastfeeding Coordinator's role is to provide leadership, support and advice to both professionals and the public; advise and coordination in relation to breastfeeding promotion and support for mothers and their families. She leads on the development of strategies working towards achieving PCT targets in relation to both the initiation and continuation of breastfeeding.

A multidisciplinary Breastfeeding Steering Group was formed in September 2008. The group meets quarterly and strengthen the work with Midwifery at Homerton Hospital and others involved locally in promoting and supporting sustainable breastfeeding. The group also oversees and supports the work of the Breastfeeding Coordinator. The group reports to the Children Health Board and the Maternity Services Strategy Group and work in conjunction with the Homerton Breastfeeding Steering Group.

Action/Initiatives/ New Services Commissioned in 2009/10

Breastfeeding Week which will take place during 11-17 May 2009.

In order to improve data quality, the Breastfeeding Steering Group (see further information about the Breastfeeding Steering Group under 'Management of Service Delivery') is exploring a variety of short and long term options:

Making Health Visiting Teams and GPs aware of the requirements to collect this data using the Red Book Forms and the need to prioritise the return of this data to the Child Health Team

Reducing the backlog of data imputing into CHIA and improving its reporting functions by having a designated person who specifically extracts and cleans the data

Maintaining a separate database until CHIA is more reliable and/or until RiO is implemented and confirmed to be 100% accurate

Look at what other PCT's that are obtaining good coverage are doing and learn from them considering new systems to be created to help with the data collection and meet targets on coverage, such as the possibility of using EMIS (a GP data system)

We will work through the Breastfeeding Steering Group and Breastfeeding Coordinator to maximise continuation, including increased training of professionals, more support groups for example in the soon to open Shoreditch Maternity Centre and Breastfeeding Friendly Status for all Children's Centres.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£10,000		£10,000	£0

Risks to Delivery with Mitigating Actions Planned

Delays in RiO implementation or that RiO is unable to support data collection for this indicator once implemented. In addition, data extracted from RiO may not be 100% accurate. The collection of the 6-8 week review data has been raised at the regional RiO Users Group but it is not yet clear yet if RiO will support the collection of data for this indicator. Clarification has been requested regarding the capabilities of RiO in relation to supporting this indicator.

Mitigating actions to minimise this risk are currently explored by the Breastfeeding Steering Group; we have developed a separate database of the 6-8 week data. This database is compared with the data on CHIA at the end of each quarter.

1.19 Effectiveness of CAMHS - VSB12

Objective/Aim

The CAMHS Plan 2008-11 has been agreed across the Multi – agency CAMHS Partnership. The main aims and objectives of the Plan are:

- a) To promote effective earlier intervention by identifying vulnerable children and young people and using effective interventions
- b) To provide high quality CAMHS Services based on best available evidence and NICE guidelines
- c) To improve access to CAMHS Services through clearer pathways and more accessible service delivery in a wide range of settings
- d) To Improve efficiency and Value For Money of services.

To help achieve these aims and objectives it is required to improve the Skills of the Work Force and to ensure children and young people are seen quickly by those with the requisite skills to meet their needs. The achievement of these aims and objectives will be subject to rigorous performance management scrutiny with explicit target for achieving timely service delivering good quality services to the maximum possible number of people to improve outcomes for users and to have high user satisfaction ratings

This will:

- Facilitate the achievement of the PSA target, and the implementation of the children's NSF standard.
- Facilitate the achievement of NI 51 particularly the proxy indicator concerning jointly commissioned early interventions in universal and targeted settings.
- Enable earlier identification of vulnerable children and young people and the provision of timely assessments and effective interventions for this group in a wide range of settings.
- Increase involvement with 16-25 year olds, particularly those at risk of social exclusion
- facilitate seam-free transitions to adult mental health services

Trajectory for 2009/10 (just note any services below level 4)	2010/11 (just note any services below level 4)
All the 4 Proxy Indicators in NI 51 will be assessed at 4/4 for 2009/10. This is an improvement on the self assessed score for 2008/9 where the Proxy indicators about CAMHS for children and young people with Learning disabilities was scored at 3/4	None

Latest Performance and forecast outturn (for each of the four requirements)

The performance and forecast outturns for 2009/10 are 4/4 for all proxy indicators

Action to Improve Performance

Data Quality

Further work has been done to improve the collection of data to measure the Performance of CAMHS across the CAMHS Multi-agency Partnership. This has resulted in a refined Performance Template which highlights key performance indicators across number receiving services, timeliness of these services , extent of improved outcomes for service users and user satisfaction rating

Management of Service Delivery

The performance of CAMHS across the partnership is monitored through the CAMHS Quarterly Performance Report. This records performance about the number of children & young people seen, how quickly they were seen , did the services improve outcomes for children and were they satisfied with the service.

It is proposed that there will be regular meetings between Commissioning Section and the full range of Providers of CAMHS services to review Performance and to agree any action that may be required to meet targets set

Action/Initiatives/ New Services Commissioned in 2009/10

Consolidation of the new services commissioned in 2008/9 is underway with the main areas of investment being in a) CAMHS Disability Service b) Outreach Youth Service & c) Early intervention service located in Children's Centres, GP surgeries and nurseries. These new services are now fully staffed and are moving well towards meeting the targets set during 2008/9. Further work is needed to keep the consolidation process moving forward, but performance reports about CAMHS Disability and early interventions in GP's surgeries are showing significant reduction in waiting times and improved outcomes. The Youth Service initiative is fully established and is now making progress.

New Initiatives Commissioned in 2009/10

Improved Paediatric Liaison Project aims to ensure that Paediatric and A&E Staff in Homerton Hospital have support to provide interventions from CAMHS specialist staff and to offer advice and consultation and clear care pathways advice to hospital staff there will also be a training role for hospital staff re CAMHS.

Commission Research project into the low take up of CAMHS preventative and support services for young people from Black African/ Caribbean Communities with a view to commissioning services that will be more accessible and useful for these groups.

Extend CAMHS to provide services to groups of young people up to 25 where it is appropriate to continue services particularly where there may be no equivalent Adult services.

Family Nurse Partnership to provide intensive support following birth and early infancy to vulnerable mothers and their babies

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£157,000	£90,000	£157,000	£90,000

Risks to Delivery with Mitigating Actions Planned

Recruitment difficulties may delay project , but recruitment plan is to include offering opportunities for existing staff to increase sessions

Research Spec needs to be agreed across partnership and then risk that no suitable research organisation bids. Try to ensure appropriate research organisations are informed of project.

1.20 Chlamydia screening - VSB13

Objective/Aim

Although the local Chlamydia screening programme was only rolled out in City and Hackney PCT in February 07, CHPCT is now one of the best performing PCTs in London. In 08/09 we are on target to screen 17% of our 15 to 24 year olds. We have also maintained high positivity rates at approximately 9%.

Trajectory for 2009/10

(DH sign-off criteria is 25%)

25%

2010/11

(DH sign-off criteria is 35%)

35%

Latest Performance and forecast outturn

Screening Figures for Q2 2008 **1142** counted (*1540 submitted*), 3.9% of the target population (compares well with the average London PCT figures of 2.2% and 2.4% and the national average of 1.8% and 2%).

For Q1 we had **1110 screens** counted, (*1430 submitted*), 3.8% of our estimated total target (15-24yr) population.

Action to Improve Performance

Data Quality

Working to improve performance on time between the tests and when the patient receives the results, which will reduce the “unknowns” on data returns.

Management of Service Delivery

Chlamydia screening is widely available in Hackney and the City including through primary care (Local Enhanced Service) and local pharmacies.

Screening is also provided at all Community Sexual Health Services.

Within hospital services CHPCT is supporting Chlamydia screening at termination of pregnancy services at Homerton Hospital and promoting opportunistic Chlamydia screening at all acute contacts with young people including A&E services.

A social marketing campaign promoting uptake of the test by young people has also been developed; it has included redesigning the test's packs and all publicity materials to make them more appealing to young people.

The Chlamydia Screening Coordinator supports Chlamydia screening and training and produces a monthly newsletter for primary care and pharmacies enrolled in the LES.

Action/Initiatives/ New Services Commissioned in 2009/10

Revise specifications of the Chlamydia screening local enhanced service in primary care and introduce incentives to practices that achieve 20% and 25% screening of their registered under 25 year old population.

Continue supporting the local enhanced service with local pharmacies.

City and Hackney PCT has developed a new website for the North East Sector called SHO-Me (Sexual Health Online) which will be publicised widely. We will monitor hits on the website to determine use of it. One of the services publicised on it will be the availability of Chlamydia screening for young people.

Work with the Condom Distribution Scheme. Outreach activities include Chlamydia screening worker to work closely with condom distribution points and other community and non-health settings, promoting uptake of Chlamydia screening. Outreach work at Hackney Community College.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
No funding allocated – Included in the capacity plan	No funding allocated – Included in the capacity plan	No funding allocated – Included in the capacity plan	No funding allocated – Included in the capacity plan

Risks to Delivery with Mitigating Actions Planned
Large number of inhibitory results – working with the laboratory to understand the root cause of the problem.

1.21 Drugs misuse - VSB14

Objective/Aim

Care pathways are being redesigned to improve the numbers of problem drug users receiving effective treatment. A new Tier 3 Community Drugs Treatment service will be commissioned and the Mental Health Trust's Specialist Addictions service will be set new performance targets and play a more significant part in clinical leadership for the whole system in City & Hackney. A new Joint Commissioning Manager will be appointed to strengthen the service co-ordination and local performance monitoring.

The objectives/aims in 2009-10 are:

To increase the number of problem drugs users maintained in effective treatment beyond the NTA target

To increase the overall numbers of all drugs users provided with effective treatment

To reduce the unit cost of treatment provided without loss of quality or effectiveness

To increase the numbers of problem drugs users receiving GP shared care with the aim of ensuring that more patients are managed by GP practices.

To try and increase the number of GP practices providing the LES.

To try and increase/improve the capacity for managing these clients by looking at alternative methods of service delivery, e.g. non-medical prescribing.

To increase the numbers of pharmacies offering supervised methadone consumption and needle exchange.

To increase the number of planned discharges from bottom quartile performance (currently 28%) to the London average

To increase the percentage of service users offered Hepatitis B screening from 20% and those offered health screening from 21%

To increase the number of service users with completed Treatment Outcome Profiles (TOPs) at the initial assessment, 3 month review and discharge stages

To increase the number of clients being entered on to the NDTMS system in order to secure adequate funding.

To commission improved services for 25 -35 year olds, crack cocaine users and specialist services for women.

Trajectory for 2009/10

Target 1343 problem drug users in effective treatment. This may be increased following discussion with the National Treatment Agency.

2010/11

Target 1410 problem drug users in effective treatment. This may be increased following discussion with the National Treatment Agency.

Latest Performance and forecast outturn

The latest NDTMS figures for September 2007 to August 2008 show 1344 problem drugs users having been treated effectively in Hackney and 27 in the City of London – a combined total of 1371. This exceeds the 2008-09 target of 1297 problem drug users in effective treatment.

The forecast outturn figure was 1358 problem drug users in effective treatment. As this figure has been exceeded, the outturn forecast will be revised when the NDTMS Quarter 2 figures become available.

Important to note that about 120 patients have not been entered onto NDTMS

Action to Improve Performance

Data Quality

NDTMS feedback reports show data quality to be high. The DAAT Partnership Board has prioritised improved data capture. The new Joint Commissioning Manger has targeted providers where data capture can be improved and it is expected that numbers shown to have been treated effectively will increase further.

Management of Service Delivery

Drugs treatment services are commissioned through the Hackney and City Drugs and Alcohol Action Teams. The Joint Head of Mental Health, Drugs and alcohol commissioning is actively involved at partnership board and Joint Commissioning Group level.

Performance management by the DAATs has been strengthened. The City DAAT has a dedicated information and performance manager. The Hackney DAAT receives regular, high quality monitoring reports through the local authority's corporate performance management team. This has led to more effective intervention with poorly performing providers as evidenced by the increasing numbers of problem drug user receiving effective treatment.

New terms of reference have been produced for the Hackney JCG and its membership will be expanded to ensure more effective inter-agency co-ordination. A separate Children and Young Persons JCG has been established to reflect local partnership arrangements. The Young Persons commissioner remains a member of the JCG in order to ensure continuity. The Hackney Adults JCG will be chaired by the lead Public Health consultant. All provider contracts have now been reviewed to ensure compliance with financial standing orders and a rolling programme of regular re-tendering has been agreed.

Commissioning arrangements were strengthened in 2008-09 with the appointment of a deputy DAAT Manager in Hackney (Joint Commissioner) and a 0.5 care co-ordinator in the City of London.

The PCT has established a Substance Misuse Management group consisting of the lead officers from commissioning, Public Health and Pharmacy and Prescribing together with the Hackney Joint Commissioner and City drugs services lead. A Clinical Governance sub-group has been established. The management group is focusing on improved harm reduction measures, increases in the numbers of shared care GPs and improvements in pharmacy and needle exchange services.

The Hackney community Drugs service was re-tendered in the course of the year and a new provider, Lifeline was awarded the contract. The new service commenced in July and has already demonstrated significant improvements in numbers of people treated and levels of effectiveness.

Similarly the Hackney Drugs Intervention Programme doctor and nurse service was transferred to Counted 4 a private GP company in July after the Mental Health Trust withdrew the service. Numbers of people assessed following arrest have increased significantly as have the numbers proceeding to treatment.

Both DAATs conduct annual needs assessments in compliance with National Treatment Agency requirements. The 2008-09 assessments demonstrate significant improvement. There have been high levels of user participation in both needs assessments and their input has led to important changes in the draft Annual Pooled Treatment Budget Plans for 2009-10.

The Plans for 2009-10 have been developed on the basis of the NTA indicative allocation figures based on the November 2007 activity levels and costs. These indicated a 10% reduction in the Adult Pooled Treatment budget for Hackney and a 4% increase in the City budget. These figures will be

revised in the light of the November 2008 outturn figures. This should lead to an improvement in the available budget in Hackney. In practice we are confident that even with a 10% reduction the number of problem drugs users in effective treatment will continue to rise and exceed the NTA target.

Action/Initiatives/ New Services Commissioned in 2009/10

1. Substance Misuse management group to map all commissioned services to include Primary Care commissioning, practice based, pharmacy and prescribing activity.
2. Implement GP Local Enhanced Scheme to include existing shared care activity and improve capacity and access in practices not currently involved in shared care.
3. Provide training to increase the number of pharmacies involved in supervised methadone and needle exchange consumption and provision of basic harm reduction advice.
4. Site visits to all drugs treatment providers to improve treatment effectiveness, increase the level of planned treatment exits, Hepatitis B and general health screening and improve the level of TOPs completions at the initial assessment, three months review and discharge stages.
5. Complete the refocusing of the Hackney Joint Commissioning Group with a new chair and wider agency representation – housing and Job Centre Plus in particular.
6. Review/re-commission services to increase provision of services responsive to the needs of 25 - 35 year olds, crack cocaine users and women.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
Hackney £4,171,974	Hackney Nil	Hackney £281,476 reduction based on NTA July 2008 figure	Hackney None
City £95,209	City Nil	City £2,239 increase	City £36,000 reduction
ELNFT Specialist Addictions Unit £706,000	City & Hackney Nil	ELNFT increase £28,000	City & Hackney £36,000 reduction
City and Hackney GP Local Enhanced scheme (LES) £200,000		City and Hackney LES £200,000 increase	
Total City & Hackney £5,173,183 before generic uplifts		Total City & Hackney net reduction £51,237	

Risks to Delivery with Mitigating Actions Planned

1. Poor/too junior level attendance at the JCG – escalate to DAAT senior partnership board members to take appropriate action.
2. Limited improvement in planned exits/Hepatitis B screening/health assessments/ TOPS completions – change contracts to provide incentives for improvements and penalties for continuing poor performance.
3. Poor take-up of GP LES scheme – conduct detailed review with GPs in the scheme to identify what attracted them and with GPs outside the scheme to identify barriers to participation

1.22 Patient experience - VSB15

Objective/Aim

The PCT endeavours to enhance the patient experience through improved service delivery. We aim to achieve this by strengthening the voice of patients and the public in decision making regarding service planning and service provision.

Numerous methods of user involvement are used including surveys and focus groups. Feedback from PALS and Complaints are also important mechanisms to gauge the views, concerns, and experiences of patients and the public. Such intelligence enables us to identify good practice, as well as risks, weaknesses and poor performance. It also helps us to identify where and how we need to improve performance and services at both PCT and provider level.

In 2009/10 we will strengthen our focus on taking forward the wider patient and public involvement agenda empowering and strengthening the voice of our users. Improving the patients' experience will be at the forefront of our business, exemplified through strengthened partnership working and initiatives such as the *public service promise* and proposed complaints' reform.

Assessing need, identifying weaknesses and gaps in service provision

Involvement of patients and carers in identifying their needs is part of the health care planning process. Collective assessment of need will be achieved by involvement of patients and the public in the *Joint Strategic Needs Assessment (JSNA)* which informs the commissioning priorities of the PCT and which is reflected in its commissioning plan.

In 2008 qualitative methods were used such as focus groups and individual structured interviews to gain more insight into the experience of the least satisfied groups identified in the 2007 MORI survey commissioned by the PCT. These groups included members of newer communities, seldom heard, and hard to reach communities.

Key findings are similar to the findings of the 2007 survey and include the need for Improved access to GP services especially in relation to making appointments, and greater awareness of out of hours services.

Improving patient, carer, and public experience.

Regular insight into user experience is gained through *Healthcare Commission PCT, and Acute Trust Surveys*. The PCT is committed to commissioning its own annual resident research such as its 2007 MORI questionnaire survey on local NHS services which included over 1000 respondents. Its provider arm also commissions a *Patient Experience Survey*.

The PCT aims to achieve year on year increase in satisfaction rates as identified by these surveys.

Based on feedback from patients derived from the above involvement methods the PCT will continue to improve services in the following areas:

- Continue to increase the number of GPs in Hackney and the City
- Support GPs to extend surgery hours
- Re-tender out of hours services. The service specification was consulted on with the local community and their representatives (LINKs)
- Embed the *Dignity Charter* developed with Age Concern across the partnership
- Additional support provided to carers with two full time support workers being recruited; the PCT will work jointly with London Borough Hackney to improve services including breaks from caring.

Trajectory for 2009/10 (VSB15_05 applies to PCTs)	2010/11
<p>Complaints Meeting the national target of 80% for acknowledging complaints within 2 working days and responding within 25 working days.</p> <p>Patient Experience (survey %) VSB15_01 = 77% VSB15_02 = 78% VSB15_03 = 76% VSB15_04 = 69% VSB15_05 = 76%</p>	<p>Complaints Meeting the national target of 80% for acknowledging complaints within 2 working days and responding within 25 working days.</p> <p>Patient Experience (Survey %) VSB15_01 = 78% VSB15_02 = 79% VSB15_03 = 77% VSB15_04 = 70% VSB15_05 = 77%</p>

Latest Performance										
<p>Complaints:</p> <p>Q2, complaints response times: 96% of complaints acknowledged within 2 working days. 63% of complaints received a response within 25 working days, 37% response sent outside this timescale.</p> <p>PALS: A total of 216 enquiries during Q2.</p> <p>The Find-a-Doctor service: A total of 1076 enquiries during Q2.</p> <p>Patient Experience (survey %)</p> <table border="0"> <tr> <td>PCT (2007/8)</td> <td>75</td> </tr> <tr> <td>Inpatient (2007/8)</td> <td>70</td> </tr> <tr> <td>Outpatient (2004/5)</td> <td>74</td> </tr> <tr> <td>A&E (2004/5)</td> <td>73</td> </tr> <tr> <td>Mental Health (2007/8)</td> <td>74</td> </tr> </table>	PCT (2007/8)	75	Inpatient (2007/8)	70	Outpatient (2004/5)	74	A&E (2004/5)	73	Mental Health (2007/8)	74
PCT (2007/8)	75									
Inpatient (2007/8)	70									
Outpatient (2004/5)	74									
A&E (2004/5)	73									
Mental Health (2007/8)	74									

Action to Improve Performance
<p>Data Quality</p> <p>Complaints & PALS Supporting the introduction of the Health & Social Care Complaints Reform in April 2009, which will provide a more uniform approach to complaints handling, strengthened local resolution processes and improved management of complaints informed by the patient's needs.</p> <p>Raising further awareness of the role of PALS and encouraging wider use of this service.</p> <p>Patient Experience</p> <p>Improve PCT patient survey response rates from around 25% to 30 %</p>
Management of Service Delivery

Complaints & PALS

Performance within these services will continue to be monitored through the PCTs internal reporting mechanisms via complaints service' standards, routine Board reports and more broadly through compliance with the SfbH core standards.

Action/Initiatives/ New Services Commissioned in 2009/10**Complaints & PALS**

Introducing and embedding the proposals outlined in the complaints reform to ensure a smooth transition into the use of the new regulations.

Training and guidance offered to staff to support them through the change.

Taking the shared Public Service Promise (PSP), Customer Care and No Wrong Door policy agenda forward, through ongoing collaborative working with our partners across City & Hackney whilst embedding the core values and principles across the PCT workforce to ensure that our users consistently receive a high standard of service delivery when accessing our services.

Patient Experience examples include :

Numerous initiatives aimed at reducing childhood and adult obesity such as community kitchens, Health Trainers, and healthy weight volunteers.

Roll out of the Year of Care programme for diabetic patients and provide self management (EPP) courses for young people.

Improved support to those with TB including programmes aimed at improving prevention, screening, and treatment of the disease.

Improving provision, access and take up of services for drug users

Continue to deliver on the development of four Primary Resource Centres which is part of the PCTs estates strategy Bigger, Brighter, Better

Linkage Plus Programme to improve access to services for isolated older people

Recruit to additional 1 wte complaints/PALS officer post

Recruit to additional 2 wte posts in commissioning to support local compact work and development of voluntary sector capacity

1.23 Public confidence in the local NHS - VSB16

Objective/Aim (inc. public engagement)

Public confidence is achieved through local people feeling valued and respected, having trust and belief in health organisations, and feeling their needs and aspirations are met.

Contributory factors include (i) patients own experience of health services especially acute services (ii) the public having awareness and knowledge regarding the role and responsibilities of the PCT, and provider organisations (iii) the public seeing evidence that the NHS is tackling health inequalities and reducing the risk of health care associated infections (iv) the NHS is managing resources well (v) trusts are performing well in relation to national, and local targets.

The PCT's **Communications and Patient & Public Involvement Strategy** for 2008/09- 2012/13 sets out a clear ambition for effective communication and engagement with users and the local community and objectives related to improving public confidence.

At Board level non-executives directors and senior officers will continue to have a visible presence in the community listening to people's views and experiences, and explaining the work of the PCT.

Social Marketing approaches will continue to support specific health priorities. Successful campaigns include GP registration and access to urgent care, 'Watch Out, Measles About' and the Spotty Bus (mobile vaccinations service).

The PCT conducts consumer research which gages residents' experience and satisfaction with local NHS services. The PCT/MORI resident survey for 2007/8 and provider patient experience survey shows high levels of satisfaction with local NHS services. We aim to achieve improved satisfaction ratings via the Healthcare Commission surveys, and PCT commissioned surveys year on year.

The public are invited to PCT Public Board Meetings which gives them an opportunity to see decision making at the highest level in the PCT. They are able to ask questions and receive answers from board members and senior managers.

Crucial to the engagement process is feeding back to users and local people how their needs, views, and experiences have made a difference. The PCT is ensuring it has an ongoing dialogue with its local community through attending public meetings and events, using the website as an interactive tool, and using monthly newsletters, newspaper articles and annual reports to report on developments and service improvements.

Homerton Hospital

Our local acute trust the Homerton Hospital have several schemes in place with the aim of obtaining patient feedback, addressing public concerns especially around hospital acquired infections, and improving services for patients and the public.

These include

- **Dr Foster patient tracker work**—bedside consoles are provided for patients to provide real-time feedback about their experience. An action plan is produced which is monitored by the hospital's multi-agency Patient & Public Involvement Group
- Patient Tracker Boards
- **Improving maternity services** – A maternity strategy is being consulted on and this will lead to a work plan which will drive forward improvement in services. One new initiative in place is the *Bump Buddies project*. They provide support to pregnant mothers from BME communities..
- **Being treated with *dignity and respect*** is a key factor in patient satisfaction. There is a dignity charter in place and this is backed up with action to improve the patient experience

such as reducing same sex wards

- **Reducing hospital acquired infections and improving cleanliness** are key priorities for the Homerton. Deep cleaning and other initiatives are in place to address this.

Trajectory for 2009/10 (to be submitted by 2010/11 Trusts only)	
71% inpatient 75% outpatient 73% A&E	72% inpatient 76% Outpatient 74% A&E

Latest Performance		
Patient Experience %		
Inpatient (2007/8)		70
Outpatient (2004/5)		74
A&E (2004/5)		73

Action to Improve Performance

Data Quality

The surveys are robust processes carried out by leading research companies

Management action

The PCT is working closely with providers and partners through partnership boards and quality monitoring meetings to ensure services are improved and the public are kept informed of the work being done to address their concerns . This is being achieved via media communications and public engagement events.

We will also work in partnership towards bridging the health gap and in increasing public e confidence in the NHS.

For example, the PCT has encouraged one of the community development projects it funds to recruit a **Polish Community Development Worker** to do some focused work with this community in 2009/10. We will also be recruiting a team of **health trainers** to support individuals in the community and they will be an important source of local intelligence on community health needs for the PCT.

We aim to support and work closely with the two **Local Involvement Networks (LINKs)** for Hackney and the City towards further strengthening the voice and influence of patients and the public in decision making.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
Refer to 1.22	Refer to 1.22	Refer to 1.22	Refer to 1.22

Risks to Delivery with Mitigating Actions Planned

Delays in recruitment of new workers, Unplanned budgetary constraints at PCT and at the Homerton

The PCT and Homerton are institutions with a sound history of financial forecasting and management. Contingency plans are in place to successfully manage any unexpected financial burdens.

1.24 NHS staff job satisfaction - VSB17

(action should relate to commissioning staff – provider service annual plan to cover provider staff)

Objective/Aim (inc. the four pledges to staff in the proposed NHS Constitution)

The measure of staff satisfaction arises from the national staff survey and covers a number of measures including support from line managers, ability to direct our work autonomy etc.

The PCT has historically had a poor response to the staff survey and also concerns about staff satisfaction as well as high levels of perceived bullying and harassment. Concerns were raised in the past about the timing of the survey in the past about the timing of the survey which in 2006 and 2007 were during major organisational restructuring or at the end of the restructuring which may have impacted on the responses. The survey also covered all PCT not just commissioning staff. The 2008 survey will be the first time we can separate commissioning and provider staff.

The PCT commissioners need excellent motivated staff to deliver the ambitious CSP for the PCT and improve health and reduce health inequalities in City and Hackney.

The PCT's Organisational Development Plan committed to improving staff capacity and capability and specifically it set out to develop a unique culture for City and Hackney commissioners and put engagement including staff engagement at the centre of everything we do. It also set out a priority to develop commitment, skills and capabilities and also develop leadership in the PCT.

These priorities in the 2008 Organisational Development Plan for World Class Commissioning support the four pledges to staff in the draft NHS Consultation:

- to provide well designed and rewarding jobs
- to provide staff with personal development, access to training appropriate for their job and line management support
- to provide support to keep staff healthy and safe
- to engage staff and empower staff

Progress nationally will be measured by the staff satisfaction score in the staff survey

Trajectory for 2009	2010	2011
3.6	3.7	4.0

Latest Performance

The staff survey for 2007 – published in May 2008 showed that staff satisfaction overall was 3.44. This was marginally above the trajectory of 3.4 for 2008.

The most recent staff survey was completed on 23 December 2008. The response rate was again low and the PCT will need to consider undertaking local surveys more frequently to measure staff satisfaction

Action to Improve Performance

Data Quality

Prior to the 2008 survey data was not split between provider and commissioners

Management action

The Commissioning Division has during 2008 undertaken a number of development sessions collectively. Continuation of these along with greater engagement across and between the three Directorates of the Division and the relevant support services is needed in 2009/10.

Work will need to be undertaken to embed the new staff development process and increase the levels of appraisals and PDP's in the division. Across the PCT this was 68% in 2007 with PDP levels in the 50's.

The Division also needs to commit to leadership and management development programmes for its staff and to ensure all managers have completed the coaching skills for managers programme in 2009/10.

There is also a need to increase the capacity and develop skills in areas such as knowledge management, analysis, market management and social marketing skills. These will be developed in-house, across Inner North East London and as part of the Commissioning Development Programme. The PCT is also developing a talent management plan for commissioning to ensure that there is effective succession planning and support recruitment.

Risks to Delivery with Mitigating Actions Planned

The risks relate to strengthening commissioning and the potential uncertainty that this will impact on roles within commissioning. This may result in loss of staff but also to lower staff morale and satisfaction. We are confident that the Organisational Development and Talent Management Plans will support this and there is a clear programme in place for strengthening commissioning.

1.25 NHS primary dental services access - VSB18

Objective/Aim

The population of CHPCT has some of the poorest levels of oral health nationally, with levels of decayed missing or filled teeth in 5 year olds being the third worst in NE London. In 2008/9 the PCT has undertaken a number of key strategic initiatives, to enable us to develop a commissioning strategy that will tackle the issues of poor oral health as well as to set ourselves stretch targets in relation to measures of oral health.

As we finalise oral health needs assessment oral health strategy and oral health action plan we have also been looking at issues of quality of services access, capacity and uptake of services.

During 2009/10 we intend to build on the start that we have made in reversing the trends of low access to and low take up of NHS dentistry.

We have undertaken a substantial piece of analysis of the oral health needs of the local population including oral health status, deprivations, access to services inflow and out flow from the borough. It is clear that we have significant outflow to surrounding boroughs of Tower Hamlets and Islington, not matched by the inflow from those boroughs.

We have a defined strategy in place to address oral health inequalities, focussed on areas of greatest need, alongside a social marketing programme to drive uptake of NHS dental services up, including a targeted investment programme to increase capacity. Our ambition for oral health and therefore uptake of services is high and the oral health action plan of the PCT sets clear targets for uptake. The revised trajectory is a realistic assessment of how we expect activity to grow, including repatriation of figures from THPCT provided CDS services.

We will continue the increased capacity within the local NHS primary care dental budgets targeting extended hours, urgent care and incentivising the implementation of NICE Guidelines for call and recall.

We will continue the delivery of innovative services targeted at difficult to reach families, creating care pathways that assist in the shift to using primary care dental services, whilst being mindful of requiring some specialist services provision for vulnerable and at risk groups and commissioning services appropriately.

We will continue to promote information to the local population and to local health professionals about NHS dental services

We will reduce the use of emergency/urgent dental care services through the development of care pathways utilising triage and high street dental care.

We will focus on the quality of NHS dental services in Primary Care through the development of care pathways and strengthening contractual compliance including implementation of PIs and a balanced score card to support the annual contract review process

Trajectory for 2009/10 (N.B. new indicator definition tbc)	2010/11
87,950	90,000

Latest Performance and forecast outturn

No figures for Q3 at present. The current projected outturn on 08/09 is 82,800 against a trajectory of 87800

Action to Improve Performance

Data Quality

We are completing a data validation exercise with the BSA across all contracts, which means that we have more confidence in the data coming through. We have agreed to undertake a data validation exercise with Tower Hamlets PCTs to deconstruct CDS data between the two boroughs, thus repatriating CHPCT activity to contribute to our targets

Management of Service Delivery

The PCT is revising and implementing revised annual contract review process, including balanced score card. As well as reviewing all GDS and PDS contracts in terms of VFM and delivery.

Specific monitoring of newly commissioned services will be undertaken to test their effectiveness in meeting the outcomes of increasing uptake of primary dental services, reducing attendance at emergency clinics and supporting the improvement of oral health in children and adults.

The updated oral health action plan and commissioning strategy will be consulted on and when agreed will be monitored through internal governance process. The needs assessment undertaken as part of the trilogy of documents on oral health, will be crucial in determining commissioning decisions.

The PCT has recently undertaken a process of re-engaging local practitioners in our work programme as well as creating forums for clinical input into the commissioning process. We continue to develop our expertise in managing poor performance both clinical and contractual.

Action/Initiatives/ New Services Commissioned in 2009/10

Continued investment against all contracts

A procurement of one new contract based in SW Hackney

Implementation of revised contract compliance initiatives, including balanced score card PI and a revised ACR process.

Continuation of mobile services to target health inequalities.

Reconfiguration of emergency dental services and potential procurement of new service model.

Implementation of strategy to raise public awareness of dental services and how to access them through a social marketing approach and regular polling of public views.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In capacity plan -No funding allocated	In capacity plan -No funding allocated	In capacity plan -No funding allocated	In capacity plan -No funding allocated

Risks to Delivery with Mitigating Actions Planned

Delays in procurement process – Project manager being appointed

On-going problems with data validation – increased investment in dental commissioning team

Reducing of funding – discussions in place in PCT

2. Local Priorities

2.1.1 London Priorities TB

Objective/Aim

Increase TB treatment completion rates Reduce the spread of communicable disease, by increasing the numbers of people with TB who complete effective treatment, achieve a 6% increase from the 2007-08 baseline (80%) by 2013.

The PCT is working with partners from health and social care and will continue to implement the local TB strategy, which includes broader initiatives to increase early identification of people with TB, particularly those with infectious pulmonary TB; increasing the uptake of BCG immunisation in infants and initiatives to support patients adhering to treatment.

Trajectory for 2009 (% treatment completed)	2010	2011
82%	83%	85%

Latest Performance and forecast outturn

The NE London TB network exists to support PCTs in determining priorities for action. A balance scorecard approach is used to measure local progress in developing an effective range of TB prevention and treatment services. City and Hackney PCT is green rated against 12 standards set by the Network. These standards are based on the Department of Health's Toolkit Tuberculosis Prevention and Treatment – high quality services in England (June 07).

Q1 08 NEL TB Network performance report: 82.4% Completion rate for CHPCT with higher completion rates at HUH (87.1%).

Q2 08 NEL TB Network performance report (as of November 08): 92.3% Completion rate for CHPCT and a slightly higher rate for HUH (92.9%).

Action to Improve Performance

Data Quality

Data quality is already of a good standard.

Management of Service Delivery

Local enhanced service in primary care supports TB screening of new patients using Mantoux testing (specifically targeting new registrations and people newly arrived in the country) and BCG administration to infants and young children. The PCT is working with Homerton TB Clinic to support training of primary care staff on administration and reading of Mantoux test and a BCG administration.

One of the components of the current DOT audit is a patient experience assessment, the results will be used to further improve this service.

TB outreach workers will deliver services where they are needed, outside of hospital to the most vulnerable clients; outreached activities include two outreach TB workers, one based at the Homerton TB clinic and another one at the Greenhouse Centre; both working together to support treatment adherence and contact tracing in patients with complex needs; outreach activities also

include visits to homeless centres and screening of high risk groups such as homeless and alcohol and substance mis-use.

The work of the TB awareness worker to increase TB awareness in staff working with high TB risk groups (at our local authorities and in the voluntary sector) helping them to learn about the disease, to reduce stigma and to help recognise clients who may present symptoms suggesting of TB and direct them to appropriate services; the TB awareness worker also work with the CHPCT Health Inclusion Worker to raise TB awareness in hard to reach communities and ensure health trainers are aware of TB symptoms.

CHPCT is also supporting the introduction of gamma-interferon testing (IGRA) to Homerton TB clinic for rapid diagnosis of TB contacts and Homerton HIV services, and supporting the adoption of the new LTBR system (introduced Dec 2007) that continually prompts nursing staff to fill in patient outcomes at 12 months and to give reasons if patients are still on treatment at that time. This will lead to minimal missing data and better understanding of why some patients have not completed treatment within 12 months.

We will be strengthening our TB Strategy Group based on recommendations made by the Healthcare Commission as the result of a complaint, including more rigorous recording in the minutes of performance data.

Action/Initiatives/ New Services Commissioned in 2009/10

The recommendations from the DOT audit including record keeping and patient experience will be implemented to improve services.

Our Service Level Agreement with pharmacies for providing Directly Observed Therapy is also being reviewed and any recommendations for changes will be implemented and monitored.

Our new Service Level Agreement with the London Borough of Hackney to provide housing to homeless people who need to be treated for TB, with the aim of reducing hospital in-patient stays will be implemented and monitored.

Screening of the HIV population for TB (new and existing patients) using Gamma Interferon Release Assay. People with HIV are 1600% more likely to develop TB than the general population. The HIV infection rate is rising by 12% per year in City and Hackney (approximately 70 new cases per year) adding to the 1000 people already living with the diseases in the locality.

Improve the effectiveness of case management of individual patients by increased co-ordination between care settings and service providers (primary care, pharmacists and hospital services). This is a collaborative commissioning initiative closely linked to CHPCT initiative on improving outcomes for TB patients.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£15,000		£15,000	£0

Risks to Delivery with Mitigating Actions Planned

Although the majority of our TB patients are managed by the Homerton TB team with adequate completion rates, collecting treatment outcomes on patients who are transferred out or patients not treated at Homerton could represent a potential difficulty to achieve the treatment completion target.

2.1.2 HIV

Objective/Aim

To reduce the proportion of patients with late diagnosis of HIV (newly-diagnosed HIV infected patients with a CD4 count <200 cells per mm³) to 15% by 2010-11 (using 2004-5 HPA baseline figures).

HIV is a serious but treatable disease. Early detection of HIV is important as late presentation is associated with adverse outcomes, notably increased risk of AIDS and death. Early diagnosis supports ensuring that newly diagnosed people can receive effective treatment, counselling, care and support to reduce onward transmission.

The HPA prevalence's from the anonymous unlinked seroprevalence study are around 1% for patients attending Homerton DoSH and TOPS, 0.33% for antenatal care, with 42% of estimated HIV cases remaining undiagnosed. We are committed to reduce the number of late presenters, a local audit at Homerton DoSH showed that around 90% of late presenters had been to hospital/GP in the previous 12 months and we will be undertaking several initiatives to increase opportunistic testing both at primary care, community and local hospital services.

A high proportion of HIV cases in CHPCT belong to high risk groups such as migrants (from high HIV incidence countries) and recently arrived groups; by working with faith groups and voluntary sector we aim to promote early identification and treatment, improving outcomes and reducing inequalities.

Trajectory with late diagnosis 2009

Reduction to 23%
(using 2004-5 HPA data as baseline).

2010

Reduction to 18%
(using 2004-5 HPA data as baseline).

Latest Performance

To be confirmed

Action to Improve Performance

Data Quality

To be confirmed

Management of Service Delivery

Within local hospital services, we are supporting Homerton's DoSH by providing additional resources to support IT systems; increase nurses and doctors working at DoSH and promoting training. Within Community Sexual Health services we are supporting improvement on IT systems and staff development on STI screening; we are providing outreach services for young people at the Adolescent Health Pilot (CHYPS Plus) including a monthly HIV outreach clinic for HIV positive teenagers.

At primary care level the Primary Care Local Enhanced Service (LES) includes an additional payment for HIV diagnoses made at general practice. We are organising several STIF courses for GPs and practice nurses signed to the LES as part of continuous professional development. Outreach activities include working with the Hackney African Forum to raise HIV awareness and support early HIV testing in African communities in Hackney. We have a very successful pilot project of STI screening at a local sauna frequented by MSM, initial results are very encouraging and we will continue to support this intervention. We will continue supporting outreach work with street sex workers.

Patient and public involvement includes work with the Hackney African Forum, activities on world AIDS day as well as a broad social marketing and publicity strategy to raise awareness of availability of services and opportunities to access sexual health screening services.

New guidelines will shortly be published by British Association for Sexual Health and HIV (BASHH), the British HIV Association (BHIVA) and the British Infection Society (BIS), recommending opt out HIV testing in primary care in areas where HIV prevalence is >3/1000 population. Screening in primary care could improve early detection of HIV. We recently showed that HIV screening using near patient (oral fluid) testing at registration health checks in primary care was welcomed by patients, and achieved an uptake of 50%. We propose a cluster RCT testing the hypothesis that screening for HIV in primary care reduces the proportion of patients with late diagnosis of HIV.

Action/Initiatives/ New Services Commissioned in 2009/10

African Health Clinics: African health clinics will provide screening services to members of the African community including HIV near patient testing (Oraquick), TB screening, blood pressure and BMI measurement and services such as smoking cessation support. Near Patient HIV testing will be made available at different African Community events and through working with Faith groups.
Pilot opt out HIV testing in primary care: Primary care practices participating in the pilot will offer registration screening including HIV testing.

Better information will be available to local people on sexual health, sexually transmitted infections and local services, including contraceptive services. City and Hackney PCT has developed a new website for the North East Sector called SHO-Me (Sexual Health Online) which will be publicised widely. We will monitor hits on the website to determine use of it. One of the services publicized on it will be the availability of Chlamydia screening for young people. Chlamydia screening is widely available in Hackney and the City including through pharmacies. Increasingly we will be linking its provision to our Condom Distribution Scheme so that both condoms and screening are available in the same settings.

This work will build on services provided, for example at Hackney Community College. Our local teenage health service already provides outreach to the Youth Offending Team, which incorporates sexual health services. This work will be strengthened and we will seek to train a small number of Youth Offending Team clients to run drop-in services in local barbers. In addition to targeting men, especially from African communities in particular to contact trace partners (we currently have far more heterosexual women diagnosed than males) we will be recruiting a new HIV Health Adviser to work as part of the local sexual health services.

Our capacity plan accounts for the diagnosis of more people with HIV who will need treatment and support, as we improve contact tracing and make available better information to local residents about sexual health.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£1,338,000	£4,000	£1,338,000	£4,000

Risks to Delivery with Mitigating Actions Planned

Hackney has a very diverse ethnic population with high proportion of individuals from regions with high HIV incidence that could present at diagnosis with very low CD4 counts; interventions to increase early diagnosis in these groups are more complex since in many instances would require intervening outside the UK. By targeting near patient HIV testing to high risk groups such as members of the African community and piloting opt out HIV testing when registering at primary care it will be possible to increase access to HIV testing promoting early diagnosis.

2.2 Locally selected priorities

2.2.1 Hypertension Prevalence

Objective/Aim

Increasing the detection and control of hypertension (high blood pressure) is one of the PCT's top 10 priorities, as identified in the CSP. High blood pressure is a major factor in local death rates from cardio vascular disease and stroke, and also contributes to kidney disease and blindness.

The ethnicity of Hackney's population is such that there are particular at risk groups who need to be targeted to reduce their chance of having a stroke or heart attack.

Currently only 48% of the estimated number of hypertensives, as calculated using the Public Health Observatory tool, are identified in GP registers. Also the number of people in an active disease management programmes when compared to estimated prevalence is low.

Trajectory for 2009/10

50%

2010/11

52%

Latest Performance and forecast outturn

48%. FOT 49%

Action to Improve Performance

Data Quality

Introduction of EMIS –web means that the PCT will be able to access anonymised patient level data from GP practices – this gives a greater scope for data scrutiny leading to targeted support to improve data quality at practice level

Management of Service Delivery

The PCT has identified that there is further scope to improve control of risk factors, such as blood pressure and cholesterol, in hypertensive, cardiac and diabetic patients. The PCT will do this by commissioning a trial primary care based education programme called "HiLo", from Queen Mary College, University of London and through introducing tighter targets on BP and cholesterol control through a new Local Enhanced Service (a "super-QOF"). Additional questions will be asked during the assessment in addition to calculating the QRISK, for example on physical activity and alcohol consumption, and appropriate referrals will be made.

Action/Initiatives/ New Services Commissioned in 2009/10

The PCT will implement a programme to deliver the Government's plan to offer a vascular check for

everyone aged 40-74 once every 5-years, as outlined in the paper “Putting Prevention First”, at an annual cost of £1.2m. The introduction of this vascular screening programme will have a significant impact on the local detection rate for amongst other things hypertension.

The first group of residents to be invited for a screen is a joint targeting of people who are already at significant risk, as defined by their QRISK score (the PCT’s risk engine of choice) and those who are already identified as having hypertension (last recorded blood pressure >140/85) but who are not on a hypertension register. This cohort will be identified through a rigorous search of pre-existing patient-level data practice by practice.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In CV Mortality	In CV Mortality	In CV Mortality	In CV Mortality

Risks to Delivery with Mitigating Actions Planned
Difficulty getting data from GP practices, mitigated against by work to introduce VRA and through the introduction of EMIS Web..

2.2.2 Diabetes

Objective/Aim

Diabetes

For diabetes there has been an improvement in the levels of control of blood glucose for local residents. In 2004 only 44.9% of diabetes patients met the control definition; by 2007 this had increased to 58.4%. In addition our detection rate is good for an inner London PCT at 87%. Our estimated prevalence is higher than the London prevalence; 5.1% compared to 4.6%.

Increasing blood sugar control in the management of diabetes is one of the PCTs top 10 goals for 09/10. Blood sugar control is a marker for optimal management of diabetes and diabetes is a major contributor to death and disability in City and Hackney.

In order to continue to improve outcomes for diabetic patients, including the proportion having adequately controlled blood sugar (defined as an HbA1c less than 7.5%) the PCT will invest in a range of new initiatives. This will include:

The roll out of the "Year of Care" programme across primary care which is an initiative designed to encourage self management through putting care planning into routine practice

Using incentives to change behaviour as part of a research trial

A new initiative focusing on nutrition and cooking skills as part of patient education

Access to support and exercise for the Orthodox Jewish Community

Tighter targets for GPs to work to in primary care

Increased community awareness through targeted events using social marketing techniques

In 2009/10 we should also start to see the impact of the 13-strong Diabetic Specialist Nurse team that was commissioned in 2008/9.

Diabetes blood sugar control

This objective is focused on 3 main areas

i) Tackling Obesity:

- Halting the year on year rise in obesity among 11 year olds by expanding the capacity of the EOR scheme for children (currently Healthy Lifestyles) and ensure exit routes available to facilitate continued exercise. Develop a service for at risk children linked to local young person specific gym (SHOKK gym). Increasing opportunities for active play and physical activity for children including increasing access to novel activities and new technologies including circus skills, climbing and games console based activity and improving access to active travel through implementation of bike loan schemes.
- Supporting adults who are already obese to lose weight as part of wider lifestyle changes. We aim to significantly increase capacity of the Exercise on Referral scheme and expand options available to participants; introduce a GP LES for obesity services and increase GP capacity to deliver a holistic service including opportunities for physical activity; use health trainers to support delivery of culturally appropriate information and advice on improving diet and accessing opportunities for physical activity; expand the capacity of Counterweight in both GP and community settings.
- Preventing those who are overweight becoming obese. We are aiming to introduce incentives for public sector staff to participate in active travel as part of a wider Healthy Workplace strategy; increase exercise opportunities for those at risk of becoming obese including community based

dance classes and walking groups; expand opportunities to gain food and cooking skills with a focus on healthy eating on a budget; use voucher schemes to facilitate local residents identified as at increased risk to access privately provided initiatives for free (e.g. Slimming World); use health trainers to deliver culturally appropriate advice and guidance around overweight and obesity prevention.

Trajectory for 2009/10	2010/11
60%	62%

Latest Performance and forecast outturn

58.4%

Action to Improve Performance

Data Quality

Introduction of EMIS –web means that the PCT will be able to access anonymised patient level data from GP practices – this gives a greater scope for data scrutiny leading to targeted support to improve to data quality at practice level

Management of Service Delivery

The new team of nurse specialists will have the greatest impact on how practices deliver diabetes care, with more time being devoted to those patients with the greatest need, etc

Action/Initiatives/ New Services Commissioned in 2009/10

Improving Diabetes Outcomes:

This will be achieved through

Better prevention:

Improving the targeting of particular communities who do not speak English as a first language with information on diabetes through expansion of lay educators team

Expanding exercise on referral towards primary as well as secondary prevention

Improving Early Identification of People with Diabetes:

Initiatives to identify people with diabetes to ensure early identification and improved early management of diabetes through engaging community pharmacists in case finding

Commissioning and promotion of a Local Enhanced Service to support practices working with patients at risk of diabetes (target group BMI >30 early intervention and health promotion)

Provision of feedback to individual practices in relation to estimated numbers of unidentified diabetics in the practice population to stimulate case finding activity

Empowering patients to manage their own disease:

Continuing development of structured patient education programmes and related increase in access to exercise on prescription

Piloting of new ways of working with hard-to-reach communities

Improving Performance in Primary Care:

Improve the performance of the poorest performing 10% of practices against the key QOF targets through incentives and robust performance management

Further investment in specialist clinical support (clinical nurse specialists and dieticians) linked to consortia based targets for Practice Based Commissioners

Commissioning of consultant support to shared care clinics held in primary care for complex patients

In summary, this objective will achieve:

Improvements in key health indicators for people with diabetes

Improvement in the identification of people living with diabetes in the population.

Reductions in co-morbidities and secondary disease e.g. blindness and stroke.

Reductions in emergency admissions for people with diabetes.

Reductions in length of stay.

- Improve quality of life for people with diabetes.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£705,000	£340,000	£705,000	£340,000

Risks to Delivery with Mitigating Actions Planned

Poor performance of the least well performing practices brings down the Hackney average. The measures to improve primary care performance will mitigate this risk.

Patient participation in structured education programmes has been difficult to date. Engagement of practices in promoting the programme and follow up are aimed at this risk.

2.2.3 Self reported experience of patients and users

Objective/Aim User reported experience

There are numerous sources of resident and patient feedback the PCT has as its disposal. One key mechanism is the PCT's resident survey.

In 2006-07 the PCT commissioned IPSOS/MORI to undertake a survey of local resident's views of local health services. The majority of residents (65%) were satisfied with the overall running of their local NHS. This was higher than those who were satisfied with the NHS overall (58%). The main factor driving satisfaction with local services was access to the Homerton hospital.

High levels of satisfaction were also shown with the most frequently used services such as the local chemist (89%), family doctor /GP (82%) and Homerton 64%.

The survey for 2009/10 will continue to explore satisfaction with the running of the NHS and with specific services. However, along with other projects such as the social marketing work stream and e.panel feedback it aims to better understand people's perceptions and motives. This will help the PCT to ensure its health promotion work is tailored towards getting health messages across effectively to different groups and communities.

Trajectory for 2009/10

66% satisfaction rating

2010/11

67% satisfaction rating

Latest Performance and forecast outturn

65% satisfaction rating

Action to Improve Performance

Data Quality

Data quality is robust as leading research company used and over 1000 residents participating.

Management of Service Delivery

In addition to PCT led research commissioners will also scrutinise findings from provider surveys and other patient experience initiatives in 2009/10

Action/Initiatives/ New Services Commissioned in 2009/10

Numerous initiatives aimed at reducing childhood and adult obesity such as **community kitchens, Health Trainers, and healthy weight volunteers.**

Roll out of the **Year of care programme** for diabetic patients and provide self management (EPP) courses for young people

Improved support to those with TB inc programmes aimed at improving prevention, screening, and treatment of the disease.

Improving provision, access and take up of services for drug users

Continue to deliver on the development of four Primary Resource Centres which is part of the PCTs estates strategy **Bigger, Brighter, Better**

Linkage Plus Programme to improve access to services for isolated older people

Choice

Improve performance of practice offering choice of provider to patients and promote awareness of choice amongst our population. A work programme is in place to accompany implementation of direct booking at the Homerton and to build on the national priority.

Homerton Hospital

Our local acute trust the Homerton Hospital have several schemes in place with the aim of obtaining patient feedback, addressing public concerns especially around hospital acquired infections, and improving services for patients and the public.

These include

- **Dr Foster patient tracker work**–Beside consoles are provided for patients to provide real-time feedback about their experience. An action plan is produced which is monitored by the hospital's multi-agency Patient & Public Involvement Group
- **Patient Tracker Boards**
- **Improving maternity services** – A maternity strategy is being consulted on and this will lead to a work plan which will drive forward improvement in services. One new initiative in place is Bump Buddies. They provide support to pregnant mothers from BME communities. Evidence show that they have higher infant mortality rates compared to other groups.
- **Being treated with dignity and respect** is a key factor in patient satisfaction. There is a dignity charter in place and this is backed up with action to improve the patient experience such as reducing same sex wards
- Reducing hospital acquired infections and improving cleanliness are key priorities for the Homerton. Deep cleaning and other initiatives are in place to address this.

As a commissioner, the PCT will be repeating our residents survey to measure satisfaction and also gathering information on best practice from other PCTs.

The PCT provider employed a patient survey as part of its service line review. The survey was independently conducted by IPSOS MORI. The learning from this in terms of outcomes as well as methodology has been incorporated into a more comprehensive plan for testing patient opinion where we will build on existing work and include:

- Surveys by telephone, across all services.
- Patient Tracker Boards
- Focus Groups

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In capacity plan, in addition to £80,000 for residents survey	In capacity plan	In capacity plan	In capacity plan

Risks to Delivery with Mitigating Actions Planned

Budgetary savings

Voluntary sector capacity

Action- two new posts in commissioning to support local compact work and development of voluntary sector capacity

2.3 Trauma services

Objective/Aim (inc. implementation of HfL)

To ensure immediate access to high quality tertiary trauma care services, supported by locally accessible rehabilitation pathways.

Action/Initiatives/ New Services Commissioned in 2009/10

NEL PCTs have initiated a major collaborative commissioning initiative focussed on the redesign of the acute hospital landscape and linked to delivery of Healthcare for London objectives.

Locally, trauma patients are transferred directly by LAS or HEMS to Barts and the London as the main trauma facility in the NEL sector. As part of the work on acute service reconfiguration, NEL PCTs will collaborate with the trauma networks across London to determine and consult upon formal designation of trauma centres and local rehabilitation services.

The outcomes of the designation process will be built into the acute service reconfiguration initiative designed to identify the settings and models of care needed in NEL to ensure a sustainable and high quality provider landscape.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In all age all cause mortality	In all age all cause mortality	In all age all cause mortality	In all age all cause mortality

2.4 Reducing alcohol related harm

Objective/Aim

In 2009/10 we aim to

1. Develop our understanding of local needs
2. Implement the City and Hackney Alcohol strategies, supported by appropriate governance arrangements
3. Reduce the harm caused by harmful and hazardous drinking
4. Gradually slow the year on year increase in the rate of alcohol related hospital admissions

Trajectory for 2009/10

2,227/ 100,000

2010/11

2,251/ 100,000

Latest Performance and forecast outturn

1773.3/ 100,000 (2006/7 data, NWPFO)

Action to Improve Performance

Data Quality

We have commissioned an alcohol needs assessment for Hackney. This is being supported by a detailed analysis of alcohol related hospital admissions by the health intelligence team.

Management of Service Delivery

We have established an alcohol harm reduction steering group to draw together the key agencies in the City and Hackney, supported by the new Alcohol Harm Reduction Coordinator post.

We continue to work with the City of London to implement the City alcohol strategy.

We will contribute to the final Hackney alcohol strategy, and adopt an action plan with the local authority to reduce alcohol related hospital admissions as one of our key Local Area Agreement targets.

We will implement recommendations of the alcohol needs assessment and service review consultant's report as appropriate – the report will be presented with recommendations to the City and Hackney DAATs in March 2009.

We will develop an alcohol LES to support practices in identifying individuals with established diagnoses (e.g. CHD, depression, epilepsy, other) who are drinking at harmful or hazardous levels and provide brief interventions to modify drinking behaviour. This will build on the National Alcohol DES. Supporting practices in screening newly registered patients.

Action/Initiatives/ New Services Commissioned in 2009/10

To re-tender community alcohol services in Hackney and increase investments by £450k in line with the recommendations to the DAATs.

To increase the residential detoxification budget by £200k in Hackney and £20k in the City.

Commission a 0.5WTE brief interventions worker in A&E (£25k) for the City.

To increase the capacity of the East London NHS Foundation Trust specialist addictions alcohol team as follows:

Key Performance Indicator	2008/9 Target	2009/10 Target	2010/11 Target
First appointments	240	340	400
Caseload	120	170	200
Contacts Face-to-Face/Phone	2,220	3,150	3,700
Numbers discharged	240	340	400

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£420,000	£0	£420,000	£0

Risks to Delivery with Mitigating Actions Planned

1. Alcohol related hospital admissions continue to increase - develop action plan based on detailed analysis of admission figures and re-commission services where necessary.
2. Newly commissioned services increase referrals for Tier 4 residential treatment rather than increasing levels of community detoxification - develop clear referral criteria and strengthen care pathways for community detox. services.
3. QUEST Consulting identify unmet needs well beyond available budget – refocus existing provision to ensure services address priority need and prepare resource bids for 2010-11.

3. Recovery Plans

Existing Commitments	Forecast outturn for '08/9 = 'achieve' so not required ✓	Forecast outturn for '08/9 is not an 'achieve' so recovery plan required ✓
A&E 4-hour wait	✓	
Primary care access to a GP In 48 hours and a PCP in 24 hours	✓	
13-week outpatient wait		✓
26-week inpatient wait		✓
3-month revascularisation wait	✓	
2-week rapid access chest pain clinic wait (in hosted Trust)	✓	
GUM clinic access within 48 hours	✓	
Cancelled operations indicators (in hosted Trust)	✓	
Delayed transfers of care at a minimal level	✓	
Ambulance response to Cat. A calls in 8 mins.		✓
Ambulance response to Cat. A calls in 19 mins.		✓
Ambulance response to Cat. B calls in 19 mins.		✓
2-week urgent cancer waits	✓	
31-days cancer wait from diagnosis to treatment	✓	
62-days cancer wait from referral to treatment	✓	
Diabetic retinopathy screening	✓	
Early intervention in psychosis	✓	
Crisis resolution	✓	
Cancer IOG implementation	✓	
Community Development Workers	✓	

3.1 Ambulance response to (1) Cat. A calls in 8 mins & to (2) Cat. B calls in 19 mins.

Objective/Aim (inc. date by which target will be achieved)

LAS 09/10 recovery plan

London PCT's invested an additional 5.9m non-recurrent resources against the recovery plan and guarantee of performance delivery by March 09

LAS proposal to meet targets: London PCTs are currently negotiating with London Ambulance Service to ensure an SLA which is resourced at a level to enable the meeting of all National Targets – including meeting Cat B 19 minutes at an average level of 95% throughout the year. Proposals received from LAS put the cost of achieving this at a **14%** uplift. The potential cost to CHPCT of incorporating this uplift is outlined within this recovery plan and built into the operating plan. It is based on average activity levels over the past 30 months from 06/07 to date. *Because PCT contributions have been on 30 months activity (i.e. 3 year rolling average) rather than the 12 months used in 08/09, there will be a further element of PCT rebasing building on the 08/09 rebasing exercise.*

PCT validation: PCT commissioners have currently validated **9%** which includes 2.2% for inflation & CQUIN, 2.1% for activity growth, 1.4% for meeting Cat B at 95% + 3% for reducing the utilisation rate of Ambulances to a level of 55% the national average. High utilisation rates (which cause ambulances not to be available when needed) have been seen to be the single biggest reason why LAS is failing to deliver required performance. High utilisation is made worse by increased demand and longer than acceptable hospital turnaround times, although the local acute trusts (Homerton) is one of the best performers in this regard.

ECPs: 2% of the additional 5% that LAS are seeking relate to the cost of 86 Emergency Care Practitioners. A funding solution is needed for these well trained staff, who until relatively recently would have been subject to individual PCT funding agreements which are now at an end. Where PCTs wish to continue with these staff, it may be necessary to charge them in addition to the main SLA, or to agree a transfer of the staff to the PCT to enable the PCT to make the ECP fully productive by better integration of the work of the ECP with local services and pathways.

City and Hackney PCT has made a commitment to LAS to support 4 ECPs as part of its hospital admission avoidance initiative. The plan was to link emergency ECP assessment to GP, district nurse and social care responses, thereby avoiding transfer to hospital. Unfortunately, LAS has now withdrawn its commitment, the LAS argues that it needs to concentrate on achieving the London wide priorities. This is despite the fact that the PCT supported investment in the recruitment and training of staff and the resources are still available. The matter is being pursued.

Turnaround Times: A further gap that is in addition to the 5% financial gap, relates to the key assumption in the LAS proposal that hospital turnaround times will reduce by 5 minutes throughout 2009/10. This will not be achieved without each local health economy taking full responsibility (with PCTs working collaboratively with LAS & hospitals) for reducing all turnaround times that exceed 40 minutes to a maximum of 40 minutes – and by reducing other turnaround times of 30-40 minutes so that they are at a maximum of 30 minutes (n.b the Homerton is an exemplar in this regard). The cost of not addressing this issue will result in either continuing failed performance or in an additional cost of £7m/3.5% through a proposed system of penalties. There are currently 15,000 turnarounds per month that exceed 40 minutes and a further 21,000 turnarounds per month of 30-40 minutes.

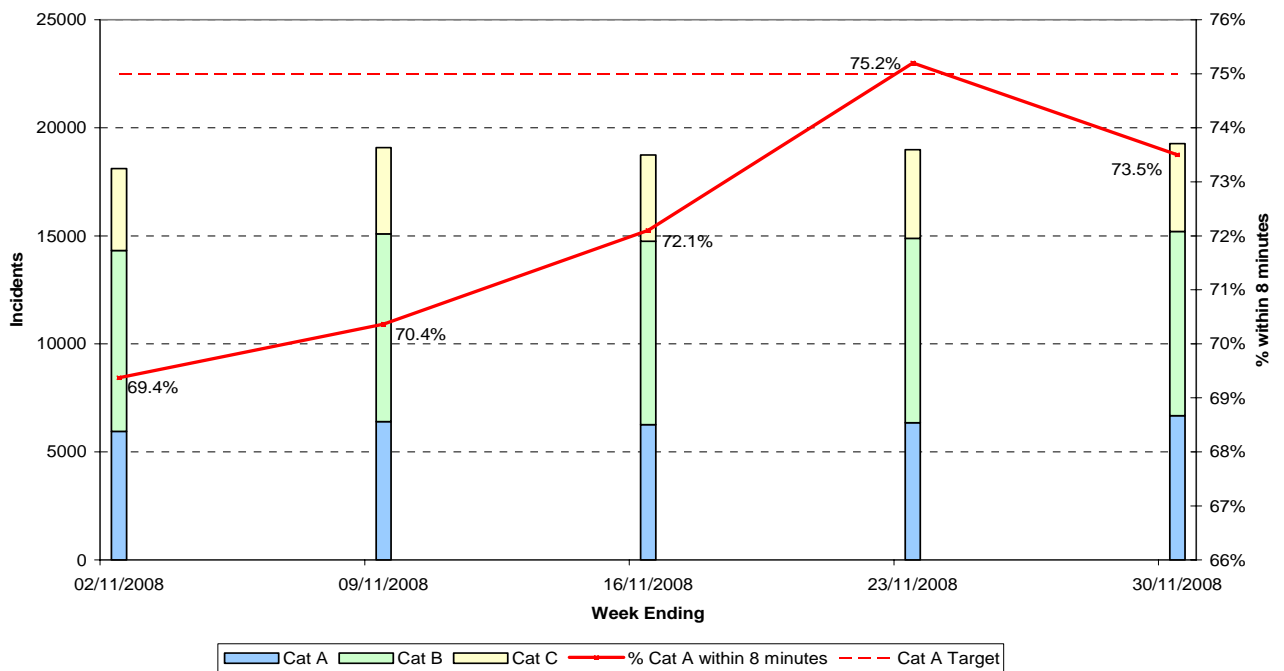
Category A

November 2008 data indicates year to date performance of 72.7% and Category A performance has improved for four weeks in a row reaching 75.2% for week ending 23/11/08. Exceptional demand during the final week of November saw this fall back to 73.5%

We are anticipating the end November position for Cat A will be circa 72.2% and is in line with the revised trajectories. Predicted year end performance per the 8minute standard is 75.02% against the 75% target.

The current **Cat A YTD** position is **73.2%** once all remaining data has been inputted.

Weekly Cat A performance



Category B

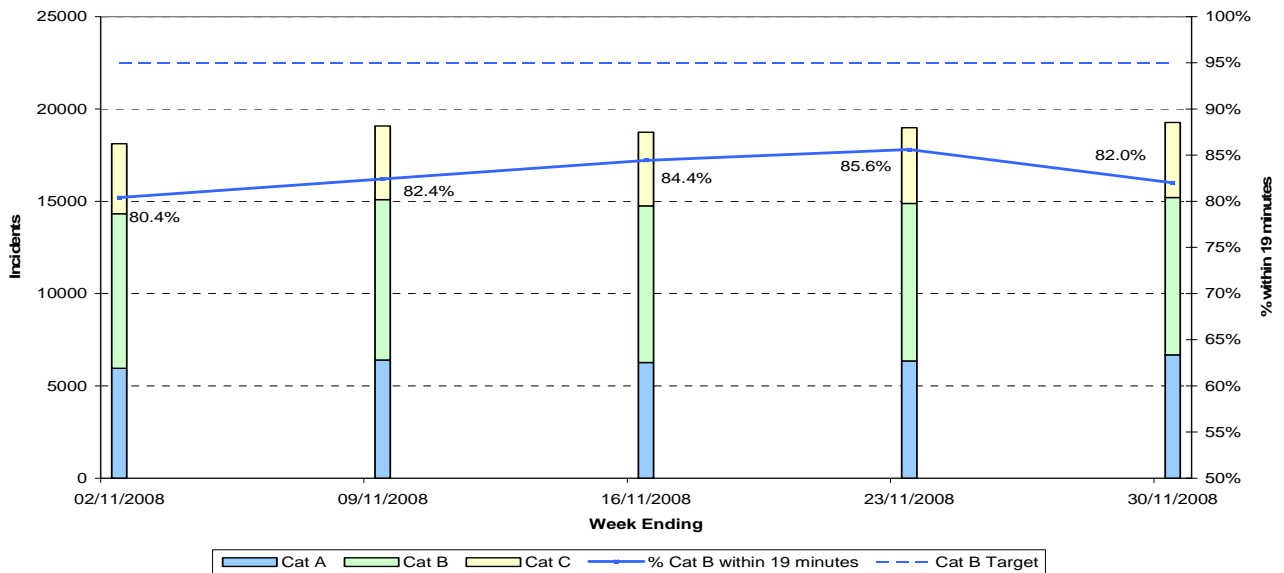
Category B performance has also improved week on week albeit slowly given that we are currently giving priority to improving Cat A whilst still making steady progress on Cat B.

As explained Category B performance is largely reliant on ambulance availability and currently ambulance utilisation levels are too high (68%) to allow us to make significant progress on Cat B without seeing a related and unacceptable drop in Cat A performance.

We are anticipating the end November position for Cat B will be circa 83.0% and is in line with the revised trajectories. Predicted year end performance for 19 minutes is 87.16% against the 95% target.

The current **Cat B YTD** position is **83.0%** once all remaining data has been inputted.

Weekly Cat B performance



Action to Improve Performance

Data Quality

C&H PCT will continue to work within the pan London commissioning approach described to improve data quality.

Management of Service Delivery

In September 2008, PCT's agreed to provide non recurrent mid year investment of £5.9M that would support the LAS programme to accelerate recruitment through providing funding for overtime costs. PCT's did however set a number of caveats including whether funds could be released and the requirement to meet revised trajectories. It is anticipated that LAS will invoice PCT's for their share of the £5.9M in three instalments at November 2008 and February and March 2009.

The action plan is held centrally and monitored by the LAS commissioning team. Please refer to the text of actions set out above for 09/10.

Action/Initiatives/ New Services Commissioned in 2009/10

Please refer to LAS 09/10 Recovery Plan.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£1,270,000		£1,270,000	

Risks to Delivery with Mitigating Actions Planned

Please refer to text of actions for 09/10 above.

3.2 13 week wait

Objective/Aim (inc. date by which target will be achieved)

To achieve zero 13+ week waiters from April 2009 onwards.

Latest Performance and forecast outturn

January 2008

71 breaches YTD. Forecast outturn – RED.

These breaches have resulted from system failures at Barts and The London.

Action to Improve Performance

Data Quality

The action plan to recover the performance on 13 weeks is part of the Stabilisation Programme at BLT to deliver on all waiting times targets.

This is a detailed programme that covers:

- ❖ Project management and governance arrangements
- ❖ Data completeness and data quality
- ❖ Improved management of the PTL
- ❖ Enhanced activity flows
- ❖ Improved performance reporting
- ❖ Strengthened clinical engagement
- ❖ Improved processes in the Central Appointments Office
- ❖ Improved service management
- ❖ Reduced waits for diagnostics and e-appointments
- ❖ PCT led initiatives

The resources in the Information Team will be reviewed to ensure that this is appropriately resourced.

The weekly and monthly performance information will be revised.

Management of Service Delivery

A new PTL report is being developed to ensure that potential breaches are flagged to service managers in advance enabling re-scheduling of these patients. A breach prevention process will be agreed and mapped for service managers to use.

Pathway co-ordinators will work with the services to improve patient flows through the trust.

High priority pathways (those at the greatest risk of breaching) will be proactively managed.

The capacity planning model used will be reviewed and updated, then training will be provided across the divisions to ensure that it is used appropriately. The high volume/high risk specialties will be

prioritised.

Clinical and managerial problem solving teams will be established for each specialty, with regular communication channels for key issues.

The Central Appointments Office and Scheduling Teams will be reviewed. There will be timely processing and booking of all appointments.

There will be ongoing work with THPCT and the PBC Executive to ensure demand management processes and services are fully achieving their objectives.

Action/Initiatives/ New Services Commissioned in 2009/10

Commissioned activity will be sufficient to deliver the waiting times targets in 2009/10. (see capacity planning assumptions outlined in 1.1)

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In capacity plan			

Risks to Delivery with Mitigating Actions Planned

Risks to delivery include:

Changes in number of referrals and increased demand
CRS issues

These risks will be managed through the performance improvement infrastructure, which will identify potential problem areas, undertake deep-dive problem solving and capacity plan refinement as required.

3.3 26 week wait

Objective/Aim (inc. date by which target will be achieved)

To achieve zero 26+ week waiters from April 2009 onwards.

Latest Performance and forecast outturn

January 2008 20 breaches YTD. Forecast out-turn RED.

These breaches have resulted from system failures at Barts and The London.

Action to Improve Performance

Data Quality

The action plan to recover the performance on 26 weeks is wrapped up in the Stabilisation Programme at BLT to deliver on all waiting times targets.

This is a detailed programme that covers:

- ❖ Project management and governance arrangements
- ❖ Data completeness and data quality
- ❖ Improved management of the PTL
- ❖ Enhanced activity flows
- ❖ Improved performance reporting
- ❖ Strengthened clinical engagement
- ❖ Improved processes in the Central Appointments Office
- ❖ Improved service management
- ❖ Reduced waits for diagnostics and e-appointments
- ❖ PCT led initiatives

The resources in the Information Team will be reviewed to ensure that this is appropriately resourced.

The weekly and monthly performance information will be revised.

Management of Service Delivery

A new PTL report is being developed to ensure that potential breaches are flagged to service managers in advance enabling re-scheduling of these patients. A breach prevention process will be agreed and mapped for service managers to use.

Pathway co-ordinators will work with the services to improve patient flows through the trust.

High priority pathways (those at the greatest risk of breaching) will be proactively managed.

The capacity planning model used will be reviewed and updated, then training will be provided across the divisions to ensure that it is used appropriately. The high volume/high risk specialties will be prioritised.

Clinical and managerial problem solving teams will be established for each specialty, with regular communication channels for key issues.

The Central Appointments Office and Scheduling Teams will be reviewed. There will be timely processing and booking of all appointments.

There will be ongoing work with THPCT and the PBC Executive to ensure demand management processes and services are fully achieving their objectives.

Action/Initiatives/ New Services Commissioned in 2009/10

Commissioned activity will be sufficient to deliver the waiting times targets in 2009/10. (see capacity planning assumptions outlined in 1.1).

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
In capacity plan			

Risks to Delivery with Mitigating Actions Planned

Risks to delivery include:

Changes in number of referrals and increased demand
CRS issues

These risks will be managed through the performance improvement infrastructure, which will identify potential problem areas, undertake deep-dive problem solving and capacity plan refinement as required.

3.4 Cancer Waiting Times – VSA11 and VSA13

Objective/Aim (inc. date by which target will be achieved)

Cancer Waiting Times Standards : 62 Day wait from consultant upgrade of screening programme
: 31 Day wait for surgery or chemotherapy subsequent treatment
: Due for delivery by December 2008

The DSCN and data definitions for these standards were delayed at a national level. Trusts have been submitting to Open Exeter. January data will be reported mid March with Q4 in mid May. The new definitions and delayed data entry mean that initial data is likely to be incomplete and also that there will be a shortened window for providers to enter a full quarter's data. Additionally, the rules for recording cancer waiting times, including facility to 'stop the clock' where clinically appropriate, have been amended to comply with the 18 Weeks process. The current operational threshold (95% for 62 Days and 98% for 31 Days) will change to lower levels which will reflect this but these are yet to be set. Robust data on compliance is unlikely to be available until later in 2009.

The aim is take mitigating action both to ensure that monitoring data is available as soon as possible and that clinically effective care pathways are in place that will deliver care within the required standards.

Latest Performance and forecast outturn

Following delays in national data definitions, providers have commenced submitting PTL data. Trusts have been submitting to Open Exeter. January data will be reported mid March with Q4 in mid May.

Action to Improve Performance

Data Quality

The Network have facilitated the development of data systems in response to the new standards. The Cancer Taskforce, chaired by the Network Director, is responsible to the Network Board for the delivery of waiting times and brings together leads from all providers and all PCTs. A data subgroup, chaired by the Network Data and Information Manager, has been in place to steer the data and monitoring information requirements of the new standards.

The Network facilitated a review of data systems which led to a recommendation that providers should procure the Somerset Cancer Register system. A grant covering the capital purchase was made available from the Network's service improvement budget and all trusts in the network have accepted this recommendation and will procure this software package that will support cancer waiting times and other datasets and has been configured to meet the DSCN for the extended standards.

In the interim and prior to installation of Somerset, providers have adapted their current systems to enable data entry to Open Exeter when this is available and to support the population of PTLs.

Management of Service Delivery

All trusts have Cancer Waiting Times Offices and operate single points of referral

These offices and functions form the hub of the management and tracking of patients through pathways both within trusts and for inter-trust referrals.

Within trusts, MDTs have the key responsibility for the delivery of treatments and care within the standards with a particularly important role for the MDT coordinator

Action/Initiatives/ New Services Commissioned in 2009/10

Network Cancer Taskforce longstanding collaborative group originally configured to support delivery on earlier cancer waiting times standards and well placed to steer the implementation of these extended standards

Data sub group of Taskforce specifically configured to oversee the complex data issues of the extended standards

Decision of providers to accept recommendation and funding from Network to standardise on Somerset Cancer Register as a widely used cancer data system that will be compliant with the DSCN

Service improvement best practice built in to existing care pathways will facilitate compliance but the good understanding of the pathways will enable further redesign if issues threatening compliance emerge

Network facilitated a General Manager level 'inter trust' forum responding to the understood challenges of compliance when treatments require referral between organisations – this group will be re-introduced if necessary to allow corporate level communication on best practice.

Network facilitating a programme of MDT coordinator training

Network facilitating a workshop specifically targeted at compliance with the screening detected cancer element of VSA13

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
See cancer mortality	See cancer mortality	See cancer mortality	See cancer mortality

Risks to Delivery with Mitigating Actions Planned

Patients are not treated within the 31 and 62 day standards: Network policy of commissioning against agreed clinically effective care pathways reduces this risk of this. Network cancer site specific Tumour Advisory Boards are monitoring agreed audit metrics/key performance indicators against each pathway and this exercise has been shown to highlight problems and constraints.

That screening patients are not treated within standard: Screening workshop aims to ensure understanding of definitions and understanding of screening pathways. Service improvement resource available if required.

Grip on patient tracking slips: Trust lead cancer teams and cancer referral office staff are critical to this and vacancies during 2008 have translated into reduced compliance with existing waiting times standards at BHR, for example. Network Team to monitor on behalf of PCTs

Data not currently available to monitor compliance: Data subgroup has agreed that trusts will copy

PTL to network team who will monitor and respond accordingly.

Providers do not submit PTL: Process established except for at BHR – Network Team to facilitate.

General risks of data collection and monitoring: Network Director and Information Manager are and will fully participate in NHS London led communications group

Open Exeter not available on time: Network Team to maintain communications with national process.

Sustainability of cancer waiting times proves to relate to data capture that is integrated with the 18 Week process: Network Team has agreed with providers to explore and pilot such integration and is working with NHS London leads on this.

Change in the national operational threshold caused by move of cancer to 18 Weeks process differs from that expected: Threshold will be determined once data is available. It is know to vary by cancer type and will vary between intra and inter trust treatments. It will therefore be sensitive to case mix and care will need to be taken to understand the data.

Data continues to lack robustness to allow informed performance management or to identify accurately the remedial actions needed: National Cancer Network Directors Forum and discussing, in a joint meeting with Network Medical Directors, communication with the Healthcare Commission to ensure understanding of the severe constraints that have been introduced by the delayed data definitions and DSCN.

3.5 Cancer IOG Implementation Plan

Objective/Aim (inc. date by which target will be achieved)

NICE Head and Neck Cancers Improving Outcomes Guidance

The requirement to fully implement the NICE Head and Neck Cancers Improving Outcomes Guidance (IOG) by 31/12/08 was not achieved.

All other IOG's required to be fully implemented by 31/12/2008 have been delivered.

The key shortfalls in full implementation are:

- The network wide Specialist Multi Disciplinary Team meeting was not in place
- A minority of the specialist major surgery required to be undertaken at the designated surgical centre and cared for in the designated cancer ward remains at Queen's Hospital Romford
- The Local Support teams, for rehabilitation, throughout the network require more robust implementation

Full implementation is planned by 30th September 2009

Latest Performance and forecast outturn

A project plan for implementation is being facilitated by the Cancer Network with input from a part time consultant project manager employed by the Network

The Specialist MDT commenced meeting on the 14th January through the combination of the MDT based at Queen's Romford with the MDT based at Barts that already covers the rest of the network.

This meeting was compromised by the functionality of the newly installed videoconferencing equipment but it is anticipated that this meeting will take place weekly from now on and with the core membership required by the IOG.

Barking and Dagenham PCT, as lead commissioner for cancer at BHRT, have signified the intention to decommission specialist Head and Neck cancer surgery at Queen's Romford and to commission it from BLT at Barts with effect from April 2009.

The Network Allied Health Professional Lead is facilitating the development of Local Support Teams and a Supportive Care MDT. This is not a function or a term used by the IOG but is considered key to the robust delivery of the Local Support Teams.

Action to Improve Performance

Data Quality

N/A

Management of Service Delivery

The Cancer Network have facilitated the delivery of the remedial action plans and have employed a part time consultant to project manage the programme. This has been steered through a group, chaired by the Network Director, bringing together operational leads from all of the trusts in the network.

The December 2008 Network Board agreed to the Director's recommendation that, once the Specialist MDT was established, the managerial lead for the action plan should revert to Barts and the London NHST as the lead provider.

Overall service delivery will be led by the Specialist MDT who will make treatment decisions for the management of each patient. MDT treatment decisions will be implemented by the appropriate provider and in line with the IOG. Diagnostics, rehabilitation and supportive care, radiotherapy, chemotherapy together with non-major and diagnostic surgery will be delivered as local as possible. Specified major surgery will be undertaken at Barts.

Action/Initiatives/ New Services Commissioned in 2009/10

- Network facilitating recovery plans on behalf of all PCTs
- Including remedial action plans from external peer review visits
- Project manager in place funded by PCTs through the Network budget
- Clinician job plans reconfigured to allow new joint SMDT meeting on Wednesdays
- Specialist major surgery decommissioned at Queen's Romford and commissioned at Barts.
- Video conferencing equipment scheme at BLT enhanced through service improvement funding from Network to enable multi-point MDT conferencing.
- Local supportive care teams facilitated by network Allied Health Professional Lead

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
See cancer mortality	See cancer mortality	See cancer mortality	See cancer mortality

Risks to Delivery with Mitigating Actions Planned

- SMDT meeting does not function: SMDT is key to the delivery of the IOG and this network wide meeting will make treatment decisions in line with the NICE requirements and therefore within a clinical governance framework. Trust Medical Directors are engaged and supportive of this new group.
- SMDT does not have full core member support including pathology: Pathology identified as a risk. Earlier network funded additional post indicates that resource should be in baseline reference costs and therefore 'in-tariff' BLT clinical director of pathology engaged and will facilitate appropriate input to MDT.
- Video conferencing equipment remains dysfunctional: Risk shared with other MDTs and Network to assess requirement for a short term technical project to remedy.
- Surgery does not transfer by April as planned. A small number of procedures are involved but surgeons have been unwilling to transfer their operating base for these and Romford based patient support group have had concerns on their need to travel for treatment. Network has liaised with support group and responded to their concerns including taking national advice. Treatments to transfer will be restricted to the confirmed requirements of the IOG and all other treatments agreed to be made available locally (including radiotherapy). SMDT decision making will determine the appropriate location of surgery within a clinical

governance framework. Trust Medical Directors engaged and supportive.

- SMDT does not take a whole pathway approach and therefore policies and processes for supportive care not fully worked through: Network will assess requirement for ongoing project management of this.

4. Other topics highlighted in the Operating Framework

4.1 Child health

(inc. Healthy Child Programme, children with a disability, safeguarding children, children's centres, new-born hearing screening)

Objective/Aim

Child Health Promotion Programme

The Child Health Programme aims to ensure that an integrated and co-ordinated multi-agency and multi-professional approach is adopted in implementing the revised Child Health Promotion Programme so that it is available and accessible to all families resident within City & Hackney. Its objectives are to:

To develop and implement the revised universal Child Health Promotion Programme.

To develop targeted programmes and design support for vulnerable children and their families e.g. parenting support

To ensure that the provision of child health services meets the needs of all children particularly 'hard to reach groups' i.e. asylum seekers, refugees, travellers, homeless families, looked after and those with special needs.

To develop systems that will promote equity of provision and access to child health services as a way in which to reduce inequalities in health.

To ensure that the core competences required in delivering child health promotion services are reflected in training programmes, which are commissioned.

To actively promote information sharing between professionals and with families regarding children's health and social wellbeing.

To agree, implement and monitor standards of care for child health promotion.

To audit activity and outcomes in relation to the Child Health Promotion Programme in City & Hackney.

New Born Hearing Screening -The early identification of hearing impairment and deafness in newly born children enables timely management which can improve hearing, language development and communication skills. This results in better educational attainment and quality of life. As part of the screening pathway all parents are offered a screening test for their infants in the first few weeks of life and referred on to specialist services as necessary,

Disabled Children The aims /Objectives in the draft Disabled Children's Plan 2009-12 include

- To promote effective earlier intervention by identifying disabled children and young people and using effective interventions and support services
- To Improve co-ordination of assessments and quality of service delivery
- To provide good quality services to meet the needs of disabled children and their families
- To provide good information to families of disabled children about relevant services and how they are accessed
- To Improve access to universal services in a wider range of settings (including- Children's centres, extended schools, play services, leisure services & housing)
- To improve efficiency and VFM of services – full implementation of Performance framework for all services for disabled children and their families
- To reduce waiting times for services
- To involve disabled young people and parents and carers of disabled children in improving services
- To develop a work force that has the necessary core competencies to deliver good quality services to disabled children and their families

Safeguarding Children

The PCT aims to contribute fully to the inter- agency arrangements to ensure the Safeguarding of all children in Hackney. This also includes liaising with Adult Mental Health services where children with parents who have mental health needs may need safeguarding services.

The PCT undertakes its responsibilities by adhering to and fully implementing the multi agency policies and procedures agreed by the Safeguarding Board. This includes ensuring all staff have the appropriate training to contribute to multi agency safeguarding arrangements and professional practice is appropriately supervised and audited.

Adolescent Health

The PCT has developed its service provision for young people aged 11-19, and also contributes to the partnership model of the youth offer for Hackney. The service aims to offer universal access, information advice and support, as well as targeted and specialist interventions for vulnerable groups. The service offers interventions to support physical health, mental and emotional health, sexual health and management of long term conditions. The service also promotes the implementation of 'You're Welcome' Standards across settings for young people and works with partner agencies to support access to health services in non-health settings, the implementation of the CAF, and better pathways across services.

Looked After Children

The PCT contributes with partner agencies to support the strategic and operational duties to promote the educational achievement of children who are looked after. The PCT provides health care, assessment, treatment and support and works with partners to support children looked after in developing personal and social skills to care for their health and wellbeing.

Children's centres

The PCT aims to contribute a full range of health services to the overall service delivery within Children's Centres. PCT staff will contribute to optimising the inter agency collaboration and liaison to support all service users with particular emphasis on providing co-ordinated health services to children under 5 and their families as well as parenting and the promotion of health and well-being of children and families using the centres.

Action/Initiatives/ New Services Commissioned in 2009/10

Child Health promotion Programme Nursery Project to improve the life chances of children by providing early therapeutic intervention in nursery setting to assist with S< services. No new services or additions to the existing NHSP service is planned for 09/10. A recent independent audit of the programme rated the service as satisfactory overall and highlighted some areas for improvement. These are being addressed within existing service resource. Strategic commissioning will continue to monitor the progress of the service.

Disabled children An extension of the Short Breaks project to enable disabled children with complex health needs including palliative care to get the opportunity for positive experiences (Increasing from £100k FYE to £200K in 09/10)7 b) Improving the life chances of disabled children to provide specialist therapist services for Children with ASD, to increase medical support for children with complex needs and to provide Leisure cards for Disabled children (£386k)

Safeguarding Children- To contribute to the increased effectiveness of the Children's Safeguarding Board

Children's centres – will continue to be the focus of much early intervention work across a wide range of services. The children's centres will be increasingly the fulcrum for the co-ordination & liaison of services and performance management will be developed during 09/10

Homerton hospital has an antenatal screening coordinator in post. They are undertaking audits including on communicable diseases. A steering group oversees the work, there is also a guideline in place for bloodspot screening and a steering group is working on meeting the new standards. Six monthly training takes place for health visitors and midwives.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£1,329,000	£9,000	£1,329,000	£9,000

4.2 Dementia

(PCT plans to improve local services)

Objective/Aim

Increasing Capacity and Choice in Dementia Care

1. Implementation of the national Dementia and Carers strategies
2. Roll-out of City and Hackney Older People's Mental Health strategy
3. Increased levels of psychological treatment in secondary and primary services
4. Earlier intervention and services routinely accessible to people over 50 years
5. Greater levels of independence maintained for longer periods of time with fewer mental health admissions
6. Improved levels of physical health with fewer/shorter acute hospital admissions
7. Under-diagnosis tackled – moving from under 50% to over 70%
8. Greater support/improved health for carers

Action/Initiatives/ New Services Commissioned in 2009/10

The multi-agency Older Peoples' Mental Health strategy will be launched in 2009-10. This will build on the programme set out in the Commissioning Strategic Plan in 2008-09 and incorporates the proposals set out in the national draft Dementia Strategy. The funding for the four year CSP programme rises from £315,000 to £630,000 in 2009-10. A budget of £550,000 (£680,000 FYE) has been allocated for the national Dementia Strategy implementation. This builds on the Older People's Mental Health needs assessment carried out in 2007-08. The budget of £585,000 (£615,000 FYE) allocated for the national Carer's Strategy will make a significant contribution to work with people with dementia.

The CSP outlined a four year programme to expand and develop the East London NHS Foundation Trust community dementia services and memory clinic and provide 2 'care navigators' and a dementia service directory through the Alzheimer's Society. The community team will become fully operational early in 2009-10 and the Memory clinic has been co-located with Homerton University Hospital Foundation Trust older people's services.

Resources for the community team consist of £660,000 savings from the closure of a 15 bed continuing care ward and a PCT investment that increases to £360,000 in 2009-10. Funding for the Memory Clinic increases from £135,000 to £270,000 in 2009-10. This will rise to £540,000 by 2011-12. The Alzheimer's Society service directory has been funded on a non-recurring basis at a cost of £17,000. The directory will appear imprinted form and will be updated on the City and Hackney Alzheimer's Society's website. Two care navigators have been appointed with recurring funding of £75,000.

The aim is to increase the level of assessments for people with dementia by 25% over a four year period and provide greater support for patients and their carers. The investments linked to the national Dementia and Carers strategies will lead to a significant increase in support and respite breaks capacity. The roll-out of the Carers strategy will involve the development of a joint approach with the local authority and appointment of a specific joint commissioner for carers' services.

The Older People's Mental Health needs assessment indicated that the projected increase in the number of people with dementia in the City and Hackney will be well below the national average identified by the National Audit Office. Overall the over 65 population will increase by just over 7% by

2018. This represents a further 1390 older people, with the largest change being in the 65 – 69 age group (760 more people) and the 85+ (430 more). There will be a very slight decrease in the 75 – 84 age group. It is estimated that there are 1770 older people with dementia in the City and Hackney. This will rise to 1903 older people by 2018. More than half of these will be over the age of 80 years..

Currently the number of people with dementia seen by the mental health trust has reflected the national picture. It is estimated that the service has seen just under 50% of the estimated need population. The trust' services are not age specific but the numbers of people with early onset dementia have been small. The PCT's aim is to increase assessment and support levels and develop preventative services for people aged 50 years and above. These services will work with younger people with a diagnosis of dementia.

The PCT investment in the national Dementia strategy aims to begin implementation through modest increases in promoting awareness and larger budgets for early intervention and additional support for people with dementia. A procurement exercise will identify the organisation(s) to promote awareness and develop a range of health and wellbeing initiatives for people aged 50 years and over, with particular emphasis on early detection as well as offering ongoing support following diagnosis and brief treatment by secondary mental health services, particularly with regard to depression and dementia.

Once commissioned, the organisation will be expected to develop new services ensuring the attachment of existing specialist CPNs to voluntary, primary and secondary settings. The intention is to promote early detection/early support pathways with particular emphasis on supporting carers and those who are isolated and live alone to access to the full range of existing leisure and cultural activities. The commissioned organisation would aim to develop the skills and abilities of volunteers to support the project and be responsible for sub-contracting where appropriate, managing spend, monitoring and evaluating the impact and outcomes of services, reporting regularly to the PCT-led steering group.

The aim is to enhance the range of options available to those over 50 years to promote understanding and management of mental health conditions and their general health and wellbeing. New services would be open to self-referral and / or signposting from GP's and other health and social care professionals. This would enhance likelihood of early detection and take up of support, improving overall health outcomes, reducing inequalities and promoting social inclusion. The project will also support Carers access to a wider range of services, including advice, information and support to access further education, training and employment.

Increasing Access to Psychological Therapies resources are being used to prioritise increased levels of referrals to Primary Care Psychology for older people with depression (see section 4.5 below). The PCT is also increasing the capacity of the secondary Older People's psychology service by 2 CBT therapists. This increase in capacity will include with people with dementia where clinically appropriate.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£680,000	£25,000	£680,000	£25,000

4.3 End of life care

(PCT plans to deliver extended and improved service provision)

Objective/Aim

During 2007 the PCT undertook a baseline audit of End of Life Care services for City & Hackney. The audit outlined a range of areas of strength and good practice as well gaps in provision for patients and carers. As well as the baseline audit, the PCT contributed to the National Audit Office, End of Life Care Audit which looked at City & Hackney's management of end of life care services.

The outcomes of these audits as well as the publication by the Department of Health, of the National End of Life Care Strategy has contributed to the PCT's and local partners action plan for strengthening end of life care services.

Within City and Hackney the number of people dying in acute hospital setting peaked in 06/07 at 678 people. We are currently unable to identify the proportion of those who, without access to EoLC support could have died at home. Current data suggests that the number of people dying in hospital has reduced by 20% since 06/07.

We have worked since 07/08 to increase available support in community settings for those in need of palliative or end of life services. (19% increase capacity). As well increasing access to specialist end of life care services we are working to increase the awareness and skills of front line staff to support carers and further supporting people to die in a place of their choice.

We are aiming to establish reliable statistics on the EoLC cohort during 09/10.

Additional investments secured service developments in 08/09 further developments are planned for 09/10.

Action/Initiatives/ New Services Commissioned in 2009/10

During 2009/2010 we will:

Further increase in capacity within First Response Provider Team, a multi-disciplinary service (nursing, therapy and home care) which supports people at home and aids hospital discharge. Capacity will increase by 13% from 11,500 care hours per year in 2008/09 to 13,000 care hours in 2009/10.

Increase capacity within the night sitting service, which support patients and carers at home and provides respite for carers. Capacity will increase by 25% from 15,000 care hours in 08/09 to 18,760 care hours in 09/10.

Develop new service capacity for Bereavement Counselling, both pre and post bereavement for patients and carers aged under 50. Expected to provide 750 counselling hours to an average 63 people per year. Bereavement services for those aged over 50, are already in place.

Develop further training programmes for front line staff, particularly looking at communication, advanced care planning and stronger knowledge of end of life care services.

Further roll out of the Liverpool Care Pathway in the across the Homerton hospital and in the community.

Increased support and information for carers.

Work with and support local nursing home providers to develop skills and competencies within end of life care.

Support the development of a Collaborative Commissioning Initiative for End of Life Care across North East London, The CCI has 5 work streams

- Education and Training
- End of Life Register
- Quality Assurance in End of Life Provision
- Bereavement Care
- Rapid Response Services

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£624,000		£624,000	£0

4.4 Mental health

(rollout of the Improving Access to Psychological Therapies programme, delivering race equality in mental health, physical health checks, ensuring that no 16-17 year olds are treated on adult wards)

Objective/Aim

1. To increase early intervention and preventative services for children and young people, reduce admissions and improve transitions to adult services.
2. To achieve full implementation of IAPT compliant psychological therapies with a maximum 2-3 week wait for treatment by primary services and 5 weeks by secondary services.
3. To increase services for people with unexplained medical symptoms and reduce inappropriate admissions, referrals and investigations.
4. To increase the numbers of people with mild/moderate anxiety and depression and people known to secondary services returning to employment and reduce the numbers of people with mental health problems becoming unemployed.
5. To further reduce the level of acute psychiatric admissions for adults and older people and reduce average lengths of stay.
6. To implement the national Dementia Strategy and increase the level early intervention and prevention, assessments, treatment and support for older people with mental health problems.

Action/Initiatives/ New Services Commissioned in 2009/10

The Mental Health of Adults of Working Age National Service Framework has been largely implemented in the city and Hackney. The Adult Mental Health Strategy 2008-11 identified a strong investment programme in community based Wellbeing and Inclusion services – housing and employment in particular – and a reduced use of institutional care. This is being re-enforced by the work of the Section 31 Mental Health Executive group to reduce the numbers of residential care placements and increase the level of supported housing tenancies and floating support workers.

In 2008 the Commissioning Strategic Plan set out the intention to increase investment in the following areas:

- Primary Care Mental Health
- Psychological Therapies
- CAMHS access and capacity with increased provision for minority ethnic groups
- Older People's services with a strong emphasis on dementia assessment and provision

The Operating Plan for 2009-10 continues these priorities with added measures relating to health and wellbeing (including physical health checks), effective use of adult inpatient beds and delivering race equality.

Primary Care Mental Health

The GP Practice Based Commissioning consortia have identified significant gaps in current mental health services. A new Primary Care Mental Health Team has been commissioned by tender with a budget of £460,000 in 2009-10 rising to £715,000 by 2011-12. The service will provide practice based workers offering individual and group sessions. The focus will be on patients with unexplained physical symptoms or people with mental health difficulties who do not meet current eligibility criteria or have been discharged by primary or secondary services. The team will work in an integrated network along with Primary Care Psychology, existing secondary services and the new

Secondary/Primary Care Liaison service that was commissioned in 2008-09. Tribal Consulting has designed a performance management framework for the team and a formal review will be undertaken early in 2010-11.

Increasing Access to Psychological Therapies

The multi-agency Psychological Therapies Strategy was launched in June 2008. This set out the road map to create a single point of referral, a stepped model of care and a radical reduction in waits for treatment with increased provision for minority ethnic groups. In April the PCT was selected as one of three Increasing Access to Psychological Therapies (IAPT) expansion sites in London. The PCT invested £1.174 million in addition to £645,000 IAPT funding. A further £1.7 million will be invested in Primary Care Psychology services in 2009-10 and an additional £200,000 in secondary services to complete a four year growth programme to achieve a maximum wait of 5 weeks to treatment.

Child and Adolescent Mental Health Services

The PCT has commissioned 15 adolescent inpatient beds and 6 day places from the East London NHS Foundation Trust at the Coborn Unit through Specialist Commissioning on a joint basis with Newham and Tower Hamlets PCTs. This provision is described by the Children's Commissioner in the report 'Out of the Shadows? A review of the responses to recommendations made in "Pushed into the Shadows: young people's experience of adult mental health facilities' as "... an excellent example of what can be achieved through joint working between local commissioners and providers is that of the East London and The City Mental Health NHS Trust.

As a result the commissioning of the Coborn Unit no 16 -17 year olds are routinely admitted to adult wards.

CAMHS commissioning is focusing on early intervention and preventative programmes. Following on from the major expansion of primary and secondary CAMHS services commissioned in 2008-09, there will be four areas of development in 2009-10.

The existing secondary Parental Mental Health service will be expanded with 3 additional staff to work with children with parents/carers with mental health problems. A new 18 – 25 year old service will be commissioned to provide services to young people who do not meet the criteria for secondary services. This will enable continuity of service and act as a bridge to mainstream community services. The third project relates to a research exercise into the reasons for poor take-up of CAMHS service from minority ethnic groups. This is described in more detail in the Delivering Race Equality section below. Finally improvements will be made to paediatric liaison services with the appointment of a part-time nurse and part-time psychologist.

Effective Use of Adult Inpatient Beds

Adult inpatient beds have been under pressure following the rebalancing of adult inpatient and low secure beds in July 2008. Delayed discharges have been reduced but further improvements can be made in admissions avoidance and average lengths of stay. A second Home Treatment Team consultant will be commissioned along with a staff grade doctor, bed manager and discharge co-ordinator.

The improvements in liaison psychiatry described in the Health and Wellbeing section below will also include a consultant, staff grade doctor, nurse and care pathway co-ordinator to work with patients with mental health problems. This element of the service will work closely with the Home Treatment team and provide earlier intervention and preventative work with frequent attendees in the A&E department.

Older People's Mental Health

Consultation on the multi-agency Older People's Mental Health Strategy has been completed and the Strategy will be launched in 2009-10. Section 4.3 sets out the detail on Dementia Services. Discussions are at an advanced stage concerning the future use of the two remaining 15 bed continuing care units for people with dementia. As well as the developments in services for people

with dementia priority has been given to increased treatment for anxiety and depression for older people by both primary and secondary services. Action is also being taken to avoid admissions and reduce lengths of stay on the older people's functional mental illness ward with the commissioning of an Intermediate Care Team.

Health and Wellbeing

The PCT has already commissioned a range of services to promote physical health. The GP Local Enhanced scheme has stimulated increases in the number of people on Severe Mental Illness registers who receive regular health checks. The remit of the Secondary/Primary Liaison Team with a consultant, staff grade doctor, 5 Gateway Workers and Physical Health Co-ordinators includes a specific priority for improved health assessments for people with mental health difficulties. Greenwich Leisure Limited has been commissioned to provide exercise referral services from GPs and practice based health trainers for patients with coronary heart disease. Additionally, the Public Health Directorate has appointed a specialist mental health smoking cessation worker.

GPs have expressed growing concerns about medically unexplained symptoms. A local GP is chair of the Healthcare for London Medically Unexplained Symptoms task group. This area has also been identified as a priority area in the NHS London Commissioning Intentions and Business Rules for 2009-10. The PCT has commissioned three areas of service development. The Primary Care Psychology service has a team that will offer specialist expertise in this area. A Liaison Psychiatry consultant, staff grade doctor and nurse will be commissioned to work with the Homerton Hospital and GPs to reduce the number of referrals and admissions of patients with medically unexplained symptoms and alcohol related conditions. One of the key responsibilities of the new Primary Care Mental Health team will be to work with patients from this group referred by GPs.

The Adult Mental Health Strategy has a strong emphasis on Wellbeing and Inclusion and the development of employment opportunity in particular. Poor physical health is an additional obstacle to employment for people

with mental health problems. There are three key initiatives being pursued by the PCT. An employment support team is being commissioned within the Primary Care Psychology Service. Funding for two existing projects will be mainstreamed - the LAA funded secondary employment support workers provided by MIND and the London Development Agency funded Akaba Project provided by KUSH Housing for African-Caribbean users. The third project will tender for a host organisation to build capacity in the voluntary sector to promote social inclusion and wellbeing with hard to reach communities.

Delivering Race Equality

The LIT has been working on a comprehensive plan to deliver race equality in local mental health services through a specific sub-group. The East London Mental Health NHS Foundation Trust has been commissioned to provide an associate director for Equality and Diversity and locality Equality and Diversity Co-ordinators with an ambitious programme of staff training and positive action. The trust has also overhauled and strengthened its interpreting and translation service.

Shoreditch Spa has been commissioned as the managing agency for the 4 Community Development Workers to provide a service that is independent of the mainstream statutory services. Voluntary sector funding has established a range of groups representing specific minority ethnic groups. Social Action for Health has also been commissioned to provide annual health guides training for ethnic minority groups. As well as increasing awareness of mainstream services these course have been very effective in helping service users find employment.

The University of Central Lancashire has carried out specific studies in relation to the Turkish-Kurdish and Orthodox Jewish communities and the PCT has commissioned specialist support workers for adults and for children and young people for these groups.

A further research project will be commissioned by identify the most effective form of preventative

and early intervention services for children and families from minority ethnic groups .tender to look into the reasons for poor take-up of CAMHS services by minority ethnic groups, African-Caribbean families in particular. This will involve action research with children and young people and older users of secondary services to identify reasons for poor take-up and barriers to using CAMHS services. Additional resources have been identified for commissioning in 2010-11 to deliver more acceptable services in the light of this research.

The PCT has commissioned five organisations to provide counselling services for minority ethnic groups and the Family Action service includes several Turkish-Kurdish workers. All these services are networked through cross-agency clinical meetings and are represented at the Psychological Therapies steering group. The secondary CBT service has conducted studies into the needs of four specific minority ethnic groups and a specific lead therapist has been appointed to implement the findings. The Trusts' Institute of Psychotrauma continues to take high numbers of referrals from minority ethnic groups, refugees in particular.

Summary of Commissioning Developments

The full list of new PCT investments in mental health services in 2009-10 and the full-year effect is set out in the table below.

	Development	2009-10 (£000s)	FYE (£000s)	Provider
Primary Care Mental Health				
1.	Practice based mental health workers – including capacity for unexplained medical symptoms cases	460	715	By tender
Increasing Access to Psychological Therapies				
2.	Primary Care Psychology staff (includes £459,755 growth in IAPT funding) - including unexplained medical symptoms team	916	916	PCT Community Services
3.	Primary Care Psychology increase in premises	804	804	PCT Community Services
4.	Secondary CBT therapists	145	145	ELNFT
Child and Adolescent Mental Health Services				
5.	Parental Mental Health Team expansion	139	184	East London NHS Foundation Trust (ELNFT)
6.	CAMHS 18 – 25 service	104	136	ELNFT
7.	CAMHS BME take-up project	85	280	ELNFT
8.	Paediatric liaison team	97	100	ELNFT
Effective Use of Inpatient Beds				
9.	Home Treatment Team enhancements	230	307	ELNFT

Older People's Mental Health			
10.	National Dementia Strategy (see.4.3)	365	930 By tender
11.	Community Dementia team	180	360 ELNFT
12.	Memory Clinic	135	540 ELNFT
13.	Older People's Intermediate Care team	120	240 ELNFT
14.	Older People's CBT therapists	58	117 ELNFT
Health and Wellbeing			
15.	Liaison Psychiatry expansion – including unexplained medical symptoms lead consultant	297	474 ELNFT
16.	Primary Care Psychology employment team and GPwSI	270	285 PCT Community Services
17.	MIND and KUSH employment workers (voluntary sector schemes)	355	411 City & Hackney MIND and Kush Housing
18.	Social Inclusion and Wellbeing voluntary sector capacity building	170	170 By tender
Total		4930	7114

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£3,098,000	£245,000	£3,098,000	£245,000

4.5 Military personnel

(commissioners to ensure priority access for military personnel for service-related conditions)

Objective/Aim

To ensure local GPs and providers of services are aware of the guidance in relation to priority access for military personnel, including pensioners.

Action/Initiatives/ New Services Commissioned in 2009/10

The PCT does not have military bases within or adjacent to the area.

Action has been taken to ensure that GPs as principal referrers to secondary care providers are aware of the guidance in relation to priority access. Local providers (the Homerton Hospital Foundation Trust, the East London and the City Mental Health Trust and City and Hackney PCT provider services have also been reminded of requirements. The matter will also be raised as part of contract negotiation and review processes.

4.6 Mixed sex accommodation

(relating to co-ordinating PCT responsibility for hosted providers)

Objective/Aim (N.B. PCTs and providers are to publish joint plans on eliminating mixed sex accommodation by 31 March)

Homerton Hospital

The Homerton have completed an action plan for mixed sex accommodation changes. These are outlined below. Single sex accommodation is defined as a single sex bay with single sex bathroom facilities.

Work completed so far:

- Thomas Audley – refurbished as female surgical
- Halley – refurbished as male surgical
- Priestley ward – female (gynae)
- Delivery Suite, Turpin (postnatal) and Obstetrics Assessment Unit – all female

All other wards are mixed wards, partitioned into single sex bays. The nearest bathroom is designated according to the gender of the bay (interchangeable according to demand)*.

Monitoring system for single sex breaches (defined per bay rather than per patient, as all patients in the bay are affected) is in place. (Clinical Site Managers report this daily to the information manager who adds it to breach report).

* On occasions this may mean patients have to pass across the head of the bay of patients of the opposite sex to reach the bathroom, although we try to keep this to a minimum.

Future Plans:

- Homerton will need to gather patient perceptions of mixed sex accommodation. One possibility is to do this via the Patient Electronic Tracker system (PET). This is under discussion
- Regular breaches report to PCT via clinical quality review group
- HUH has agreed to participate in a DH project starting end Jan 09 to develop a tool to support Trusts in understanding of where there is non-compliance with mixed sex accommodation guidelines and the reasons for it.

East London Mental Health Foundation Trust

In regard to ELMHFT, no mental health patients are in mixed wards because they are either in single rooms or small single sex shared rooms located within a 'ward' with separate male and female toilet/bathroom facilities. In some cases, patients have to pass other rooms which may be occupied by the members of the opposite sex in order to access the toilet/bathroom areas. Arguably, the single/shared rooms meet the 'screened off' criteria. There is also a female only ward and mother and bay unit.

The long-term plan is to relocate all the MH admissions wards to a new building on the St Leonard's site by 2012. This will have single rooms for all patients with en suite facilities to meet the DH 'Privacy and Dignity' standard for MH inpatients. CHPCT offered ELMHFT £195k in November for building works to improve privacy and dignity. The trust declined this because they did not feel that there were any significant adjustments they could make with such a small sum and adapting the current single rooms to en suite was not justified for such a relatively short period of time. It is doubtful that ELMHFT will be able to achieve all single sex wards in the new building the new building because of the pressure on beds.

Trajectory for 2009/10 for hosted Trust (sleeping accommodation)	2009/10 for hosted Trust (bathrooms)
A 5% improvement in patient perception on the 2007 position. At least 26% in 2008 if not better.	A 5% improvement in patient perception on the 2007 position. At least 36% in 2008 if not better.

Action/Initiatives/ New Services Commissioned in 2009/10
Please refer to plans described in main text.

4.7 People with learning disabilities

Objective/Aim (inc. annual health checks)

The learning disability service has been jointly commissioned by City and Hackney PCT and the London Borough of Hackney, since April 2004. The service has worked hard at developing integrated pathways to meet the needs of changing and more complex learning disability population. The Learning Disabilities Commissioning Strategy highlights gaps in local provision, which are being addressed through initiatives in brokerage, further integration, personalisation and a planned housing strategy for 2009/10.

There is a strong commitment to a partnership approach for learning disabilities service locally. The aims and intended outcomes of this partnership are:

1. to improve services for people with learning difficulties;
2. to provide a seamless service that will simplify access to services for service users with learning difficulties and their carers;
3. to establish single line management structure with clear lines of service and professional accountability within a single integrated service framework;
4. to develop integrated and co-ordinated approach to the assessment of individual needs based on a combined application of the care management policies of both Partners;
5. to enable a co-ordinated approach to the planning and development of services;
6. to enable an integrated approach to clinical case and service audit;
7. to develop integrated programmes of service improvement based on joint standards and service monitoring;
8. to ensure that resources are deployed in the most efficient way to avoid overlap and duplication;
9. to lead to an improvement in the way the Partners' Functions are exercised.

Subject to the results of a review of learning disability services which is currently being undertaken, these aims are likely to be amended to reflect new service models and pathways.

Action/Initiatives/ New Services Commissioned in 2009/10

The key elements of the Partnership Strategy for people with learning disabilities for 09-10 are:

As a result of the review of specialist community Learning Disabilities services, including day opportunities and in partnership with the London Borough of Hackney; re-specify and remodel the community learning disability team.

Inform, consult and involve service users, carers and local providers in the implementation of the emerging service model for learning disabilities.

Continue to promote the Learning Disabilities local enhanced service,

To address the issues concerning people with learning disabilities and their cares identified in the JSNA, by improving access to specialist learning disabilities services and work with generic primary and secondary health services to improve access and the patient experience for this client group.

To develop quality outcomes for the service this can be assessed annually by commissioners and self advocates and reported to the Partnership Board.

To commission a self advocacy service, aimed at improving user consultation and feedback on services. Improve support and participation in the activities of the learning disabilities Partnership Board.

As a result of the Review of services, strengthen governance arrangements of learning disability section 75 Executive Group.

Ensure the independence agenda is taken forward by increasing the number of people with learning disabilities in receipt of direct payments. Implement an Individualised Budgets project.

Review and develop protocols with Children's Services to ensure a smooth and effective transition of young people to adult services.

Develop a housing strategy for people with learning disabilities.

To maintain wait times for non-urgent outpatients assessment and therapies at less than 4 weeks.

To enhance the experience of Learning Disabled patients in acute hospital settings through the appointment of a Learning Disabilities Specialist Nurse at the Homerton, providing support to patients and their carers, as well as hospital staff.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
£470,000		£470,000	£0

5. Finance

Latest Performance and forecast outturn ('08/9)

The PCT has met all of its statutory financial duties since its inception and we did so again in 2007/08, namely we achieved operational financial balance, lived within our revenue and capital resource limits, lived within our cash limit, and achieved full cost recovery on our provider functions. We delivered a year-end surplus of £9.339m (2.28%), £21k within our Control Total in 2007/08. This surplus was returned to the PCT in 2008/09 under the rules of RAB (Resource Accounting and Budgeting).

Following the review of the national weighted capitation formula we have moved from being 3.5% under target (i.e. 3.5% below our 'fair share' target funding), to 6.6% over target. Subject to confirmation of the national pace of change policy to move PCTs to their target allocations, this is likely to mean less growth for City & Hackney from 2011/12 onwards, notwithstanding the uncertainties about future NHS growth generally. In the worst case scenario this could even mean real terms reductions in the PCT's funding.

All NHS organisations are required to break-even or deliver a small surplus each year as determined by SHA-set Control Totals. In previous years we have also contributed resources to the wider NHS community in London through top-slices of our allocation. In addition we voluntarily contributed resources by lodging funds with NHS London.

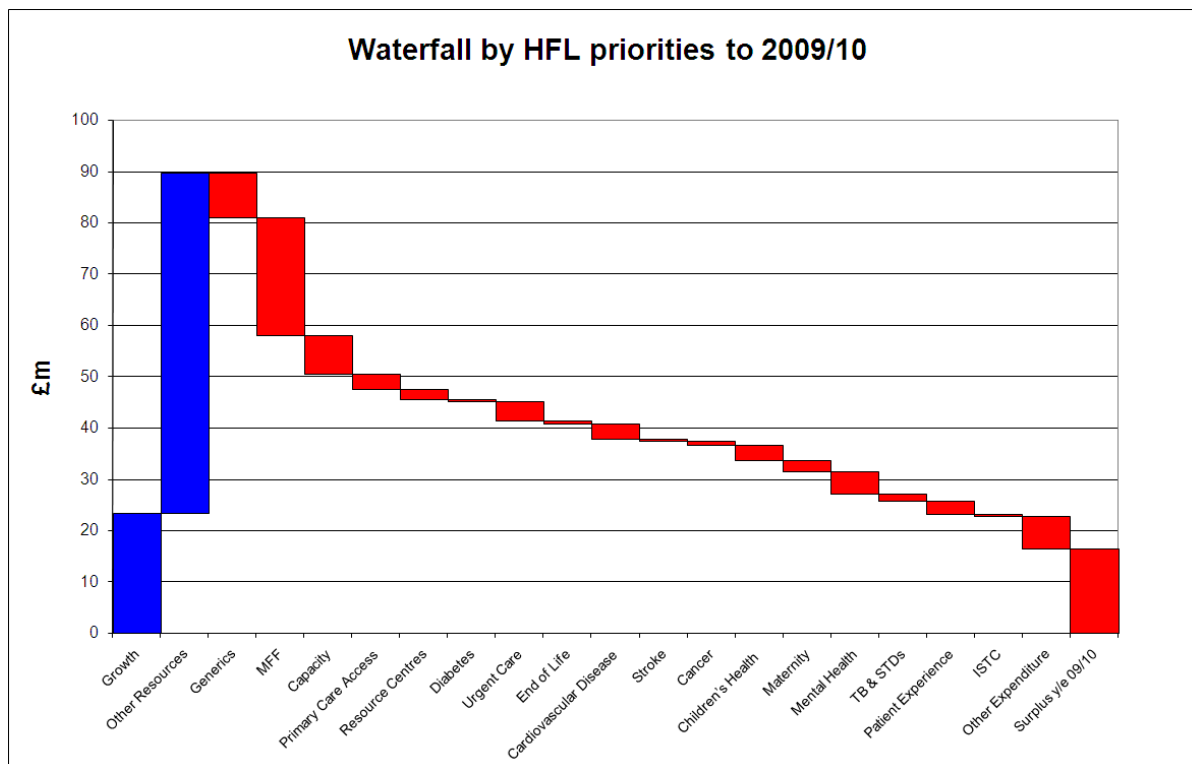
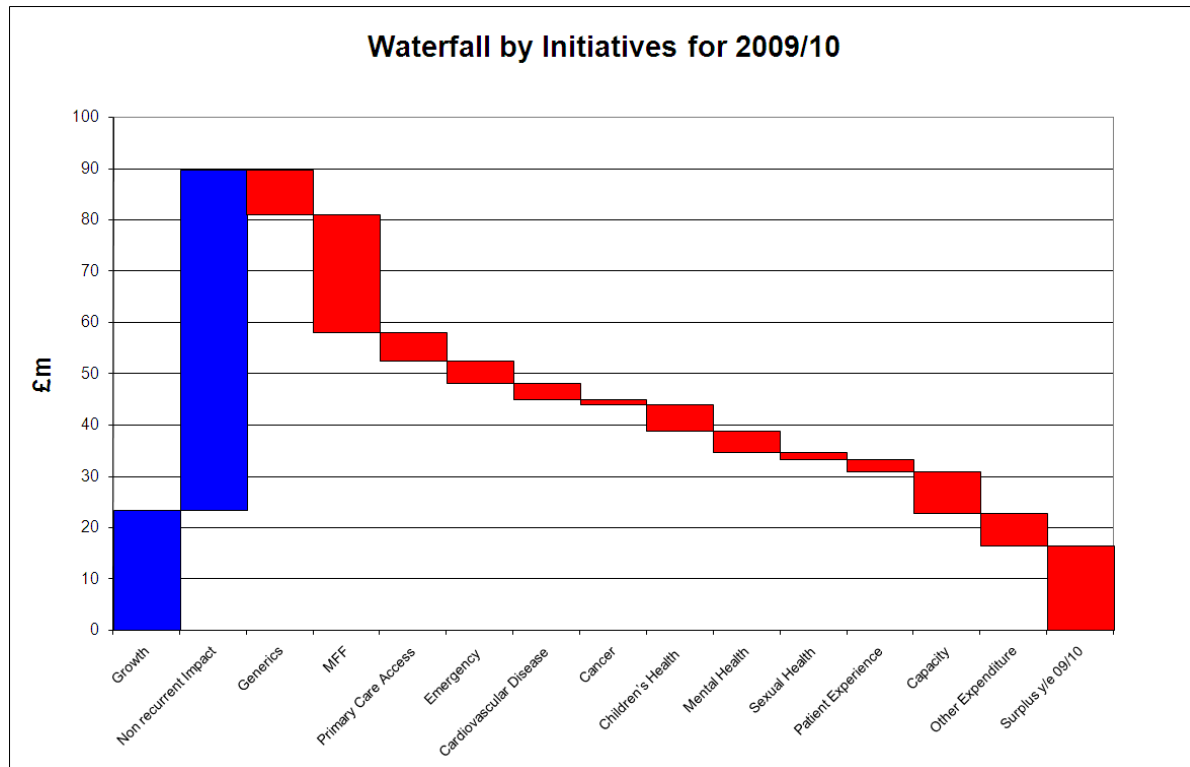
We again set a balanced budget for 2008/09 and also lodged £16.7m with NHS London. Our current forecasts indicate that we will achieve our Control Total of a year-end position of break-even (as per our monthly FIMS returns), despite identifying in-year slippage against our significant investment programme. However our systematic and robust Programme Management approach identified this position early in the year and was used to identify additional in-year investments in line with our priorities and previous CSP.

Lodgements totalling £29.4m and top slices totalling £11.3m will be held by the SHA on behalf of City & Hackney PCT as at the end of 2008/09. The recently agreed Medium Term Financial Strategy (MTFS) for London from 2009/10 to 2012/13 will result in our historic top-slices being used to write-off historic accumulated deficits, with a further non-recurrent levy being taken from those PCTs that can afford it in 2009/10 and 2010/11. Our lodgements will be returned in 2009/10 and we will finance the new non-recurrent levies from this non-recurrent source of funds. The London planning assumptions require our surplus and lodgements to be reduced to 0.8% of our Resource Limit over the next 2 years. We are therefore also developing plans to spend the balance of our non-recurrent lodgements and have factored these into the Operating Plan. They will be used to fund non-recurrent investments, pump priming or capital schemes. (We are seeking advice about whether and how we can make capital contributions to our LIFT schemes). Details of the MTFS are included in the assumptions below.

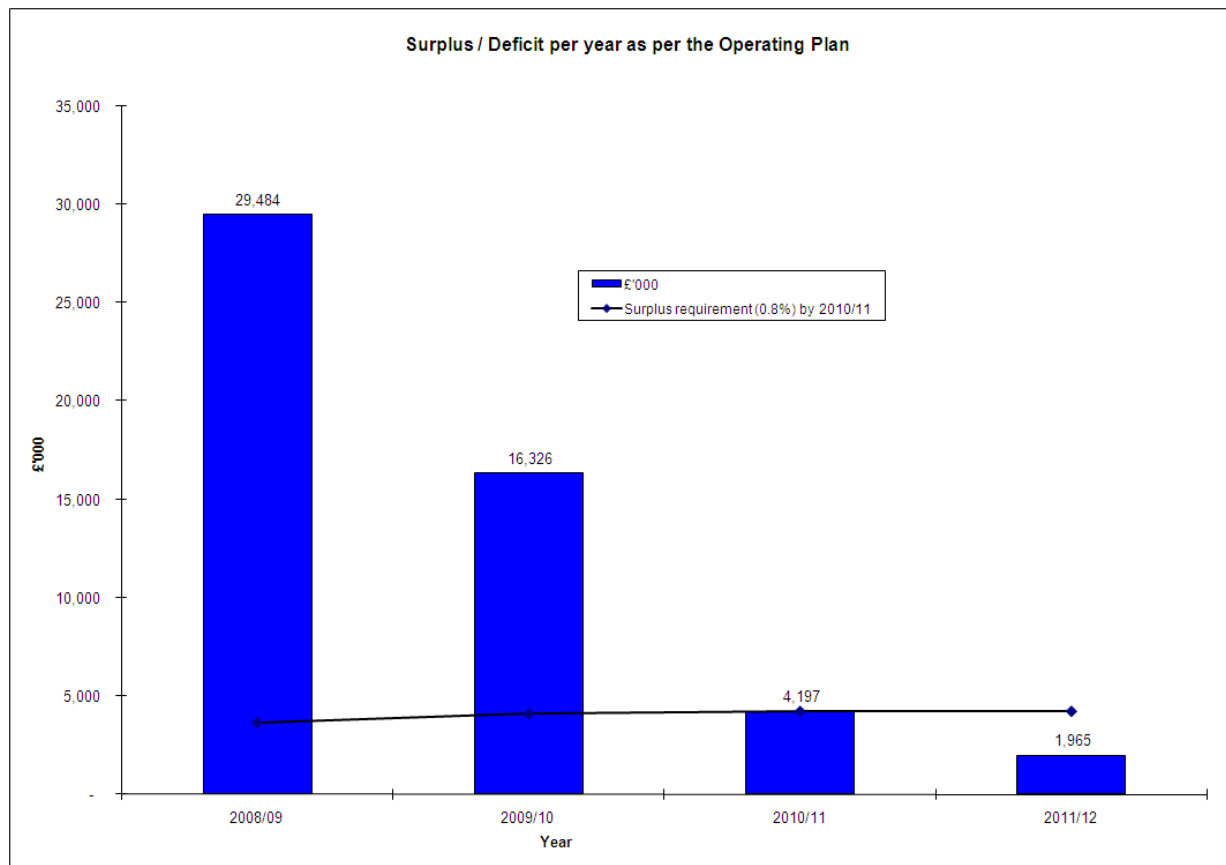
As required by the latest planning assumptions from NHS London, our lodgements have been added back to the financial years in which they were generated. Readers should therefore take this into account when trying to reconcile the surpluses shown in our financial model and in the tables below, as they will exceed the surpluses recorded in our 2007/08 audited accounts and the FIMS/Board reports for 2008/09 by the value of the relevant lodgement in each year.

During the planning and budgeting round, our partnership mechanisms are used to agree how our resources will be deployed. Each year we establish a multi agency Service, Workforce and Financial Framework Group (the SWAFF Group) which has delegated authority from the Board and Clinical Executive to determine annual spending plans within the strategic framework set by the Board. This SWAFF Group has membership from all partner organisations and oversees the entirety of our growth funding, including an assessment of risk for those areas that do not receive further

investment. The final decision about which investment proposals to fund rests with the commissioners on this group, namely the PCT commissioner and Practice Based Commissioners. A set of criteria were used to prioritise the investment proposals so that they could be ranked. Our investments therefore have a clear link to our CSP priorities and have been matched with what we can afford. The investment criteria covered: health benefit, National/London/local priority, innovation, value for money, and deliverability. Further detail is shown in the investment table at the end of this section and a summary of the Source and Application of resources is shown in the Waterfall diagrams below, by CSP Initiative and by Healthcare for London (HfL) Priorities:



Our financial modeling as shown in this Operating Plan for 2009/10 – 2011/12 indicates that we will be able to maintain financial balance in 2009/10 and beyond and this is summarised in the graph below. However, we recognise that we cannot be complacent and there are a number of financial risks that will need to be managed, notably the risk of under-spending due to slippage of our investment programme, the likely changes to future growth, and the impact of HRG4 and the new PbR tariff.



Going forward, as resources become tighter, we need to make sure we deliver our demand management strategies to ensure that patient activity can be afforded under the PbR (Payment by Results) regime. To remain in financial balance, in addition to ongoing sound and prudent financial management, we need to not only continue to develop responses in Primary Care to reduce avoidable hospital admissions and manage referrals more effectively, but actively accelerate these plans and invest in public health initiatives that improve well-being and prevent ill health. This is even more evident if we look further ahead to 2011/12 and beyond where there is likely to be less growth in the NHS. We will implement rigorously our Demand Management Strategy, with support from Practice Based Commissioners, and hope to see the benefit of public health and social marketing initiatives beginning to have an effect.

The SHA risk assessment of our financial position as presented in our 2008/09 Operating Plan, taking into account the surpluses in 2006/07 and 2007/08 and the level of contingency reserves set aside in 2008/09, was scored 4 out of 5 (5 being the maximum). This has subsequently been revised upwards to a risk rating of 5 as at Q3 in 2008/09, due to 5 consecutive quarters being rated at 4.

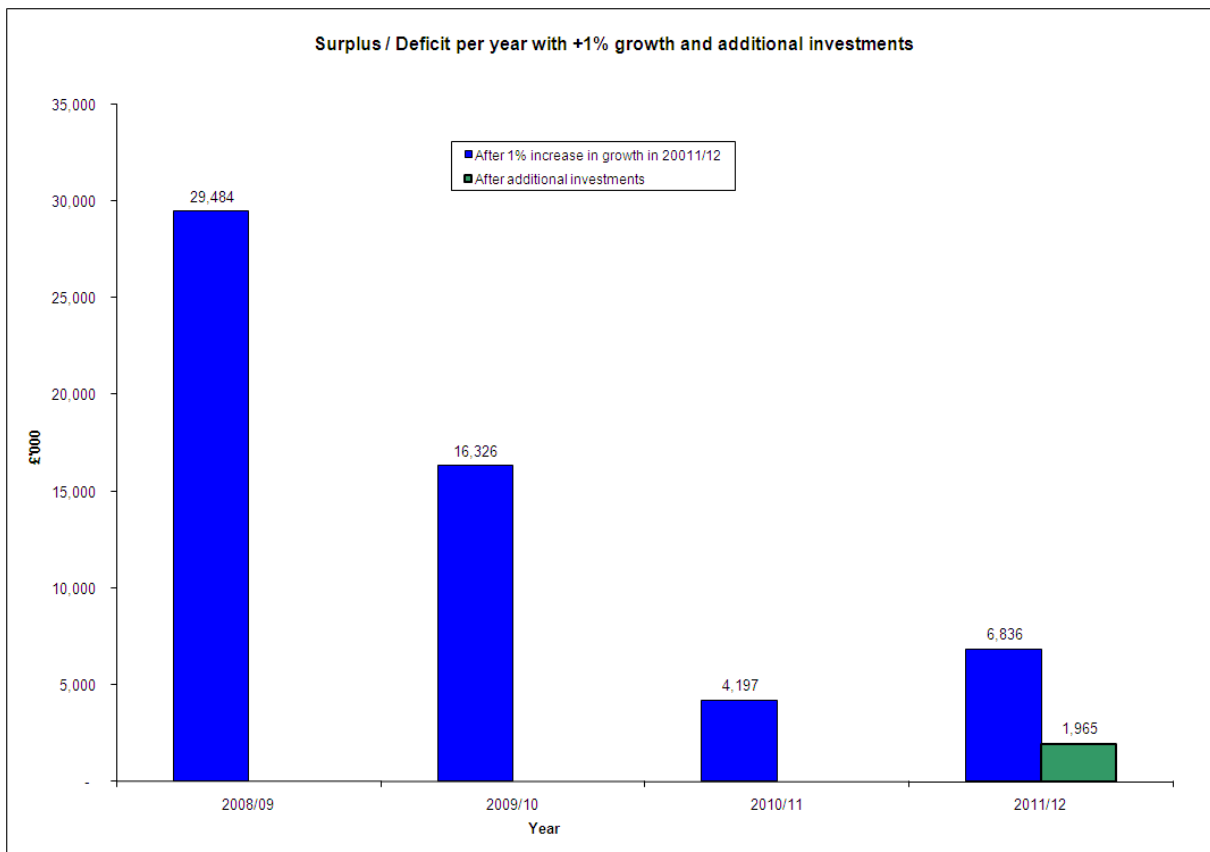
We have scored 2 (adequate), for Use of Resources in the Auditor's Local Evaluation (ALE) as part of the Healthcare Commission's annual health check in 2006/07 and 2007/08. This masks significant improvement across a number of the ALE criteria and the PCT has an action plan, agreed and monitored by the Audit Committee, which should result in a score of 3 (good) in 2008/09, with further progress planned the year after to reach the maximum of 4 (excellent), subject to the same criteria

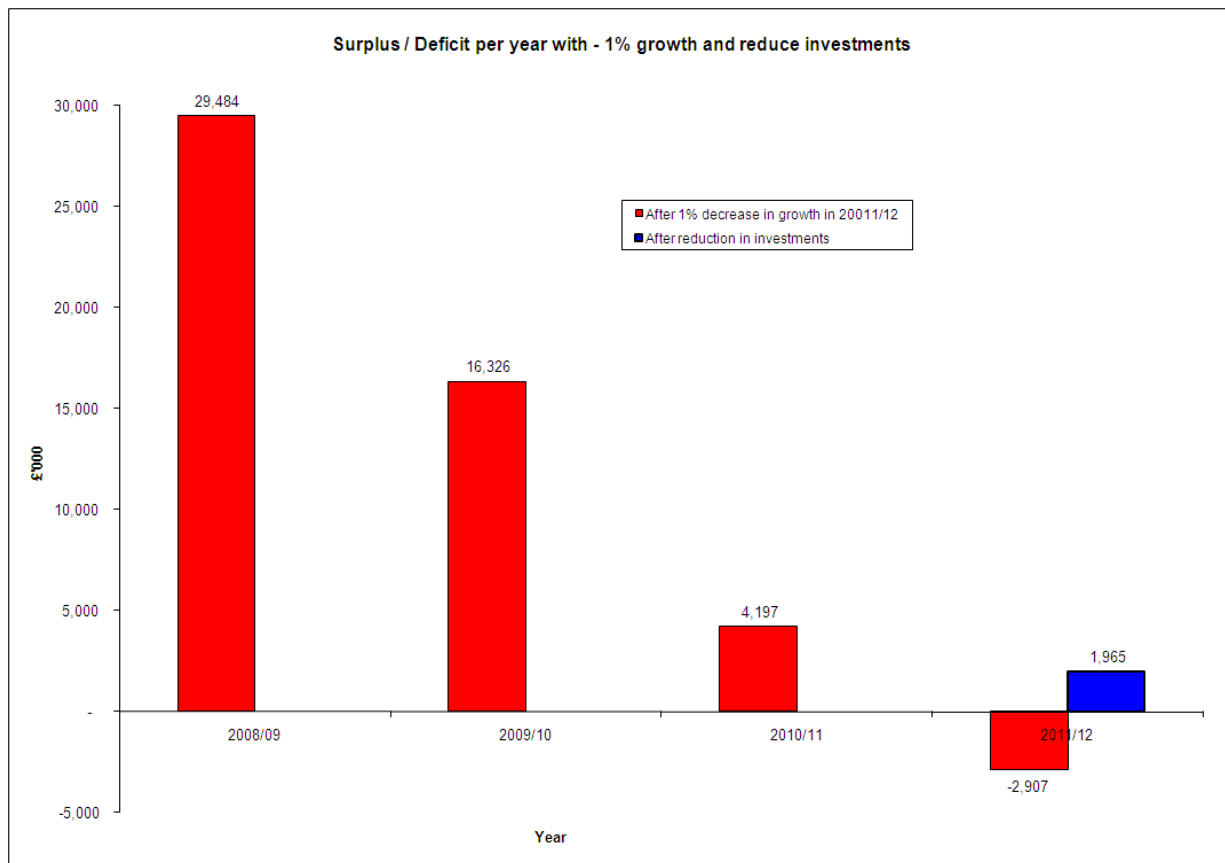
and scoring methodology applying to the Use of Resources, (which replaces ALE in 2008/09).

As well as delivering our Revenue Control Total in 2008/09, we will also meet our statutory duty to balance our Cash and Capital Resource Limits. Capital expenditure is in line with plan and we will fully utilise this finite resource to improve our buildings and premises and address known risks and priorities. Our Capital Working Group (CWG) prioritises the use of the capital resource, taking into account statutory and regulatory compliance (e.g. health and safety issues, Disability Discrimination Act compliance), any significant risks that need addressing, and other local needs. Our longer term estates programme and strategic capital developments are explained further below.

Our medium term financial plan builds on the longer term financial modelling undertaken for the Fitness for Purpose review and our previous CSP and reflects the need to move resources from secondary care to primary and community care through substitution and demand management. It also strives to demonstrate that the services we commission and provide deliver value for money and meet the health needs of our population. We will be systematically testing our own provider services for value for money and effectiveness against a set of indicators (which will also dovetail with the work on separating and externalising our provider arm as part of *Transforming Community Health Services*).

The plans and scenario modelling as presented in our CSP have been updated and revised to take account of our new weighted capitation position. In order to balance the need for prudent financial planning with sufficiently ambitious investment in health gain for local people, further use has been made of World Class Commissioning (WCC) benchmarks, the development of more robust commissioning metrics, and Programme Budgeting (as the latter becomes available). The investments included in our plan already reflect the priorities identified in the PCT's JSNA. Revised scenario modelling, showing best and worst cases, is shown in the charts below. The best case shows 1% additional growth above the planning assumption in 2011/12, which would allow for additional investment in initiatives. The worst case shows a reduction of 1% growth compared to the planning assumption in 2011/12, and would therefore require a reduction in investments and/or further demand managements and savings.

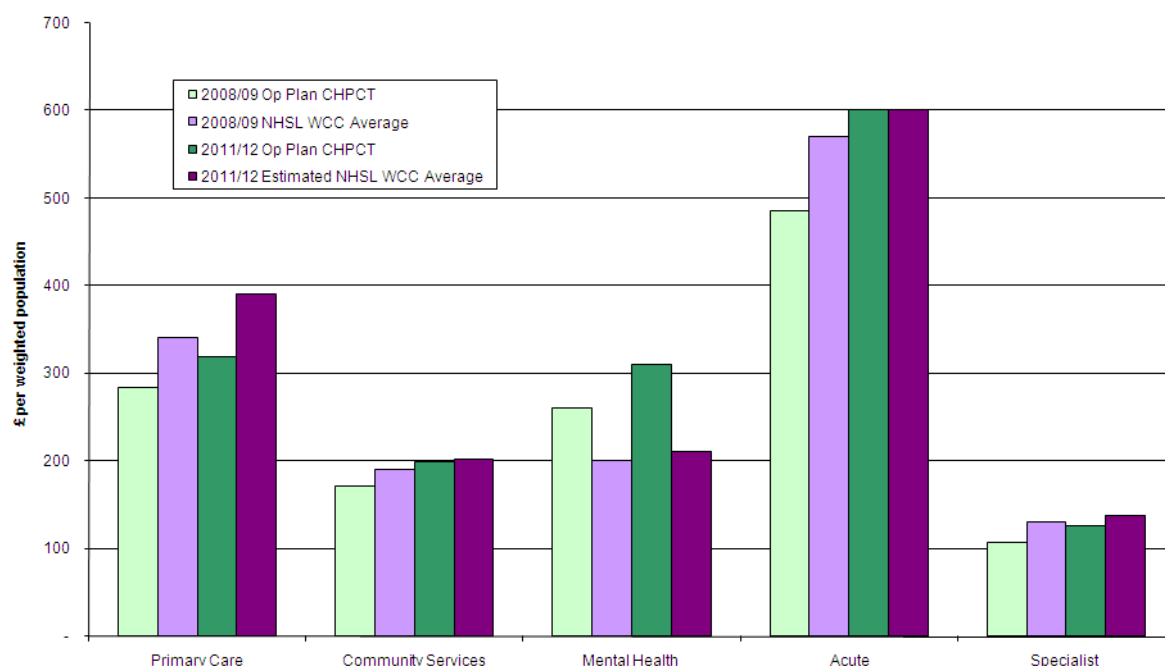




An ambitious but affordable programme of investment to deliver the identified Initiatives over the period of the CSP has been included in this Operating Plan. Given the risks of delivery, consideration is being given to using some of the non-recurrent monies to become available when the lodgements are returned, to support or pump prime the delivery of the Initiatives. The Programme Management Office (PMO) we have established during 2008/09 will again be used to manage the delivery of our investment programme. Our investment programme may need re-visiting if there are unintended and unaffordable cost pressures arising from the new PbR tariff and HRG4 in 2009/10 that cannot be mitigated.

We had previously undertaken some benchmarking analysis, based on old information received from the Fitness for Purpose (FFP) exercise, to see how our investment pattern changed over time. Last year we included a table that showed how our changes in investments compared with other London PCTs in the FFP benchmarking group, however this information is now out of date and unavailable. We have therefore updated this analysis, following the investment in the initiatives included in this Operating Plan, using the feedback received during the WCC Assurance process, suitably updated for the revised London Operating Plan assumptions and extrapolated to 2011/12. This analysis is summarised in the charts below. We will seek benchmarking information of this type from NHS London following the submission of all London PCT Operating Plans, to enable us to more robustly benchmark our pattern of expenditure. In addition we have undertaken a Board-level review of our Programme Budgeting data and will be undertaking more detailed analysis of this data to maximise the health gain we can achieve from our finite resources, using health economic techniques to support investment and dis-investment decisions.

CHPCT Spend compared to NHS London WCC Average Spend



Our longer term estates strategy, 'Bigger Brighter, Better' has been out to public consultation and will see the development of 4 Primary Care Resource Centres and the refurbishment of GP owned premises, funded by external capital from the East London LIFTCo or private 3rd party developments (usually funded by GPs). Our revenue expenditure plans include the financial consequences of these schemes. Financially this means that we can provide the physical sites to deliver the strategy for an additional £500k approximately (net), depending on the value of any section 106 gain we achieve, although this is subject to the treatment of LIFT schemes under IFRS (International Financial Reporting Standards).

A summary of these developments, with best estimates of opening times, is shown in the table below

Project	Location	Partners	Expected Opening Date
St Leonard's Community Hospital -South West Resource Centre	St Leonard's Hospital	London Borough of Hackney, Lawson GP practice	Autumn 2011
South East Resource Centre	Hackney Hospital site	GP practices and Network Housing	Spring 2010
North East Resource Centre	Stamford Hill	London Borough of Hackney	In negotiations
North West Resource Centre	Woodberry Down	Woodberry Down Regeneration, GP practices	Autumn 2012
Nightingale Practice redevelopment	Nightingale Practice	Nightingale GP practice	Summer 2010
Somerford Grove Health Centre redevelopment	Somerford Grove HC	GP practice	Summer 2010
Dalston Town Centre development	Dalston	TBD	Summer 2012

Already completed			
Children's Development Centre (Hackney Ark)	Dalston	London Borough of Hackney, The Learning Trust	17 March 2008

There are some risks around the timing of these developments. The Children's Development Centre/Hackney Ark development is now open. The provision of the North West Resource centre is intimately linked with the Woodberry Down regeneration scheme and likely to be funded from s106 and land sale monies by the Regeneration developer. They have indicated that this will form one of the first elements in the overall scheme with an expected completion date of 2012. The North East Resource Centre proposals may involve the re-provision of a Library as part of the scheme. Alternative sites and solutions are being explored. The South East scheme is likely to be in a position to achieve financial close by March/April 2009 and the OBC for the redevelopment of St Leonard's has recently been approved by NHS London.

Summary of assumptions 2009/10

Growth assumptions as follows:

'09/10 - 5.34% on initial resource limit (IRL)

'10/11 - 5.25% on initial resource limit (IRL)

'11/12 - 2.0% on initial resource limit (IRL)

Voluntary Lodgements have been added back to the year in which they were generated, as requested by NHS London. This has the effect of increasing the surpluses in 07/08 and 08/09 so they will not equal the surpluses in the 07/08 annual accounts or as forecast in 2008/09, but they can be reconciled. Any unused lodgement is then returned in 09/10 (by carrying forward the inflated surpluses as RAB adjustments).

MTFP for London

Historic top-slice not returned and forgone (£11.3m)

Non recurrent, non-repayable levy in 2009/10 and 2010/11 for residual deficits = 0.8% (£3,778k) and 0.75% (£3,724k) respectively (after £100m funding for RAB deficits from DH)

No levy required in 2009/10 and 2010/11 to fund HfL investment pool in North East London.

Tariff uplift applied to all as 1.7% in 2009/10 & 1.2% in 2010/11 and then 1% thereafter, except 5.0% on Prescribing outturn, (less than the PPA recommended 8% uplift on budget, due to historic under-spends and under-prescribing), and 1.5% on Primary Care Contracts. An additional 0.5% has also been allowed for CQUIN.

All acute activity and costing based on 08/09 forecast outturn, with growth applied as per McKinsey HfL model

Growth on Mental Health and Community linked to McKinsey HfL growth assumption

Growth on Specialist Commissioning linked to Complex NEL Medicine from McKinsey HfL model

Growth in Public Health at standard 10% each year

£6.9m of 'Plan B' Investments added to Non Pay spend

Any Non Recurrent expenditure from the Recurrent Allocation is not shown as funds available in following year

Outpatient shift in polyclinic in future years is as per Mckinsey assumption shift and where activity

was not possible to classify in any main specialty the shift is 16% first attendance and 50% follow-ups.

The shift in the inpatient (elective, emergency), day case, regular attenders, and other is as per HFL assumptions.

Summary Investment 2009/10

	Investment	Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
1.1	18 week wait	4219	90	4219	90
1.2	Healthcare Associated Infections	137		137	0
1.3	Primary care access	865	6086	865	6086
1.4.	Cancer waits – max. 2-week wait			0	0
1.5.	Breast screening	75	0	75	0
1.6.	Bowel screening	10		10	0
1.7.	Cancer waits – 31-day	185		185	0
1.8	Stroke care	361		361	0
1.9.	Cervical screening	110		110	0
1.10	All-age all-cause mortality	10820	64	10820	64
1.11.	Cardiovascular mortality	1520	50	1520	50
1.12.	Cancer mortality	277	0	277	0
1.13	Smoking	308	30	308	30
1.14	Maternity	2218	0	2218	0
1.15	Teenage conceptions			0	0
1.16	Childhood obesity	1051	610	1051	610
1.17	Immunisation	125		125	0
1.18	Breastfeeding	10		10	0
1.19	Child and adolescent mental health services (CAMHS)	157	90	157	90
1.20	Chlamydia screening			0	0
1.21	Drugs misuse			0	0
1.22	Patient experience	1543	45	1543	45
1.23	Public confidence in the local NHS			0	0
1.24	NHS staff satisfaction			0	0
1.25	NHS primary dentistry access			0	0
2.1.1	London priorities - HIV	1338	4	1338	4
2.1.2	London priorities - TB	15		15	0
2.2.1	Priorities chosen by the PCT - Hypertension			0	0
2.2.2	Priorities chosen by the PCT - Diabetes	705	340	705	340
2.3	Trauma – if not a priority chosen by the PCT	0	0	0	0
3.1	Ambulance	1270		1270	0

4.1	Child health	1329	9	1329	9
4.2	Alcohol-related harm	420	0	420	0
4.3	Dementia	680	25	680	25
4.4	End of life care	624		624	0
4.5	Mental health	3098	245	3098	245
4.6	Military personnel			0	0
4.7	Mixed sex accommodation			0	0
4.8	Learning disabilities	470		470	0
5	Other			0	0
	TOTAL	33940	7688	33940	7688

Footnote:

1.1 18 week wait – Total Planned spend, £4.2m – includes capacity plans for acute and community services (including the delivery of 18 weeks)

1.3 Primary Care Access – Total Planned spend (Non Recurrent), £6m – includes primary care infrastructure (potential purchase of properties), and PBC savings plans.

1.10 All-age all-cause mortality - Total Planned spend, £10.8m – includes Specialist Commissioning, dehosting of A&E and GUM, Investment in London-wide and NE London-wide commissioning support, Contingency, Social marketing, Telehealth, ISTC and Joint commissioning.

	Recurrent	Non- Recurrent	Recurrent	Non- Recurrent
	2008/09	2008/09	2009/10	2009/10
	£'000	£'000	£'000	£'000
Source of Funds				
Revenue Resource Baseline	416,671		439,430	
Growth Allocation	22,759		23,448	
Financial Headroom from prior year	-1845	-8442	30191	-9063
Return of 08/09 surplus		23,758		-141
Return of lodgements				29484
Application for use of Sector Strategic Investment Fund for HfL reconfiguration				
Application for use of Sector Strategic Investment Fund for other reconfiguration				
Available Resources (before internally generated funding)	437,585	15,316	493,069	20,280
CIPS	1,360		1,390	
Demand Management Schemes	501		-	
Total Resources Available	439,446	15,316	494,459	20,280
Less: Application of Funds				
Contribution to the London levy for write-off of legacy debt				3,778
Contribution to the Sector Strategic Investment Fund				-
SLA / Non-SLA expenditure (including inflationary / generic cost pressures)	383,338	7,100	446,714	6,293
Contingency	-		2,550	
Balance available for investment	56,108	8,216	45,195	10,209
Investment Programme	32,158	2,682	31,390	7,688
Surplus / Deficit	23,950	5,534	13,805	2,521

Risks to Delivery with Mitigating Actions Planned		
Risk	Consequence	Mitigation
Failure to maintain financial control/stay within £ control total	Loss of locality resources/Loss of reputation	Monthly reporting, Programme Management approach to new investment and savings. PBC demand management.
Slippage on investment	Loss of opportunity for health gain/Improved health outcomes	Programme management approach to new investment Fortnightly review against planned milestones.
Over capitation PCT, extreme levels of need, emergency led health economy	Failure to maximise population health benefit from resources deployed	Prioritisation approach to new investments/dis-investments. Urgent care planning. PBC demand mgt.
Financial uncertainty (economic climate. PBR/HRG tariffs, London-wide top slices, Revision to national pace of change policy for moves to capitation targets)	Planning blight – failure to progress – risk of overspend	Prioritised investment plan – adjust commitment in light of available resources, Deploy contingencies/reserves Reduce planned surplus. Use of programme budgeting and health economic modelling to identify areas for dis-investment and re-deployment of resources.

6. Enablers - and other issues

6.1 Empowering patients

Empowering patients – choice and personalisation (inc. fulfilment of the duty to deliver the proposed new legal right of choice about care which could be in place from April 2009)

The PCT takes a broad approach to promoting the empowerment of patients across the range of services commissioned. This includes the following:

- Involving patients in assessing their needs, and agreeing their care plans and desired outcomes
- Ensuring patients have reliable and up to date information on services, treatments and risks associated with treatments
- Providing information as to how, and why decisions are made about which treatments and services are provided by the PCT.

There are numerous initiatives taking shape which will facilitate the empowerment of patients and promote patient choice:

PPI Commissioning Advisory Group, and PPI Provider Steering Group

These involve managers, staff, patients and community representatives from across City & Hackney. The aim of the groups are to drive forward the PCT's work on ensuring effective patient and public involvement in the commissioning, and provision of services, to monitor implementation of the rights that will be enshrined in the *NHS Constitution*, and to drive up the care and quality standards as prescribed in *Standards for Better Health*. This will include the development of appropriate policies and procedures, producing up to date information on services and treatment, providing guidance and advice to staff, and organising public information events.

CHOICE Board

This group promotes patient choice in choosing acute and community health service providers

Difficult Decisions Policy, and Difficult Decisions Panel

This clarifies the PCT policy on provision of drugs and other treatments, and offers patients an appeal process where appropriate.

Developing constructive and productive relationships with the LINKs

There will be LINK representation on the PPI Advisory Group strengthening the voice of patients.

Expert Patient Programmes

For 2009, 16 courses will be delivered with a minimum of 160 people completing these courses. Patients have been involved in developing the service specification when the service was tendered out in 2007, and in selecting the providers. Courses for adults, carers, will continue to be provided, and this year courses for young people will also be provided.

Development of "Dignity in Care" initiatives

The PCT's aim is to raise individual's expectations of services and to ensure the "Essence of Care" benchmarks are applied to all appropriate services.

Dignity in care is achieved in service provision by the use of service user assessments (one such example being SAP), and the PCT's medications policy. The focus is on outcome plans encouraging self care, as well as support from link workers. Service users are provided with person centred care plans.

6.2 Emergency preparedness

Emergency preparedness (inc. pandemic influenza plans)

CHPCT has a robust Major Incident Plan (MIP) that prepares the organisation to provide a coordinated response to any major incident or emergency situation ensuring compliance with our statutory obligations under the Civil Contingencies Act (2004). The plan is regularly tested and updated (last updated in December 2008) and is available to all staff on the CHPCT intra-net. New CHPCT staff are advised to familiarise themselves with the plan and receive Major Incident training at the monthly staff inductions. A brief document "What to do if you witness an incident" and an "Incident Action log" form are also available to all staff.

CHPCT also have a Multi-Agency Flu Pandemic Contingency Plan that is regularly updated and tested in order to ensure a coordinated response to an influenza pandemic. The plan describes the likely impact of pandemic flu in City and Hackney and identifies strategic interventions to ensure a coordinated and adequate response. It was last updated, agreed and disseminated to all partners in December 2008 (in accordance with the latest evidence and DoH Guidance).

CHPCT also have a Vulnerable People's working group to ensure that all PCT vulnerable clients are adequately supported in the event of a major incident. An active list of all vulnerable clients (Adults and Children) is available to all directors on call; clients are RAG rated according to the level of service needed/degree of dependency to facilitate prioritisation of the response. This group also liaise with London Borough of Hackney Social Services to ensure a List of Lists of vulnerable clients. The Emergency Preparedness Group and the Multi-Agency Flu Pandemic Planning Group continues to meet every two months to identify priorities and coordinate testing and training.

In addition CHPCT has a generic and Directorate specific Business Continuity Plans that are regularly updated by each service directorate. Business continuity plans include identification of core services and a risk assessment template for each service contemplating issues such as staff shortages, fire, flooding, electricity, IT and other eventualities that may result in disruption to the service or the need for relocation.

Summary of action plan- Emergency Preparedness and Flu Pandemic

There is a testing and training schedule in place for 2009/10 that includes 2 Major Incident simulated exercises and an unannounced exercise in order to assess the emergency communications pathway; in particular, call out procedures for key CHPCT emergency preparedness staff and information cascade, assess our response procedures and ensure the emergency preparedness team are familiar with their roles and responsibilities and strengthen resilience. The lessons learnt and evaluation report from the exercises will be disseminated to CHPCT staff involved in the incident response and used to update the current MIP.

To continue training of all staff on emergency planning and raise awareness within the PCT of the existence of the Major Incident Plan by conducting monthly presentations at the monthly corporate inductions.

Work with the Communications department to raise awareness and disseminate the summary of the Major Incident Plan to all staff.

Continue regular update and testing of Service specific business continuity plans and ensure Business Continuity Planning is an integrated part of all new and existing contracts with external suppliers and service providers to the trust.

To produce a comprehensive 'Vulnerable People's Plan for identifying people who are vulnerable in a crisis as required by the UK Resilience Guidance for Emergency Planners and Responders (2008). The Vulnerable People working group will liaise with CHPCT local partners in order to develop an

integrated plan that will include 'list of lists' of local organisations that deal with vulnerable people who can be contacted in the event of an emergency to provide relevant information. The plan must also include an agreed data sharing protocol between the PCT and partners in the event of an emergency.

To continue the testing schedule by carrying out a Multi-Agency Flu Pandemic table-top exercise in order to test out the current Multi-Agency Flu Pandemic Contingency Plan and to progress work on the different working groups within the Multi-Agency Flu Pandemic Group including finalizing and disseminating to all partners the Influenza Pandemic Communications plan; Risk assess all primary care sites and develop migration protocols and develop a Service Level Agreement (SLA) with community organisations or the voluntary sector within the borough in order to train and support volunteers for low risk support activities during a pandemic.

6.3 High Quality Care for All

High Quality Care for All (inc. implementation of the CQUIN payment framework)

The PCT sets out in its five year plan the ambition to improve the health and well being for the population of City & Hackney. As the lead commissioner of health services in City and Hackney, the PCT aspires to become a world class commissioner; assessing needs, making decisions to secure services to meet those needs within available resources and ensure that health benefits, high quality care and positive clinical outcomes are achieved.

We have made significant progress in developing our commissioning function, in respect of increasing access to services, value for money and reducing waiting times during the last 3 years. Part of this process has focussed on assuring patient safety and the quality of services commissioned; engaging the public and improving the patient experience. It is recognised however, that although the PCT has developed more rigorous quality review processes for commissioned services during 08/09, it acknowledges that further work is required to further improve quality and manage performance.

Delivering the highest quality of care development for all is a fundamental goal of the NHS and is a priority for City & Hackney. It is the intention of City & Hackney that all services commissioned will demonstrate the highest quality of care. To this end, all contracts and service level agreements will contain a quality specification based on the CQUIN framework, to include service specific quality performance indicators.

Monitoring will be strengthened via formal clinical quality review performance meetings. The patient and user experience of service quality will be captured and strengthened and this data used more robustly in the evaluation and outcomes of care.

To deliver high quality services, City & Hackney local health/social care community will need to develop a consistent approach. This will require the PCT to drive the implementation of minimum quality standards via the contracting process and for providers to work collaboratively with each other, developing effective relationships across patient care pathways.

High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the CQUIN payment framework. CQUIN is a key addition as CHPCT moves to the national NHS contract for 2009/10. CQUIN payments is a new process through which funding will be provided to Trusts when agreed quality targets have been achieved. It is expected that the total CQUIN payments would be up to 0.5% of the annual contract value based on performance against agreed indicators.

Local CQUIN schemes should reflect the three dimensions of quality:

- safety,
- effectiveness (including clinical outcomes and PROMs),
- user experience

And also recognise innovation.

Early prioritisation of local goals may take into account:

- Regional NSR visions
- PCT strategic plans
- Existing local improvement initiatives
- Areas of performance where there is potential for significant improvement
- The need for improved data in some areas
- Consideration of health inequalities; integrated care; and innovation.

Quality bond payments are already present in the 2008/09 contract between the CHPCT and the Homerton Hospital for several quality improvements such as A&E targets, performance reporting and

service improvement initiatives. This type of quality related payment will be further developed in the form of CQUIN payments in 2009/10.

Based on the contract negotiations to date, the areas proposed for CQUIN in 2009/10 between CHPCT & Homerton are:

- Patient Experience – particularly for maternity services, and older peoples services (respect and dignity code).
- Cancer
- Diabetes
- Stroke – Quality standards from HfL framework
- Further reduction of the wait time to below 18 weeks target
- Patient reported outcome measures.

The agreed CQUIN focus areas are reflective of local priorities and the dimensions of quality. Several of these areas have had some investment in recent years. Rigorous testing will be applied to gauge improvement. For each area of focus, there will be agreed targets to be monitored via the Clinical Quality Review meeting and balanced scorecard report. Agreed targets will have to be met before funding will be released from the PCT to the Trust. Many of these targets will be in addition to, or as an extension of standards and externally required targets. CQUIN related quality targets will be finalised through the contract negotiation process.

Whilst not mandated for community health services or mental health services in 0910, the PCT is actively exploring with the relevant provider, quality bonds based on the CQUIN principles.

6.4 PBC

PBC in 2009/10 (inc. improved information, management and financial support from the PCT)

The PCT has enthusiastically embraced Practice Based Commissioning as a key driver of our strategy to provide the right care in the right place at the right time. The PCT launched PBC by issuing indicative budgets to practices in 2005 and the majority of our practices signed up to budgets for the second half of 2005-06. Since then the PCT has achieved 100% coverage with 42 PBC practices grouped into 8 consortia plus a further 3 practices managed by independent providers under APMS contracts.

The early engagement of practices has led to a number of successful demand management initiatives being established which were set out in the Operating Plan for 2007-08. During 2007-08 a new GP with Special Interest in ENT service was fully established and further initiatives to support the management of long-term conditions within primary care were implemented including the further development of specialist support to practices with respect to heart failure and diabetes to enable a shift of management of patients from secondary to primary care.

The PCT has also majored on providing good information to practices on finance and activity but also comparative information on referral rates. Whilst there are delays in providing data which are due to the constraints of the national timescales for finalising activity and financial information the PCT has provided detailed practice based information via a web-based system, Corporate Radar, that allows practices to analyse activity down to patient level. Quarterly reconciliation is completed two weeks after provider returns are finalised and paper reports are circulated to practices to support information provided on Corporate Radar.

Practices have been encouraged and supported to collaborate on PCT-wide pathway redesign projects with each consortia leading on one major redesign project. The outputs of these projects for 2007-08 have included changed pathways with greater management of conditions in primary care by all of our practices, faster access to diagnostics, easier access to consultant and other specialist advice and referral guidelines.

Consequently, the PBC practices and consortia have now received, and begun to invest, freed-up resources (2.3m) resulting from their PBC efforts in 2006-7 and we anticipate that there will be further resources for practices to re-invest resulting from 2007-08 activity.

In summary the PCT's approach has been to make PBC a central element of the commissioning process. The active engagement of local clinicians through PBC is leading to a shift of care from secondary to primary care settings through primary care providing more care – through Local Enhanced Services (LESs), implementation of referral guidelines, faster and direct access to diagnostics and the use of GPwSI's where appropriate. We have also placed a continuing emphasis on supplying good quality information to practices both on activity and finance data and on referral rates to enable them to focus their PBC activities on areas that will make most difference.

Practices have provided indicative PBC plans for 2007-8 which detail practice and consortium specific initiatives that they will actively pursue in the coming year, as well as actions that require PCT-led commissioning. In broad terms, practices have indicated that 2008-9 they will continue to:

- Monitor and manage referrals, including the development of new pathways enabling more care to be delivered in a primary care setting
- Use the existing PCT or PBC demand management (triaged) services
- Case manage patients at risk of emergency admission
- Monitor patient use of A&E and intervene where appropriate
- Use the direct access diagnostics available to GPs

Whilst no new PBC demand management services are planned for introduction for 2008-9 effort is being focused on evaluating and maximising the effectiveness and utilisation of the current demand

management services (such as practice-based anti-coagulation therapy and dermatology and ENT GPwSI's.) This learning will be used in future service redesign.

In addition there are a number of practice-based services being established to promote management of conditions in primary care including COPD, osteoporosis and maternity care. New services will be commissioned in support of overall pathway redesign.

A general, composite, description of the PBC Plans is provided below. These are aligned to the PCT's strategic initiatives set out in the CSP.

1. High quality primary care

Practice/consortia initiatives to improve standards of care

Monitor and manage PBC budgets

Identify and manage high resource users

For high referring practices within consortium – continue education sessions

2. Urgent and unscheduled care

Pathways/access to diagnostics (existing) to increase management in primary care and reduce OPD
PUCC/A&E triage – continue scrutiny of primary care attendees

Frequent emergency admissions - continue scrutiny

A & E diversion scheme with London Ambulance Service

Service models (new) requiring PCT commissioning

Agreed protocols for patients attending WiCs

Clearer protocols for onward referral to A&E for the out of hours provider

3. Cardiovascular disease

Pathways/access to diagnostics (new) to increase management in primary care and reduce OPD

Management of arrhythmia

Service developments (new)

Hypertension (supported by CHD LIT) – develop specialist team

Consultant advice outreach & education sessions - Cardiology , COPD – introduction of

4. Diabetes (with obesity)

Pathways/access to diagnostics (existing) to increase management in primary care and reduce OPD

Diabetes – development of SLAs to support specialist nursing

5. Cancer

Service models (new) requiring PCT commissioning

Improved community support for end of life care

6. Tackling inequalities – children and adults

Services developments (new)

Community midwifery - increase to support practices & improved working arrangements

Pregnant women attending A&E – clear protocols for management; revised protocol for N12 admissions

Osteoporosis (proposed) LES – to develop specialist team

LES for Disease Modifying Anti Rheumatic Drugs (DMARDs)

Direct access audiology

“Red eye” management by optometrists

Phlebotomy

Minor surgery

LTC related services developments (new)

Community based COPD team – business case submitted as willing provider

Consultant advice outreach & education support. Plus explore OPD referral triage Ophthalmology,

Gynaecology, Obstetrics & Urology

Increase outreach & liaison with Homerton – for care of the elderly

Management of pain – potential integration with PCT Locomotor service

Service models (new) requiring PCT commissioning

Outreach & primary care liaison from Community Paediatric service to support hospital avoidance

Introduce practice based CPNs/MH workers

Integrated service for pelvic floor dysfunction between PCT provider & Homerton

Service models (existing) requiring review and PCT commissioning

Development of new models for priority PCT areas of provision; Adult community nursing, Psychology fit with MH services, Locomotor, Dermatology GPwSI, Health visiting and Ivy & Community sexual health services

Revised prescribing protocol & formulary for community dressings

Implementation of District nursing & Health visiting specifications

Clearer pathways/model of care between psychology & ELCMHT services

Pathways/access to diagnostics (new) to increase primary care and reduce OPD

Erectile dysfunction

Use of vitamin D

Chronic kidney disease

Irritable bowel syndrome

Management of epilepsy

Management of alcohol dependency (potential LES)

Potential LES for Learning disabilities

Pathways/access to diagnostics (existing) to increase primary care and reduce OPD

Rectal bleeding

Post menopausal bleeding

Osteoporosis & Falls (potential LES & improved access to DEXA diagnostics)

Glaucoma management – plus new optometrist service for routine testing

Physiotherapy – (pilot) practice based in 2 consortia. Integration with PCT locomotor pathways

Anticoagulation services – continue

Urology pathways – implement & audit

Menorrhagia pathways – implement & audit

6.5 Workforce & Leadership

Workforce, talent and leadership plans for 2009/10 (summary of approach, aims and key actions, assurance that providers have fully integrated the operational, financial and workforce implications within their business and service plans, proposals for change should include a comprehensive assessment of the workforce risks, that a robust risk assessment has been carried out to identify any potential workforce capacity and capability issues, including the need for compliance with the EU Working Time Directive)

The PCT will during 2009/10 be implementing its Organisational Development Plan, Workforce Plans and Talent Management Plans building on its previous HR Strategy and Workforce Development Plans.

The PCT will during 2009 work closely with NHS London and other local NHS organisations to support and develop talent management across London and the health economy and ensuring that there is collaborative commissioning for non medical workforce education with higher education providers which is responsive to service development plans and emerging models of care.

The PCT provider will continue to develop its workforce development planning linking the development of services and new models of care to the workforce plans and ensuring that capacity or capability issues are identified and mitigated so that the risks to service delivery are managed.

During 2009 the PCT will put in place mechanisms for assuring itself that providers with whom it commissions services have robust plans in place for workforce planning and staff engagement and satisfaction.

The PCT will continue to develop its Workforce Development Plan ensuring that this links to the Service Workforce and Finance Framework and MPET monies. It will ensure there are feedback mechanisms for learning and development and the effectiveness of this. The challenge will be to ensure that Workforce risks and capacity within providers is given the same weighting as financial risks. The PCT will for example need to work within its main acute providers to ensure that the EU Working Time Directive implementation in August 2009 does not impact on capacity and service delivery and this degree of review, scrutiny and development will need to continue if the PCT is to become a World Class Commissioner.

The key challenges for the Organisational Development Plan and Workforce Plans will be the delivery of strengthening commissioning across Inner North East London and the HUB and also the separation agenda between commissioning and provision. All of this underpins the development of World Class Commissioning. This will require real leadership and developing this leadership will be another key priority for the PCT.

Ensuring that staff are supported, engaged, empowered and have personal development are all key attributes of good leaders which is one of the organisational development priorities. The PCT's Organisational Development Plan falls out of the Commissioning Strategy Plan and is supported by the Talent Management Plan and workforce development plans.

The PCT wants to collaborate where possible across NHS and other partners to deliver its workforce, leadership and talent management plans and delivery of these plans.

Development of specific skills and improvement in staff engagement and motivation are all key priorities from a workforce/organisational development point of view.

6.6 Crime & Disorder

Crime and disorder reduction (local partnership working, inc. on knife crime)

The PCT has a responsibility through crime and disorder partnerships to improve the health care response to domestic violence, as part of a coordinated community response, and a commitment to reducing health inequalities by improving outcomes in mental health.

Domestic violence services are limited primarily in their focus on women in crisis ready to seek refuge from a violent home. However, many patients attending primary care are either in crisis, but not ready to leave, or have chronic rather than acute problems. Furthermore female patients attending a practice that is not domestic violence aware are not accessing domestic violence services, and thereby do not get the help they need.

The PCT will be funding the mainstreaming of an expert advocacy for women disclosing domestic violence to GPs and practice nurses. There is trial evidence that advocacy for survivors of DV have improved quality of life and mental health outcomes and the provision of expert advocacy is part of DH policy.

A randomised control trial funded by the Health Foundation of a domestic advocacy based educational and support intervention in 12 Hackney practices over 18 months, found a marked increase of DV disclosures in the practices and 104 referrals to the Nia project (formerly Hackney Women's Aid – a third sector DV agency).

The funding will provide a full time advocate-educator post to sustain activity in the 12 intervention practices and extend it to an additional 6 practices. The advocate-educator, based in the Nia project will provide support to practices in the identification and management of women experiencing partner violence and take referrals for advocacy. As such, the IRIS advocate meets the needs of a group of women who would not otherwise be supported by domestic violence services currently available.

The PCT works in close partnership with Hackney's Domestic Violence and Hate Crime Team along with other community based agencies and projects to reduce DV, support victims and children and work with perpetrators.

The PCT will also be working closely with the Homerton and the police in regards to knife crime and are active members of both CDRPs.

6.7 Informatics

Informatics plan for 2009/10 (refer to the annex to the Operating Framework. Draft plans should be submitted separately to LPfIT by the end of January 2009. Below, please a) outline the LHC's governance arrangements, including the nominated SRO; b) specify which organisations comprise the LHC; and c) the LHC's proposed timetable for finalising the LHC plan and the review cycle)

The 2009/10 plan will be completed at the end of February 2009. The PCT is currently developing a LHC Plan with the Homerton Foundation Trust and East London Health Trust with the Chief Executive of the PCT as the SRO. Our Informatics Plan will also be fed through in to a wider Inner North East London Plan which will include Newham and Tower Hamlets PCT. The Care Community Plans will be approved by the North East London Care Community Board (with representation of all the Chief Executives within North East London) and the Joint Committee of PCTs .

The 2008/09 NHS Operational Framework IM&T Plan was developed to incorporate the City and Hackney PCT's strategic delivery of the London Programme for IT. The Trust included in the plan local interim solutions and corporate solutions to reflect a more varied and localised plan meeting the needs of the PCT and service provision. The 2009/10 Informatics Plan will focus on the continuation of the improvements to the infrastructure and the migration of services to RiO and E-SAP in 2009 and beyond. In addition, the completion of Information Systems security enhancements to ensure the physical and logical security of data held by the PCT and GPs.

The main priorities have been and will continue to be:

Infrastructure

focused with a significant upgrade to the IT infrastructure both within the PCT and Primary Medical Services, in particular:

Upgrading IT specifications within GP practices for GP Systems of Choice (GPSoC).

Enhancement of the new Virtual servers to accept new services including Electronic Document Management (EDM)

PC Replacement programme

Migration to the N3 Network to a Community of Interest Network (COIN) that will improve connection speeds and Business Continuity for the Trust, GP Practices and Homerton Hospital. In addition the benefits of higher bandwidth will aid connection to all network services (E.g. Choose and Book). Also, the use of voice over IP telephony that will give free calls within the LHC.

Building on the transfer of the PCT Main Virtual Server to a very secure location, the

Second Virtual server will be located at the Homerton Hospital as part of the Disaster Recovery and Business Continuity procedures, accessed via the COIN.

Implementation of 2nd phase of EDM within the PCT

Implementation of Secure FTP Server infrastructure.

Corporate Systems including, Data Metrics, Data Modelling and Data Analysis and PBC

In 2008/09 the ICT Department undertook a review of Informatics within the PCT and have drafted a forward looking Informatics strategy. As part of the review the ICT Department are also implementing a Trust wide data warehouse to improve the monitoring of performance of the organisation and provide meaningful information from the data collected.

The data management for the Provider metrics is centrally managed through the Head of Service Modernisation and Integrated Provision under one collection and reporting system. The existing sources of data are from TSS, CHIA, PAS and in 2009/10 Rio. There is some manual recording across areas– the Provider will look at the most appropriate options to migrate areas of manual recording. The ICT Department provides the data reports in line with formal reporting timetables to support its performance management requirements and to meet the requirements of the contract between the Provider and the Commissioner.

For the PCT to discharge its commissioning responsibilities with due diligence, it is crucial that it has access to the most up-to-date and relevant information on a wide range of key performance indicators. This includes service quality, productivity and efficiency, contracting, health outcomes and user responsiveness.

Board-level and senior management scrutiny will be targeted on the most critical areas of the PCT's performance. Key achievements and shortcomings will become more transparent, and dialogue with providers will be more focused on the areas that really matter to patients.

CHIA to RIO and RiO Community

As one of the 10 PCTs who use CHIA as the interim Child Health System the decision was made in March 2007 to migrate to the London LSP strategic solution RiO. The project formally started in August 2007 with Child Health and Adult Community Nursing Services planning to go live in the summer of 2008. However the project has been delayed by BT not delivering the system to plan. It is now expected that the system will be implemented during 2009/10.

E-SAP

As a partner on the eSAP Board for the local health community the Trust signed the Declaration of Intent to take forward the deployment of the E-SAP system. It was previously reported that the system would go live in June 2008. The system went live in November 2008, however due to a number of issues the implementation of the System has been suspended. It is hopeful to go live in 2009/10

A Trust wide Project Team are currently driving forward the agenda to support the work of the eSAP Board and partnership working is taking place across the Homerton, East London & The City Mental Health Trust and the London Borough of Hackney.

CAF – the single assessment for children

Work has been taking place to develop children and families in line with the joint service delivery model. We are developing joint services in our newly built Child Development Centre and integrated services with our Children Centre model, Hackney Ark. Planning is underway to ensure appropriate IT systems and hardware are in place to support integrated working in line with Every Child Matters a reality.

ICT Security

The Trust has invested significantly in IT security including Encryption. The PCT has implemented full hard disk encryption and this will be extended to the GP community in 2009/10. In addition, additional security systems will monitor the whole COIN network to ensure that all systems are secure and that any new device connecting anywhere on the COIN is authorised to do so.

During 2009/10 the Trust will work to obtain BS7799/ISO27001 certification that will demonstrate that all systems within the PCT are secure especially those systems holding sensitive personal data.

6.8 Carbon Footprint

Action Plan to reduce the PCT's carbon footprint

The Trust takes a holistic view of its environmental impact, not limited to its carbon footprint. However, given the interplay between environmental resource issues, the majority of the Trust's environmental initiatives will impact positively on its carbon footprint.

The Trust's activities to mitigate against and reduce its environmental impact and carbon footprint fall into five areas of focus which will be periodically reviewed:

Advocacy and Engagement – which aims to encourage participation in carbon reduction activities, both direct and indirect

Energy and the Built Environment – which includes energy efficiency measures, sustainable energy and carbon management (the majority of the trust's scope 1 and scope 2 emissions)

Green Procurement – which seeks to reduce the trust's scope 3 emissions and help to support the industry for recycled products and sustainable goods and services

Transport and Travel – which provides information, support and impetus to reduce transport related emissions – the remainder of the trust's scope 1 emissions

Waste and recycling – which is reducing the Trust's volume of waste sent to landfill and includes the avoidance of some scope 3 emissions from procurement

Advocacy Engagement

The Trust's advocacy and engagement initiatives are aimed at raising the level of environmental awareness, including carbon literacy, amongst staff and visitors. The scope of these initiatives will primarily affect the following four action areas, but the Trust will seek to be receptive to ideas beyond this scope in order to support the learning, networking and ideas-generation processes implicit in public engagement on the environment.

Examples of existing initiatives to be continued and enhanced include the bicycle users group, which will be expanded to advocate and support all forms of zero and low carbon travel and participation in the Energy Saving Trust's annual Energy Saving Day. Amongst new initiatives to be explored and developed include a gardening club which will look at options for on-site food production possibly connected to on-site catering facilities.

The Trust will seek new and engaging ways to become an active member of the health community taking action and sharing advice on climate change and the environment.

Energy and Built Environment

The Trust has recently completed the mandatory process of obtaining Display Energy Certificates (DECs) for its applicable buildings, in accordance with the Energy Performance of Buildings Directive. As a result, the Trust will be in receipt of a set of recommendations for action which will be assessed and prioritised. In parallel, the Trust will approach the Carbon Trust to participate in its NHS Carbon Management Programme. A key barrier in this process will be to ensure that carbon management is no longer seen as 'just an estates issue', but becomes the responsibility of the whole organisation.

A process of information gathering will take place which will lead to the development of guidance and policy. These will include (i) an audit of energy efficiency and (ii) sustainable energy generation opportunities which will be compared with the recommendations received in conjunction with the DECs; an assessment of (iii) opportunities to participate in wider sustainable energy schemes; (iv) an

audit of opportunities for the enhancement of biodiversity at each of the Trust's sites; and (v) opportunities to improve water conservation and sustainable urban drainage (SUDS). Internal water savings from WCs and plumbed water filters will be delivered where replacement is feasible and when work is scheduled. Cost effective options will be scheduled for implementation.

The Trust will review its scope 2 emissions arising from electricity procurement and assess best value procurement options, taking account of emissions as a key factor, in line with recommendations from the NHS Sustainable Development Unit. It will also be vigilant of the possible introduction of carbon pricing within the NHS and will be willing to participate in any piloting where it is considered an advantageous 'warm up' exercise. It will also establish the costs and benefits of implementing an environmental management system to create an overarching structure to all of its activities impacting on carbon emissions and the environment.

Green Procurement

The Trust will establish the appropriate pathway to membership of the London Mayor's Green Procurement Code: (i) A business case and set of possible strategic aims and objectives will be developed for consideration by the Board. This will document the key nodal points where the Trust is likely to have the greatest influence and impact on sustainable procurement. (ii) A number of case studies will be developed exemplifying alternatives to current procurement practices which would be of benefit to the local economy, would create a greater focus on ethical suppliers and/or would increase the Trust's procurement of recycled or 'sustainable' products and services. These will be used to support (iii) a gap analysis of the potential impacts of green procurement by the Trust leading to more informed best value judgements based on whole life costing. This will (iv) form the basis of a green procurement plan.

Transport and Travel

The Trust has already commissioned a *Green Travel Plan Review* which sets out the necessary background information for the development of a full *Green Travel Plan*. A draft plan will be produced for consideration and review by the Board, to include targets for modal shifts towards more sustainable travel. In preparation, the Bicycle Users Group – to cover all forms of zero-carbon travel – will meet to review and discuss necessary facilities, of which an audit will be carried out.

The Trust will seek to make the *Cycle2Work* scheme available to staff and will review arrangements for pool bicycles and other vehicles, improving them where possible in line with best practice guidance from Transport for London. Information about walking, cycling and public transport will be made clear and accessible for staff and visitors to all of the Trust's sites.

Waste and Recycling

The Trust has recently introduced a desktop recycling system to separate recyclable and residual material at five of its main sites, involving the removal of waste bins from offices. This programme of roll-outs will continue to all sites where possible, with the aim of reducing the Trust's volume of waste to landfill and increasing its volume of materials recycled. A commitment to closed-loop recycling will help to reduce scope 3 emissions and will form part of a resulting draft waste and recycling policy for the Trust to include recycling targets.

The Trust will continuously review its volume of waste to landfill and to recycling from this system and will establish opportunities to incorporate additional waste streams. These will focus on the most achievable recyclables and those which are most hazardous to the environment, making best use of information sharing, available resources and advice.

6.9 Governance

Governance - (inc. PCT organisation, issues and risks, actions, reporting on 'Never Events' within commissioned services and root-cause analyses)

The PCT's Board Assurance Framework is the vehicle through which the PCT identifies risks to the delivery of key objectives arising from both internal and external factors. As part of the development of the Commissioning Strategy Plan and the detail of the Operating Plan, risks are identified and action plans put in place to mitigate them. The PCT Board monitors progress in year. New or unexpected risks are included in year as they arise. A scoring system is used. The likelihood (L) and consequences (C) of the risk are scored 0-5 to establish the risk rating (RR). $L \times C = RR$. Risks with a score of 15 or more are tracked via the Board Assurance Framework.

The following are the PCTs (draft) risks for 09/10

Risk	Consequences	Mitigation
Failure to maintain financial control/stay within £ control total	Loss of locality resources/Loss of reputation	Monthly reporting, Programme Management approach to new investment.
Slippage on investment	Loss of opportunity for health gain/Improved health outcomes	Programme management approach to new investment Fortnightly review against planned milestones.
Under capitation PCT, extreme levels of need, emergency led health economy	Failure to maximise population health benefit from resources deployed	Prioritisation approach to new investments. Urgent care planning. PBC demand mgt.
Financial uncertainty (economic climate. PBR/HRG tariffs, London-wide top slices, Potential revision of capitation formula)	Planning blight – failure to progress – risk of overspend	Prioritised investment plan – adjust commitment in light of available resources, Deploy contingencies/reserves Reduce planned surplus
Inadequate IM & T systems in community health services, particularly children's services and community nursing (Failure of call/recall system)	Risk to public health of reductions in herd community Business risk to PCT as provider	Active engagement in CHIA, Procurement Board, Interim PCT solutions to be sought, Proactive management measles outbreak and contingency plans
Gaps in capacity and skills to drive business functions (commissioning and provider)	Failure to achieve World Class Commissioning status Risk to APO and business viability	Organisational Development plan - Strengthening Commissioning plans, APO delivery, Board, Clinical Exec and leadership development
Risk to local partnerships of focus on London/sector wide priorities	Reduced clinical engagement, reduced engagement PBC, Loss of reputation, loss of opportunity for joint work priorities	Maintain strong locality focus and engagement of senior personnel
Organisational uncertainty – PCT reconfiguration	Staff demoralised, reduced focus on key objectives, loss of key personnel	Clear Organisational, Development Plans, (APO/strengthening commissioning), supported by staff engagement and communication
Emerging tensions between key players re acute services configuration	Lack of agreement – destabilisation of local health economy	Engagement across Inner North East London. PCTs Strategic planning via joint committee of PCTs (JCPCT)
Failure to achieve key targets, HCC compliance	Poor services, loss of reputation	Assign lead officers/director, Clear accountabilities, Action plans, Contingencies, Monthly performance reporting (RAG) Action plans for red/amber ratings
Failure to maintain financial control/stay within £ control total	Loss of locality resources/Loss of reputation	Monthly reporting, Programme Management approach to new investment and savings. PBC demand management.
Slippage on investment	Loss of opportunity for health gain/Improved health outcomes	Programme management approach to new investment Fortnightly review against planned milestones.
Over capitation PCT, extreme levels of need, emergency led health economy	Failure to maximise population health benefit from resources deployed	Prioritisation approach to new investments/dis-investments. Urgent care planning. PBC demand mgt.
Financial uncertainty (economic climate. PBR/HRG tariffs, London-wide top slices, Revision to national pace of change policy for moves to capitation targets)	Planning blight – failure to progress – risk of overspend	Prioritised investment plan – adjust commitment in light of available resources, Deploy contingencies/reserves Reduce planned surplus. Use of programme budgeting and health economic modelling to identify areas for dis-investment and re-deployment of resources.