

PCT Interim Operating Plan 2009/10 Commentary

NHS Barking and Dagenham

27 February 2009

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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)

- To ensure that, as a minimum, 90% of admitted patients and 95% of non-admitted patients are seen within 18 weeks.
- To support other, non-consultant led, community services, to achieve the standard for non admitted patients
- To maximise the provision of acute services in a community setting
- To maximise delivery against the contract for the ISTC
- To maximise uptake of extended choice
- To ensure that choose and book is fully utilised

Latest Performance and forecast outturn

Since mid December, BHR have reported that through their weekly PTL that they have exceeded the 90% threshold for admitted, and the 95% threshold for non-admitted. Despite concerns regarding A&E performance in recent days and the impact that this has on elective capacity, with the actions outlined below, the PCT is confident that both targets will be met by the end of March 2009.

The projected outturn has moved from October to December 2008. Negotiations with BHRT are close to conclusion for PbR. The outturn for 2008/09 will include the 18-week backlog work which will not be replicated in 2009/10.

Non-elective is similar to outpatients where forecast outturn has shifted from October to December 2008. Planning assumptions assume a 5% admissions avoidance target, after factoring in population growth. Negotiations with BHRT for the non-elective baseline are close to resolution.

Audiology is currently at 100% achievement for 18-weeks.

Action to Improve Performance

Data Quality

- Community services will be incentivised to improve waiting time data collection through CQUIN
- In the event of the need for outsourcing, the current processes for collecting data associated with inter-provider transfers will be improved
- BHR is now performing well against data completion metrics
- Work with Tower Hamlets PCT to improve/challenge data quality issues at BLT

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)

Negotiations for 2009/10 include an assessment of capacity to deliver 18-week sustainability, which is underpinned by specialty level analysis. Outsourcing will be maintained to meet capacity shortfalls. Pinch-points for admitted pathways will be vascular surgery, rheumatology and dermatology for non-admitted pathways.

Assumptions are:-

- 5% shift in OP attendances undertaken in a community setting
- 2% reduction in elective work
- 1.8% general growth in demand

Action/Initiatives/ New Services Commissioned in 2009/10

- The new contract for community service provision will incorporate a 0.5% of total contract value for CQUIN uplift; this equates to a total value of £133k. The proposed CQUIN has three indicators, all of equal value, one of which focuses on the collection of 18 week RTT data for all AHP services. The service will be rewarded for the provision of 18 week RTT data for all AHP service provided, from December 2009 onwards.
- PBC staff are currently working through patient pathways with secondary care consultants to identify action required to encourage diversion of referrals into CATS service for Dermatology, Neurology, Gynaecology and ENT
- BHR to improve internal performance monitoring at specialty level
- Development of JCPCT to harmonise acute commissioning across ONEL will also support BHR and PCTs in developing, implementing and monitoring action plans for these targets
- Outsourcing to be maintained to meet capacity shortfalls

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Bed pressures due to non-elective admissions	3	3	9 (S)	IS providing Additional Capacity; Additional Beds at Gray's Court; Rapid Response Team.
High average length of stay at BHRT.	4	3	12 (S)	Commissioners will support BHRTs plan to reduce ALOS in key specialties.

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

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

NHS Barking and Dagenham is committed to ensuring that the effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday clinical practice and applied consistently by all staff. Under the Department of Health's Standards for Better Health (2004) document for infection control, the Health Act 2008 - Code of Practice for the Prevention and Control of Health Care Associated Infections and from April 2009, under the requirements of The Health and Social Care Act 2008, the Trust is required to minimise the risk of infection to patients, staff and visitors.

The PCT is working closely with its service providers to build on previous plans to address cleanliness and infections control issues which include preventative measures such as implementation of the deep cleaning programme, collaborative working with matrons and other stakeholders, as well as providing antimicrobial prescribing guidance to general practitioners.

Improving cleanliness and reducing HCAIs

With the view of minimising the risk of cross infection, the Trust has system in place to ensure that all parts of the premises in which it provides health care are suitable for the purpose, are maintained in good physical repair and are kept clean in line with the NHS Healthcare Cleaning Manual. Together with Cleaning Monitoring Team/ Cleaning Supervisor & Site Managers, the Infection Prevention & Control team monitors on a continuous basis the standard of cleanliness of healthcare premises. Where standards are found to below acceptable level, action plans are produced to rectify the problems.

The Trust's Infection Prevention & Control Team lead on the development, audit and review of infection control policies in line with infection prevention and control requirements as described in Annexe 2 of the Health Act 2008 and other relevant legislative and published professional guidance. This includes having appropriate policies & procedures in place and working in relevant parties in order to prevent legionella outbreaks as well as pest infestations.

Surveillance and audit

A system of alert organism surveillance is well established for the Trust's inpatient facilities. This system is based on laboratory information, together with information from clinicians, and seeks to detect those infections, which are most liable to give rise to outbreaks. Surveillance information is reported to the Infection Control Committee and includes information on Meticillin Resistant *Staphylococcus aureus* (MRSA) isolates, *Clostridium difficile*, Norovirus and bacteraemia surveillance by both ward and organism.

The PCT monitors both MRSA and *Clostridium difficile* rates in our acute care provider. The Infection Control Team receives copies of RCA on cases of MRSA bacteraemia and *Clostridium difficile* at the local acute care provider.

Where an MRSA bacteraemia or a case of *Clostridium difficile* infection is identified in the community, a pathway is in place to ensure that a root cause analysis (RCA) is carried out and findings are shared with the Health Protection Agency and the local acute care provider.

An audit program agreed by the Infection Control Committee is in place, to ensure that all services provided in PCT healthcare premises as well as contractors are audited regularly to so that infection control risks are minimised and high level of cleanliness is maintained in these facilities.

MRSA Screening of elective admissions

The introduction of MRSA screening by April 2009 within NHS Barking & Dagenham Community Hospital is currently being taken forward by the Trust Infection Control Committee. The Infection Control Team are currently addressing the following issues:

- Workforce training/awareness
- Ensure laboratory facilities are in place to meet the need
- Development and implementation of management strategies for patients with MRSA
- Performance monitoring and management arrangements.

Trajectory for 2009/10 (C. diff.) - annual only, taking account of revised baseline	2010/11 (C. diff.) - annual only, taking account of revised baseline (N.B. this will be set by DH for each organisation)
70	63

Latest Performance and forecast outturn

The PCT inpatient facility at Gray's Court Community Hospital continues to maintain low rate of HCAs (MRSA bacteraemia & *C.difficile*) since its opening in June 2007. This has been achieved via strict infection control and admission policies, collaborative working with contractors, including cleaning staff as well as investments in equipments such as shared equipment washer/disinfector, infection control compliant wipeable PC equipments.

Action to Improve Performance

Data Quality

- Strengthening of Cleaning and Waste Management contracts;
- Ratification of identified key infection control policies;
- Patient information leaflets for Healthcare Associated Infections and Precautions to prevent cross infection.

Management of Service Delivery

- KPIs for decontamination, cleaning and waste management established and presented to the Infection Control and other Committees;
- MRSA screening of all elective admissions and de-colonisation of positive cases from April 2009;
- Collaborative working with the Health Protection Agency and other stakeholders in order to reduce the rate of community acquired infections in care homes;
- Provision of portable alcohol gel to all nursing staff and allied health professionals working on wards at Grays Court Community Hospital;
- Provision for additional hand washing sinks to wards at Gray's Court Community Hospital;
- Provision of hand wipes to all patients in the Community Hospital.

Action/Initiatives/ New Services Commissioned in 2009/10

- MRSA screening of all elective admissions to Gray's Court Community Hospital;
- Decolonisation of all MRSA positive patients;
- Implementation of Yearly Deep Cleaning Program;
- Refurbishment of premises to meet infection control and decontamination 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)

Risks to Delivery with Mitigating Actions Planned				
Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Inability for local microbiology lab to process MRSA swabs	4	3	12 (S)	Working with BHRT as part of the Commissioning process to ensure this requirement is delivered.

1.3

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

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)

NHS Barking and Dagenham aims to improve satisfaction with access to 85.6% in 2009/10 by increasing the capacity and responsiveness of primary care. The following aims will support the achievement of this target:

- Commission new APMS practice services for NHS Barking and Dagenham primary care hubs – procured December 2008.
- Commission a GP-led Health Centre at the redeveloped Barking Hospital Site – due to open in 09/10.
- Ensure that any practice not providing reasonable access as defined in the GMS/PMS/APMS contract is subject to a formal performance process.
- Reduce the number of single-handed practices in the borough
- Produce routine monitoring reports covering opening times, workforce, level of appointments offered, A&E attendances, emergency admissions, 48hr breaches,
- Set a benchmark of 72 appointments per 1000 patients per week for all practices and performance manage practices delivery against this benchmark.
- Set a benchmark of 1 telephone line per 2500 patients per week for all practices and performance manage practices delivery against this benchmark along with the average response times.
- Build on the success of the local extended hour's scheme, increasing the number of practices offering 8am-8pm and Saturday opening from 4 to 10.
- Build upon the success of the salaried GP scheme maintain 101 WTE GP's in Barking and Dagenham and move all practices towards the target of 1 WTE GP per 1750 patients.
- Review the practice nurse workforce in Barking and Dagenham and move all practices towards a nursing workforce of at least 0.4 WTE per 1750 patients
- Develop a new local enhanced service contract for access that gives incentives to practices to improve patient satisfaction and only rewards strong performance.
- Review repeat prescribing and extend these services in local general practices so that patients are routinely offered this service as appropriate.
- Publishing information to support patient choice when access health services including key quality metrics.
- Continue to invest in schemes aimed at preventing ill health and manage demand for services such as health champions and Pharmacy First.

Trajectory	2009/10	2010/11
Satisfaction with telephone Access	89.9%	92.1%
Ability to see a GP within 48 hours	80.3%	82.4%
Ability to book GP consultations 3+ days ahead	79.2%	81.2%

Ability to see a specific GP if wanted	88.6%	90.8%
Satisfaction with GP practice opening times	87.0%	89.2%
Average of five elements of access to primary care	85.6%	87.8%

Latest Performance	2007 Survey Results
Satisfaction with telephone access	83%
Ability to see a GP within 48 hours	76%
Ability to book GP consultations 3+ days ahead if wanted	75%
Ability to see a specific GP if wanted	85%
Satisfaction with GP practice opening times	81%
Average of five elements across primary care	78.7%

Action to Improve Performance

Data Quality

The access satisfaction survey is a national survey and is considered to be fully representative of the ability of patients in Barking and Dagenham to access primary care services. These survey results can be compared with other boroughs in a similar socio-demographic grouping.

In 2008/09 the PCT was reliant on unvalidated paper-based practice reports to monitor the degree to which the 48hr target for appointments was being met. Since then the PCT has commissioned agency support to conduct a review of primary care access and develop high quality, validated metrics and monitoring process with data drawn directly from the practices own IT systems. In 2009/10 each practice will have a performance dashboard for access that is regularly updated and incorporates an assessment of capacity including number of appointments offered and the demand for services.

Management of Service Delivery

In 2008/09 the PCT has responded to the patient access survey for general practice by completing a diagnostic with all practices that scored less than 80% satisfaction across the survey, in order to set a minimum level of care hour's access at 70 appointments per week per 1,000 people on the list.

Implementation of these initiatives will be overseen by the Primary Care Contracting Group which reports to the Professional Executive Committee. This committee will also review the performance of primary care providers and agree actions to remedy poor performance.

The Primary Care Contracting Team have put in place new systems for the close monitoring and scrutiny of individual practice systems and will be reviewing access performance dashboards with providers on a quarterly (for strong performers) or monthly (for poor performers) basis.

Action/Initiatives/ New Services Commissioned in 2009/10

- Equitable Access to Primary Care Scheme / Practice & GP-led Health Centre Procurements:** Barking and Dagenham PCT has undertaken an open competitive tender exercise for the procurement of three new 6-9000 list size APMS practices to be based within new primary care hubs at Porters Ave, Barking Town Centre and Barking Hospital. The practice at Barking Hospital will be integrated with other GP-led health centre and urgent care services offering walk-in and bookable GP services for non-registered patients.
- Primary Care Access Performance Improvement Programme:** The PCT has commissioned an

independent review of general practice accessibility in core GMS hours in 2008/09. This programme will continue throughout 09/10. This will identify practices that are not operating appropriate levels of services in-line within the spirit of the GMS contracted hours and advise practices on approaches for improving primary care efficiency and accessibility for example through the introduction of new triage systems.

3. **Extended Opening Hours:** In 2008/09 the PCT significantly expanded the range of extended hours with 90% of general practices providing evening and/or weekend opening arrangements. The PCT currently has 4 practices offering 8am-8pm Mon-Fri and Saturday opening and is anticipating an expansion of this figure to a minimum of 10 sites in 2009.
4. **New Access LES:** Rewarding attainment of 72 appointments per 1000 patients per week, rapid telephone access and improvements in patient satisfaction.
5. **Online Appointment Booking System:** In 2009/10 the PCT will pilot an online booking system for EMIS practices to allow patients to book their appointments remotely and will reduce the volume of telephone calls received by a practice.
6. **Patient Information:** NHS Barking and Dagenham will be publishing information to support patient choice when access health services including key quality metrics. Make full use of NHS Choices, a revamped PCT website guide to services and other appropriate communication tools for the local population.
7. **Salaried GP Scheme:** NHS Barking and Dagenham were on target in 2008/09 to bring GP workforce levels to a minimum level of 1 per 1800 by the end of March 2009. In 2009/10 NHS Barking and Dagenham will continue to maintain the salaried GP scheme with a view to repatriating new GP's into local surgeries.
8. **London Deanery GP Graduates Scheme:** Outer NE London general practices have been offered the opportunity to employ new graduate registrars as salaried GP's with additional 95% funding support directed by the Department of Health via the Deanery for this purpose. The London Deanery is coordinating this scheme 10 GP's will be identified for ONEL and a number of training practices in Barking and Dagenham are bidding for this additional GP resource.
9. The following **performance management approach** for general practice in relation to Access targets has been adopted:
 - In 2008/09 NHS Barking and Dagenham commissioned McKinsey's to undertake a review of access in 21 practices. This resulted in a 27% increase in core hours appointments offered
 - The performance approach agreed to sustain this improvement includes a RAG rating scorecard system for all practices against the following measures:
 - No. of Appointments provided
 - Usage of a Breach Board
 - Patient Feedback (both the MORI poll and the practice feedback card)
 - Action plan progress
 - Practice staff /mindsets/ skills/ behaviour
 - Telephone response times
 - Red rated practices must attend fortnightly interviews
 - Amber rated practices must attend monthly interviews
 - Green rated practices are called quarterly for an update
 - Where a lack of commitment or improvement is seen with Red rated practices the PCT escalates the issue as a potential contractual breach.
 - This process was piloted in Tower Hamlets PCT in 2007/08 and they are now able to guarantee 9 out of 10 patients an appointment within 48 hours.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
35187		1438	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Reduction in GP numbers from GP retirements	4	2	8 (S)	Succession plan in place; Performance monitoring of the number of WTE per 1000 for individual practices and focusing on outputs such as number of appointments delivered per patient.
Time – lag between “real” increases in primary care capacity and access and “perceived” increase in patient satisfaction levels.	4	3	12 (S)	Public Communications Strategy to highlight improvements to services.

1.4

Cancer - 2 Week maximum wait for all referrals for breast symptoms (i.e. not just urgent referrals) - VSA08

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)

100%

2010/11

Latest Performance (local estimate if no robust data)

Following delays in national data definitions, providers have commenced submitting PTL data and, although the Network undertook a 'stock take' that did not indicate major concerns, the available data is not yet robust enough to measure performance.

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 workstream is led 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. This will not be available until 18 March 2009. 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.

The Cancer Lead for the PCT sits on the acute trust's Cancer Services Management Board, where issues of service delivery at tumour group level are discussed. This will include breast cancer services and the extended waiting time delivery. Action plans, implementation and capacity issues are brought to the Co-Commissioning Group between PCTs and the acute trust. Barking and Dagenham specific issues are discussed in detail at the Cancer Locality Board.

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.

The PCT will be providing timely advice to GPs as to the extension of the existing two week wait standard. The GP Macmillan Facilitator sits on the Cancer Locality Board and changes in practice are disseminated via the facilitator at the Gold Standards Framework meeting and at PTI meetings. BHRT referral forms have been

disseminated across all GPs in the Borough.

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 workplan and including the understanding of demand and capacity for breast referrals. For the Outer North East London locality the Service Improvement Facilitators are accountable for their workplan through the Barking and Dagenham Cancer Locality Group. The Cancer Lead for Health Improvement sits on the BHRT Cancer Services Management Board, where progress against waiting times is monitored.

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)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Inadequate outpatient capacity to achieve waiting times targets.	3	3	9	Service improvement programme led by the Cancer Network; Monitoring for ONEL by the B&D Cancer Locality Board – including technical assessment of demand and the rationalisation of follow up for breast cancer.
The implementation of the common cancer data collection system that will be key to the successful implementation of this standard and which will feed Open Exeter is delayed.	4	3	12 (S)	The Cancer Lead for the PCT sits on the acute trust's Cancer Services Management Board, where issues of service delivery at tumour group level are discussed. This will include breast cancer services and the extended waiting time delivery. Action plans, implementation and capacity issues are brought to the Co-Commissioning Group between PCTs and the acute trust. Barking and Dagenham specific issues are discussed in detail at the Cancer Locality Board

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
<ul style="list-style-type: none"> • To maximise the number of eligible women who attend for screening that meets national Standard (>70%) • Effective plan to maintain round length (<36 months) • Improve accessibility to women contacting the service • Implement digital mammography • Introduce age extension • Commence Family History clinics

Trajectory for 2009/10	2010/11

Latest Performance (current age range) and forecast outturn			
<u>Barking Area:</u> Screening period 29 th May to 18 th August 2008 show a total 3392 women screened in Barking			
Uptake:			
	Invited	attended	uptake (%)
Recall Batches	2277	1835	81
Call Batches	1115	531	48
Total	3392	2366	70%
<u>National Screening Targets</u>			
Screening to Normal Results – 98% within 2 weeks (National Minimum Standard: >90% within 2 weeks)			
Screening to assessment – 94% within 3 weeks (National Minimum Standard: >90% within 3 weeks)			
Round Length – 99% within 36 months (National Minimum Standard: >90% within 36 months)			
Did Not Attend (DNA) –Telephone Call DNA's – (all DNA's are offered a 2 nd appointment but do not attend. The project contact women by phone to offer them an appointment)			
Total DNA's (within the period)	Contacted	Attended	Uptake of DNA
483	150	111	23%
<u>Dagenham Area:</u>			
Uptake:			
	Invited	attended	uptake (%)
Recall Batches	4490	3565	79
Call Batches	<i>To be invited in Feb 09</i>		
<u>National Screening Targets</u>			
Screening to Normal Results – 99% within 2 weeks (National Minimum Standard: >90% within 2 weeks)			
Screening to assessment – 96% within 3 weeks (National Minimum Standard: >90% within 3 weeks)			
Round Length – 99% within 36 months (National Minimum Standard:>90% within 36 months)			
Total DNA's (within the period)	Contacted	Attended	Uptake of DNA
446	210	175	39%

Action to Improve Performance

Data Quality

- Service performance information are collated on Cristal Reports for National Breast Screening Services (NBSS) using KC63 and KC62
- Information on DNA's is being collated and reported by the BSS Victoria Unit.
- Implementation of automated data entry introduced in July 2007
- Quality Management System – audit schedules have expanded to include systematic review of service statistics (KC63 and BASO)
- Monthly performance meetings between commissioners and clinicians

Management of Service Delivery

Assumptions are:

- Increase uptake for the first time women screening by 3%
- Age-extension (2010-2011) – 4223 women to be screened
- Digital mammography –replacement of analogue machines with Digital (publication from NHSBSP on what machines will be suitable for breast screening is to be published shortly)
- Family History clinics – establish pathway and ascertain baseline

The PCT is working with BHRT to roll-out the extended age range of breast screening to 47-73 years from 50-70 years. Extended age-range adds approximately 4,000 women to the programme. To achieve the Trust will need additional radiography, radiologist and pathology capacity in 2009/10.

Action/Initiatives/ New Services Commissioned in 2009/10

This will be delivered through a number of actions, including:

- Health promotion coordinator post is in place: an active action plan will be managed by the Commissioning Screening Manager
- DNA's telephone project to increase uptake of first time screeners
- A feasibility study on how the service can deliver to proposed age-extension in terms of analysis of staff requirements to meet increase activity and static sites to maximise increase uptake
- A scoping study and formal consultation with women on the location of sites.
- Review of costs of screening, staff and location of static sites and plan to roll out digital mammography and family history clinics
- Project manager post funded between the Trust and PCT to develop and oversee the transfer of site and plan for age extension and roll out of digital mammography
- All local PCTs are working with BHR to facilitate extension of age range in 2010/11 (see above); the numbers to be screened will depend on DH decision on whether extension to age range will be phased. Consideration currently being given to location(s) of site, and additional radiography, radiology and pathology staffing to cope with increased demand

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Recruitment of key clinical staff	4	3	12	Recruitment campaign will commence during 2009/10.
Disruption to service due to the transfer of services to another site	4	3	12	Project Plan; Breast Screening commissioning and business planning group meets fortnightly.

1.6

Bowel screening (trajectory submission deferred but action plan summary required)

Objective/Aim

- Screening men and women aged between 60 and 69;
- To detect bowel cancer at an early stage, when treatment is more likely to be effective;
- To reduce mortality from the disease;
- By 2010, extend screening invitation to all women and men ages 60 to 75 years.

Trajectory for 2009/10

2010/11

Latest Performance

Since the commencement of the screening programme in May to October 2008:

- The estimated eligible population for Barking and Dagenham in 2008 was at 14605 (source: London Screening Hub Report). The 2% (about 292 people) anticipated to have positive test will be offered colonoscopy procedures at Royal London Hospital;
- Since May 2008, 1.3% (11 of 843 returned test kits) tested positive for FOBt. (It is estimated that only 10% of positive tests are attributed to bowel cancer);
- The average uptake rate for Barking and Dagenham population was at 38.7%. The London average is at 45%, and the national minimum standard is 60%;
- Uptake rate by GP practice shows that out of the 37 practices currently involved in bowel cancer screening:
 - 4 practices are at 50% and over
 - 8 practices are at 40-49%
 - 10 practices are at 20-39%
 - 15 practices are at 0%

Action to Improve Performance

Data Quality

- Performance data information is provided by the Screening Hub and circulated with PCTs;
- Performance data by GP practice allows for targeted health promotion with local populations.

Management of Service Delivery

- Homerton Hospital responsible for the overall sector wide implementation and PCT's coordinating local delivery;
- Health promotion interventions coordinated on collaboratively with neighbouring PCT's.

Action/Initiatives/ New Services Commissioned in 2009/10

A dedicated bowel cancer screening health promotion specialist has been recruited to work with primary care to:

- Monitor uptake and supporting strategies to improve uptake at GP Practices;
- Set-up multi-Agency Partnership working and community outreach to raise local awareness;
- Develop and maintain effective health promotion communications;
- The PCT has commissioned North East London Treatment Centre to establish a bowel screening service and this will be funded from the existing minimum-take agreement.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Lack of awareness of importance of screening.	4	3	12	Engagement will local voluntary and primary care groups to mobilise local awareness; Local media campaign and health promotion events developed in collaboration with the Health Improvement Team.

1.7

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

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)

65%

2010/11 (confirmation of plan for 100% by January 2011)

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 time's 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 lead 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 workstream is led 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. This will not be available until March 2009. 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.

The Cancer Lead for the PCT sits on the acute trust's Cancer Services Management Board, where issues of service delivery at tumour group level are discussed. This will include breast cancer services and the extended waiting time delivery. Action plans, implementation and capacity issues are brought to the Co-Commissioning Group between PCTs and the acute trust. Barking and Dagenham specific issues are discussed in detail at the Cancer Locality Board.

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. **Monthly cancer waiting times reports are produced by the PCT Cancer lead with commentary on projected performance to year end. This stimulates any required internal action, and provides briefing to the Co-Commissioning Group.**

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 levels 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 workplan. For Outer North East London, the Service Improvement Facilitators will be accountable to the Barking and Dagenham Locality Board for their workplan. The Cancer Lead in Health Improvement also sits on the BHRT Cancer Services Management Board, where this work is reported. 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)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
That physical capacity proves to be inadequate.	3	2	6 (M)	The London baseline suggests that this will not be the case but the emerging strategy will assume that, if necessary, flows can be commissioned across providers to maximise available capacity. Service improvement will be prioritised.
That workforce capacity is inadequate to meet demand. (Whilst waiting times standard will be achieved the guidance is clear that both waiting times and the numerical standard for the	3	2	6	The funding included in the Commissioning Strategy Plan will 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.

population should be met)				
The implementation of the common cancer data collection system that will be key to the successful implementation of this standard and which will feed Open Exeter is delayed.	4	3	12 (S)	The Cancer Lead for the PCT sits on the acute trust's Cancer Services Management Board, where issues of service delivery at tumour group level are discussed. This will include breast cancer services and the extended waiting time delivery. Action plans, implementation and capacity issues are brought to the Co-Commissioning Group between PCTs and the acute trust. Barking and Dagenham specific issues are discussed in detail at the Cancer Locality Board

1.8

Implementation of the national stroke strategy - VSA14

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

The aim is to bring parity of access and reduce inequality of provision of stroke services for local people in Barking and Dagenham. This links closely with Healthcare for London's framework for action which identified stroke care as a priority issue.

Trajectory for stroke care 2009/10 (Q4 figure, sign-off criteria is 70%)

70%

2010/11

(Q4 figure, sign-off criteria is 80%)

80%

Trajectory for TIA cases 2009/10 (Q4 figure, sign-off criteria is 45%)

50%

2010/11

(Q4 figure, sign-off criteria is 60%)

60%

Latest Performance and forecast outturn

At Q3 2008/09 25% admitted to a Stroke Ward and performance on the TIA target is 100%.

Action to Improve Performance

Data Quality

Data is from BHRT and data quality is relatively good.

Management of Service Delivery

Service delivery is primarily through BHRT and in line with the HfL designation criteria and National Stroke Strategy quality markers. Mapping against the standards is required and resultant robust action plans when the standards or service are below the line required by HfL. The plans will be signed off the JCPCT in July 2009. An ongoing stroke action plan will then be in place for progression up to 2011.

A GP lead for stroke was appointed in 2008 to provide clinical input to support the community in-patient rehabilitation beds at Grays Court and the establishment of a community-based post stroke and TIA follow up clinics and to advise on secondary prevention.

Action/Initiatives/ New Services Commissioned in 2009/10

- An information pack is provided for patients and carers on or prior to discharge;
- A community rehabilitation team is in place;
- Procurement of early Early Supported Discharge (ESD) with Clinicenta as part of the N11 Wave 2 ISP;
- A nurse consultant and nurse specialists for Stroke / TIA are in place;

- 8.5 wte PA consultant provision of service at both KGH and Queens for Stroke;
- Vascular screening will start in general practice in 2009/10;
- Acute service at BHRT are being consolidated on the Queen's site to improve patient outcomes as measured by SENTINEL audits;
- In 2009/10 the PCT will use CQUIN to incentivise BHRT to achieve HfL quality standards;
- Consultation and designation process for Hyper-Acute Stroke Unit, Stroke Unit and TIA 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)
85		85	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Designation is not agreed by JCPCT in July 2009	4	3	12 (S)	NEL Stroke Network and B&D are working with BHRT to undertake the mapping of services against the HfL criteria and the resultant robust action plans. A high level steering group will coordinate progress chaired by B&D Director of Commissioning.
Failure to recruit adequate skilled stroke workforce.	4	3	12 (S)	Robust workforce action plans will be required as part of the HfL designation package.
Inadequate provision of community rehabilitation to support stroke survivors and meet the HfL standards and national quality markers.	4	3	12 (S)	To ensure that the levels of staffing at Gray's Court are sufficient to meet the needs for workload for the population.

1.9

Cervical screening test results to be received within 2 weeks - VSA15 (trajectory submission deferred but action plan summary required)

Objective/Aim

- Improve both the coverage and uptake of cervical screening;
- Implement Direct Referral system to improve management of abnormal cervical samples;
- Monitor quality of smear taking and rate and source of inadequate smears;
- To monitor and reduce the rate of exceptional reporting processes by GP Practices;
- Plan to achieve the two week cervical screening target turnaround.

Trajectory for 2009/10

2010/11

Latest Performance

As per June 2008 KC53 data shows:

Cervical screening coverage by GP practices

- 15 out of 43 practices (36%) rated GREEN with average screening coverage >80% (National Screening Target >80%)
- 22 out of 43 practices (54%) rated AMBER with average screening coverage 75%-80%
- 5 out of 43 practices (11%) rated RED with average screening 52%-65%

Quarterly Coverage Data (KC53) for (July to Sept 2008): 73.8% coverage

Action to Improve Performance

Data Quality

- KC53 collate and report on coverage data by PCT and GP practice (quarterly)
- KC61 collate and report data on laboratory turn around time (quarterly)
- KC62 collate and report data on colposcopy referrals and turn around

Quarterly analysis reports are systematically produced from these data sources.

Service performance and coverage data are presented and discussed locally at Cervical Screening Policy and Operational Group Meetings.

Management of Service Delivery

Primary Care

- GP practices - cervical screening is part of primary care services provided by local general practices under NGMS contract
- Walk-in centres – introduced weekend cervical screening

Secondary Care

- Cytology Laboratory and Colposcopy services are provided by the local Trust

Commissioning

- Services are agreed in service specification with Trust in line NSHCSP standards and targets. BD is the lead commissioner for the NEL outer sector.
- Commissioner lead and a commissioner manager are responsible for the performance and quality assurance of the programme

Governance and Quality Assurance

- Local governance and quality assurance of the programme has been agreed in line with Quality Assurance Office

Action/Initiatives/ New Services Commissioned in 2009/10

This will be delivered through a number of actions, including:

- Recruit a part-time administrator to remind women to attend for sample taking, near to the appointment date;
- Colposcopy community nurse recruited to identify and work with GP Practices that are not meeting the target 80% coverage, and improve quality of smear taking practice;
- Data analysis of women 'never attended' screening (particularly the age group of 25-34 years) with help of data extracted from Exeter System (commissioned from Dr Foster's);
- Focus group discussions with identified women who 'never attended' (commissioned from Dr Foster's);
- Implement Direct Referral system to shorten time from referral to treatment and improve management of abnormal cervical samples;
- Pilot implementation of 14 days turn-around target by end of Quarter 3 based on local partners action plans (GP practices, call and recall teams and laboratories).

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating

Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Competing priorities in GP practices make it difficult for practices to participate and collaborate with colposcopy community nurse.	3	3	9	Colposcopy community nurse recruited to identify and work with GP Practices that are not meeting the target 80% coverage, and improve quality of smear taking practice.

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)

Please see sections 1.11 – 1.13 which cover the main issues in relation to this target area.

Trajectory for males 2009	2010	2011
724	710	692

Trajectory for females 2009	2010	2011
510	484	472

Latest Performance and forecast outturn

<u>Action to Improve Performance</u>
Data Quality
Management of Service Delivery

Action/Initiatives/ New Services Commissioned in 2009/10

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

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions

1.11

Cardiovascular mortality - VSB02

Objective/Aim

Aim: To deliver a programme of targeted vascular risk assessment (9,500 people per annum) and targeted interventions to reduce morbidity and mortality, to the adult population at increased risk of vascular disease.

Objectives:

- To establish the programme and target adults aged 40 – 74 in the first twelve months. Within this to ensure that every adult (18 or over) with severe mental illness receives a vascular risk assessment within the first twelve months. Within this to ensure that every adult (18 or over) with learning disabilities
- To develop a means for identifying risk, calling and recalling persons identified for screening and referring them for intervention
- To provide this in a range of community and primary care settings
- To deliver this by means of a range of providers including pharmacists, GPs, CVD technicians, local authority and voluntary sector agencies
- To commission a Local Enhanced Service from pharmacy and general practice. Includes a call and recall system.
- To gather information on risk and report for the whole population.
- To commission the Health Trainers and Healthy Advocates Programme.
- To commission the Healthy Adults exercise, smoking and obesity management programmes.
- To deliver care pathways which chart progress and criteria through the process
- To run a large scale CVD Campaign.

Outcomes

The outcomes of this programme will be:

- The screening of everyone in the age group 40 – 74 at heightened risk of Cardiovascular Disease through identification in primary care registers and through existing services, and their appropriate management through lifestyle, diet, advice or clinical intervention and onward referral if necessary by April 2010.
- A reduction of 20% in vascular disease events and emergency admissions by April 2010 against the April 2008 baseline
- A reduction of 20% in vascular disease mortality by April 2015 against the April 2008 baseline in the populations at risk
- A reduction of 10% in new diagnoses of vascular diseases by April 2015 against the April 2008 baseline
- An increase of 20% in persons taking part in physical activity on a regular and sustained basis against the Sport England 2006 baseline by April 2015
- QoF registered prevalence of vascular disease will be in line with epidemiological estimates for the population by April 2010
- 85% of those screened and identified as being at increased or high risk of vascular disease will have been through a programme of lifestyle or pharmacological management by April 2010, including access to a health trainer or health advocate
- An integrated vascular disease prevention pathway will be in place by April 2009

2. Healthy Adults & Health Trainers

Healthy Adults

Aim; To deliver the Adult Obesity Strategy through a means of actively engaging people with physical activity and/or weight management in a range of settings.

Health Trainers

Aim: The Health Trainers and Health Advocates Programme aims to contribute to achieving a sustained increase in healthy lifestyles and sustained decrease in onset of disease and mortality, based on the 2006 baseline, by 2015

Objectives

- To improve uptake of physical activity in adults (18+) in the borough especially adults of working age.
- To support LAA and local authority targets on update of leisure facilities, participation in sport and physical

activity.

- To provide a mechanism of assessing people for lifestyle risk and suitability for referral for physical activity including existing vascular disease (including heart disease, stroke, diabetes chronic kidney disease, vascular dementia), cancer risk due to lifestyle or heightened vascular disease risk, depression and mental ill-health obesity, overweight and hypertension/hypercholesteraemia
 - Through Health Trainers for people who identify they want to improve their health
 - Through pharmacists, GP's and community primary care services where clinicians feel a referral to the programme would be appropriate.
 - Through the newly commissioned vascular screen programme for 40-74 years.
- To provide people with a means of self referral to a range of programmes.
- To provide a range of activities and programmes in a range of settings.
- To subsume the current GP exercise referral programme within the new programme.
- To provide a balance of availability across daytime, evenings and weekends, across the borough, in the following settings:
 - Health Trainers – Community settings and local authority settings
 - Health Advocates – GP surgeries and primary care and social care settings
 - Faith Health Trainers – Faith Community settings and community settings

Outcomes

- Increase the proportion of obese and overweight patients who's Body Mass Index is recorded by their general practitioner, as measured through the quarterly PCT performance set by ONS.
- Reduce year on year the rate of increase in the annual prevalence of obesity and overweight patients aged 18yr to 65yrs.
- Contribute to a reduction in cancer and Vascular disease mortality (heart disease, stroke, diabetes and associated diseases) of 3% based on the 2006 mortality baselines.
- Contribute to a reduction in onset of vascular disease in adults of 3% against the 2005 baseline.
- Contribute to an increase in people reporting uptake of physical activity of 20% based on 2005 Sport England baseline, in the people using services .
- Contribute to an increase in uptake of healthy eating of 50% in the population using services based on the estimated baseline of 2006 in the population using them.
- Achieve an outcome of increased self-efficacy to address their own health in 50% of people who come through the programme.
- Achieve an outcome of increased ability to manage stress and anxiety reported by those using the service in 50% of users.
- Achieve an onward referral into healthy lifestyle activities (whether organised or not) for 50% of those who come through the programme

Trajectory for 2009	2010	2011
90	89	88

Latest Performance and forecast outturn

2007/08, achievement was 110.68 per 100,000 population. This target is annually measured. The current year target is 98 per 100,000.

Action to Improve Performance

Data Quality

Please see below

Management of Service Delivery

Please see below

Action/Initiatives/ New Services Commissioned in 2009/10

Vascular Screening

- Call and recall system
- Pharmacy LES
- Advertising campaign
- Learning disabilities specific programme
- Mental Health programme

Healthy Adults

- Advertising campaign
- Fit for Life – gym exercise referral scheme
- Fitness for your future – baseline fitness assessment & psychological test
- YMCA – exercise programme assessed by qualified instructor
- SureSlim – weight loss clinic specialising in tailor made eating plans
- Disability Association Barking & Dagenham (Learning Disabilities) – address obesity and physical activity promotion and the reduction of CVS and cancer common risk factors
- Older people weight management – to develop/facilitate activities which can promote healthy active life for older people

Health Concern – exercise i.e. belly dancing, juggling, salsa dancing, tai chi and chair based exercises

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Lack of engagement with the public for the programme	3	2	6	Contract with our provider covers marketing and engagement with local people.
The evaluation does not show positive impact	3	2	6	The contract sets out the required outcome indicators and the PCT will undertake routine monitoring of the contract.

1.12 Cancer mortality - VSB03

Objective/Aim

National target of a 20% reduction in cancer mortality in people aged under-75 years by 2010 (from 1995/97 baseline). This indicator monitors all aspects of cancer services from prevention through to timely diagnosis and treatment.

Trajectory for 2009

124

2010

122

2011

120

Latest Performance

	DSR per 100,000		Target 20% reduction by 2010	Change since baseline
	1995-1997 (Baseline)	2004-2006 (Pooled)		
England & Wales	141.42	115.48	113.14	-18.35
London	141.94	111.96	113.55	-21.13
Barking and Dagenham	173.56	137.00	138.85	-21.07

The decrease in cancer mortality in the borough has been greater than the national trend year on year since the original LDP targets were set, and the PCT is likely to achieve the national target of a 20% reduction in cancer mortality in people aged under-75 years by 2010 (from 1995/97 baseline) and also to achieve the spearhead target to reduce the gap between (the fifth of areas with the lowest life expectancy at birth) and the population as a whole by 6% by 2010 (from 1995/97 baseline). Last year, Barking and Dagenham experienced a considerably greater change from the baseline compared to the rest of London, though London caught up in the last year for which data was available.

Based on the steep decline in cancer mortality in the late 1990s, ambitious targets for reducing cancer mortality were set in our LDP that will be very challenging to achieve. Trajectory as below.

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Year 1 (2008)	Year 2 (2009)	Year 3 (2010)	Year 4 (2011)
166	195	160	159	168	166	138	154	148	126	142	142	127	126	124	122	120

Action to Improve Performance

Data Quality

Data is compiled annually by the Compendium, with a one-year time lag. These form robust analysis and are used to benchmark nationally.

Management of Service Delivery

A Commissioning Implementation Plan has been agreed by the North East London Cancer Network and will be monitored through their board.

All cancer-related activity is monitored through the bimonthly Cancer Locality Board and the North East London Cancer Network.

Action/Initiatives/ New Services Commissioned in 2009/10

Many of the initiatives that the PCT has invested in this year will support the achievement of this target in the years ahead. For example, the Healthy Adults programme, investment in health promotion materials and health trainers will encourage healthier lifestyles, and investment in diagnostics, as well as screening programmes such as bowel screening, will assist in earlier detection. The PCT also continues to perform well against the cancer waiting time targets.

This year the PCT has also become a member of the Healthy Communities Collaborative, aimed at raising awareness of the early signs and symptoms of different cancers through community engagement. The PCT has appointed a project manager to develop and oversee a series of targeted initiatives encouraging the earlier presentation of symptoms, and is working towards mainstreaming this work for future years. The PCT is committed to supporting and funding this project over a two-year period in the first instance.

In 2008/2009 a single integrated programme architecture was devised to create the Adult Health Improvement programme. In 2009/10 the programme will continue to develop to deliver this integrated programme, with relevant aspects as follows:

- Expansion of the Health Trainers and Health Advocates programme by July 2009 to increase capacity in the programme by 45% (based on the number of referrals made in 2008-09 and the capacity needed by the Vascular Screening programme);
- Expansion of the Healthy Adult Exercise referral programme in line with the assumptions made for the Health Trainers programme above, to enable every adult identified by the prevention pathway, and every adult with obesity requiring treatment to be able to access structured physical activity pathways by July 2009;
- The delivery of health promotion and behaviour change skills across the PCT and partner agencies to enhance lifestyle change and the capacity of frontline staff to deliver it;
- Delivering improved smoking cessation and tobacco control to provide an integrated approach to reducing smoking prevalence as requested in the National Support Team report;
- Delivering targeted physical activity programmes for older people which will reduce cancer risk, improve stability and emotional wellbeing and contribute to independence;
- Delivering targeted health promotion to adults with learning disabilities and people with severe mental illness to reduce their risk;
- The roll out of a "well women" programme to specifically target women within the programmes above;
- The non exercise referral activity aspects of the Adult Obesity Strategy (Food planning and food use – roll out of the Barnsley programme in food outlets – and transport and planning programmes).

Supportive and Palliative Care

NHS Barking and Dagenham has been working toward full compliance with the NICE Supportive and Palliative Care IOG by December 2009. A gap analysis has been conducted on the ten priorities, as summarised below:

1. Key worker – in post for all cancer tumour groups, promotional key worker material available, continuing care funding available and GPs act as key worker in the community through GSF. *Mature operating framework*
2. Holistic assessment of patient supportive palliative care needs – NELCN pathway adopted and supported through Collaborative Commissioning Intentions (CCI) as a PCT priority. There is a CSP bid pending to recruit an in-reach End of Life Care Facilitator to focus on transition from hospital to community care. *Moving towards a mature operating framework*
3. Advanced communication skills – Advanced communications skills information leaflets commissioned for entire pathway. Training made available for entire pathway and additional training to be commissioned through CCI. *Moving towards a mature operating framework*
4. Patient Information – Information prescriptions implemented at BHRT and community implementation underway through NELCN. Information centres available in hospital and in the community. *Mature*

operating framework.

5. Specialist palliative care services – Commissioned through Saint Francis Hospice, including out of hours. *Mature operating framework*
 6. Psychological Services – A full-time Consultant Psychologist has been recruited, with scheduled community sessions. *Mature operating framework*
 7. Cancer Partnership group – Cancer support groups, cancer partnership group, patient satisfaction surveys, PPI forum and community forums. *Mature operating framework.*
 8. Rehabilitation Services – A business case has been submitted through NELCN. *Progress being made.*
 9. Advanced care planning tools – Two End of Life Care Facilitators have been recruited to oversee this work, supported by the quality assurance priority in the CCI. Preferred Priorities of Care is operational in nursing homes. GSF has been adopted by 25/45 GP practices. Saint Francis Hospice has implemented LCP, which is being rolled out to care homes. *Moving towards a mature operating framework.*
- Bereavement Services – Group sessions available through Saint Francis Hospice and West & Co Hope services. Two CSP bids are pending; one to expand the existing Relate services counselling cancer patients and families into bereavement, the other to pilot a Spiritual Care Coordinator post linking the faith forum with NHS services. *Moving towards a mature operating framework*

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
283		283	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
The reduction in cancer mortality has already been achieved. Ongoing work is to reduce mortality beyond the original target by 2010.	3	2	6 (M)	The programme described above and the commissioning implementation plan monitored through the Board and local network co-ordinator

1.13

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

Objective/Aim

The PCT is committed to reducing smoking rates, in line with the continued commitment specified in *High Quality Care for All*. Its success in achieving this goal will be measured by the number of patients that quit smoking for four weeks, as indicated in the Vital Signs trajectory.

Trajectory for 2009/10

(sign-off criteria remains unchanged)

2010/11

1,236

1,296

Latest Performance and forecast outturn

Full year target: 1296

Actual position: 615 (based on cumulative position at end of October)

Action to Improve Performance

Data Quality

- Pilot new drop-in / advice session in GP practices. Those recorded as a smoker on GP database will be contacted and invited to drop-in / advice session in practice. This will help validate recording within GP practices.
- The work undertaken by EHS to help identify patients at risk of CVD will also help validate GP databases

Management of Service Delivery

-
- Actions taken to achieve target:
- Reorganisation of the locality structure supporting smoking cessation and integrating with the Specialist Community Public Health Nursing Service.
- Build on the recent development of the Health Shop at Barking Train Station which has both train and bus hub services.
- Following a review of effectiveness of the Health Shop, whilst the core hours remain 9am - 5pm Monday to Friday
- Level 2 training to increase the number of level 2 providers.
- A Christmas/New year campaign to increase the number of 4-week quitters is underway. To promote the campaign mass awareness/outreach programme throughout the borough including, stands in local supermarkets, flyers distributed within market place/shopping centres, newspaper ads, ad in citizen, and promotion through level 2 advisor outlets
- No Smoking Day campaign being planned for March. PCT target needs to be included, with a description of how this will be achieved
- The first 600 4-week quits will receive a £25 supermarket incentive voucher. To promote the campaign mass awareness/outreach programme throughout the Borough including, stands in local supermarkets, flyers distributed within market place, shopping centres, newspaper advert, advert in citizen, promotion through level 2 advisor outlets.

Action/Initiatives/ New Services Commissioned in 2009/10

- In addition to the shop, new clinics will be set up across the three localities.
- Smoking cessation service will be commissioned to expand opening times for shop, offering services 8am - 8pm Monday to Friday and 10am - 4pm Saturday.
- The work undertaken by EHS to support the CVD at risk programme will help in identifying and encouraging smokers to quit
- The PCT will continue with its innovative health promotion schemes, such as the 52 ways website, to encourage smokers to quit
- The smoking cessation service will continue to provide clinics targeted to the needs of minority 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)
24	100	24	100

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
As progress is made the remaining group will be those most reluctant to quit.	2	3	6 (M)	A proactive approach to identifying the risks and providing one to one counselling will be provided through the CVD at risk programme.
Manual workers shift patterns may prevent access to clinics.	3	2	6 (M)	Extended opening times will help address this issue.

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)

We aim to commission high quality, timely and appropriate antenatal, perinatal and postnatal maternity services which meet the needs of our local population.

To achieve this aim in 2008/09 we are part of, with NHS Havering and NHS Redbridge and Barking, Havering and Redbridge Hospitals Trusts, a Joint Strategic Maternity Partnership Board.

We will work towards this aim through addressing the following objectives:

- Undertaking a maternity needs assessment, which projects forward both capacity and complexity demands on local maternity services and workforce implications.
- Strengthening patient and clinician involvement in commissioning and performance management of services.
- Work with providers to explore new skill mix models to support midwife and consultant workload.
- Developing stronger antenatal education programmes within a clear commissioning framework.
- Reduce the proportion of women smoking during pregnancy.
- Reviewing the provision of targeted support for high risk mothers.
- Supporting choice for local women.
- Reviewing the provision of paediatric cover for maternity and neonatal services.
- Develop community based IT solutions for case management.
- Work towards our local providers achieving WHO Baby Friendly status by 2012
- Develop a partnership Breastfeeding Strategy
- Work with local authority partners to strengthen the presence of maternity services in local children's centres.
- Develop an infant mortality strategy and action plan.
- In addition, to the desired increase in number of homebirths, NHS Barking and Dagenham will be opening a stand-alone midwifery led unit at Barking Hospital in 2012.
- Increase the number of midwives within the community based teams thus reducing the case load for each individual midwife and reducing day care attendances at Queens.

Trajectory for 2009/10	2010/11
2,245 (81%)	2,570 (91%)

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)

Performance at Quarter 3 2008/09 is 69%

The PCT has made recurrent investments over the last 2 years to improve midwifery ratios. Ratios to move to 33.1 in 2009/10 from current 37.1. Barking Hospital comes on stream in Q4 2009/10 as low-risk birth unit.

Action to Improve Performance

Data Quality

BHRT have established an electronic patient record system for Maternity, we are working with them to enable this to be used in community settings across the borough.

Screening and Pregnancy: There is a proposal being assessed by the Joint Partnership Maternity Board to establish a dedicated resource for an antenatal screening co-ordinator and BHRT have already been working to improve the information available for parents on screening.

Management of Service Delivery

We have worked over 08/09 to improve service delivery through the following actions:

- Additional investment in maternity services at BHRT
- Established quality indicators for BHRT maternity Services
- Partnership to establish the Maternity Services Liaison Committee
- Support for BHRT to implement the Maternity Services Action plan following the RCOG visit
- Worked with partners to establish the Joint Strategic Maternity Partnership Board
- Piloting community sector based breastfeeding advocates through Lifeline
- Expansion of LaLeche breastfeeding support workers in the Children's Centres
- Development of the Women's Wheel in partnership with the Polyanna Project to help signpost women to appropriate support.
- Built links between BHRT Maternity services and local domestic violence projects, and participation with GLDVP project on domestic violence during pregnancy.

Action/Initiatives/ New Services Commissioned in 2009/10

The following are actions planned for 09/10:

- Commission a Joint Maternity Needs Assessment for Barking & Dagenham, Havering and Redbridge completed by December 2010 and maternity equity audit in 2011 in partnership with NHS Havering and NHS Redbridge and BHRT;
- Infant mortality strategy and action plan in place by 2010
- Implementation of universal neonatal BCG from April 2009
- Achievement of 1:33 midwife ratio by 2012 with interim of 1:37 by 2010 and 1:35 by 2011;
- Reduced maternal and neonatal deaths with the aim to reduce rolling cumulative total to less than 3 maternal deaths over 3 years and less than 10 neonatal deaths per year;
- Improved clinical outcomes measured through reduction in complications rates and emergency caesarean section;
- IT systems connecting community clinics with BHRT Maternity Systems by 2012 through the National Programme for IT initiatives;
- Breastfeeding strategy in place by 2010;
- BHRT and community services achieve UNICEFF Baby Friendly Standards by 2012;
- Reduction of% of women smoking during pregnancy from 13% in 2007 to 8% by 2012.
- Meet the 1:1 ratio of midwives to women in labour;
- Increase obstetric consultant to meet demand in labour ward cover;
- Strengthening community midwifery services for socially excluded groups, and adopting progressive universalism and putting in place systems to support early assessment of pregnant women including direct access to midwives;
- Increase antenatal capacity to offer booking by 10 weeks and late presenters by within 1 week;
- The PCT is working towards implementing the themes of Maternity Matters with our partner trusts including the choice guarantees and the commitment around midwifery support.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
100		100	

Risks to Delivery with Mitigating Actions Planned				
Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Failure to agree business case with BHRT for service expansion.	4	2	8 (S)	The joint strategic Maternity Partnership Board is addressing this risk.
Lack of qualified midwives or the retention of this skilled group, which affects all providers.	4	4	16 (H)	Development of a recruitment and retention strategy through the Collaborative Commissioning Group.
No robust information systems in place to support new ways of working.	3	3	9 (S)	North East London Programme team supporting CRS and other ICT initiatives and the development of the sector ICT strategy. In addition the new patient record system for Maternity will support better data quality and information.

1.15

Teenage conceptions - VSB08

Objective/Aim

Barking and Dagenham is working towards a reduction in the rate of teenage conceptions amongst under 18yr olds. We acknowledge that the target baseline was abnormally low and are working to create a sustained reduction in the rate of teenage conceptions year on year.

In 07/08 to achieve this aim we have restructured and mainstreamed our approach to teenage conception prevention through an integrated sexual and reproductive health strategy for young people based on a local needs assessment. We have commissioned a condom distribution service for young people from the Terrance Higgins Trust which will strengthen and expand the existing Young People Friendly brand. Working with the local authority we have built on the learning from the SRE audit to provide higher quality SRE education in schools from trained and supported teaching capacity, further to this we launched the school based health advisor initiative in 2008 to support access for young people to confidential information on health topics including SRE in schools.

In 2009/10 we will work towards this aim by:

- Increase access to contraception for young people in the Borough, both through community services provided in youth access sites such as the Foyer, funding a full time youth focused outreach nurse.
- Increase condom and EHC access via community pharmacies and YPF sites across the Borough.
- Work with local schools to influence SRE policies to enable reproductive health services provision on school sites.
- Expand LARC provision in the Borough.
- Develop a broad based peer education PSHE programme to replace Straight Talking.
- Expand the Speakeasy programme to provide training to all youth interface staff as well as parents.
- Undertake a social marketing campaign focused on youth sex and relationships awareness.
- Rollout the school population risk assessment tool across Year 8 in all schools to identify young people at risk of becoming teen parents and refer them into targeted youth support services.

Work with young people to ensure that our approach to teenage conception prevention is targeted and appropriate to the intended audience.

<u>Trajectory for 2009</u>	<u>2010</u> (PCTs have set targets)	<u>2011</u>
	182	176

Latest Performance

2006 figure whilst continuing the downward trend established in 2005 is still 9.2% above our 1998 baseline. This is the first year since 1998 that the rate has fallen below 60 conceptions per 1,000.

Q1 & 2 & 3 data for 2007:

	Q1	Q2	Q3 (P)
Rolling quarter rate per 1,000	61.4	55.0	57.3
Quarterly rate	62.5	46.2	58.0
No. of conceptions	51	40	49
London rate	46.4	46.9	46.1

Indications from midwifery data and abortion data suggests that the annual rate may have increased again in 2007 overall.

Action to Improve Performance

Data Quality

We have jointly funded with the local authority a data and research post specifically for teenage conception to help the partnership better understand local data and work towards providing more timely indicators for teenage conceptions.

The PCT is working with the London Borough of Barking and Dagenham (LBBD) to develop a single risk assessment tool for NEET, TP and YOT, which is being piloted across year 8 in 4 schools in the borough in 2009/10

Management of Service Delivery

We have been working with the local authority to establish Head of Service level responsibility for teenage pregnancy across Children's Services and the Director of Children's Services chairs the Teenage Pregnancy Executive Board. Teenage conceptions remains a high priority for the partnership and is a regular focus for Children's Services directorate challenge sessions which are attended by the PCT TP lead (Joint Assistant Director of Health Improvement for Children and Young People). Moving forward we have identified a performance management structure within the Children's Trust for the teenage conceptions target and it is regularly reviewed through the DCS Performance Board.

We continue to work with the acute trust (BHRT) to improve the quality and capacities of youth focused sexual and reproductive health services in the Borough and are working with our contracting partners to include teenage conceptions as part of the quality framework for the acute service provider.

We will be working more closely with the freshly divided Provider services in 2009/10 to ensure that teenage conception remains high on the agenda of all staff working with children and young people in the borough and to support the roll out of the Speakeasy training to their staff.

We have commissioned Terrance Higgins Trust to take over the condom distribution and training associated with the Young People Friendly brand and this will hopefully refresh and revitalise the service for providers and users with the implementation of a C-card scheme in advance of the borough's wider ambitions for a single youth access card in 09/10.

Action/Initiatives/ New Services Commissioned in 2009/10

- Peer education programme for PSHE;
- Youth Mystery Shopper programme (linked to Your Welcome and YPF);
- Growth in Speakeasy training programme to cover the whole borough and youth workforce;
- Strengthening of Sex and Relationship education in Schools;
- Social marketing campaign targeting teenage conceptions;
- Growth in targeted youth sexual and reproductive health services and access to LARC.

The PCT is working with the London Borough of Barking and Dagenham (LBBD) to develop a single risk assessment tool for NEET, TP and YOT, which is being piloted across year 8 in 4 schools in the borough in 2009/10. This identifies potential at risk young people who then move on to a pre-CAF assessment which is used to identify needs. This is followed (if necessary) by a full CAF and target youth support through the integrated Youth Services team.

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

Risks to Delivery with Mitigating Actions Planned				
Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Failure to source adequate provision or capacity of services	3	2	6	Early engagement with providers and transparency about planning.
Lack of engagement by schools.	3	2	6	The Ofsted wellbeing indicator will support engagement; Provision response to health advisors has been positive; Close working with PSHE lead and School Improvement Head of Service.

1.16

Childhood obesity - VSB09

Objective/Aim

Aim: To reduce the prevalence of childhood obesity in reception and year 6 children as measured by the school based measurement system.

Objectives:

To have a strong partnership approach to childhood obesity with a supported and evidence based strategy for intervention and prevention.

To provide a range of evidence based interventions to support children, parents and families address weight issues such as HENRY and MEND.

To work with partners to increase access to healthy food in school and community settings.

To work with partners to increase opportunities and uptake of physical activity for young people.

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%)

86% Completeness
 14% obese

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%)

87% Completeness
 14.1% obese

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%)

85% Completeness
 24.4% obese

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%)

85% Completeness
 24.5% obese

Latest Performance

School based measurements started in 2006/07 with an opt-in model, in 2007/08 we moved to an opt-out model which increased coverage.

	06/07	07/08
% reception coverage	58	86
% year 6 coverage	67.3	82
% reception overweight	13.5	14.9
% reception obese	14.4	13.5

% year 6 overweight	16.4	16.6
% year 6 obese	19.9	23.9

We recognise that in improving the coverage rates we have identified to a fuller extent the burden of childhood obesity in the Borough.

Action to Improve Performance

Data Quality

We have moved from an opt-in model for school based measurements to an opt-out model which has significantly increased coverage.

To support coverage we produced additional marketing materials and awareness campaigns to inform parents of the measurement program and we will continue this and broaden it with the support resources for parents following the measurements.

Management of Service Delivery

Over 2008/9 we have taken stock of work to date on childhood obesity and disinvested in projects which have failed to deliver and are refocusing efforts into pre-reception interventions through the children's centre network and in primary school expansion of the MEND program.

We have worked with the local authority to improve the quality of school catering and promote the uptake of school meals. We have also worked with the PSHE leads to ensure that healthy eating messages are being mainstreamed throughout the curriculum.

We have worked with voluntary sector partners to pilot interventions to promote breast feeding as part of our prevention work and developed a range of social marketing resources targeting young people to promote healthy eating and physical activity.

In July 2008 we launched a two year pilot of free swimming for under 18yr olds with the local authority, this included a 12.5% year on year increase in school based swimming, implementation of a leisure access card for young people which over a third of all eligible young people have already registered for, adult and toddler free swimming sessions and a 40% increase in under 18 unique swims in the first year, rising to 60% by the second year. The project is in partnership with London Swimming and is being externally evaluated by Sheffield Hallam university.

The PCT is linking to "Change for Life" where appropriate and are developing a Change for Life grid to show how our local programmes link into Change for Life themes.

HENRY an RCPH recognised pre-school programme to reduce childhood obesity is being rolled out from September 2009 across the Children's Centre network.

The PCT has also been developing more work to promote breastfeeding which is an important aspect of pre-reception prevention and parent and toddler swimming to promote early years physical activity.

Action/Initiatives/ New Services Commissioned in 2009/10

We plan to undertake the following new services in 2009/10:

- Establish a care pathway for primary care for referral of obese and overweight children and young people.
- Implement a sustainable model of HENRY through the children's centres.
- Establish a dedicated obesity implementation team to provide multiple MEND type interventions across the borough.

Continue and expand social marketing approach to childhood obesity, including launching parent support resources.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
165		165	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Failure to recruit staff to implementation scheme	3	2	6 (M)	Programme will use appropriate marketing techniques and recruitment processes to attract high level staff.
Failure to secure support from clinicians for clinical care pathway.	3	2	6 (M)	The PCT will build on learning from the CAMHS clinical care pathway development to engage clinicians and PBC clusters early;
Failure to identify appropriate staff for HENRY training	2	2	4 (M)	Close working with LBBD is addressing this risk.

1.17

Immunisation – VSB10

Objective/Aim

Aim: To ensure that all children registered in Barking and Dagenham have the opportunity for appropriate protection through national immunisation programmes.

Objectives:

- Promote awareness and understanding of the role of immunisation through social marketing, health awareness and staff education campaigns.
- Increase the uptake of childhood immunisations.
- Implement the national HPV immunisation programme and achieve 90% coverage by 2011.

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)

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)

	Target
3 doses of DTP at 1yr	80
1 st dose of MMR at 2yr	85
DTP booster 13-18yrs	81
HPV vaccine 12-13yrs	70

	Target
3 doses of DTP at 1yr	90
1 st dose of MMR at 2yr	95
DTP booster 13-18yrs	90
HPV vaccine 12-13yrs	90

Latest Performance and forecast outturn

MMR

To date the CHIA system has been unable to provide data on MMR immunisation in 2008. Only the 07/08 data below was separated into Barking and Dagenham uptake alone. The PCT has been running an MMR catch-up programme over the first three quarters of 2008 and an additional 998 children had their MMR state clarified, 155 received booster vaccinations and 204 declined immunisation.

Age/Quarter	Q3 06/07	Q4 06/07	Q1 07/08
2yr	74	69.3	78.3
5yr	87	82.3	80.1
5yr (booster)	64	55.2	58.9

DTP

	Q3 06/07	Q4 06/07	Q1 07/08
3 dose of DTP by 1yr			
13-18yrs (booster)			

HPV

The PCT launched HPV immunisation of 12 and 13yr olds through secondary schools in September 2008. The first cohort will complete their immunisation schedule by February 2009. Alongside this the Immunisation Support Team is rolling out a catch-up scheme targeting 17 and 18yr olds.

Age Group	% coverage		
	1 st Dose	2 nd Dose	3 rd dose
12-13yrs			
17 & 18yrs			

Action to Improve Performance

Data Quality

The migration to RiO will address some of the current issues about extracting local data on immunisations. In addition the MMR catch-up identified and updated records on CHIA which were not accurate.

The RiO migration is scheduled for June 2009.

Clearly it will be important to ensure that data capture continues during the period of transfer to the RiO system. The activities for this cut-over period will be documented in a separate document called the "Post Data Migration Plan". In summary the PCT is proposing to continue to use CHIA to support Child Health operations until the PCT can confirm that its patients have successfully been migrated into RiO while keeping paper copies of all information inputted into CHIA during the cut-over period."

Management of Service Delivery

The PCT established an immunisation support team from September 2008 to support the MMR Catch-up, HPV implementation and Hib Catch-up. This dedicated teams of nurses work with the specialist community public health nurses to increase the capacity and access for immunisation in the borough.

We have continued to run a series of immunisation awareness campaigns, working with the children's centres to promote awareness through their resources as well as promoting our own campaigns.

We developed local resources with input from young people to promote HPV immunisation locally to support and strengthen the national marketing campaign. We also integrated immunisation messages into general youth health campaigns such as MyBook/MyLife and the BADHealth website.

Action/Initiatives/ New Services Commissioned in 2009/10

We plan to:

- Migrate to the RiO system
- Establish a dedicated campaign budget for immunisation
- Work with providers to integrate immunisation awareness into all child health services

Review the baseline allocation for health visitors in light of population growth.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
	60		60

Risks to Delivery with Mitigating Actions Planned				
Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Capacity to deliver if demand increases	3	3	9	Reviewing baseline allocation for health visiting and continuing the immunisation support team.
Lack of community engagement	2	3	6	Working with children's centre managers to support holistic approach to raising awareness.

1.18

Breastfeeding at 6-8 weeks - VSB11

Objective/Aim

Breastfeeding is a vital part of a healthy start for babies and also reduces child obesity.
We aim to increase the rates of breastfeeding initiation and continuation at 6-8wks to 50% by 2012.

NHS Barking and Dagenham aims to:

- consult new mothers on their attitudes and views of breast feeding and how NHS Barking and Dagenham can support improvements in initiation and compliance
- ensure that all new mothers receive information advice and support about breast feeding at every stage of the maternity care pathway (pre & post-natal) to enable them to make an informed choice
- ensure that all staff providing maternity services are appropriately trained, resourced to support new mothers to breast feed
- performance monitor all providers of maternity services to ensure that breast feeding advice is provided
- raise awareness amongst the local population about the importance of and issues related to breast feeding so that friends and relatives can support new mothers with this.

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

35% of new mums breast feeding at 6-8weeks
(trajectory under review)

Data Quality in breastfeeding – 90%

2010/11 (inc. % data coverage, which should be at least 95%)

50% of new mums breast feeding at 6-8weeks
(trajectory under review)

Date quality in breastfeeding – 95%

Latest Performance and forecast for Q4

% of new mothers breastfeeding at 6-8 weeks:

24% at Q1

26% at Q4 (Forecast)

Action to Improve Performance

Data Quality

Current data quality:

- Recording of breastfeeding status at 6-8 weeks by primary care providers is poor;
- Reporting systems for monitoring individual primary care providers recording performance of breast feeding status not available;
- Audit of paper returns to be undertaken to establish an accurate baseline by general practice. Currently only 50% of practices upload data onto CHIA, the paper audit will capture additional data.

- Despite the lack of validated data available, local GP feedback indicates that a 24% baseline may be accurate for Barking and Dagenham population.

Improving data quality:

NHS Barking and Dagenham are investing in the RIO system to handle child health information and this will be in place during 2009. This system will allow the commissioners to access more detailed statistics and extract reports.

It is acknowledged that information on local prevalence of breastfeeding is not systematically collated and input to CHIA. Data entry and completion at 6-8 week appointments by GPs is not 100% reliable and for this reason we are unable to set a local target.

- validate data for quarters 1-3 07/08 in general practices;
- To develop and performance manage service specification with Operational Service (Provider Arm) for Child Health Records to collate and upload data into RiO and set clear targets and timescales for the uploading of data;
- All GPs and Practice Managers to be sent regular briefing notes asking them to code the information consistently;
- Infant feeding status at the 6-8 week check will be subject to a QUEST query (retrospectively) as well to validate these data obtain the data from child health records (RiO).

Management of Service Delivery

Improving performance is being supported through ante-natal education in Children's centres and GP uptake of recording. The establishment of the local Maternity Board will support on retention of breastfeeding by new mothers.

Action/Initiatives/ New Services Commissioned in 2009/10

- Develop a coordinated approach to the promotion and support of breastfeeding through a shared breastfeeding strategy with BHRT, NHS Havering (Lead) and NHS Redbridge. Implementing the principles of the UNICEF Baby Friendly Initiative in hospitals and community settings.
- Work with providers through the Joint Strategic Maternity Partnership Board to develop appropriate antenatal education to support and promote breastfeeding.
- Deliver an annual campaign promoting breastfeeding modelled on national examples of good practice.
- Work with Children's Centres to support continuation of breastfeeding through breastfeeding advocate and support volunteer networks.
- Work with primary care to improve the recording and reporting of breastfeeding status.
- Pilot of breastfeeding advocates through voluntary sector provision with LifeLine

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
100		100	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Data quality and capture	3	3	9 (S)	RiO Implementation will support the production of better quality data; Paper audits in primary care will be implemented;
Low public awareness or ownership	2	2	4 (M)	Social Marketing Campaign.
6 – 8 week checks and recording not completed	3	3	9 (S)	Performance management of practices and health visitors.

1.19

Effectiveness of CAMHS - VSB12

Objective/Aim

- Commission services on basis of epidemiological needs and outcomes based on user views of the quality of the service
- Develop a joint CAMHS strategy and refresh local commissioning intentions
- Build and expand access to Tiers 1 and Tiers 2 CAMH services
- Streamline and agree care pathways for young people with disabilities to access Tier 2 and Tier 3 services

Trajectory for 2009/10

2010/11

4

4

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

Performance reporting – April to September 2008 (total to date)

	To date	Admissions	FOT Forecast	Outturn 08/09	Outturn (07/08)
Target					
<u>Inpatient Activity</u>		1	2		13
OBD's	94	-	188		593
765					
Under 16 on					
adult ward OBDs	0	-	0		
16/17 on adult ward	14		28		
OBDs					
HDU		1	2		
<u>Community activity</u>					
Brookside					
No. receiving service	21		42		
No. face to face contacts	68		136		
No. telephone contacts	29		58		
<u>PMHT</u>					
1 st appointment	62		124		50
44					
F' up appointments	273		546		148
616					
DNAs	22		44		2
Patients on waiting list	18				
Maximum waiting time	7.7 weeks				
<u>Tier 3 services</u>					
1 st appoint	287		574		389
632					
F' up appointments	3133		6277		2690
8848					
DNAs	809		1618		766
Patients on waiting list	117				
152					
(average)					
Average waiting time	6 weeks				
<u>School counselling</u>					
1 st appointment	111		222		256

228			
F' up appointment	1090	2180	2196
2880			
DNAs	515	1030	746
Patients on waiting list (average)	59		
Average waiting time (weeks)	4.5		
Paed. liaison service	3		
900*			

Note: 6 PMHW have been recruited in October and due to start inputting into Tier 1 and Tier 2 services

Action to Improve Performance

Data Quality

- Performance data is reported by North East London NHS Foundation Trust and reported quarterly to commissioners;
- Performance outcome data to be piloted on counselling services in primary and secondary schools;
- Service quality data to be collated from patients surveys and service audits agreed in service specification.

Management of Service Delivery

- Tier 4 inpatient/outpatients/outreach services is operated from Brookside;
- Tier 3 services have recently been re-allocated with all other community children services;
- Tier 2 counselling services have expanded to include all secondary schools in the borough and 24 primary schools;
- PMHWs to be based on each locality in borough.

In 2008/09 the PCT invested £635k in CAMHS by mainstreaming the CAMHS grant. The grant monies have been reinvested in primary care workers, psychology, psychiatric and nursing support for Learning Difficulties.

KPIs have been agreed with NELFT for CAMHS services that will be incorporated into the 2009/10 contract.

Action/Initiatives/ New Services Commissioned in 2009/10

This will be delivered through a number of actions, including:

- 6 PMHWs to act as an interface between universal first contact service for children and families (tier 1/2) and Specialist CAMHS with the aim of:
 - a) Supporting and strengthening Tier 1& 2 provision through the building of capacity and capability within the Community and Primary care staff, (Health Social Care, Education and non- statutory sectors), in relation to intervention with children mental health needs
 - b) To provide early identification of the development of mental health problems in children and families.
 - c) To work across boundaries to help develop a co-ordinate response to children's mental health needs between agencies
 - d) To provide indirect intervention to children and their families by the use of undertaken joint assessment or the use of consultation with the worker involved with the service user, or to provide educational and support to the worker about specific mental health problems.
 - e) To provide a direct service (intervention) to children and young people and their families, in an accessible and less stigmatising environment. Where the needs of the child have not been responsive to interventions undertaken by Tier 1/2.
- Commission epidemiological needs assessment and development of a Joint CAMHS strategy;
- Pilot and expand counselling service in primary schools in the borough (24 schools) match funding with schools and LBBDD;

- Pilot and roll-out agreed patient pathways for LDD.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
6		6	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Failure to achieve targets	3	2	6	Monitored monthly with providers.

1.20

Chlamydia screening - VSB13

Objective/Aim

- To ensure that 25% of the population aged 16-24 are opportunistically screened for chlamydia

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

By the end of November, coverage was 9.7% v a target of 11.6%. However, as the impact of the actions outlined below are realised in spring (notably the GP champion and the second mail out), the PCT is confident that the 17% target will be realised.

Action to Improve Performance

Data Quality

Management of Service Delivery

Service will be delivered through three main routes:-

- Provision of outreach clinics by Terence Higgins Trust (community venues, colleges, and extended schools)
- Provision of integrated sexual health service by BHR (family planning clinics and spokes at level 1 and 3)
- Provision of services by independent practitioners (Marie Stopes and Brook London)
- Local Enhanced Services with GP practices (22 out of 42)
- Local Enhanced Services with Community Pharmacies
- GP Champion

Action/Initiatives/ New Services Commissioned in 2009/10

- GP champion will be assigned to all practices with highest number of 16-24 year olds in the first instance, to increase awareness and improve uptake
- 90% GP practices sign up to the Chlamydia LES
- Contracts with Marie Stopes and Brook services to include higher targets on uptake of Chlamydia screening
- Mailing out invitation to test for chlamydia to all 16-24 yrs old to coincide with Valentine's Day followed up by text message
- THT GP Champion to cover half of all practices in collaboration our GP champion

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
20		20	

Risks to Delivery with Mitigating Actions Planned				
Risk	Impact	Likelihood	Risk Score	Mitigating Actions
BHRT do not see Chlamydia as a key target.	3	3	9	Reinforced through the integrated sexual health board; Rewarded through the APMS contract.
GP practices and pharmacies do not engage in screening programme.	3	2	6	GP champion will target units with greatest need.
Patients / target group become immune to the message re: Chlamydia screening.	3	2	6	Series of different health promotion messages using a variety of media will be adopted to encourage uptake.

1.21

Drugs misuse - VSB14

Objective/Aim

To increase the number of problem drug users (crack and/or opiate users) recorded as being in effective drug treatment by 5%

Trajectory for 2009/10

5% increase on 2008/09 baseline

2010/11

5% increase on 2009/10 baseline

Latest Performance and forecast outturn

As at January 2009 the partnership are on track to meet its target on a 5% increase on the 2007/08 baseline of 429.

Action to Improve Performance

Data Quality

Data is scrutinised by both the DAAT partnership and the National Treatment Agency to ensure it is reflective of actual practice. Data collected in 2008/09 to inform the partnership annual drug needs assessment and treatment planning in 2009/10 will be built upon over the coming year to ensure as full a picture as possible of substance misuse in the borough is obtained in order to inform future commissioning.

Management of Service Delivery

The DAAT hold quarterly formal contract monitoring meetings with all commissioned services to ensure performance targets, quality assurance issues and requirements in the contract specifications are being met.

Action/Initiatives/ New Services Commissioned in 2009/10

The following priorities have been set for 2009/10:

- To establish substance misuse data collection systems for tier one agencies that will inform the expert group and the 2009/10 needs assessment to inform commissioning in 2010/11.
- Increase the number of service users accessing treatment from BME communities.
- Ensure UK guidelines on clinical management are fully implemented across the treatment system.
- Increase engagement by injecting drug users through the pharmacy needle exchange schemes.
- Improve transitional arrangements between young persons and adult services.
- Improve planned discharge rates.
- Improve links to training, education, employment and housing for those exiting treatment in a planned way.

The following objectives to achieve the priorities have been set for 2009/10:

- To ensure services across all tiers meet the needs of diverse communities in B&D.

- To ensure all areas in the Clinical Guidelines on drug misuse and dependence are adhered to.
- Increase efficiency and value for money of DAAT expenditure.
- To ensure through findings in the needs assessment that commissioned services match the needs of the local population.
- To Increase access to treatment via criminal justice pathways.
- To increase the number of hard to reach and at risk drug users in B&D accessing treatment.
- To engage more 18-24 year olds in tier 3 treatment and ensure all services are actively following hidden harm guidance.
- To build on the work started in 2008/09 to ensure the substance misuse workforce in B&D have the skills, competency, and access to training to be able to deliver treatment in line with Orange Guidelines on Clinical Management 2007 and the wider objectives outlined in the national drugs strategy.
- To reduce the harms associated with drug use for the drug using and wider population of B&D.
- To determine reasons for early drop out of treatment and to increase planned discharge rates.
- To increase the numbers of individuals in employment during or upon leaving treatment.
- To ensure opportunities for seamless community re-integration upon leaving treatment are maximised.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Finalised funding arrangements are not yet known. If the cut is bigger than anticipated the delivery of planned actions in the Adult Drug Treatment Plan may be at risk.	3	3	9	If funding is not available the Substance Misuse Joint Commissioning Board will work to identify further efficiencies and alternative funding streams.

1.22

Patient experience - VSB15

Objective/Aim

As we move to become a commissioning PCT and separate out the provider functions we are working towards a model of commissioning where the patient experience is a fundamental aspect of informing our performance management process for providers.

We aim to:

- Have a World Class Commissioning loop which engages with the patient experience at every level.
- Provide multiple portals for patients to feedback on their experiences through PALS, Complaints and Patient Satisfaction Surveys.
- Develop and enhance our patient engagement structures and implement our patient engagement strategies.

Through Commissioning structures we aim to ensure all contractors have appropriate patient engagement structures in place.

Trajectory for 2009/10 **(VSB15 05 applies to PCTs)**

2010/11

Adult inpatient experience score	75
Adult outpatient experience score	77
A&E patient experience score	76
Patient experience score	74

Latest Performance

Annually measured.

Action to Improve Performance

Data Quality

Development of surveys and evaluation processes to support and act on messages from engagement activities.

Management of Service Delivery

- It is believed that the action being taken to address the A&E target, and sustain the 18 week RTT performance, will contribute significantly to an improvement in patient experience for inpatients, outpatients and A&E. Other actions being undertaken to improve patient experience include:-
 - CQUIN indicators are incorporated into contracts for 09/10, which will improve patient experience for stroke, maternity, cancelled operations, and A&E (by improving ambulance turn round times);
 - An action plan based on an analysis of the recent IPSOs/MORI poll on patient experience relating to 18 weeks is to be developed by March 2009, focusing on how communications with patients at the point of referral and thereafter can be improved;

- Work being undertaken to improve patient experience in Primary Care (see VSA06).
- Development of Community Engagement through LINKS;
- Development of the Communications and Engagement Plan.

Action/Initiatives/ New Services Commissioned in 2009/10

- As part of the CQUIN process for community services, clinical services will be rewarded for an indicator relating to reports on regular patient surveys.
- The PCT as part of its Organisational Development Plan is developing its Stakeholder Engagement Plan to ensure that:
 - all stakeholders and patients are engaged in a way that is appropriate to each stakeholder group;
 - methods to engage for particular issues or circumstances are identified;
 - all stakeholders and patients feel appropriately engaged and informed in the development of the PCTs strategic plans
- The PCT will act on the messages from patient surveys and undertake work to support findings, such as the primary care core hours access work;
- There will be a focus on choice with patients (and practices) through the empowering patients – choice and personalisation action plan (see section 6.1 for action plan);
- Undertake Healthcare for London consultation on Stroke and Trauma;
- Participate in the Health Scrutiny event to review local health services to inform the Annual Health Check declaration;
- To improve real time monitoring and engagement with the public and 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)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Don't reach the right population or hard to reach groups that have the highest health issues.	3	3	9	Development of LINKS and working closely with a range of community groups through the Equalities and Diversity lead and the Health Improvement team.
Make assumptions based on inappropriate or small sample size.	3	2	6	The Communications and Engagement Strategy and developing capability and capacity as part of the Organisational Development Plan.

1.23

Public confidence in the local NHS - VSB16

Objective/Aim (inc. public engagement)
Local Trust based Target

Trajectory for 2009/10 (to be submitted by Trusts only)	2010/11

Latest Performance

<u>Action to Improve Performance</u>
Data Quality
Management action

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

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions

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)

In line with Organisational Development Plan for NHS Barking and Dagenham 2009-2011:

- NHS Barking and Dagenham will aim to have an organisation wide, structured approach to staff development
- NHS Barking and Dagenham will aim to have an effective and robust staff reward and recognition framework for recognising innovation and improved quality
- NHS Barking and Dagenham will aim to have an effective framework and forum for effective staff engagement

In addition, along with other NHS organisations:

- NHS Barking and Dagenham will strive to provide all staff with well-designed and rewarding jobs that make a difference to patients, their families and carers, and communities
- NHS Barking and Dagenham will strive to provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed
- NHS Barking and Dagenham will strive to provide support and opportunities for staff to keep themselves healthy and safe
- NHS Barking and Dagenham will strive to engage staff in decisions that affect them and the services they provide, individually and through representatives. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families

<u>Trajectory for 2009</u>	<u>2010</u>	<u>2011</u>
4	4	4

Latest Performance

We are currently awaiting the trust score for 2008/09 staff survey.

Action to Improve Performance

Data Quality

Management action

- Implementing a KSF (Knowledge and Skills Framework) project management plan
- Undertake an audit of existing staff skills
- Review organisation's training plan to align with WCC (World Class Commissioning) competencies
- Develop a user-friendly appraisal process
- Review current reward and recognition practices in the organisation
- Develop a reward strategy, following the review of current reward and recognition practices, which also works within the current Agenda for Change framework
- Review existing staff engagement group to widen the level of workforce representation and widen its scope and terms of reference
- Review and strengthen the organisation's communication strategy
- Strengthen staff engagement methods and put in place effective feedback and monitoring systems

Our strategy for delivery the above actions is that they are built into our OD Plan and we are taking a project management approach based on Prince 2 methodology in implementing the OD plan. As part of this, an OD Steering Group with the Chief Executive as Chair, has been formed and the group oversees the delivery of the OD plan.

In line with the project management approach, all the actions have clear timelines and this is captured in the ID plan gant chart, and used by the OD Steering Group in monitoring the implementation process. The OD plan also has clearly defined KPIs for each action and these are presented as milestones.

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Unsettling aspect of change through for example WCC Organisational Development and provider arm externalisation may affect the level of staff engagement in the organisation.	3	2	6	A robust communications plan is in place to reassure and keep staff informed of developments. TUPE consultation underway.

1.25

NHS primary dental services access - VSB18

Objective/Aim

Barking and Dagenham dental practices have increased activity levels overall since the start of the contract in 2006 and the PCT continues to invest in additional UDA growth year on year. In the 2008/09 vital signs report for dental commissioning NHS Barking and Dagenham was one of the highest performing organisations achieving a green RAG rating on for increases in the numbers of patients seen and providers ability to deliver all commissioned activity.

NHS Barking and Dagenham aims to continue investment in additional NHS dental activity year on year and to improve the accessibility, capacity and quality of dental premises.

Barking and Dagenham dentists undertake a higher case mix of more complex treatments (Band 2-3) and fewer general check-ups (Band 1). This indicates that the take-up of dental services as a preventative / early intervention is low and that the population is more likely to attend once problems have occurred / when in pain rather than for routine check-ups.

NHS Barking and Dagenham aims to increasing regular attendance for routine check-ups particularly for children.

Trajectory for 2009/10

2010/11

(N.B. new indicator definition tbc)

Latest Performance and forecast outturn

Q 1 2008/09

24 Month Access:

Number of patients seen in last 24 months
 % change in patients seen since March 2006
 % change in patients seen since last quarter

84,021
 6.3%
 0.2%

Activity:

% UDA delivered in "v" commissioned

102%

Action to Improve Performance

Data Quality

Data is taken from practice systems and reported through the DPB. Quarterly returns for vital signs are made based on the number of units of dental activity (UDAs) commissioned.

This data set includes information on uptake of dental services by age groups and details of the complexity of interventions required.

The data set is reflective of actual activity and service utilisation in Barking and Dagenham for NHS dental

services.

Management of Service Delivery

Implementation of these initiatives will be overseen by the Oral Health Advisory Group which reports to the Professional Executive Committee. This committee will also review the performance of NHS dental providers and agree actions to remedy poor performance.

The Premises Team has commissioned a survey of all dental premises to assess the potential for future expansion / sustainability. CSP proposals for investment in a new premises lead for dental services that can direct a capital development fund to meet premises priorities.

The Primary Care Contracting Team will monitor the performance of individual dental activities on a monthly basis to review delivery of activity commissioned and patient satisfaction with access.

The Health Improvement Directorate has identified oral health promotion as a priority for future investment as part of the Child Health Promotion Strategy.

Action/Initiatives/ New Services Commissioned in 2009/10

- Fund growth in UDA activity in line with population demand for services
- Commission opportunities for expansion and development of dental premises and chairs
- Run annual oral health awareness raising campaigns and advertise NHS dental services.
- Work with schools and children's centres to continue the schools oral health project and oral health training started in 08/09
- Monitor and performance manage dental practices to ensure they continue to provide suitable accessibility in line with the GDS contract.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
9099		329	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Demand plateaus	3	2	6 (M)	Oral health campaigns and awareness raising of eligibility for NHS services and access to NHS dental care in B&D.
Lack of new capacity	3	3	9 (S)	Identified funding for additional premises developments and maintenance incentives for growth and development.

2. Local Priorities

2.1 London Priorities

TB

Objective/Aim

We aim to achieve a green rating in the NHS London performance standards for TB prevention, identification and treatment through our commissioned services and the partnership of the JPCT.

In December 2008 the PEC supported the recommendation from the HPA to implemented universal immunisation of neonates with BCG following year on year increases in the rate of TB in the borough. This will be implemented from the 1st April 2009 with a trajectory towards 90% coverage by 2012.

Trajectory for 2009 (% treatment completed)	2010	2011
88%	89%	90%

Latest Performance and forecast outturn

Performance on the target of treatment completion has been as follows:

Year	% completing treatment in B&D
2005	86.7
2006	89.8
2007	87.8
2008	April to June 92.9

NHS London Performance Standards	2007	2008	
		Q1	Q2
85% patients complete treatment within 1 year of start of treatment	87.8	92.9%	87.5
Liquid culture is used for TB culture	N	No	Yes
Laboratories report smear turnaround within 1 working day	Y	Yes	Yes
There is 1 nurse for every 40 notifications with full administrative support	70	1:37	1:37
>80% of TB patients >16 years have a recorded offer of HIV testing	N/A	78.2%	80.9%
Services are able to report their quarterly contact tracing activity and the outcome of these contacts	N/A	Yes	Yes
>90% of patients have a recorded risk assessment for illicit drug use, alcohol misuse, homelessness, immigration and language	82.9	78.3%	87.5%

N/A due to being unable to capture data

For acute activity apply 22-30% growth to forecast outturn

Action to Improve Performance

Data Quality

We are working with BHRT to support the implementation of the electronic patient record system which will help improve data quality and accuracy.

Management of Service Delivery

We continue to work with BHRT through the commissioning framework to improve service delivery in partnership with the NE London TB Network and Commissioning Unit. We will be working with them to ensure the safe and efficient delivery of the universal neonatal immunisation program from April 2009 and will continue to run public awareness campaigns to promote early identification of TB in the community.

Action/Initiatives/ New Services Commissioned in 2009/10

- Universal Neonatal BCG Immunisation through BHRT Paediatric services;
- Screening those with HIV for Tuberculosis;
- Developing and interim accommodation SLA with Local Authorities

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
20		20	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Disruption and changes to existing care pathways as a result of the outcome of HfL.	3	2	6 (M)	TB pathway redesign.
Ensuring effective inputs to CSPs				Continuing dialogue with London TB group and NHS London TB lead.
Data quality to identify resources for accommodation for socially hospitalised patients in 2009/10	3	3	9 (S)	Development of TB CCI for 2009/10.
Local PCT initiatives not linking in to the CCI.	3	3	9 (S)	Participation at the Directors of Finance & Commissioning meeting and circulating the CCI to PCT CSP leads.
LA not collaborative with accommodation plans.	2	2	4 (M)	Dialogue with local authority as stakeholder in project management process
HIV network unable to deliver coordinated testing programme.	4	3	12 (S)	Collaboration between TBCU and HIV network to develop effective care pathways.

HIV

Objective/Aim

- Reduce the prevalence of undiagnosed HIV
- Increase access to rapid testing based in the community settings within BD with results provided at the same visit
- Fast track to GUM services for all testing positive

Trajectory with late diagnosis 2009

2010

	baseline (2004 + 2005)	2004	2005	2006	2007	2008	2009	2010
Number of newly diagnosed HIV-infected patients accessing care with known PCT of residence	4,339	2,171	2,168					
Number of newly diagnosed HIV-infected patients with CD4 count <200 cells per mm ³	1,493	770	723					
Percentage of newly diagnosed HIV infected patients with CD4 <200 per mm ³						30%	28%	

Latest Performance

Patients seen in 2007* Reported by HPA September 2008 (adapted table)

Table 1: Numbers of diagnosed HIV-infected patients by most advanced clinical stage, gender and age group when last seen for care in 2007.

Patients resident in:

5C2 Barking And Dagenham PCT

	Asymptomatic		Symptomatic pre AIDS		AIDS		Total (all ages)
	M	F	M	F	M	F	
Total	89	151	53	81	33	45	456

Patients seen in 2007* Reported by HPA September 2008 (adapted table)

Table 6: Numbers of diagnosed HIV-infected people by last CD4 count and level of anti-retroviral therapy when last seen for care.

Patients resident in:

5C2 Barking And Dagenham PCT

Level of anti-retroviral Therapy (ART)	CD4 Category						Total
	0-100	101-200	201-350	351-500	500+	not reported	
None	6	1	27	38	38	13	123
Dual	0	0	3	1	1	0	5
Triple	9	24	57	72	88	12	262

Quadruple+	3	5	16	16	20	1	61
Not known	1	1	0	1	2	0	5
Total	19	31	103	128	149	26	456

New HIV Patients at Sydenham Centre

From 1st January 2007 to 31st December 2007

There were 91 newly diagnosed patients

- 90/91 (98.9%) patients had CD4 counts <200
- 40/91 (44%) were B&D PCT residents

Late presenters with CD4 count <200

B&D PCT
11/40
27.5%

Source: BRHT Sydenham Centre

Newly Diagnosed CD<200 as per September 2008

B&D PCT Late presenters	Age	Sex	Country of origin	Sexual orientation
	35	F	Congo	Hetero
	44	F	Nigeria	Hetero
	30	F	Somalia	Hetero
	53	F	Angola	Hetero
	54	M	Ghana	Hetero
	43	M	Zimbabwe	Hetero
	42	M	Zimbabwe	Hetero
	38	F	Zambia	Hetero
	34	F	Zimbabwe	Hetero
	21	F	Malawi	Hetero
	32	M	Zimbabwe	Hetero

Source: BHRT Sydenham Centre

Action to Improve Performance

Data Quality

Data Collection by Terrence Higgins Trust

To include:

- Date attend clinic;
- Gender, DOB, Postcode of residence, ethnicity and country of origin;
- Sexual orientation, Investigation undertaken, Diagnosis, Referral to appropriate, number of sexual partners in the last 3 months, % of uptake of HIV tests, reason for not testing;

In addition, BHR under the new APMS contract for Integrated sexual health service report quarterly on data:

Rate of undiagnosed HIV:

- % of patients had an undetectable level of HIV virus on year after first starting treatment (HIV Consortium Standard 70%);
- % of patients had achieved a specified level of white blood cells after more than one year under the care of their treatment site (HV Consortium Standard 80%);
- % of patients seen within four weeks (HIV Consortium Standard 100%);
- % of patients known to have died within 12 months after being diagnosed (no standard agreed by the HIV Consortium).

Management of Service Delivery

- Terrence Higgins Trust (THT) responsible to operate 1 rapid testing clinic a week and 1 mobile clinic

every month;

- Widows and Orphans International (WOI) responsible for mobilisation, campaign of rapid HIV testing service in the community;
- BHR integrated sexual health service responsible for confirmation and follow-up of patients;
- Maternity services responsible for antenatal screening of pregnant women.

Action/Initiatives/ New Services Commissioned in 2009/10

- Set up Rapid HIV testing clinic based in detached settings across BD;
- Fast track into GU for all those who test positive;
- Local campaigns and mobilisation workshops targeted at African communities.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
1865		474	

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Stigma against testing within new populations	4	3	12 (S)	Piloting project with widows and orphans international (WOI) to do testing through churches.
Local political tensions re: our at risk population of new immigrant black Africans limiting partnership ability for action.	4	3	12 (S)	Needs assessments undertaken which helps support understanding and developing relationships around joint working on World Aids day.

2.2 Locally selected priorities

2.2.1 Long Term Conditions / Unique Care (Please note this also covers Diabetes)

Objective/Aim

To implement a robust integrated community response for Diabetes care across three layers of service prevention (Primary care), early intervention (PC and intermediate care and tertiary intervention (Acute Care) through a robust Clinically Effective Pathway (CEP) that focuses on the needs of Diabetic patients and their carer's.

To review the care pathway for heart failure and atrial fibrillation and increase capacity in the community CHD service to manage the introduction of valve clinics and an increased proportion of heart failure and rehabilitation patients in primary care.

To develop and implement an integrated care pathway for COPD across primary, secondary and community care; to increase access to pulmonary rehabilitation, oxygen assessment, COPD management, early hospital discharge.

To evaluate the impact of the Unique care model in 24 practices across Barking and Dagenham. To further build on the model to deliver integrated health and social care for patients with long term conditions and complex needs, supporting patients with an individualised care plan.

Trajectory for 2009/10

2010/11

Services	2009/10	2010/11
Community CHD outpatients attendance	6960	7310
Community COPD outpatient attendance	1404 ¹	
Community diabetes outpatient attendance		
Unique Care	5% reduction (08/09 FOT) in emergency admission	5% reduction (09/10 FOT) in emergency admission
Elective	18,648	19,367
Non-elective	21,607	21,416
Out-patients	155,761	141,242

Latest Performance and forecast outturn

Services	Cumulative attendance M8	Forecast attendance 08/09
Community CHD outpatients attendance	4418	6630
Community COPD outpatient attendance	1981	2972
Community diabetes outpatient attendance	69 ²	104

¹ Extrapolated based on M9 target

Unique Care			
Elective	11,597	17,396	
Non-elective	13,830	20,745	
Out-patients	100,470	150,705	

Action to Improve Performance

Data Quality

1. To ensure that data quality relating to long term conditions is included as part of the wider PCT performance framework review. Key success factor is to ensure that relevant activity / information is actively shared in order that informed decisions are made across the commissioning community (Competency 2)
2. To review data collection to show evidence of engaging 'hard to reach' groups and comply with the Healthcare Commission's 'Data quality on ethnic groups' indicator (Competency 3)
3. To ensure data / activity / intelligence routinely contributes to the robust and on-going reviews of clinical and service quality, as well as to further assist commissioning and decision making (Competency 5)
4. To ensure performance evaluation findings lead to regular and constructive performance conversations with stakeholders, working with them to resolve issues (Competency 10)
5. To review the need for patient reported outcome measures to drive service quality.

Management of Service Delivery

1. To consider additional quality requirements as part of the performance management framework, including clinical quality performance indicators with clear methods of measurement and defined consequences for failure to remedy performance problems.

Action/Initiatives/ New Services Commissioned in 2009/10

Community diabetes service supported by an integrated pathway

The service will be supported by an integrated care pathway that implements a robust integrated community response for Diabetes care across three layers of service (prevention (Primary Care), early intervention (PC & Intermediate Care) and tertiary intervention (Acute Care)). To achieve this ambition, all key stakeholders (General Practices, Diabetes Specialist Nurses, Allied Health & Acute Trust partners) will review current practice, and develop a robust Clinically Effective Pathway (CEP) that will cater to the needs of our patients diagnosed with Diabetes and their carer's.

The project is divided into six stages and is expected to go live in early 2009. The development of the B&D (and BHR wide) IDS service model will be closely aligned to the Department of Health NICE Guidance, NSF Policy and Map of Medicine initiatives. These frameworks provide the national guidance for diabetes based targets and benchmarks. Clinically effective care pathway metrics will assist in ensuring that national Diabetes service targets are commissioned and implemented.

As part of the Barking and Dagenham Integrated Diabetes Service project, the current retinopathy pathway was reviewed and updated. The retinopathy screening programme has the following service improvement initiatives currently underway, which will continue to develop in 2009/10:

- PCT and acute partnerships in developing a business case to purchase retinal laser and fluorescein angiography, in conjunction with pathway development, to ensure local patients have quick and timely access without need for outsourcing;
- A communication and training strategy is being developed to ensure GPs' and Practices are well briefed on retinopathy screening pathway requirements and continuity of care for patients progressing along the pathway.

² Estimated attendance

The vascular screening programme aims to bring the registered prevalence of diabetes in line with epidemiological estimates by 2010. This would indicate that around 690 newly diagnosed diabetics would be added to disease registers during 2009. The integrated diabetes care pathway enables early intervention and access to structured education programmes with defined intervention points for the management of diabetes complications.

Other service developments planned for 2009/10 include:

- Developing the capacity of the community CHD service for heart failure, cardiac rehabilitation, and arrhythmia, follow ups for valve replacements;
- Developing the capacity of the community respiratory service to increase access to pulmonary rehabilitation, oxygen assessment, COPD management, early discharge;
- Extending Unique care to ensure NHS Barking and Dagenham coverage (action to complete 2011/12)
- Commissioning an integrated falls service.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

Risk	Impact	Likelihood	Risk Score	Mitigating Actions
The availability of funds for new services.	4	3	12	The development of robust business cases for new services; To undertake scenario planning to identify potential risk areas.
Recruitment difficulties	4	3	12	Posts substantive and at appropriate grade; Utilisation of existing staff to pump prime services; Lean project identified blocks in the recruitment pathway which are currently being resolved.
Lack of treatment guidelines	4	3	12	LITs for CHD and COPD agreed pathways and protocols.

2.2.2 Outpatients and Diagnostics

Objective/Aim

In the recent months, there has been a significant emphasis on the PCT meeting the 18 weeks waiting times target. Particular emphasis was placed on modernising the patient pathway, including the way in which outpatients and diagnostic services are delivered to ensure that patients were treated within 18 weeks following referral.

Two particular scenarios drive the case for change. The population of the PCT is projected to rise by 22% by 2020 with the development of the Thames Gateway and it is acknowledged that the PCT will need to identify, and commission additional capacity for outpatient type activity in the local health economy to meet increasing demand over the next few years. This includes Direct access to diagnostic services to support care pathway redesign and faster access to treatment.

Another case for change is designing services that improve the patient experience from local settings. This direction of travel is in line with *Our Health, Our Care, Our Say* in that services will be provided in more convenient local settings. This message has been further reinforced in *The Next Stage Review* and *Healthcare for London*. Early pilots from the Care Closer to Home demonstration sites have reported positive evaluation from the patients' perspective with patients experiencing shorter waiting times for services and finding services more accessible than hospital clinics.

In addition to the above, other priorities for outpatients and diagnostic services are:

- To sustain the admitted and non-admitted 18 weeks RTT target in 2009/10;
- Diagnostics will be operating at a 2 week wait in 2009/10. This will apply to all key diagnostic tests (including the receipt of reports following assessment);
- To extend the choice of outpatient services and to provide care closer to home where clinically appropriate, and maximise the range of services to be provided within the Borough;
- To intensify the simplification of care pathways to support the 18-week target by providing access to diagnostics prior to acute referral and promoting more direct access from community clinical assessment and treatment services into elective surgery.
- To obtain better efficiency and value for money from services, in line with the commissioning competencies identified under world class commissioning;

To work with the private sector to implement the Independent Sector (IS) diagnostic elements in 2009/10.

Trajectories

Services	2009/10	2010/11
RTT for admitted patients	90%	90%
RTT for non-admitted patients	95%	95%
Outpatients activity	155,761	141,242
Outpatient activity – list by services provided by CATS (gynae, urology, ENT, etc)		
Diagnostic waiting times		
DNA rates (?)		
Productivity indicator at CATS (capacity, demand, attendance, etc)		
To include KPI's from the CATS contract		

Latest Performance and forecast outturn

Services	Cumulative attendance M8 / Actual	Forecast attendance 08/09 / Target
RTT Admitted		90%

RTT Non-admitted		95%
Outpatients	100,470	150,705
Out-patient activity against plan (list by key specialties?)		
Diagnostic waiting times (list by key specialties?)		2 weeks

Actions to Improve Performance

Data Quality

- To ensure that data quality relating to waiting times and CATS is included as part of the wider PCT performance framework review. Key success factor is to ensure that relevant activity / information is actively shared between primary and secondary care including key areas such as adherence to pathways, waiting times, discharge information and times, in order that informed decisions are made across the commissioning community (Competency 2)
- To review information systems and processes and aspire for this to be available on a 'real time basis' in line with becoming world class commissioners. (Competency 10)
- To review data collection to show evidence of engaging 'hard to reach' groups and comply with the Healthcare Commission's 'Data quality on ethnic groups' indicator (Competency 3)
- To ensure performance evaluation findings lead to regular and constructive performance conversations with stakeholders, working with them to resolve issues (Competency 10)
- To review the process in which data / information / waiting times is cascaded to the various stakeholders
- To review information systems and ensure compliance with the 18 weeks RTT target.

Management of Service Delivery

- Working closely with NHS Redbridge, NHS Havering and BHRT as part of a whole sector economy to deliver the 18 weeks target;
- Working with Practice Based Commissioners on delivery of the 18 weeks target, redesigning patient care pathways, commissioning services closer to the patients' home and services in the community to reduce referrals into secondary care.
- Working closely with the independent sector (InHealth) to deliver diagnostic services.

Actions / Initiatives / New Services Commissioned in 2009/10

- Intensify the focus on re-designing the care pathway programmes, including a clear performance management framework for those pathways of services that will be reviewed in 2009/10;
- To finalise the review of the orthopaedic and optometry pathways for the ISTC by June 2009.
- To further build on clinical engagement and commitment in the development of clinical pathways (Competency 3);
- To review the current infrastructure within primary care, in conjunction with the IS Wave 2, to address future capacity issues;
- To review the skills and knowledge of the workforce to provide services, in line with the actions identified within the PCT Organisational Development Plan. (Competency 1)
- To publish Map of Medicine pathways in line with the Local Health Economy;
- To commission additional direct access services, including endoscopy;
- To review and monitor capacity at the CATS.

Investment in 2009/10

Services	Total Planned Spend ('000) (Recurrent)	Total Planned Spend (Non-recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-recurrent)
Outpatients	14,118		-5.45%	

CATS	1,000			
Diagnostic (InHealth)				
IS Wave 2	686			

Risks to Delivery with Mitigating Actions Planned				
Risk	Impact	Likelihood	Risk Score	Mitigating Actions
Delay in Independent Sector diagnostic provision in B&D	2	2	4 (M)	B&D residents can access services London wide and not restricted to case mix set out in original procurement; NELTC up and running and supporting diagnostic waiting times (ongoing).
GPs do not refer into new diagnostic services	2	3	6 (M)	Care pathways taken to protected learning time events; PBC incentives to use service; The organisation has appointed an 18-week lead who will work with practices to maximize the use of services.
Diagnostic test in the community replicated unnecessarily in acute setting	3	4	12 (S)	Care pathway protocols (ongoing); Tariff unbundling for outpatient appointments with acute sector (ongoing); Maximise referrals into clinical assessment and treatment services (ongoing).
Delay in establishing clinical assessment and treatment services	3	2	6 (M)	Continuation of current GPWSI services; Reserves for service moved to cover acute SLA over performance.
GPs do not refer into new clinical assessment and treatment service	4	3	12 (S)	PBC incentives to use services in place – 75% of tariff price generate PBC savings; Introduced through Protected Learning Time; 18-week co-coordinator to support GP referrals.

2.2.3 Trauma services (to be completed if not selected by a PCT as a Local priority)

Objective/Aim (inc. implementation of HfL)

The main priority for 2009/10 for the PCT will be to consult on and implement the Healthcare for London service model for major trauma centres across London. The service is being developed through a Joint Committee of London PCTs (JCPCT) with delegated authority from PCT Boards to approve the pre-consultation business case and consultation options.

The PCT will be serviced by the Northeast London and Essex network with the major trauma centre being based at Barts & The London. Queens Hospital will provide local trauma services as a spoke of the major trauma centre at Barts & The London. In preparation for this trauma services have been consolidated by BHRT at Queens.

The major trauma centres represent an increase in capacity over and above current services.

Expected benefits accruing from the London trauma system will be:

- Improved patient outcomes by greater focus of specialist skills
- System-wide prevention strategy to reduce incidence of severe injuries
- Improved education and training for those delivering trauma care
- Increase ability to deliver a pan-London Major Incident Plan
- More people surviving injury and returning to optimum social and economic functioning

Action/Initiatives/ New Services Commissioned in 2009/10

The timetable and milestones for 2009/10 to develop the major trauma centres are as follows:

- JCPCT meeting in public to approve the consultation document – January 27th
- London Joint Overview & Scrutiny Committee notified of consultation start – January 28th
- Consultation start – January 30th
- Consultation end date – May 8th
- Consultation evaluation completed – June 4th
- PCT Board meetings to consider proposals following consultation – July 13th – 22nd
- JCPCT meeting in public to review final proposals – July 31st
- Service commencement – Quarter 4 2009/10

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
100		100	

2.2.4 Diabetes (to be completed if not entered as a Local Priority above, otherwise please delete this page)

Objective/Aim (inc. implementation of HfL)

Please see the section on Long Term Conditions / Unique Care above. (Section 2.2.1)

Action/Initiatives/ New Services Commissioned in 2009/10

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

2.2.5 Vascular Health Checks

Objective/Aim (inc. implementation of HfL)

Please see the section on Cardiovascular Mortality (section 1.11) above.

Action/Initiatives/ New Services Commissioned in 2009/10

Please see section on Cardiovascular Mortality (section 1.11) above.

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. Recovery Plans – (Please note recovery plans are currently being developed and will be included in the next draft plan)

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	tbc	
Community Development Workers	tbc	

3.1 Recovery Plan for A&E – 4 hour wait

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

Health Economy wide recovery plan to ensure that performance reaches the 98% threshold.

Latest Performance and forecast outturn

Current performance (mid January 2009) is 92.99%.

A proposed trajectory for the remainder of the year has been submitted to NHS London. This trajectory has been agreed with BHRT to deliver A&E 98% performance. The PCT is leading on the community bed capacity plan and revision to the escalation plan.

Action to Improve Performance

Data Quality

Category	Action	Date	Lead
Staffing	<ul style="list-style-type: none"> Ensure A&E nursing cover to establishment though use of agency, PCT in-reach and any new Sector-wide Bank arrangements Senior Nurse Navigator employed at BHRT AAU consultant in post at BHRT 	January 25 th	BHRT & PCTs
		January 18 th	BHRT
		March 1 st	BHRT
Discharges	<ul style="list-style-type: none"> 7-day working by Allied Health Professionals in place, with potential to use local examples of incentive schemes for weekend working Focus on out-of-borough repatriation as part of sector-wide programme PCT and Borough daily review of lists from BHRT indicating people medically fit for discharge Dedicated ASW/Therapist support in place to review daily lists of people medically fit for discharge across the 3 PCTs Medical MDT review for all people with LOS in excess of 28 days PCT commissioner case management of neuro-rehab delays 	February 1 st	BHRT / PCTs / Boroughs
		February 1 st	PCTs / Boroughs
		January 18 th	PCTs
		February 1 st	BHRT
		March 1 st	PCTs
Cross-Borough working	<ul style="list-style-type: none"> Sharing of continuing care panels across Boroughs as panels work to same national criteria to remove delays accruing from panel decisions Spot purchase community equipment across Borough stores to remove equipment delays Implementation of integrated discharge teams across Boroughs 	January 18 th	PCTs
		January 25 th	PCTs / Boroughs
		March 1 st	PCTs
Capacity	<ul style="list-style-type: none"> Opening of Sky B Scope for additional community bed capacity reviewed LOS review of acute and community beds Maintain elective outsourcing to meet 18-week target performance 	February 1 st	BHRT
		January 25 th	PCTs
		January 26 th	BHRT & PCTs
		On-going	BHRT & PCTs

Category	Action	Date	Lead
Admissions avoidance	<ul style="list-style-type: none"> Implement nursing home protocols to ensure GP/rapid response triage prior to calling LAS and admission Review out of hours communications from GP 	January 18 th	PCTs
		January 25 th	PCTs

	<ul style="list-style-type: none"> practices Communications strategy in place with message to public about not using hospitals when appropriate community alternatives in place Transfer of KGH Urgent Care Centre service model to Queens Adoption of existing LAS protocols for patient drop-off at Walk-in-Centres or MIU as alternative to A&E 	February 1 st January 18 th February 1 st	PCTs BHRT & PCTs LAS & PCTs
Systems	<ul style="list-style-type: none"> Weekly CEO meetings and Whole Systems meetings to review performance and problem solve Acute assessment workshop at BHRT Daily involvement of PCTs in bed management meeting and performance review Daily performance measurement across A&E, Urgent Care Centres, and Walk-in-Centres Participation in Sector-wide on-call arrangements and escalation 	January 18 th February 1 st January 18 th January 25 th TBC	ALL BHRT BHRT & PCTs BHRT & PCTs ALL

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

Risks to Delivery with Mitigating Actions Planned
<ul style="list-style-type: none"> During December there was sustained pressure on A&E and this has continued in January 2009. The action plan outlined above will support achievement of the target in the remaining months of the year.

3.2 13- week Outpatient Wait and 26-week Inpatient Wait

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

To achieve both waiting time standards through minimising the number of breaches annually.

Latest Performance and forecast outturn

Outpatients – 13 breaches to end of November 2008.
 Inpatients – 34 breaches to end of November 2008.

Action to Improve Performance

Data Quality

- Review all breaches to date and confirm accuracy of monthly returns;
- Review all breaches to date and confirm accuracy of monthly returns;
- Review and validate pathway (date of referral and first attendance) and impact of patient choice / appointment offers / DNAs for each breach;
- Review trend and place of breaches across the year;

Management of Service Delivery

Action/Initiatives/ New Services Commissioned in 2009/10

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

3.3 Ambulance Response to Category B calls in 19 mins

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

To work collaboratively with lead commissioner and the LAS to achieve response time standards.

Latest Performance and forecast outturn

Performance up to end of November 2008, shows 82.9% achievement.

Action to Improve Performance

Data Quality

LAS will continue to:

- Collect and collate A&E capacity information across London via EBS

Management of Service Delivery

- Review and discuss turnaround times at BHRT using best practice from elsewhere;
- Discuss performance challenges with LAS.

Action/Initiatives/ New Services Commissioned in 2009/10

The LAS recovery plan includes:

- Utilising additional out of hours GPs in control centres to assist with triage of calls and risk management;
- Discussing patient flows at specific hospitals;
- Greater use of walk-in-centres and minor injury units;
- Transportation of mental health patients to mental health facilities rather than A&E;
- Undertaking further work with nursing homes to avoid inappropriate A&E admissions.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

Risks to Delivery with Mitigating Actions Planned

--

3.4 31 Days and 62-Days Cancer Wait from Referral to Treatment

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

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

31 Day target is border line at present although it is anticipated that this will be achieved locally.

62 Day target there are currently 7 breaches (to end of November)

Action to Improve Performance

Data Quality

The Network has 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)

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.

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

We aim to work in partnership across the Children's Trust to deliver a combination of targeted and universal services delivered in a range of community settings to ensure that all children registered in Barking and Dagenham have the opportunity to reach their health and well being potential.

Our objectives are to:

- Increase childhood immunisation rates;
- Increase the proportion of new born and children taking up screening opportunities;
- Increase the rates of breastfeeding;
- Improve children's oral health;
- Improve children and young people's nutrition;
- Improve children and young people's mental health and wellbeing;
- Improve access to primary and secondary healthcare services for children and young people;
- Improve access to health and well being initiatives for marginalised groups of children and young people including those from ethnic minorities, diverse sexual orientations, living with disabilities, children affected by domestic violence, travellers and refugees and young offenders;
- Improve the level of partnership and integrated working for children's health and social care services, particularly through Children's Centres and services for children with learning disabilities and disabilities;
- Improve our level of engagement with children and young people to inform commissioning and performance management of services;
- Sustain and strengthen our high level commitment to the safeguarding of children and young people;
- Reduce childhood obesity;
- Reduce teenage conceptions;
- Reduce the number of avoidable accident and emergency attendances for children and young people;
- Maintain low levels of infant mortality and child mortality;
- Development of a coherent child health promotion strategy for the Children's Trust;
- Improve the supply and access to community equipment services for children with disabilities;
- Increase access and provision of short-break and palliative care services for children with disabilities through effective commissioning with LBBD;
- Improve the quality of data provided on children and young people in the borough.

Action/Initiatives/ New Services Commissioned in 2009/10

- Ratification of child health promotion strategy by PCT Board and Children's Trust by May 2009 with implementation from September 2009;
- Development of an infant mortality strategy and action plan by December 2009;
- Completion of an LGBT Needs Assessment which specifically includes LGBT youth by June 2009;
- Implementation of child oral health strategy by September 2009;
- Safeguarding audit in Spring 2009 followed by restructuring of Safeguarding functions following division of Provider function in April 2009;
- Two dedicated children and young people health events in 2009/10;
- Completion of audit and review of children and young people's access to accident and emergency services and follow-up action plan by August 2009.

- Implementation of RIO by September 2009.

As covered in previous parts of the document:

- Additional investment into child and adolescent obesity to establish a child and adolescent obesity delivery team;
- Development of antenatal education tariff and SLA with BHRT and Breastfeeding Strategy lead by BHRT;
- Expansion of Young Offenders Team healthcare support team to address wider CAMHS needs;
- Continuation of Immunisation Support Team with additional investment in public awareness campaign focused on immunisation;
- Revision of teenage conceptions strategy and structures with additional investment in peer education programmes enhanced teaching support in schools and access to condoms in the community;
- Implementation of the Access and Connect youth access card, incorporating the condom C card and free swimming card and healthy school meals cashless system.

4.2

Alcohol (to be completed only if it is not a chosen local priority above)

Objective/Aim

The updated national alcohol strategy in 2007 "Safe.Sensible.Social" and the new Public Service Agreements (PSA) attached to this strategy places a responsibility on Crime Reduction Partnership to develop a local Alcohol Harm Reduction Strategy prioritising health, crime reduction and community safety issues. This Strategy is intended to cover the contribution that all partners can make to this important agenda. The Government Office for London has reviewed the Barking and Dagenham DAAT partnership strategy and has indicated that it represents a model of best practice.

Aims of the Local Alcohol Strategy

- To help young people to resist alcohol misuse in order to achieve their full potential in society.
- To protect communities in B+D from alcohol related crime.
- To enable people with alcohol problems to overcome them and lead healthy lives and to reduce hospital related admissions.

Action/Initiatives/ New Services Commissioned in 2009/10

Key recommendations from the strategy include:

- A comprehensive annual alcohol needs assessment, tied to the annual drug needs assessment;
- Expansion of current alcohol treatment provision with a greater focus on outreach and community support (including provision for Black and Minority Ethnic (BME) groups);
- More targeted focus on young people with better liaison between young people's services; and
- More joint local education campaigns, targeting "at-risk" groups.

The currently commissioned tier three alcohol service is due to be retendered in September 2009 and the specification for this contract will be in line with recommendations in the alcohol strategy.

NHS Barking and Dagenham are financially supporting the delivery of this agenda along with the Local Authority.

4.3

Dementia (PCT plans to improve local services)

Objective/Aim

B&D PCT Commissioned a Health Equity Audit for Dementia in 2007. The findings indicated especially the need to develop capacity for young onset dementia, out of hours provision and support for carers. The National Dementia Strategy is pointing towards 15 recommendations.

Action/Initiatives/ New Services Commissioned in 2009/10

Existing hospital inpatient beds are based at Magnolia Ward, Mascalls Park Hospital and they will close by April 2009 and will be re-provided much closer to borough at Camara Lay Ward, Goodmayes Hospital. As community services improve, the need for inpatient beds reduces and B&D's current bed numbers of 22 will reduce to 10. The released resource will be used to develop further the community resources. In particular, the current Home Treatment Team (under 65 years only) will expand to manage patients over 65 years (at least for people with functional mental illness) and people with dementia will have more services including out of hours (but the nature and location of the dementia services have yet to be decided.) Existing dementia services in NELFT's Memory Clinic, Psychology service and OPCMHT will adapt in line with national strategic recommendations. Recent investment in dementia services has been 2 Admiral nurses and STaR worker in OPCMHT and £298K to Young Onset Dementia Service.

CSP bid under consideration is for Mental Health of Older People Acute Hospital Liaison Service approx £102K.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)

4.4

End of life care (PCT plans to deliver extended and improved service provision)

Objective/Aim

The End of Life Care Strategy provides guidance to develop end of life care services. A local strategy is under development to tailor this guidance to local needs and facilitate implementation.

End of Life care occurs in virtually all areas of health and social care delivered by a wide range of providers from the NHS, social care, voluntary and independent sectors. Currently dying people and their carers have variable experience of care with inequalities of access and availability of key services. Presently most people die in hospital, though it is considered that the majority would prefer to die elsewhere.

The complexity of end of life care means that a collaborative approach to commissioning services would promote a common approach to care delivery and outcomes, reduce inequalities and improve patient and carer experience. Healthcare for London proposes the commissioning of end of life care service providers at a sector level with the purpose of co-ordinating care and maintaining a register of people with end of life care needs.

Our trajectory is based on the proportion of people dying in their home, which is interpreted as permanent place of residence (this encompasses home, residential home and nursing home). The projection is based on the network-wide Collaborative Commissioning Intentions that in five years there will be a reduction in people dying in hospital to 58% in year 5 (2012). Taking hospice and other deaths into consideration, we have estimated this equating to 33 % of deaths in home by 2012, a stretch target of above London's current average proportion, NHS Barking and Dagenham is currently a high performing PCT with North East London but does fall behind the rest of London according to this definition of dying at home.

NHS Barking and Dagenham: 23.5%

North East London: 22%

London: 27.5%

This trajectory is subject to refresh following an in-depth network wide needs assessment, due for completion in summer 2009 and the completion of an audit of care homes currently being conducted by Saint Francis Hospice, as commissioned by NHS Barking and Dagenham.

Proportion of deaths at home in Barking and Dagenham

	Trajectory				Projection			
	2004	2005	2006	2007	2008	2009	2010	2011
B&D	24.6%	22.9%	25.6%	23.8%	25.6%	27.4%	29.2%	31.1%

Action/Initiatives/ New Services Commissioned in 2009/10

- Baseline review completed, December 2007
- 27/45 GP practices and 2 care homes signed up to GSF
- St Francis Hospice fully implemented LCP
- PPC fully implemented in care homes
- Place of death: 69.4% hospital; 16.6% home; 4.9% nursing home; 2.3% care home; 4.4% hospice; 2.4% other
- Recruited 2 End of Life Care Facilitator posts, including one In-reach post with BHRT.

End of Life Care focuses on addressing a common need within the population, rather than focusing on condition-specific end of life care services. Three tools have been developed by the Department of Health to facilitate end of life care within the community: the Gold Standards Framework, the Liverpool Care Pathway and Preferred Priorities of Care. To ensure a smooth palliative care pathway is in operation, the PCT has

funded three, End of Life Care Facilitators to implement these tools across the borough. This means that patients with identified need have access to specific services which support their needs. The PCT has committed to working with other PCTs in the NEL sector to support collaborative commissioning and to improve access and reduce inequalities.

- Implement and monitor an agreed care pathway for end of life care;
- Develop co-ordinated care engaging all stakeholders;
- Invest in best practice;
- Assess capacity of existing resource and invest in service development where needed;
- Enable the PCT to be compliant with NICE Supportive and Palliative Care Guidance and implement the national End of Life Care Strategy.

Awaiting confirmation of the following proposals:

- Two-year fixed term in-reach end of life care facilitator (part-funding secured from NELCN Palliative Care slippage for the first year)
- Extension of existing Relate counselling services to encompass Bereavement counselling
- One-year pilot for spiritual care facilitator

Other specialist palliative care investment:

Richard's House investment of £13,918

Haven's House disinvestment of £8,787

Saint Francis' Hospice increased investment, decision pending

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		125	

4.5

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	
a)	<p>IAPT KPIs include:</p> <ul style="list-style-type: none"> • Vital signs and PSA indicates – more people accessing treatment • Extending Access to NICE – Compliant Services – half of those who leave treatment moving to recovery • Helping people back to work – fewer people on sick pay and benefits • Building a skilled work force – newly trained high and low intensity therapists <p>(The B&D approach is to build upon existing services, allowing them to build capacity and competence and to tender out the services in 2009/10 and 10/11 without de-stabilising the services).</p>
b)	DRE. To achieve the DRE 12 outcomes by 2010.
c)	To achieve full coverage in GP SMI registers and annual physical health checks for all patients on CPA.
d)	Ensure no children less than 18 years admitted to adult psychiatric wards.

Action/Initiatives/ New Services Commissioned in 2009/10	
a)	<p>The new investments £633,182 into the NELFT primary care mental health service, Advice and Brief Intervention Team (ABIT) in 2008/09 will bed in and the service will operate from a new base away from secondary care and in a primary care setting (Church Elm Lane).</p> <p>One part of the existing primary care mental health service is £120K p.a. Relate Counselling. In 2009/10 this part will be re-specified and re-tendered in order to improve outcomes and value.</p> <p>The Tulip primary care counselling service (1 year Challenge Fund £60,730) will be evaluated with particular interest on the extent to which it has been successful in targeting BME communities.</p>
b)	DRE. We have our required number of 2 CDWs (Com. Dev Workers for BME communities.) The first is providing strategic co-ordination, the second is located in local voluntary sector with clear objectives for 2009/10.
c)	In 2009/10 we plan to work with GPs in partnership with Lilly UK to develop a Health Improvement Tool for Schizophrenia which, among other things, can be the mechanism through which we extend physical health check-ups for people with serious mental illness.
d)	The PCT and NELFT are already fully committed to ensuring that no children under 18 years are admitted to psychiatric wards. To this end, recent investment has been in NELFT's Tier 4 CAMHS Outreach Service in 2008/09 and the PCT's commitment to purchase capacity from NELFT's in-patient High Dependency Unit. The PCT is working with NELFT;
e)	Maintain the yearly target of 7,500 early intervention cases.

Investments in 2009/10			
Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
29720	376	2062	376

4.6

Military personnel (commissioners to ensure priority access for military personnel for service-related conditions)

Objective/Aim
N/A

Action/Initiatives/ New Services Commissioned in 2009/10

4.7

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)

As lead commissioner for BHRT, NHS Barking and Dagenham recently participated in an external audit of mixed sex accommodation during September 2008. It was agreed that the PCT would, as a result of the visit, review the 2008 targets and discuss the targets for 2009-2010 with the Trust, based on improvements identified through a balance scorecard. The PCT will continue to review the progress of this mixed sex accommodation action plan as part of its performance management regime and will continue to ensure that the targets and action plans are published.

We are broadly satisfied that the commissioned service from NELFT is compliant with requirements about single sex accommodation. However, there still remain concerns regarding possible non-compliance at NELFT's Woodside Villa Ward (for "rehabilitation") at Mascalls Park.

This ward is planned for closure in 2009 and some of the patients will be discharged to community settings and others will be transferred to capacity at Goodmayes Hospital's Emily Bronte Ward, but we need to check with NELFT whether this ward will be compliant with single sex standards. This will be led by NHS Redbridge as co-ordinating PCT.

Trajectory for 2009/10 for hosted Trust (sleeping accommodation)

2009/10 for hosted Trust (bathrooms)

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Action/Initiatives/ New Services Commissioned in 2009/10

New guidance has recently been issued and the PCT will monitor its providers on implementation. In addition BHRT's action plan for Mixed Sex Accommodation is available on both the PCT's and BHRT's websites. This action plan arose from the visit undertaken by NHS L in autumn 2008. The action plan is reviewed by the Operational Group meeting between BHRT and the ONEL PCTs on a regular basis.

4.8

People with learning disabilities

Objective/Aim (inc. annual health checks)

To secure general health services that makes reasonable adjustments for people with learning disabilities. This will involve ensuring that the DES for patients with LD is fully implemented across the borough, that the recommendations of Valuing People Now regarding the commissioning of LD services are fully implemented, and that the PCT undertakes a more joined up approach to commissioning specialist health services with the local authority.

Action/Initiatives/ New Services Commissioned in 2009/10

The above will be achieved through a number of initiatives:-

- In recognition of the level of underinvestment in specialist health services, the PCT will create additional posts to provide specialist nursing input for patients with LD, training for general clinical staff in both the acute and primary care setting, and a safeguarding post for patients with LD;
- The new LD contract will be used to contract for this service, and both PCT and LA commissioners will monitor progress against the contract at monthly intervals;
- Similarly, the PCT will be involved in the monitoring of those contracts commissioned by the LA, including those for residential/nursing care;
- Both of the above will be monitored against the health and lifestyle outcomes identified within the Local Area Agreement for patients with LD;
- The PCT will use the new APMS contract for sexual health services to ensure that the sexual health needs of those with LD are considered;
- The PCT will ensure that the DES is fully implemented, and where a practice does not wish to participate, the funding will be used to either support the LD team in providing annual health checks, or in developing a GPwSI post for these clients;
- The recommendations of Valuing People Now regarding the transfer of commissioner responsibility to LBBD will be fully implemented by April 2009.

Investments in 2009/10

Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
6029		150	

4.9

Breaks for Carers

Objective/Aim

- Improve the access to short break provision for disabled children and their families - including children with complex health needs
- Prevent crisis intervention and emergency placements
- Increase provision of home-based support and residential short breaks in the borough
- Delivering an outstanding customer service

Action/Initiatives/ New Services Commissioned in 2009/10

- PCT and LBBD commissioned a Joint Needs Assessment of Children with Disabilities carried out in 2008 (available);
- PCT commissioned a joint needs assessment on paediatric palliative care across NEL (to be published Feb 2009);
- PCT commissioned a review of short-break/respite and care packages of children on disability team register (available);
- Developed Joint Short Break Strategy for 2008-11 (available);
- PCT Nurse/key worker attached to LBBD disability team to oversee assessment, care plan and review of short-break/respite care packages jointly funded with local authority (in post);
- A joint funding assessment criteria for short-breaks and respite provision (being developed);
- 15 Short break care-packages were jointly funded in 2008/09 (health contribution in year).

5. Finance

Latest Performance and forecast outturn ('08/9)

The financial position at the end of December is an underspend of £1m against current budgets.

The PCT is expecting to achieve a year end surplus of £18.5m which is within current total range notified by NHSL.

- The key risks identified are within acute commissioning with significant increases against the contract with BHRT, which the Director of Commissioning is currently investigating. In addition the position at Barts and the London is not clear given the caveats currently being placed on their information reports. The Director of Commissioning is in the process of renegotiating a block agreement for the year to mitigate this risk.

Summary of assumptions 2009/10

The key assumptions for 2009/10 are:

Income Assumptions:

- Growth as per the exposition book issued on 19 December 2008.
- Market Forces Factor retained with the PCT in full, rather than top-sliced for central payment.
- Forecast of non-recurrent allocations in 2009/10 included, these are rolled – forward from 2008/09.
- The PCT's forecast surplus in 2008/09 (£18.6m) is shown as a source of income in 2009/10 and replaces the surplus for 207/08 (20.7m) as a source of non-recurrent income. The net effect of movements in annual surplus is therefore a reduction of £2.1m from 2008/09 to 2009/10. This is consistent with investment assumptions in the CSP.

In 2009/10 the PCT lodgements to be returned from NHSL have been reduced by £1.5m for brokerage agreed with NHS Havering. NHS Barking and Dagenham is assuming that the £1.5m will be returned to this PCT in 2010/11.

Expenditure Assumptions:

- Forecast surplus in 2008/09 (18.7m) is returned in 2009/10 and is resource only (not matched with cash).
- Contract uplifts are applied in line with planning guidance, with the uplift in acute baselines set at 1.7% with a 0.5% position for CQUIN achievement.
- Other uplifts applied include 8% for prescribing as per NHSL planning assumptions 30 October 2008 and 1.5% to Primary Care Contracts.
- A 3% efficiency requirement is applied to all contracts.
- The CSP includes technical adjustments or assumptions for the following:
 - Top-slice for the Medium Term Financial Strategy at 0.9% (2.7m);
 - A provision for the increase in Market Forces Factor payments following adjustments to 2009/10 PbR tariff at £1.5m;
 - A provision for the impact of HRG4 at £0.75m;
 - A provision for CQUIN at 0.5% of contract baselines at £1.5m;
 - The PCT's investment profile for 2009/10 takes into account these technical adjustments before making any service development commitments. The summary of investments is set out below:
 - Demographic growth is built into all cost and volume contracts across acute, specialist, mental health, community services and primary care, with an average uplift of circa 1.4%. Demographic trends are built into all acute activity assumptions in line with Healthcare for London modelling assumptions;
 - The CSP assumes that the application of IFRS will not place LIFT schemes onto the PCT balance sheet and therefore does not assume any additional revenue changes in

2009/10. This assumption is made by reviewing LIFT schemes against IFRS standards but is made without central guidance from Auditors. The in-year revenue risk is £2.5m if LIFT schemes go onto the PCT balance sheet.

The Operating Plan reflects a position prior to final sign-off of acute contracts. The impact of HRG4 and Market Forces Factor adjustments on contract baselines will be key to the PCT's ability to deliver 2009/10 contracts from within existing Operating Plan envelopes. This will be a price rather than volume impact as PCT activity baselines for PbR are close to current proposals for Trusts. The PCT will re-align priorities for 2009/10 in the operating Plan to cope with any acute cost overspill over the defined envelope.

Summary Investments in 2009/10 (£000s)

	Total Planned Spend (Recurrent)	Total Planned Spend (Non-Recurrent)	Net Change in Spend (Recurrent)	Net Change in Spend (Non-Recurrent)
18 week wait				
HCA's				
Primary care access	35187		1438	
Cancer waits – 2 wk wait				
Breast screening				
Bowel screening				
Cancer waits - 31 day				
Stroke care	85		85	
Cervical screening				
All age all cause				
CVD mortality				
Cancer mortality	283		283	
Smoking	24	100	24	100
Maternity	100		100	
Teenage conceptions				
Childhood obesity	165		165	
Immunisation		60		60
Breastfeeding	100		100	
CAMHS	6		6	
Chlamydia screening	20		20	
Drugs misuse	2626		250	
Patient experience				

Public confidence in NHS				
Dentistry access	9099		329	
London priorities - TB	20		20	
London priorities - HIV	1865		474	
PCT Priorities ...Out of Hospital	800	400	800	400
PCT Priorities ...HI Schemes...	5328		537	
PCT Priorities – Strengthening Commissioning	860	440	860	440
PCT Priorities - Continuing Care.....	4682		288	
PCT Priorities – Premises Strategy		3793	1848	3793
Trauma (if not above)	100		100	
Diabetes (if not above)	482			
Acute & Specialist Services	147298		4937	
Recovery plans – NHSL MTFS		2409		2409
Corporate Services and Contingency	17278			
CQUIN			1166	
Uplifts			6227	
Prescribing	22995			
Community Services	34399	500	795	500
Dementia				
End of life care	125		125	
Mental health	29720	376	2062	376
Learning disabilities	6029		150	
TOTAL	319194	8078	23189	8078

	Recurrent	Non Recurrent	Recurrent	Non Recurrent
	2008/09	2008/09	2009/10	2009/10
	£000s	£000s	£000s	£000s
Source of Funds				
Revenue Resource Baseline	267023		285811	
Growth Allocation	14585		15269	

Financial Headroom from prior year				
Return of 08/09 surplus		20977		18563
Return of lodgements			4757	
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)	281608	-807	305837	7690
CIPS		381		
Demand Management Schemes		2503		2437
Total Resources Available	281608	23054	305837	28690
Less: Application of Funds				
Contribution to the London levy for write-off of legacy debt				2409
Contribution to the Sector Strategic Investment Fund				
SLA / Non-SLA expenditure (including inflationary / generic cost pressures)	251447		282843	8078
Contingency		1500		2676
Balance available for investment	30161	21554	22994	15527
Investment Programme	33152		23189	8078
Surplus / Deficit	-2991	21554	-195	7449

Risks to Delivery with Mitigating Actions Planned

There is a potential that the application of IFRS could mean £2.5m risk if LIFT schemes go on the PCT balance sheet.

6. Enablers - and other issues

6.1

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 national survey in July 2008 showed that NHS B&D was just over the national average for offering choice to patients with 50.2% of patients recalling being offered choice. The national average in July 2008 was 47%.

In February 2009, the PCT is developing a new Choice Action plan to support choice and personalisation and to support the delivery of our new legal responsibility to ensure that choice is offered.

In terms of the PCT's strategy to empower choice, it is essential that this takes into account our patients who may not be able to speak English or impairments that may affect their access to information. The objective of the plan under development is to adopt a range of activities and projects which will reach the widest possible audience and to communicate the essential facts about the choice programme.

The actions being planned are as follows:

- Increase the use of C&B and Choice at point of referral by GP practices by:
 - Monitoring the use of C&B using DH C&B weekly returns;
 - Using PBC quarterly visits to explore any issues and reinforce usage;
 - Encouraging practices to select more than one provider and documenting this in patients records;
 - Engaging with providers to ensure appointment slots are available for direct booking.
- Increase awareness of choice to patients through:
 - A bus campaign to start in March 2009;
 - Engaging local libraries in assisting in awareness of choice and booking appointments;
 - Using existing patient participating groups (PPG) to discuss experience of being offered choice;
 - Using PPGs to promote the choice website;
 - Distributing posters and leaflets at strategic locations across the borough in different languages;
 - Co-ordinating local campaign with the national campaign;
 - Utilising voluntary organisations to cascade choice e.g. Age Concern.
- GP and Practice Staff:
 - Distributing choice material to practices;
 - Ensuring all patients that are referred are given information on choice;
 - Encouraging practices to refer patients to the library services;
 - Communicating choice using digital boards at practices;
 - Liaising with IT to install choice screen savers on all PCs in the practice.
- Other Stakeholders:
 - Engaging with PALS to promote awareness of choice;
 - Engaging with PPI to disseminate awareness of choice;
 - Submitting articles in local press;

6.2

Emergency preparedness (inc. pandemic influenza plans)

The Civil Contingencies Act 2004 requires the PCT to prepare for major incidents and other civil emergencies which may affect our borough and its population. The PCT delivers this work through an Emergency Planning Group where partner agencies are involved, close working with the Local Authority and Health Protection

Agency, and through development, testing, and regular updating of plans to deal with major emergencies. The *NHS Emergency Planning Guidance 2005* stipulates arrangements for PCTs in implementing the Act and *Standards for Better Health* requires PCT Boards to assure themselves that emergency preparedness arrangements for the PCT are in place, exercised regularly and show evidence of continuous improvement.

In 2009/10 the PCT and our partners will focus on strengthening our joint plans for responding to a flu pandemic. This will culminate in the running of a major multi-agency table-top exercise designed to test the plans of the participating agencies in their response to a flu pandemic. This is the second time such a large event has been held by the Council, local NHS organisations, the Police, Ambulance Service, Fire Brigade and local community organisations to test our collective plans to maintain essential services during a flu pandemic and also to care for those ill with flu.

During the 2007/08 exercise, partners looked at how they would manage their services in a scenario where many of their own staff would be off sick with flu and how we would transform a care home for elderly people into an emergency hospital, and made calls to the Council's contact centre to ask for advice on coping with flu.

The exercise identified a number of important issues that their current plans did not fully address. These included:

- Current plans needed to be revised and brought in line with organisation and departmental business continuity plans;
- Inter agency co-operation to develop core resources with agreement on pooling certain resources to maintain service levels;
- Identifying at what point the overriding priority is to manage the outbreak, with the diversion of all other resources bar essential services, to achieve this aim;
- Being clear on who had the information or knowledge on specific issues, and how to access that information as quickly as possible, so that necessary decisions could be taken;
- The importance of using every available means to get clear and consistent information out to residents, because local newspapers or radio stations may themselves become vulnerable in the event of a major outbreak;
- Develop more training for personnel and distribute to a wider audience

The exercise was successful in testing individual agencies plans, in some cases it proved that the plan isn't widely known or understood within an organisation. It is evident from some of the comments that the plan needs some work carried out on it for most of the agencies involved.

The aim of the 2009/10 exercise is to test the revised plan in particular the trigger points for organisations and demonstrating the partners' co dependencies and their joint resilience.

6.3

High Quality Care for All (inc. implementation of the CQUIN payment framework)

The PCT will embrace the actions outlined in High Quality Care for All through a number of actions. Many of these (such as working on key priority areas, the implementation of the financial framework, etc.) are described elsewhere in this document.

In terms of enablers, the PCT will build on its current approach to work with local partners to improve the quality of care for local residents/patients, as identified in its world class commissioning submission. NHS Barking and Dagenham have identified a number of local outcomes and indicators as part of this framework and as part of the Local Area Agreement, and will work with other partners within the Local Strategic Partnership to meet these requirements.

Specific actions will include:-

- Using the CQUIN mechanism to reward the local acute Trust for meeting agreed quality indicators notably that support the direction of travel identified in HfL. This is likely to include indicators

associated with stroke, maternity investment, and non-PbR elements of the agreed contract;

- Using the CQUIN mechanism to incentivise our local community services to improve the quality of data used to monitor activity/waiting times provided through the new community service contract;
- Continuing with the fortnightly monitoring of the quality metrics schedule as a key feature of acute contract with BHRT;
- Expansion of the Expert Patient Programme to provide wider coverage for patients with long term conditions;
- Regular publicising of progress against Vital Signs targets;
- Continuing to work through the findings of the National Support Team on health inequalities within B&D undertaken last year;
- Continuing to tender out work as and when the opportunities arise, to support the development of high quality care through plurality of provision;
- Commissioners, IM&T staff and other key individuals will work closely together to develop IM&T plans that meet the needs of local providers and commissioners, in keeping with the priorities identified by the North East London Care Community;
- Supporting local providers in the agreement of suitable quality indicators to inform their annual quality accounts.

PBC in 2009/10 (inc. improved information, management and financial support from the PCT)

Information

The PCT provides patient-level activity information to practices for patients registered with them for the purposes of analysis, validation, audit and checking that billing is appropriate.

A reporting template has been developed to cover the following areas of activity:

- Elective activity
- Non-elective admissions, including length of stay
- First outpatient appointments and follow-up appointments
- A&E attendances

The PCT will publish a timetable for the release of data to practices and its return to the PCT for validation purposes. Criteria for data validation and the process for reporting savings to practices/ clusters will be reviewed by April 2009.

Practices and clusters will receive quarterly summary reports of activity and finance for PBC budgets, including prescribing information. PBR reports will be compiled following the freeze date for the quarter and circulated within an agreed timetable. The change in reporting from SLAM to SUS will improve the timeliness of data.

Financial support

Practices will receive PBC budgets that include:

- Secondary care PBR activity for inpatients, outpatients and A&E attendances
- Primary care prescribing
- Clinical Assessment and Treatment Services
- Unique Care
- Anticoagulation
- Primary care prescribing

All other services, including PCT management overheads, will be allocated indicatively on a weighted capitation basis and blocked back at the PCT.

It has been agreed that budgets for 2009/10 will be allocated on a fair shares basis using the national toolkit, with appropriate adjustments made for variations in prevalence, deprivation and local intelligence.

Prescribing budgets will be allocated using the Prescribing Support Unit Budget Setting Utility, the pace of change from historic to capitation budgets being agreed by the PBC Steering Group.

A population reserve of 2% of the PBC budget is topsliced to manage list size changes at practice level. The PCT manages the activity for unregistered patients and an indicative amount has been allocated for this based on historic spend. A contingency reserve will also be held for the prescribing budget, specifically to cover variable prescribing costs associated with high cost drugs.

All practices in PBC clusters have signed up to a risk sharing arrangement within their cluster inter-practice agreement, which covers PBC budgets and prescribing.

Where resources are freed up that were not planned for in PBC business plans, practices are entitled to use a minimum of 70% for reinvestment in patient care. SLA baselines will therefore be set at levels net of modernisation assumptions accruing from PBC agreed schemes. The practices/clusters will be asked to develop proposals for the use of savings (level of detail commensurate with amount of savings), and submit these to the PCT for approval. Windfall gains associated with data anomalies will be excluded from commissioning efficiency savings.

Management support

The PCT has a dedicated team within the Commissioning Directorate to support PBC. There is a senior management lead for each PBC Cluster and an Information Analyst to support the information requirements. PBC Clusters are also able to access wider PCT support including Finance, Primary Care Contracting and Public Health

Specific functions to be undertaken by the PCT include:

- The allocation of indicative budgets to practices for PBR activity and prescribing
- Monitoring and negotiating existing and new service level agreements and contracts with providers
- Administering a PBC incentive scheme that covers the scope of PBC budgets
- Providing management support to PBC clusters to support the development of commissioning plan and PBC business cases
- Providing activity and financial reports and support in their interpretation
- Provide support to practices on the above through training and practice visits
- Providing support to PBC Cluster meetings

The PCT operates a PBC incentive scheme ("Commissioning Incentive Scheme") to cover PBR activity and prescribing.

The Commissioning Incentive Scheme is a framework for incentivising practices to implement activities at practice level that will contribute to the achievement of Practice Based Commissioning (PBC) Cluster priorities. It recognises that practices are required to take on some additional work in order to deliver the outcomes resulting from service redesign. It offers a financial incentive to practices to develop their capacity for reviewing and acting on activity data and developing services that improve health outcomes for their patients.

The incentive scheme does not duplicate other activities that are financially incentivised, for example the Quality and Outcomes Framework. Practices are required to register for the scheme and are monitored on their achievement by the PBC team at the PCT.

PBC Focus Areas for 2009/10

PBC priorities for 2009/10 have been identified by the PBC Steering Group and include:

- Supporting the development of an integrated care service for adults with long-term conditions, building on the successes of Unique Care to reduce emergency admissions;
- Embedding the integrated care pathway for diabetes into practice across primary and secondary care enabling the management of most diabetics to take place in the community;
- Developing the scope of the community CHD service to provide additional capacity in the community for atrial fibrillation, valve replacement follow ups and rehabilitation;
- Further review of clinical pathways that support activity being transferred from secondary care to the Clinical Assessment and Treatment Services;
- Investment of PBC savings into the development at practice level to deliver additional vascular screening;
- Provision of pharmaceutical support to practices to increase the quality and cost effectiveness of prescribing.

6.5

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)

As part of our OD plan the PCT has a number of actions and initiatives lined up to tackle its workforce, talent and leadership needs, some of which are already being implemented. WE have an ongoing Board Development programme managed by Ernst and Young; we are currently implementing a KSF staff development and user-friendly appraisal process.

Based on analysis of our workforce capacity and capability issues, carried out as part of the process of developing our OD plan, the following actions will be implemented during 2009/10:

- Development of a new workforce strategy and implementation plan;
- Development of a succession planning process;
- Development of a talent management programme;
- Review of our current reward and recognition practices;
- Review of existing structures and systems for staff engagement;
- A review of existing equalities and diversities frameworks and infrastructures;
- An assessment of recent statutory and sector policy changes on workforce management.

6.6

Crime and disorder reduction (local partnership working, inc. on knife crime)

The PCT contributes to the Crime Disorder Reduction Partnership (CDRP) Board, and is working with partners to fulfil our duties under current legislation.

In 2008 the PCT established a strategic lead for domestic and launched www.domesticviolencelondon.nhs.uk , as a resource for healthcare professionals.

The PCT is a member of the Domestic Violence and Hate Crime Steering Group, and are piloting the divert model of response to domestic violence which reduces A&E pressures as well as providing rapid medical response for victims and perpetrators. Counselling is also funded for victims of domestic violence through the Women's Trust.

In 2008 a needs assessment was undertaken on domestic violence and children which is feeding into the refresh of the Children and Young Peoples plan in 2009/10.

A domestic violence strategy will be developed this year, which will feed into the PCT's commissioning and strategic direction.

The PCT works closely as part of the Drugs Action Team and have funded a Tobacco Control Officer to reduce illegal sales of counterfeit cigarettes.

6.7

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 outer NE London LHC consists of Waltham Forest PCT, Havering PCT, Barking & Dagenham PCT, Redbridge PCT, North East London Foundation Trust, Barking Havering and Redbridge NHS Trust, Whipps Cross Hospital Trust.

The SRO for the outer NE London LHC is shared between Ralph McCormack and Heather O'Meara. The overall plan will be co-ordinated by the NE London programme office and signed off through the joint committee of PCTs.

The timetable for finishing and reviewing the plan is as notified by Kevin Jarrold, the London SHA CIO.

The outer NE London LHC will be discussing implementation of the Summary Care Record at its March 2009 meeting.

6.8

Action Plan to reduce the PCT's carbon footprint

A key priority for the PCT is to ensure it does what it can to reduce its carbon footprint and give environmental issues the importance they deserve. There are three main areas that the PCT is focussing on – building energy use, transport and procurement. With this in mind the PCT has already commissioned an analysis of the environmental impact of its estates and facilities through an energy assessment inspection of PCT owned/leased and GP owned/leased properties as a start to addressing environmental legislation.

The energy assessment inspection of each site will classify the facilities under a "traffic light" RAG system with approximate costs to remedying the "red" light premises. The surveys look at the building fabric and the engineering services to establish the energy efficiency of the premises, making comparisons against current standards. This database will be available for strategic planning with a view to display energy performance certificates by early 2009.

Parallel to this data gathering exercise, discussions have taken place between the PCT and the Climate Change Manager of LBBD to initiate collaborative working and tackling carbon management and environmental performance in partnership. The emerging suggestions will be incorporated into the future sustainability action plan of the PCT.

Key objectives up to 2010 are:

- To calculate the carbon footprint of facilities and activities within three main sectors: building energy use, travel and procurement;
- To establish a baseline and risk register of the environmental impacts;
- To establish Board level leadership on carbon reduction and approve an Environmental Management System (EMS) by April 2009 inclusive of:
 - Carbon management strategy and sustainable action plans
 - Waste management and minimisation
 - Sustainable green travel plans on new schemes

- Green procurement strategy
 - Communication strategy and community engagement
 - HR strategy, Education and training and PCT policies
 - Methods of quantifying and checking and recording energy usage
 - Incentives, policies and measurable and non- measurable targets
 - Auditing, record management and reporting processes
 - Investment and programmes in energy saving measures
 - Partnership arrangements with LBBB and controlling authorities
- To commit to reducing the level of primary energy consumption by 15% from March 2000 to March 2010.
 - To recognise the European Union's Energy Performance of Buildings Directive and enforce energy-efficiency targets in all new capital developments and major refurbishments at 35-55GJ/100m⁻³/yr¹ and 55-65GJ/100m⁻³/yr¹ in existing facilities from March 2000 to March 2010.
 - BREEAM (Building Research Establishment Environmental Assessment Method) sustainability standard of excellent in all new builds and very good in refurbishments.
 - To ensure Energy Performance Certificates (EPC) are in place for all properties when constructed, sold, bought or let showing the expected level of energy running costs for the building and the level of carbon emissions (environmental impact).
 - By 2009, Display Energy Certificates (DEC) will also be required for facilities larger than 1,000 sqm² showing the actual level of energy consumed over the previous period.
 - Demonstrate that the good corporate citizen model has been used to assess developments and a commitment to using the model to re-assess the development regularly. Good Corporate Citizenship embraces sustainable development and tackle health inequalities through their day-to-day activities around six areas: transport, procurement, facilities management, employment and skills, community engagement and new buildings.

To achieve this the PCT will commission a project manager to lead on this work and develop a group of staff trained to provide advice and support and monitor and report back on progress. A key aim will also be to encourage staff to become green "champions".

As well as this the PCT manages the storage, collection and disposal of its clinical waste collections from its health centres, GP practices, Optometrists, Pharmacists and Dentists in line with the requirements of Safer Management of Healthcare Waste around correct colour coding and labelling of waste; and its safe disposal.

A recycling of paper initiative is in place as well in partnership with the local authority.

All the PCT's LIFT buildings are naturally ventilated reducing the need for mechanical ventilation. The PCT's Headquarters building has also had heat/ lighting and ventilation studies undertaken in order to reduce energy consumption and costs and to improve the working environment for staff. Details of the PCT building's energy consumption is recorded and analysed through the annual ERIC (Estates Return/ Information Collection) and analyses of these results are useful in identifying sites and buildings where a greater emphasis can be placed on reducing energy consumption.

6.9

Governance - (inc. PCT organisation, issues and risks, actions, reporting on 'Never Events' within commissioned services and root-cause analyses)

The process to externalise the PCT provider arm from 1 April 2009 to NELFT is underway with due diligence work and is being led by a Provider Transfer Joint project Board which reports into the PCT Board. There are a range of workstreams as well as a communications plan to ensure that all issued are worked through, due diligence is tested and that staff are kept up to date with the changes. A TUPE transfer consultation process is currently underway. The outcome of this work will determine the future roles and responsibilities for each organisation.

The externalisation of the provider arm will mean that the PCT as a commissioning body will review its Corporate Governance Framework and delegation scheme to support this change. As already set out in this document, there is an Organisational Development implementation plan which will support the development of the PCT as a World Class Commissioning Organisation. An implementation plan with actions to address capability gaps has also been developed. As part of this process there is a Board development plan to support the leadership, knowledge and skills to take the organisation forward and to have the right combination of skills, structures and systems to deliver world-class services and good governance to enable the PCT to embrace change through critical self-awareness.

Board assurance is a key factor and the key risks going forward into 2009/10 relate to:

- Financial issues particularly around acute commissioning;
- Capability and capacity;
- Poor performance against key targets;
- Uncertainty around the future configuration of primary and secondary care services.

The recommendation in "High Quality Care for All" that there should be a way of identifying and monitoring "Never Events" to drive improvements in patient safety is supported by the PCT. The PCT currently has good risk assessment and management systems in place, incident reporting and investigation processes, including root cause analysis. Lessons learnt are implemented through governance structure in particular the Integrated Governance Committee and Performance Panel. There is a reporting process in primary care. In terms of information governance and interim SIRO has been identified and there is an action plan in place which is monitored by the Integrated Governance Committee and key issues are reported to the Board.

In 2009/10, the PCT will:

- Ensure that providers report "Never Events" through established routes, including local serious incident reporting arrangements to the PCT and national reporting to NRLS;
- Develop assurance that appropriate systems drawing on national standards and guidance are in place to prevent Never Events;
- Provide assurance that appropriate root cause analysis will be undertaken where Never Events occur, with support from NHS London and national tools available on the NPSA website.