

NHS London

2010/11 OPERATING PLAN

PCT / Sector Name: NHS Kingston
SWL

Version: Final Draft

Date: 26 February 2010

NHS
London

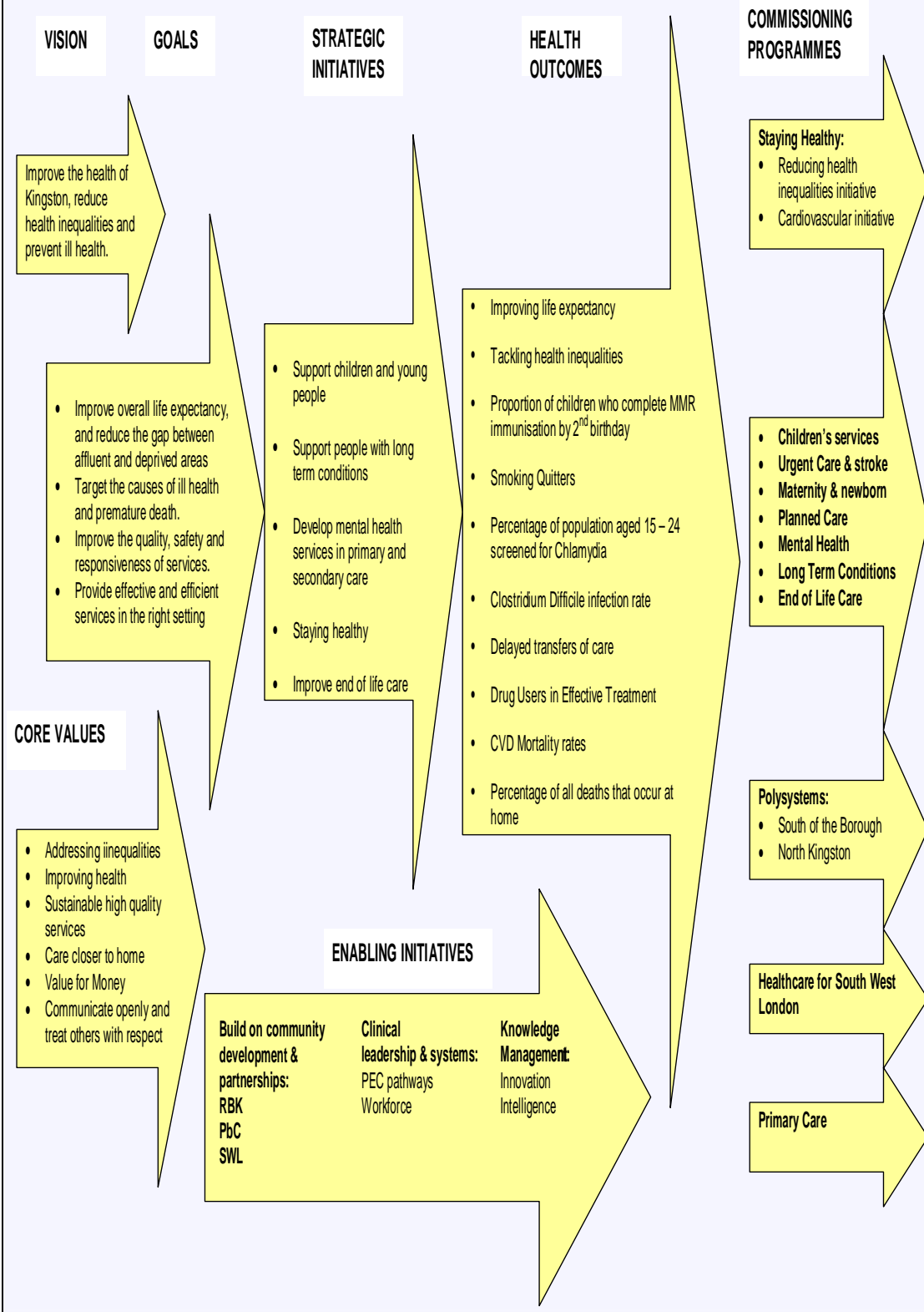
Key contacts at PCT / Sector			
Name	Title	Telephone	Email
Executive Lead:	P Taylor	02083398193	Penny.taylor@kpct.nhs.uk
Finance:	J Molyneux	02083398141	Jonathan.molyneux@kpct.nhs.uk
Workforce:	C McGruer	02083998094	Celia.mcgruer@kpct.nhs.uk
Performance:	P Taylor	02083398193	Penny.taylor@kpct.nhs.uk
Informatics:	P Taylor	02083398193	Penny.taylor@kpct.nhs.uk

PCT operating plans should contain all of the sections below, and the annexes. Sector operating plans should contain the sections indicated only.

SECTION 1: STRATEGIC OVERVIEW (PCTs and Sectors)

1.1 Summary

Summarise your organisation's five year strategic plan (1000 words maximum or a diagrammatic summary).



1.2 Care pathway priorities

List your organisation's priorities in redesigning the Healthcare for London care pathways.

- Coronary Heart Disease: Establishing Heart failure services in the community and bedding down a comprehensive cardiac rehabilitation service. Implementing a wider programme of NHS Health Checks with associated weight management clinics.
- Stroke: Improving existing rehabilitation services.
- Ophthalmology: Commission redesigned care pathways.
- Sexual Health: Establishing a Managed Clinical Network to implement agreed comprehensive sexual health service.
- Long Term Conditions: Diabetes and respiratory care.
- Dentistry: increasing our commissioning to support the development of GDwSIs.
- Maternity: completing phase II of the redesign of services.
- Diagnostics: Developing criteria to support care pathways and enable increased and effective use of direct access services.
- Substance Misuse Services: develop and review current services following a comprehensive review of commissioning and provision with Borough partners.
- End of Life Care: Increasing the ability of people to choose where they die.

We have well developed plans to implement these changes during 2010/11

1.3 Strategic initiatives

Supporting children and young people

- Implement the recommendations of the Healthcare for South West London Clinical Workgroup
- We will continue to commission through a formal safeguarding arrangement, to ensure children and young people are protected from harm.
- Develop with our stakeholders the HCfL local hospital paediatric assessment alongside redesigned unscheduled care services
- Implement our Joint CAMHS Strategy

Maternity and the New Born

This programme of work focuses on implementing phase II of the local workstream.

Supporting people with long term conditions:

Focus on diabetes, the respiratory system and dementia: to develop a new model for supporting people with long term conditions, starting with diabetes and COPD, and making additional services available to people closer to their homes. It will also be designed to cope with the expected increased prevalence of LTC's (diabetes) in the population

Developing mental health services in primary and secondary care.

- Drive better performance/ outcomes through joint PCT-Borough commissioning and ensure Integration of mental health care into Polysystems
- Coordinate the adult mental health care pathway across mental health teams and primary and secondary services:
- Improved LOS and outcomes promoting social inclusion and reducing stigma in the community
- Reduced inpatient admissions and associated costs
- Discharge of mental health patients to appropriate rehabilitation facilities
- We have introduced a new primary care based service to improved access to psychological therapies
- We will improve services for drug misusers via a redesigned community based service

- A new care pathway for elderly mentally ill will be developed and introduced
- Continue with our mental health promotion initiatives
- Implement NSF Standards, “Twelve points to a safer service” and NICE Clinical guidelines on self-harm

Staying Healthy

- Reducing health inequalities – healthy living centres and projects for disadvantaged populations and prevention programmes targeted at older people, people with or at risk of mental health, drug & alcohol problems and people with sexual health needs
- Cardiovascular initiative – vascular prevention programme, interventions on obesity, physical activity, tobacco control and cardiac rehabilitation

Improving End of Life Care

- We will implement the recommendations of the Health care for South West London Clinical working Group
- We are redesigning our local acute hospital care pathway based on a Gold Standard Framework pilot
- An overall redesigned care pathway based on the HCfL commissioning guidance will be introduced 2010/11
- A Locally Enhanced Service (LES) will be introduced
- Gold Standard Framework for nursing homes will be introduced
- NHS Kingston is a Healthcare for London pilot site for End of Life Care
- We have undertaken a comprehensive needs assessment and service mapping

1.4 Settings of care

What shifts in activity, services and expenditure between the settings of care do you plan to achieve?

NHS Kingston is undertaking an ambitious programme of service redesign in developing polysystems. We will complete the development of a number of care pathways with our clinical leads which will impact on activity which currently flows into acute settings. These focus on the Healthcare for London pathways.

In the initial phase the following services will be delivered.

- Diabetes – establish a 4 tier service to move tier 1,2,3 patients out of acute care
- Rehabilitation services – Pulmonary care – Commission a service which reduces emergency admissions and early assisted discharge reducing inpatient activity
- Rehabilitation Services- Cardiac – commission a comprehensive service in the community.
- Rehabilitation Services- Stroke – redesign and augment current services available in the community
- Sexual Health – establish a 4 tier comprehensive sexual health service which will increase activity in the community and reduce the demand on existing acute based services.
- Dentistry – develop GDwSI to reduce routine dental extractions in acute care and instigate an assessment clinic to manage orthodontic referrals.
- Ophthalmology - Eye Care- Glaucoma management to reduce demand for follow up in acute care and improve the ongoing maintenance in the community closer to peoples homes.
- Diagnostics – developing direct access services in the community.
- The development of the integrated disabled childrens service will consolidate services at Moor Lane and the service will move from Kingston Hospital’s responsibility.
- The development of our local IAPT service will increase the number of people accessing the local service.
- The development of a memory clinic coupled with our falls services seeks to capture patients earlier, manage them proactively and reduce emergency events. This

underpins the implementation of the older peoples mental health service strategy.

1.5 Implications for provider configuration

What changes do you expect to your provider configuration during 2010/11 (acute, mental health, community and primary care)?

We plan to externalise our Provider Services by creating a new Social Enterprise Yourhealthcare. Approval by NHS London is anticipated to be given in March 2010.

Changes to the configuration of NHS Trusts in South West London will follow the publication of the Healthcare for South West London strategy.

Polysystems

This programme of work supports the delivery of the change in care settings mentioned above and is described in detail in our commissioning strategy plan. There are to be two systems within Kingston, one covering the south of the Borough and one in the north. The polysystems in Kingston are being developed so that they are flexible enough to meet the needs of groups of patients and individual patients. There is a broad spectrum of services contained in such a system ranging from the provision of all primary care services needed for the resident population through to those elements of care that will not be directly provided in the system but will be accessed and commissioned from specialist acute hospitals.

Our aim is that any patient will be able to have a diagnosis and treatment as part of the service provided in our polysystems and much of the outpatient work delivered in acute hospitals will be accessed via our spokes or if necessary for example urgent care on a 24/7 basis in one of the two hubs.

A hub will include Urgent Care, Diagnostics, GP services, Minor procedures, community services, outpatients, health information, Long Term Conditions Care, Pharmacy and mental health. The hub on the Kingston Hospital site will commence with the Urgent care centre in July 2010, the Surbiton development is planned to open 2013 with a first phase commencing at Tolworth hospital while the site is being redeveloped in 2010.

We will define this care using very specific care pathways. Which elements of the care will be provided within the polysystem and which elements will be provided by other providers and how the interface will be managed will be described in detail for each care pathway. Our clinicians have agreed to a phased approach to transform our services and implement pathways which are in line with our local needs and the HCfL strategy.

To deliver the expected benefits of our system and to accompany the service delivery and provision described above we must have strong system management. Our polysystem will be led by clinicians and supported by new management systems and processes. By this means we will bring together and organise and manage the services provided in primary care, acute hospitals, "Your Healthcare" and potentially the non NHS service providers.

Each polysystem will develop into the commissioner of services for the registered population and as such will be responsible for the spending of significant NHS resources.

The Polysystems will determine how resources are allocated to individual service lines to ensure the delivery of national and NHS Kingston priorities.

The successful introduction of a polysystem in Kingston that has developed as a way of working for primary and community care means that we must work with our neighbouring PCTs across South West London. A network is being established under the leadership of the Chief Executive of NHS Sutton & Merton and this will be supported by a small

implementation team which will be drawn from both PCT and sector resources.

In 2010 the NHS Kingston will establish a temporary polyclinic at Tolworth. The range of care offered will include an Urgent Care Centre, Services relocated from Surbiton Hospital site – therapies, diagnostics, screening, and existing out patients, new care pathways, Mental Health Out patients, general medical services. Urgent and unscheduled care services will be available 14 hours daily.

Our local Programme Board oversees the progress made in implementing this ambitious plan, with separate workstreams for the north and south of the Borough. In line with the development of Surbiton Hospital site as our polyclinic in the south of the Borough, a comprehensive Project Initiation Document will be considered by the NHS Kingston's Board in July 2010 which supports the submission of the Outline Business Case in October 2010.

The initiation of north Kingston will begin with the development of the Urgent Care Centre which is described below. The intention is to further develop the system with the development of the change in planned care pathways. As in the south of the Borough, strong clinical leadership and wider clinical engagement has been employed to make our challenging plans a reality.

SECTION 2: WORLD CLASS COMMISSIONING (PCTs and sectors)

What are your priority delivery areas in 2010/11 for year one implementation of:

These build on the priorities for 2009/10 and include an additional focus on board development, strategic alliance with RBK and a focus on productivity, quality and efficiency.

- Develop a workforce capable of delivering WCC
- Develop the organisation as local leader of the NHS
- Improve engagement with all community partners and the public, focusing on robust Strategic Alliance with RBK
- Improve engagement and communication with a wide range of clinicians
- Improve financial management and medium to longer term financial planning
- Improve information and intelligence to support commissioning
- Equip the organisation to stimulate the market and offer choice
- Complete the externalisation of the provider services
- Undertake a comprehensive board development programme
- Improve productivity, quality and efficiency

SECTION 3: PERFORMANCE (PCTs and Sectors)

Describe the detailed actions which will be taken in 2010/11 in relation to each of the strategic initiatives identified in section 1. Actions should be described to deliver the priorities in NHS London's planning guidance, and the DH Operating Framework.

The impact of each action on commissioned activity and finance must be quantified.

Strategic initiative 1a: Supporting Children and Young People

Programme:

Services for children and young people have been identified as a priority through Every Child Matters (ECM) and the National Service Framework for Children, Young People and Maternity Services (Children's NSF). NHS Kingston has an established plan with the Royal Borough of Kingston upon Thames focussing on the needs of Children and Young People (2006-2010). NHS Kingston will commission a fully integrated service for Children and Young People with Disabilities in the community in line with the needs clearly identified in the joint strategic needs assessment.

Linked pledges and targets:

Strategic objective of the Children's Trust Board.

VSB12 – CAMHS effectiveness

VSB15 – Self reported experience of patients and carers

VSC10 - Number of delayed transfers of care per 100,000 population

VSC11 & VSC20 – Proportion of people with long term conditions supported to be independent and in control of their condition

VSC15 - Proportion of deaths that occur at home

VSC29 – Hospital admissions caused by unintended or deliberate injuries

VSC32 Patient and user reported measures of respect and dignity in their treatment

Linked WCC outcome(s):

Improving life expectancy

Tackling health inequalities

Delayed transfers of care

Percentages of deaths that occur at home.

Actions:

When will the action be completed? (month)

Implement a Section 75 agreement to commission RBK to provide the integrated children's service

1 June 2010

Articulate and agree a joint commissioning role between health and social care for children and young people

1 April 2010

Articulate and agree a method for managing individual children's funding requests jointly with RBK.

1 April 2010

Commission services which reflect the implementation of the Joint CAMHS Strategy

31 March 2010

Performance measure(s):

Baseline level of performance:

Target level of performance each quarter:

Number of children accessing the service

This service is being negotiated and the

Q1

TBC

Q2

Waiting times for assessment Activity data relating to care package agreed Survey annual determining patient views Number of short breaks agreed and % uptake by family.	baseline is to be agreed prior to 1 April 2010	Q3	
		Q4	
Has a full range of CAMH services for children and young people with learning disabilities been commissioned for the council area? (rate1-4)	4		Q1-Q4: 4
Do 16 and 17 year olds from the council area who require mental health services have access to services and accommodation appropriate to their age and level of maturity? (rate1-4)	4		Q1-Q4: 4
Are arrangements in place for the council area to ensure that 24 hour cover is available to meet urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated? (rate1-4)	4		Q1-Q4: 4
Is a full range of early intervention support services delivered in universal settings and through targeted services for children experiencing mental health problems commissioned by the Local Authority and PCT in partnership' (Indicator in Development (rate1-4)	4		Q1-Q4: 4
Impact on activity and finance (commissioned / decommissioned): The decommissioning of services from Kingston Hospital has been agreed to enable the transfer of staff to RBK for 2010/11. The PCT has agreed to roll forward the historical funding for this element of the service to underpin the Section 75 agreement. Efficiency gains will be delivered by establishing a single commissioning team with RBK..			
Impact on workforce:			

Improved productivity of staff who are co located at Moor Lane. Improve the commissioning of services by establishing seamless commissioning with RBK. This will impact on teams within NHS Kingston and RBK.		
Risks:	High/ Medium/ Low risk	Mitigating actions:
The TUPE transfer of the staff delivering services to children with disabilities, developmental and complex health needs from Kingston Hospital to Royal Borough of Kingston is not achieved by 1 st April 2010	Medium	Roll forward current contractual arrangements with revised timescale to implement new currencies and tariffs by end of Quarter 1
New contract currencies and tariffs are not agreed for the retained children's services	Medium	Roll forward current contractual arrangements with revised timescale to implement new currencies and tariffs by end of Quarter 1
Strategic initiative 1b:		
Supporting Children and Young People - Safeguarding and promoting the welfare of children through the development of integrated children's services and community paediatrics. Nhs Kingston has undertaken a significant review of current processes to provide assurance that safeguarding processes are fit for purpose, this initiative reflects the implementation of the recommended actions drawn together by the LSGB		
Linked pledges and targets: Safe guarding The right to be treated to a professional standard of care. (NHS Constitution) All children will be well protected from being physically, sexually or emotionally abused or neglected. (Kingston Children and Young People's Plan)	Linked WCC outcome(s): Reducing health inequalities	
Actions:	When will the action be completed? (month)	
Focus on prevention and early intervention to safeguard children – review model for community paediatrics to develop local integrated services within polysystems	October 2010	
Review service specification for health visiting and school nursing in line with safeguarding priorities, Child Health Strategy, a part of polysystem and Children's Centre development.	July 2010	
Review contracts for named safeguarding professionals in the light of provider separation	April 2010	
Increase health resource to LSCB to provide multi agency support and leadership by £40,000	April 2010	
Increase GP input to case conferences	October 2010	
In line with advice from the NHSL safeguarding improvement team:	July 2010	

To review the resourcing and arrangements for designated professionals to strengthen commissioning for safeguarding across the health economy. Increase in 1pa for Designated Doctor .(£10,000)		July 2010	
To further develop safeguarding KPIs and review quarterly through CQR meetings with all provider organisations.		July 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Increase training uptake by all providers by 10%. Increase attendance at LSCB by all providers by 5%. Increase HV and SN use of CAF with vulnerable families. Identify and train GPwSIs for paediatrics Increase GP case conference attendance by 10%	80% 60 – 90% individual trajectories being agreed 0 To be established	Q1	
		Q2	
		Q3	
		Q4	Increase training uptake by all providers by 10%.- 90% 2 GPwSI
Impact on activity and finance (commissioned / decommissioned): Increased safeguarding activity through training, LSCB and case conference attendance. Increased safeguarding resource (£50,000) will support improved practice, early identification and prevention. Development of GPwSIs will support polysystem programme and reduce referral to secondary care.			
Impact on workforce: Children's workforce plans developed across health and social care to support safeguarding. Professional development - new HV and SN roles and integrated teams in line with national agenda. Aim to improve recruitment by 10% GP role development in child health.			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Difficulty to attract and recruit staff	Med	Skill mix models for career development Recruitment plans	
Insufficient trained staff to protect children	Med	Development plans support new integrated service models.	
Strategic initiative 1c: Maternity Services and the New Born			
Implement Year 2 of the service improvement programme for maternity services at Kingston Hospital <ul style="list-style-type: none"> • new service model and pathways to deliver integrated maternity care • increase community midwifery teams to deliver maternity care closer to home aligned to GP practices and children's centres focusing on the community hub / poly systems model • Extend choice for mothers 			

This initiative has a significant work plan, implemented through the Joint Health Improvement Programme for Kingston. The detailed plan is available which demonstrates the significant change programme already implemented in 2009/10. Detailed plan available.			
Linked pledges and targets: 12.6 week health and social care assessment/maternity booking Breast feeding rates UNICEF Baby friendly status Maternity Service improvement Programme Success Criteria Teenage Pregnancy rates		Linked WCC outcome(s): Tackling health inequalities Improving life expectancy Smoking Quitters	
Actions:		When will the action be completed? (month)	
Further roll out of the integrated teams to NHS Kingston women – to result in 5 community teams This is confirmed through the commitment to improve the ratio to meet the birthrate plus recommended rate of 1:30. Kingston Hospital has demonstrated improvement from 1:37 in 2008/9 to 1:34 in 2009/10. Through the maternity improvement and recruitment programme the planned increase the midwifery workforce is expected to lead to further improvement .		September 10	
To ensure increase in consultant hours meets CNST standards and the Case for Change as set out in the SW London review.. This work will be reviewed during the year as part of the revised SW London arrangements for maternity care		March 2011	
Fully implement the new maternity service model and care pathways		December 10	
Implement shadow performance monitoring and the provision of community midwifery team activity data		April 10	
Stock take against DH plans and develop an action plan to achieve UNICEF baby friendly status across Kingston including baby cafes and peer support		June 10	
Benchmark maternity services to identify opportunities for performance improvements and productivity gains		September 10	
Develop local tariff structure for non PbR maternity services e.g. scans and community midwifery for implementation in 2011/12		December 10	
Implement the 3 rd year of the SW London NICU/SCBU service developments		April 11	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
12.6 week assessment standard Breast feeding – initiation	12.6 week Breast feeding initiation	Q1	Activity will be as profiled in the acute contract activity schedule with

and uptake rates Contract volumes against activity model and plan Maternity Service benchmarks e.g. delivery to non delivery event ratio Teenage pregnancy rates Maternity Service improvement Programme Success Criteria JHIP Reporting Framework	and uptake rates Service Improvement Programme Success Criteria Maternity CQUINs Contracted activity volumes		Kingston hospital JHIP Reporting Framework MSIB Reports
		Q2	
		Q3	
		Q4	
VSB06 The percentage of women in the relevant PCT population who give birth to one or more live or still born babies of at least 24 weeks gestation where the baby is delivered by either midwife or a doctor and the place of delivery is either at home or in an NHS hospital who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and six days of pregnancy.	76.58% as at Q3	Q1	85%
		Q2	85%
		Q3	85%
		Q4	90.1%
OPT2 Infant Mortality: Breastfeeding initiation rates	86.54 as at Q3	Q1	91.7%
		Q2	91.7%
		Q3	91.7%
		Q4	91.7%
VSB08 Conception rate per 1,000 females aged 15-17.	23.20 (08/9)	Q1	18.4
		Q2	18.4
		Q3	18.4
		Q4	18.4
Impact on activity and finance (commissioned / decommissioned): Complexity A review of 200910 activity baseline modelling assumptions has identified that the baseline volume for outpatient attendances for complex women is understated and therefore additional investment is required. This will be negotiated using the acute contract.			

KHT data shows 2 obstetric consultant activities per booking therefore for NHSK based on delivery quota of 2240 require 4480 OP activities, this is an additional 1120 attendances above the 0910 baseline @ £78 equates to **£87k** required

Scans

A review of 200910 activity patterns has highlighted that an attrition factor needs to be applied to 12 week scan volume as has been applied to bookings (26%) This equates to an additional 582 scans above the 0910 baseline @ £78 - **£45k** required

Baby Friendly Initiative

Pump priming monies to support an increase in baby cafes and the establishment of peer support - **£50k** required

Impact on workforce:

The 2 year service development programme to introduce enhanced community midwifery services and the integrated teams requires an increase in midwifery and maternity support staff.

Maternity: recruitment plan to increase number of midwives and develop integrated community midwifery teams.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Inability of KHT to recruit the maternity staff to enable the new model of service to be fully implemented	Medium/Low	Review and modify the service model
Inability to access reporting data which is accurate and timely due to implementation of CRS. This challenges the ability to achieve the target	Medium	Work with the provider to improve reporting from the system, but initially accept manual counts.

Strategic initiative 2a: Supporting people with Long Term Conditions

Programme: Enable those people living with Diabetes to take control of their condition and access a four tier service where services will be available in primary care, the polysystem hub and the hospital.

This work stream undertaken through the Joint Health Improvement Programme has reviewed the needs of the local population, validated established disease registers and mapped current and future pathways. The resulting case for change has been considered by the Programme Board and a detailed business case has been drawn up. The procurement of tiered services is underway. The detailed plans are available.

Linked pledges and targets: Develop Polysystems within Kingston Develop Urgent and unscheduled care centres VSC23 / VSB 02 – CVD VSC27 – Diabetes EC17 – Diabetic Retinopathy Screening (DRS)	Linked WCC outcome(s) Improving life expectancy Tackling health inequalities Smoking quitters CVD mortality rates
Actions:	When will the action be completed? (month)
Commission tier 2 and 3 service for people with Diabetes	1 April 2010

Increase provision of Desmond training so all patients newly diagnosed as diabetic attend this and introduce the Foundation Desmond course to enable people who have had diabetes for a long time have the opportunity to improve their self management.		From 1 October 2010	
Diabetes – Increase Diabetic Retinopathy Screening (DRS) to NSC standards Provision of clinical governance support for the programme DRS remote desktop access for image viewing and outcome of treatment feedback		December 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Diabetes – Numbers of Diabetic patients to have DRS Increase the number of patients with diabetes attending Desmond training Number of patients with established diabetes attending Desmond Foundation training. Detailed performance measures to be determined in agreed contracts	DRS – 100% at December 2009 KPI data to be agreed and trajectories set.	Q1	<i>Desmond: 2 courses/month 1200 patients attending DRS</i>
		Q2	<i>Desmond: 3 courses/month 1200 patients attending DRS</i>
		Q3	<i>Desmond: 4 courses/ month Desmond Foundation Course: 1/month 1200 patients attending DRS</i>
		Q4	<i>Desmond: 4 courses/month Desmond Foundation Course:21/month 1200 patients attending DRS</i>
VSC27 Proportion of people on the diabetes register whose HbA1c has been measured in the previous 15 months, and is 7.5 or less	67.65 as at Q3	Q1	56.4%
		Q2	56.4%
		Q3	56.4%
		Q4	56.4%
EC17 Diabetic Retinopathy screening	99.48	Q1	95%
		Q2	95%
		Q3	95%
		Q4	95%
VSC23 Percentage of practices with PCT validated registers of patients without symptoms of cardiovascular disease	100%	Q1	89.7%

with an absolute risk of CVD events greater than 20% over the next 10 years.			
		Q2	89.7%
		Q3	89.7%
		Q4	89.7%

Impact on activity and finance (commissioned / decommissioned):

Diabetes – Locally Enhanced Service for Diabetes care plan (£180k)
 Reduced out patients at Kingston Hospital and Epsom General
 Increased activity in primary care and hubs
 Commission a Tier 3 service for diabetes care
 Increase Desmond provision: £60/patient:: £600/course
 Introduce Foundation Desmond provision: £60/patient: £600/course
 Commission training to deliver new care pathway: £20,000 in year 1 (primary care staff)
 DRS programme governance support: £50,000
 DRS remote desktop access for image viewing and outcome of treatment feedback £8,000 (capital bid)

Impact on workforce:

Diabetes – training for community staff and general practice staff to deliver Tier 1 & 2 care and deliver LES for diabetes. Impact on current provider staff with development of Tier 3 service. Training of staff to deliver Tier 3 service.
 DRS: appointment of clinical lead, programme manager, failsafe officer across the 3 PCT programme (third share) and failsafe administrator in secondary care (0.5WTE).
 Change in role of the specialist Diabetes team.
 Relocation of dietetic service into the community.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Lack of diagnostic equipment for LES	Medium	Ensure diagnostic equipment and software are budgeted for.
Delay in establishing accredited workforce to deliver service in primary care	High	Detailed transition plan will seek to manage the transformation of patient flows.
Lack of staff with skills to deliver new diabetes care pathway	Medium	Commission appropriate training for staff to deliver the service required.
Increased ascertainment of diabetes due to vascular checks and also increased prevalence of diabetes due to increasing numbers of people in higher risk groups eg BMI >27; certain BME groups	High	Develop contracts that are flexible with respect to the numbers of people with diabetes they are able to provide care for
Lack of assurance with DRS screening programme	High	Commission appropriate support to DRS programme. Commission remote desk top access for DRS programme between community screening and secondary care.

Strategic initiative 2b:

To commission a comprehensive community based rehabilitation service for people with

cardiac, respiratory disease or for those who had had a stroke. This work has already been significantly progressed through the Joint Health Improvement Programme with Kingston Hospital. In order to ensure sustainability of the service the PCT is looking to bring services together. A detailed revised business case reflecting the amalgamated approach is available.

(See also Vascular Prevention: Community Cardiac Rehabilitation)

<p>Linked pledges and targets: VSA05 – Supporting Activity Lines VSA14 – Quality Stroke Care (Outcome: Reduction in stroke related mortality and disability VSB15 Self reported experience of patients/users</p>	<p>Linked WCC outcome(s): Improving life expectancy Tackling Inequalities Smoking Quitters Delayed Transfers of care CVD Mortality rates</p>
--	--

Actions:	When will the action be completed? (month)
To complete a specification bringing all three, cardiac, stroke and pulmonary rehabilitation services together.	February 2010
Confirm activity anticipated activity shifts.	February 2010
To commission the service following a review of existing provider to understand the existing market.	March 2010

Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Number of people accessing an assessment Number of people with each condition. Number of DTOCs for Stroke Number of people staying on rehabilitative programme for each condition. Number of COPD emergency attendances.	TBC – activity forecast being collected.	Q1	TBC
		Q2	
		Q3	
		Q4	
VSC23 Percentage of practices with PCT validated registers of patients without symptoms of cardiovascular disease with an absolute risk of CVD events greater than 20% over the next 10 years	100%	Q1	89.7%
		Q2	89.7%
		Q3	89.7%
		Q4	89.7%
PCS05 Practice based registers - patients called for review	96.17 (March 09)	Q1	95.5%
		Q2	95.5%

		Q3	95.5%
		Q4	95.5%
VSA 14 Proportion of people who spend at least 90% of their time on a stroke unit	61.11 as at Q3	Q1	70.3%
		Q2	70.3%
		Q3	70.3%
		Q4	81.1%
Impact on activity and finance (commissioned / decommissioned):			
Increased investment in community based services for the delivery of the rehabilitation service (TBC)			
Reduced emergency acute respiratory attendances by 10%			
Reduction in delayed transfers of care			
Reduced ALOS			
Impact on workforce:			
Increased therapy capacity within the community.			
Training for GPs and other primary care staff to ensure familiarity with new care pathway.			
Stroke: workforce development for stroke unit specialist therapy and nursing staff.			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Delay in commissioning new service.	Medium	Stroke rehabilitation is already available, as is Cardiac rehab, there is a need to reinvigorate current programme in Respiratory care.	
Strategic initiative 2c:			
Programme: Vascular Prevention: Community Cardiac Rehabilitation			
Prevention of vascular disease has been identified as a priority both nationally and London-wide and is a priority detailed in the 'Next Review'.			
This initiative will also help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.			
Linked pledges and targets:		Linked WCC outcome(s):	
Target the causes of ill health and premature death.		CVD Mortality Rates	
Narrow the inequalities in premature death from vascular conditions including: CHD, CKD, DM, stroke, TIA and PAD		Smoking quitters	
Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas.		Tackling health inequalities	
Reduce the number of people developing cardiovascular disease.		Improving life expectancy.	
Prevent unplanned admission to hospital			
VSB01: All age all cause mortality rate			
VSB02: CVD Mortality rate in under 75s			
OPT21: CHD/stroke mortality rates			
Actions:		When will the action be completed? (month)	

Develop a community cardiac rehabilitation centre in Kingston that will house the following programmes: 'Healthy Hearts' - a conventional community cardiac rehabilitation programme (CCCRP) for ischaemic heart disease (IHD) patients who have not undergone a cardiac event. 'Heart Manual' – home cardiac rehabilitation programme for people who are unable to join a venue based cardiac rehabilitation programme. Community Cardiac Rehabilitation Programme for post-event patients.		October 2010	
Recruit staff to deliver the post-event cardiac rehabilitation programme		April/May 2010	
Launch the post-event cardiac rehabilitation programme		July/August 2010	
Target people living in disadvantaged areas and Black & Minority Ethnic Groups who are eligible to attend these programmes.		April 2010	
Provide accessible service serving all IHD patients in the borough		October 2010	
Provide individually designed programmes that meet patients need.		October 2010	
Develop a dynamic network with key stakeholders, and signpost patients to community resources that can help them maintain the changes they have achieved.		October 2010	
Audit uptake and outcomes with the aim of making improvements to the programme		first evaluation report in April 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Number of patients attending the 'Healthy Hearts' Programme Number of patients attending the 'Heart Manual' Programme Number of patients attending the post-event cardiac rehabilitation programme. Number of patients living in deprived communities who have attended a cardiac rehabilitation programme. The number of Black & Minority Ethnic patients who have attended a cardiac rehabilitation programme Under 75's CVD mortality rate.	Number of patients attending the 'Healthy Hearts' Programme/quarter = 20 (this programme is currently at a developmental stage) Number of patients attending the 'Heart Manual' Programme. This programme will be launched in February 2010. Number of patients attending the post-event cardiac rehabilitation programme. This programme will be launched in July 2010.	Q1	40 patients attending the 'Healthy Hearts' Programme 40 patients attending the 'Heart Manual' Programme 70 patients attending the post-event cardiac rehabilitation programme 150 people attending cardiac rehabilitation/quarter
		Q2	40 patients attending the 'Healthy Hearts' Programme 40 patients attending the 'Heart Manual' Programme 70 patients attending the post-event cardiac rehabilitation programme 150 people attending cardiac rehabilitation/quarter
		Q3	40 patients attending the

			'Healthy Hearts' Programme 40 patients attending the 'Heart Manual' Programme 70 patients attending the post-event cardiac rehabilitation programme 150 people attending cardiac rehabilitation/quarter
		Q4	40 patients attending the 'Healthy Hearts' Programme 40 patients attending the 'Heart Manual' Programme 70 patients attending the post-event cardiac rehabilitation programme 150 people attending cardiac rehabilitation/quarter

Impact on activity and finance (commissioned / decommissioned):

The net investments associated with this initiative are outlined below. Please note that these initiatives are still at a developmental stage and hence these initial estimates may be subject to change.

Healthy Hearts programme = £109K

Heart Manual Programme - £68K

Cardiac rehabilitation programme for post-event patients = £134K.

Impact on workforce:

Staff were recruited in 2009 to run the Healthy Hearts and the Heart Manual programme. Recruitment of staff to run the post-event Cardiac Rehabilitation Programme will be undertaken in April, this will include the appointment of:

1 WTE service coordinator at band 8A

1 WTE Coronary Rehabilitation professional at band 6

0.6 WTE Admin support at band 3

Risks:	High/ Medium/ Low risk	Mitigating actions:
Provider will fail to recruit clinical staff to run the post-event C.R. Programme	Medium	Contact recruitment agencies. Kingston Hospital to consider interim arrangement at QMR and /or use sessional staff from other C.R. providers.
Only a small number of patients will be referred to the programme	Medium	Publicise the programme to GPs and practice nurses and work with them to audit their CHD registers and identify patients requiring cardiac rehabilitation.
High attrition rate	Medium	Rehabilitation team to investigate reasons and report monthly
Low adherence rate at 6 & 12 months	Medium	Work with team to improve patient adherence
Rehabilitation team fail to	Medium	Monitor performance of the team on

rehabilitate the specified number of patients		monthly basis.
Lack of capacity at chosen venues	Medium	Rehabilitation team to consider alternative venues and times.
Strategic initiative 2d:		
<p>To commission comprehensive unscheduled care service with the development of an Urgent Care Centre at the front end of A&E. This work has already been established through the Joint Health Improvement Programme. The focus has been to review our current model of service which includes GPs within A&E to establishing a much stronger focus of primary care at the front door of the service. This work will also include the review of our Out of Hours provision, with the intention to assess the impact of both the UCC and extended opening hours on current commissioned model. This reflects the development of polysystems in the north of the borough.</p> <p>This also links with the polysystem programme where an additional UCC will be built into the intended hub in the south of the Borough.</p> <p>The implementation of the 30% non elective threshold will be via the contract with all providers. A detailed project plan is available.</p>		
<p>Linked pledges and targets:</p> <p>VSA06 Patient reported measure of GP access VSA07 Gp Access Extended Hours VSB01 All age all cause mortality VSB 13 Chlamydia screening VSB15 Self reported experience VSC 11 People with long term conditions VSC15 proportion of deaths that occur at home EC01 A&E 4 hour wait</p>	<p>Linked WCC outcome(s):</p> <p>Improving life expectancy Tackling health inequalities Delayed Transfers of care Proportion of the population screened for chlamydia End of life care</p>	
Actions:		When will the action be completed? (month)
Establish a local Project Board to agree the exact model and determine operational details of a UCC.		Febraury 2010
Produce a detailed plan reflecting the following: Type of integration Impact on workforce Patient streaming Single point of access Contractual arrangements Consultation		Feb 2010
To implement a revised care pathway which flows through a Urgent Care Centre on the Kingston Hospital site.		July 2010
To review and re commission the delivery of Out of Hours care (OoH).		March 2011
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
Number of people seen in	15% diversion of primary	Q1 15% diversion

services Conversion from UCC to A&E Emergency admission rates Proportion of people seen in primary care following visit to UCC Improved OoH performance on national benchmark	care care activity from A&E established	Q2	17%
		Q3	35%
		Q4	35%
VSA07 Percentage of practices in the PCT offering extended opening in compliance with Department of Health guidelines	100%	Q1	100
		Q2	100
		Q3	100
		Q4	100
VSA06 Satisfaction with GP practice opening times (%) – Patient Survey	81.13% (2009/10 survey-Q1&2)	Q1	
		Q2	
		Q3	
		Q4	87%
<i>Able to see a doctor fairly quickly (Q7)- patient survey</i>	86.20% (2009/10 survey-Q1&2)	Q1	
		Q2	
		Q3	
		Q4	86%
Rating of the care received from the out-of-hours GP service (Q36) – Patient survey	57% (2009/10 survey-Q1&2)	Q1	
		Q2	
		Q3	
		Q4	66%
Impact on activity and finance (commissioned / decommissioned): Conversion of at least 60% of current workload seen in A&E to UCC. Reduction in emergency admissions by 10%, noting the potential increase in conversion of attendances to admissions from A&E due to the change in caseload. Reduction in hours of OoH service and the re commissioning of the service			
Impact on workforce: Change in role for both GPs and A&E staff.			

Reduction in use of OoH care			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Delay in agreeing the operational detail of the new model	Medium	A robust programme management approach has been adopted in Kingston overseen by a CEO led Board. Senior leadership commitment enables the early resolution of issues.	
Delay in capital development programme necessary to establish service	Medium	An early review of remedial solutions will be made in the first stages of implementation	
Strategic initiative 2e :			
<p>Delayed transfers of care has been an issue in Kingston. An audit of all delays in acute and community beds has identified a number of actions. These are being resolved but a programme of work is needed to bring about the sustainable change that will improve the patient experience within Kingston.</p> <p>As with many large and complex work streams this work will be progress through the Joint Health Improvement Programme.</p> <p>Aim: To identify the bottlenecks and barriers to effective discharge across the end to end patient journey and then to support the implementation of agreed solutions to enable sustainable improvement to the patient journey.</p>			
Linked pledges and targets: VSC10 Delayed transfers of care per 100,000 population aged 18+		Linked WCC outcome(s): Tackling Inequalities Reducing the number of DTOCs	
Actions:		When will the action be completed? (month)	
Engage the expertise of an individual(s), skilled in transformation techniques and facilitation.			
Establish the current end to end journey experienced by patients living in Kingston by process mapping			
Obtain actual feedback from people who have experienced the journey using discovery interviewing			
Produce a detailed project plan to enable the delivery of effective discharge.			
Facilitate local health and social care staff to actively participate in mapping, planning and then delivery of agreed transformation			
Establish a number of specifically focussed working groups that will deliver improvements in the patient's journey.			
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
VSC10 Delayed transfers of care per 100,000	12.54 (as at Q3 09/10)	Q1	8.55
		Q2	8.55

population aged 18+		Q3	8.55
		Q4	8.55
<p>Impact on activity and finance (commissioned / decommissioned): The intended outcome of this work is to reduce the number of delays in acute and community settings. The decommissioning of DSTs undertaken by the Intermediate Care Team in the Acute Hospital setting and a refocus of this resource into the community to provide care packages in peoples homes, and to manage the reduction in unnecessary attendances in acute care. Review of existing enhanced services incenivising the improved primary care management people with LTC and older people with more complex needs. This will be coupled with a reduction of unplanned admissions. Focus on CQIN –reflecting the national and London priorities.</p>			
<p>Impact on workforce: Anticipated greater consistency in acute care to manage people effectively through the system, shared understanding of Expected day of discharge.</p>			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Lack of engagement of clinicians in undertaking redesign	Medium	Support from Partnership with Senior buy in and incentives provided through CQIN Use of patient views through discovery interviewing.	
Strategic initiative 2f:			
<p>This project focussing on patient and public engagement will help deliver the Health for London key themes of improving the health and wellbeing of Londoners and sits within the Healthcare for London 8 care pathways – Long term conditions.</p> <p>This programme will be delivered through a variety of out of hospital care settings including primary care and third sector organisational settings; this will be reviewed inline with the polysystem development. Self-management/Self-care has been included as a key component of the Polysystem Development Plan</p>			
<p>Linked pledges and targets: Improved communication about self care options - Strategic Plan. Your health, your way - a guide to long term conditions and self care' December 2009 DH. NHS 2010 – 2015 from good to great DH December 2009 –providing education and support for people with COPD and asthma through self management programmes / action plans, thus reducing hospital admissions and ensuring adherence to drug therapy.</p>		<p>Linked WCC outcome(s): Tackling Inequalities, Improving Life Expectancy CVD mortality.</p>	
Actions:		When will the action be completed? (month)	
Recruitment of permanent Expert Patient Programme		Completed Dec 08	

Coordinator			
Coordinator to be trained to assess volunteer tutors		March 2010	
Coordinator to be trained to be a train the Trainer		Jan 2011	
Recruitment of 2 volunteer tutors		1 in October 2010 1 in January 2011	
Run 8 courses to reach at least 100 patients		April 2010 – March 2011	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
<p>KPIs: 2009 / 10 Baseline data pre course gathered from September 2009 to March 2010: GP attendees A&E activity Other hospital attendances End of year evaluation of impact and patient satisfaction</p> <p>2010/11 Pre course data for new courses Post course data collected quarterly End of year evaluation of impact and patient satisfaction</p>	<p>2009/10 This is the first year of collecting data and there has been some activity available A&E activity being collected through performance team quarterly. GP attendee data will be available from March 2010.</p> <p>2010 /11 Pre course data for new courses Post course data collected quarterly End of year evaluation of impact and patient satisfaction Hold 8 courses throughout the year To reach at least 100 Long Term Conditions patients</p> <p>A GP/Clinical Referral System has been drawn up and is being disseminated across the NHSK Area, providing GPs and other Primary Care Health Professionals the facility for referring long-term condition patients that meet appropriate criteria onto an Expert Patients Programme.</p> <p>Read Codes have been allocated to the Expert Patients Programme Referral System in</p>	Q1	<p>To reduce the number of attendances by patients post course to GP and hospital care setting.</p> <p>% target will be set for 2011/12 using 2010/11 as a baseline. [5% target is anticipated]</p>
		Q2	
		Q3	
		Q4	

	<p>anticipation of the establishment of a Local Enhanced Services Agreement. This will ensure that General Practices are encouraged to use the Expert Patients Programme as fully as possible. A referral pathway with Read Codes is being circulated to all GP practices and other appropriate clinical sites.</p> <p>The outcome of courses is currently monitored by an immediate Post-Course Questionnaire. A 12 month follow-up Questionnaire utilising the same Question Set for Outcome/Perceived Benefit will be sent to each attendee and evaluated on an ongoing basis. This will enable NHSK to produce a snapshot of the course outcomes at the 12 month mark and summarise to the required reporting date.</p>	
--	---	--

Impact on activity and finance (commissioned / decommissioned):

The programme increases the self management of local people with a long term condition, there will be a reduction in activity and cost for GP appointments / prescriptions, referrals and admissions.

Project impact - reduction in hospital attendances.

Impact on workforce:

EPP coordinator substantive post to be trained as

- Assessor March 2010
- Train the trainer January 2011

The programme is dependant on recruiting, training and developing a volunteer workforce. Training to be provided to all programme volunteer delivery staff either via EPP Coordinator or Expert Patient Programme Community Investment Company.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Capacity to deliver according to demand	Low	The ability to recruit capable new tutors.
Lack of Tutors with recognised Competencies	Low	NHS K has access to Training and Development
Not be able to get the number of identified patient on the course through GP referral	Low	Promotion and Education of GPs and other clinicians by the EPP coordinator.

Strategic initiative 3a: Develop Mental Health Services in primary and secondary care			
To undertake a comprehensive review of in patient care and look to shift activity into a community setting by strengthening the provision of community mental health services.			
NHS Kingston and South West London and St Georges have committed to improve services through the existing Mental Health Project Board. This will be CEO led.			
Linked pledges and targets: In line with programme budgeting data seek to decommission a proportion of in patient beds and improve the provision of community services.		Linked WCC outcome(s): Tackling inequalities Reduce DTOCs	
Actions:		When will the action be completed? (month)	
Review current care model adopted by South West London and St Georges Mental Health Trust (SWL&StG)		June 2010	
Undertake benchmarking of the existing service		April 2010	
Re-specify service to ensure timely access to care for people in the community, designing appropriate packages to manage people effectively in the community.		June 2010	
Commission new service via a contract variation		April 2010	
Establish joint commissioning post with Royal Borough of Kingston		April 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Number of people admitted for inpatient care Referral rates into CMHT Waiting time for people to be seen by CMHT		Q1	
		Q2	
		Q3	
		Q4	
Routine use of the national MH clustering tool (HoNOS-PbR) (source: CW - proposed MH CQUIN)	Longstopped in contract	Q1	25%
		Q2	50%
		Q3	75%
		Q4	100%
Impact on activity and finance (commissioned / decommissioned): Reduction of in patient activity – reduction in investment of £500,000 Continued reduction in continuing care capacity			
Impact on workforce: Review and reconfiguration of CMHT's Establishment of single consultant model for the management of inpatient activity			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Delay in articulating required change	High	Establishing the joint commissioning post will provide a dedicated resource to support the implementation of any changes.	

Inability of SWL&StG to instigate transformation	High	CQUIN to be developed will target the reduction in ALOS and in patient activity	
Strategic initiative 3b:			
Establish accredited Improving Access to Psychological Therapy Service to be delivered via Hub and spoke poly system model.			
Linked pledges and targets: VSB04 Suicide VSB14 Drug treatment		Linked WCC outcome(s): Targeting Inequalities Reducing mortality Number of drug misusers in effective treatment	
Actions:		When will the action be completed? (month)	
Review pilot programme which has been running for 12 months.		Jan 2010	
Review current IT system		Feb 2010	
Articulate CQIN for both providers to enable improved working model		Feb 2010	
Agree contract with KPIs which delivers an accredited programme		Feb2010	
Accept agreed remedial action plans from providers to deliver all elements of the service.		March 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Monthly activity by referrals, onward destination Length of time in treatment Re referral rates DNAs by level of care and practitioner	Standards agreed in care pathway and now baseline being agreed.	Q1	
		Q2	
		Q3	
		Q4	
All referrals should be seen within 48hrs (2 working days)	KPIs in Service Spec agreed at IAPT meeting 24/02/10	Q1	100%
		Q2	100%
		Q3	100%
		Q4	100%
At step 2 1 st definitive treatment (second session)to be within 18wks		Q1	100%
		Q2	100%
		Q3	100%
		Q4	100%
At step 3 1 st definitive treatment (1 st treatment is as part of 1 st meeting as is therefore at assessment) to be within 18 weeks		Q1	100%
		Q2	100%
		Q3	100%
		Q4	100%
Referrals into RBK workstart team responded		Q1	100%
		Q2	100%

to within 1 week.		Q3	100%
		Q4	100%
Impact on activity and finance (commissioned / decommissioned): Increase in activity to reach benchmark average			
Impact on workforce: Increased number of trainees. Staff enabled to work remotely in line with service model.			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
The current providers of level 2 and 3 are unable to establish robust relationships that allow for the delivery of a robust model of care	High	If no improvement in delivery a decision will be made to re commission the service	
Enabling the provision of training to 11 trainees identified for NHSK in October 2010	High	If no improvement in delivery a decision will be made to re commission the service	
Unable to secure suitable accommodation for delivery of new service	Medium	Review will identify alternative accommodation	
Strategic initiative 3c:			
Improve the delivery of services for substance misusers access timely and appropriate care. To be completed			
Linked pledges and targets: VSB04 Suicide VSB14 Drug treatment		Linked WCC outcome(s): Drug Users in effective treatment Tackling health inequalities Reducing Mortality	
Actions:		When will the action be completed? (month)	
Following a comprehensive review of drug and alcohol services in Kingston develop a plan to transform care pathways.		April 2010	
Establish commissioning project board		Feb 2010	
Develop methodology for establishing a managed clinical network to champion and then lead on the implementation of a respecified service.		June 2010	
Implement the plan and use contract variations to commission desired model of care.		Dec2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
VSB14 The number of drug users using crack	284 (as at Sept 09)	Q1	290
		Q2	290

and/or opiates recorded as being in structured drug treatment in a financial year who were discharged from treatment after 12 weeks or more, or who were discharged from treatment in a care planned way.		Q3	290
		Q4	290
Impact on activity and finance (commissioned / decommissioned): Unknown at this time			
Impact on workforce: Unknown at this time			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Lack of engagement by providers	Medium	Production of robust plan including providers of the service in redesign process	
Inability to achieve target for people staying in treatment	High	Redesigned service and improved monitoring of delivery are anticipated to improve performance	
Strategic initiative 4a: Staying Healthy			
Programme: Vascular Prevention, NHS Health Checks Vascular prevention has been identified as a priority both nationally and London-wide and is a priority detailed in the 'NHS Next Stage Review'. This initiative will also help to deliver the Healthcare for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.			
Linked pledges and targets: Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. VSB01: All age all cause mortality rate VSB02: CVD Mortality Rate in under 75s OPT21: CHD/stroke mortality rates		Linked WCC outcome(s): CVD Mortality Tackling health inequalities, improving life expectancy Smoking Quitters.	
Actions:		When will the action be completed? (month)	
Commission local GP Practices to deliver a phased programme of vascular checks for everyone aged 40-74, starting with the people identified to be at high CVD risk.		March 2010	
Assess and stratify the cardiovascular risk of all practice patients between 40 -74 years of age and invite high risk patients to attend the NHS Health Check.		Annually	

Commission a community vascular risk assessment programme.		February/March 2010	
Pilot the delivery of the NHS Health Check programme in community pharmacies located in the deprived areas of Kingston.		February/March 2010	
Employ social marketing techniques to increase the accessibility of the programme to people from Black and ethnic Minorities; people living in disadvantaged areas; travellers, homeless and refugees who all have poorer health than the general population.		December 2010	
Ensure that all providers of this programme are targeting BME/socially disadvantaged populations or geographical areas where they reside.		Annually	
Target hard to reach groups by providing these checks in accessible venues in their communities.		Annually	
Provide a menu of CVD risk management programmes that include; dietary advice, weight management, stop smoking, exercise referral, walking for health, active aging, alcohol management, educational programme for people with diabetes.		June 2010	
Work with the CVD risk management programme leads to raise the profile of these programmes and encourage providers to refer more patients to them.		Annually	
Monitor and evaluate the delivery of this programme.		First report in April 2010 then annually	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
The percentage of people aged between 40 -74 who have received a NHS Health Check (VSC23) - - <i>this target will be introduced in April 2010.</i>	The PCT has launched the NHS Health Checks programme in General Practice in November 2009. Extracted data from practices in January 2010 will define the baseline level of performance for this programme.	Q1	1,807 checks to be delivered in General Practice 188 checks to be delivered in community pharmacies 600 checks to be delivered in the community
		Q2	1,807 checks to be delivered in General Practice 188 checks to be delivered in community pharmacies 600 checks to be delivered in the community
		Q3	1,807 checks to be delivered in General Practice 188 checks to be delivered in community pharmacies 600 checks to be delivered in the community
Impact on activity and finance (commissioned / decommissioned):			
A. Number of NHS Health Checks undertaken annually:			

Number of checks to be delivered in General Practice = 7,227
 Cost = £326,000
 Number of checks to be delivered in community pharmacies = 750
 Cost = £25,000
 Number of checks to be delivered in the community = 2,400
 Cost = £120,000
 Total annual number of checks to be delivered = 2,594
 Total annual cost = £471,000

B. Number of people requiring CVD risk management programmes:

Stop Smoking = 413
 Brief exercise chat = 1,084
 Physical activity programmes = 1,793
 Obesity intervention: 1,152
 CKD diagnosis = 327
 Anti HT prescription = 860
 Statin prescription = 628
 Diabetes = 127
 IGT diagnosed = 304
 Total = 6,688

Impact on workforce:

The three components of this programme will be delivered in General Practice, community pharmacy, and by an external provider. There will be increased data analysis and contract monitoring requirements as a result of implementing this programme for the local workforce of the PCT.

To support patients who are found to have modifiable risk factors for CVD, the PCT is expanding many of the risk management programmes to deal with the extra demand that will be placed upon them as a result of introducing the NHS Health Check Programme. These plans are outlined in the Obesity, Physical activity, Smoking Cessation and Diabetes sections of this document.

Risks:	High/ Medium/ Low risk	Mitigating actions:
High cost of the check will limit the number of checks undertaken annually	Medium	Market analysis undertaken to ensure competitive contract rates are achieved.
Complexity of programme delays planned implementation dates.	Medium	Detailed project management arrangements.
Scheme does not deliver anticipated improvements due to poor uptake for assessments and follow up interventions	Medium	Social marketing and market research to ensure most appropriate pathways commissioned. Ongoing evaluation and review.
Unsuccessful tendering for the provision of services within timescales	Medium	Robust and detailed project plans. Provider engagement sessions.
Overspending due to undertaking larger number of	Medium	Highlight the risk of overspending and add it to risk register.

vascular checks than estimated.		
Strategic initiative 4b:		
<p>Programme: Physical activity promotion A reduction in prevalence of obesity through a healthier lifestyle including physical activity will contribute to vascular prevention which has been identified as a priority both nationally and London-wide and is a priority detailed in the 'NHS Next Stage Review'.</p> <p>This initiative will also help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.</p> <p>This programme will be delivered through a variety of care settings including primary care, the voluntary sector, local authority and commercial leisure settings.</p>		
<p>Linked pledges and targets: Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. Reduce the number of people developing certain cancers. Reduce the number of people developing diabetes.</p> <p>Linked with the National Vascular Checks (NHS Checks) programme VSA14: stroke care VSB01: All age all cause mortality rate VSB02: CVD Mortality Rate in <75s VSB03: Cancer mortality rate in <75s VSB09: Diabetes OPT21: CHD/stroke mortality rates OPT22 – Obesity Physical activity target: Increase participation in physical activity across Kingston to 35% by 2012- joint target as outlined in Kingston Community Plan</p>	<p>Linked WCC outcome(s): CVD Targeting health inequalities Improving life expectancy. Work with community partners Engage with public & patients</p>	
Actions:		When will the action be completed? (month)
Develop Get Active exercise referral and physical activity (Including cycling) programmes to support the demand of referrals from the NHS Health Checks.		Ongoing
Renew contracts for exercise referral specialist posts in order to ensure on-going delivery of Get Active exercise referral programme.		By February 2010
Expand opportunities for community green gym concept and allotment programmes, linking in with cook and eat and obesity agenda		By May 2010
Increase Walk4Life and Bike4Life programmes particularly in areas of deprivation and to BME		By May 2010

communities			
Introduce weekly Parkrun programme to engage adults and children in outdoor physical activity focussing on a priority neighbourhood.		By April 2010	
Undertake monitoring and evaluation of all programmes.		Ongoing	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
<p>Referrals to Get Active and physical activity programmes via the NHS Health Checks, target of 1,793 patients from all sources.</p> <p>Number of referrals from BME and disadvantaged communities.</p> <p>Number of referrals completing programmes</p> <p>Short and long term effectiveness of programme outcomes based on national target of 1% of people continuing to be active.</p> <p>Change4Life walking and cycling initiatives: Walk4Life - increase in volunteer leaders to deliver health walks by 100%. Increase participation in walking programmes by 20% Bike4Life – increase levels of cycling by 70%</p> <p>Community green gyms/allotments – increase participation by 50% Parkrun – increase participation by 100%</p>	<p>Deliver Get Active and physical activity programmes to NHS</p> <p>Check patients assessed at risk:</p> <p>GPs – 1,345 annual Pharmacies – 90 annual Community – 346 annual</p> <p>Change4Life: Walk4Life programme – 650 annual; Bike4Life programme – 40 annual.</p> <p>Community green gyms – to start April 10 – no baseline established. Parkrun – to start April 10 – no baseline established.</p>	Q1	
		Q2	
		Q3	
		Q4	<p>GPs – 20% increase Pharmacies – 20% increase Community – 10% increase</p>
Refer to obesity targets			
<p>Impact on activity and finance (commissioned / decommissioned): Get Active exercise referral staff - £96,5k new investment Get Active staff - £30k existing funding Physical Activity staff - £42k existing funding Physical Activity operational - £10k new investment</p>			
<p>Impact on workforce: Additional staff resources employed to expand Get Active exercise referral programme to meet the demand of the additional workload generated by the NHS Health Checks</p>			

programme.		
Risks:	High/ Medium/ Low risk	Mitigating actions:
Cannot meet demands of referral numbers into Get Active.	High	Establish contingency plan & introduce patient waiting list. Expand programmes and utilise other community facilities/providers to deliver activities.
Insufficient referrals emanating from NHS Checks into Get Active & physical activity programmes.	Medium	Improve tracking process to determine early identification of low referral rates and introduce plan of action to improve social marketing to GPs and other referrers & community.
Review of exercise referral specialists six month contract not renewed.	High	Look into commissioning leisure centre instructors or independent specialist providers
Post of Change4Life officer (joint PCT/RBK post) contract not renewed.	Medium	Explore external funding opportunities and review programme structure.
Strategic initiative 4c:		
Programme: Smoking Cessation		
Vascular disease prevention has been identified as a priority both nationally and London-wide and is a priority detailed in the 'NHS Next Stage Review'. In the last year we widened the membership of the Tobacco Alliance across the borough, investigate and implement the actions from the 10 high impact changes to achieve tobacco control issued from the DH.		
This initiative will also help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.		
Linked pledges and targets: VSB01 All age all cause mortality VSB02 CVD Mortality VSB05 Smoking Quitters	Linked WCC outcome(s): CVD Tackling health inequalities Improving life expectancy	
Actions:	When will the action be completed? (month)	
Further develop the in-house stop smoking service at Kingston Hospital, train all staff in brief interventions and ensure that every smoker is referred to the service and offered nicotine replacement therapy. Work with the Hospital to implement truly Smokefree Grounds. Consider this as one element of the CQUIN smoking cessation target in 2010/11	December 2010	
Evaluate the Young People Smoking and Cannabis pilot project and implement the recommendations in 2010/11	December 2010	
Develop further and implement evaluation from the mental health stop smoking advisor at SWL&StG's MHT	Ongoing	
Develop programmes and target disadvantaged areas working with community development workers and	Ongoing	

Children's Trust			
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
<p>Increased number of smokers quitting including pregnant smokers and contributing the KPI's</p> <p>Increased number of young people quitting smoking and contributing the KPI's</p> <p>Increased number of people with mental health problems and staff quitting smoking and contributing the KPI's</p> <p>Increased number of people from routine and manual workers and those from disadvantaged groups mental health quitting smoking and contributing the KPI's</p>	<p>400 referrals for 2009/10</p> <p>Estimated 20 under 18's using the service in 2009/10</p> <p>High prevalence of people with mental health smoking and low take up of services, High prevalence working with users of mental health services smoking</p> <p>High prevalence of smoking of people from disadvantaged groups</p>	Q1	<p>200 referrals</p> <p>20 under 18's using the service</p> <p>20 people with mental health problems using the service</p> <p>100 people from disadvantaged areas using the service</p>
		Q2	<p>200 referrals</p> <p>20 under 18's using the service</p> <p>20 people with mental health problems using the service</p> <p>100 people from disadvantaged areas using the service</p>
		Q3	<p>200 referrals</p> <p>20 under 18's using the service</p> <p>20 people with mental health problems using the service</p> <p>100 people from disadvantaged areas using the service</p>
		Q4	<p>200 referrals</p> <p>20 under 18's using the service</p> <p>20 people with mental health problems using the service</p> <p>100 people from disadvantaged areas using the service</p>
OPT02 Infant Mortality: Smoking during pregnancy	5.56% as at Q2	Q1	6.0%
		Q2	6.0%
		Q3	6.0%
		Q4	6.0%
VSB05 Smoking quitters per 100,000 population aged 16 and over.		Q1	111.77

		Q2	96.13
		Q3	116.24
		Q4	172.88
<p>Impact on activity and finance (commissioned / decommissioned): Increase in numbers of smokers quitting Increase awareness and numbers of young smokers quitting. Funding already identified for this project Youth Worker to be identified to carry out this project Increase awareness and numbers of people with mental health problems quitting. Funding already identified for this project Increase awareness and numbers of people from disadvantaged areas quitting. Funding already identified for this project</p>			
<p>Impact on workforce: Staff already appointed from Choosing Health funding Youth Worker to be identified to carry out this project Mental Health advisor already identified Core service, primary care services and pharmacists in disadvantaged areas trained</p>			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Non-engagement of staff at Kingston Hospital	Medium	Ownership by Director level at Kingston Hospital	
Non-engagement of Young People	Low	Promotion and awareness raising by youth workers and substance misuse staff	
Non-engagement of Smokers	Low	Promotion and awareness raising by staff at SWL & St G MHT	
Non-engagement of Smokers	Low	Promotion and awareness raising	
Strategic initiative 4d:			
<p>Programme: Adult Obesity A reduction in prevalence of obesity will contribute to vascular prevention which has been identified as a priority both nationally and London-wide and is a priority detailed in the 'NHS Next Stage Review'.</p> <p>This initiative will also help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.</p> <p>This programme will be delivered through a variety of care settings including primary care, the voluntary sector, local authority and commercial leisure settings.</p>			
<p>Linked pledges and targets: Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. Reduce the number of people developing certain cancers. Reduce the number of people developing diabetes.</p>		<p>Linked WCC outcome(s): CVD Targeting health inequalities Improving life expectancy. Work with community partners Engage with public & patients</p>	

Linked with the National Vascular Checks (NHS Checks) programme VSB01: All age all cause mortality rate VSB02: CVD Mortality Rate in <75s VSB03: Cancer mortality rate in <75s OPT21: CHD/stroke mortality rates			
Actions:		When will the action be completed? (month)	
Adult Cook & Eat		March 2012	
Rosemary Conley Weight Management Programme		March 2010 (evaluation may extend)	
GP/ Community Pharmacy based Weight Management Programme		March 2012	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
KPIs relating to the number of programmes delivered in Kingston, numbers of adults attending programmes, percentage reporting positive change.	Adult Cook & Eat: 4 organisations delivering at 5 different sites, providing 13 programmes in Year 1, expected reach 106 adults Rosemary Conley: approximately 10 referrals per quarter, no other data currently available, evaluation of current scheme will guide future commissioning intentions GP/ CP Weight Management Programme: New programme, therefore no current baseline	Q1	
		Q2	
		Q3	
		Q4	106 adults completed weight management programme C&E
Impact on activity and finance (commissioned / decommissioned): LES with Primary Care (GPs and Community Pharmacies) Minimum of 5 different organisations commissioned Adult Obesity: £124K new investment			
Impact on workforce: Training to be provided to all programme delivery staff either via commissioned organisation or NHS Kingston			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Target not reached in Adult Cook & Eat programme	Low	Marketing solutions as part of project performance management but demand and or need is currently high. These programmes are specifically targeted.	
Rosemary Conley referral rates not reached	Low	Patients will be able to access these scheme though the NHS Health Checks programme	

Practices and pharmacies don't sign up and patients not recruited	Low	Practices and pharmacies for the pilot are already signed up (only 2 pharmacy spaces left), patients will be actively recruited in line with eligibility criteria
Strategic initiative 4e:		
<p>Programme: Tackling childhood obesity</p> <p>A reduction in prevalence of obesity will contribute to vascular disease prevention which has been identified as a priority both nationally and London-wide and is a priority detailed in the 'NHS Next Stage Review'.</p> <p>This initiative will also help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.</p> <p>This programme will be delivered through a variety of care settings including primary care, the voluntary sector, local authority and commercial leisure settings.</p>		
<p>Linked pledges and targets: VSB09 Childhood Obesity</p> <p>In the long term: Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. Reduce the number of people developing certain cancers.</p>	<p>CVD Targetting health inequalities Improving life expectancy. Work with community partners Engage with public & patients</p>	
Actions:		When will the action be completed? (month)
MEND (Weight Management programme for 8 -11 year olds)		Currently in place
Cook & Eat in Children's Centres		July 2010 (pilot)
Chef's Club in Primary Schools		March 2010 (pilot)
Weight Management Programme 5 – 7 year olds		March 2011
Weight Management Programme 11 – 14 year olds		March 2011
National Child Measurement Programme		December 2011
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
KPIs around number of programmes delivered in Kingston, numbers of families attending programmes, percentage reporting positive change, % obesity, % coverage (children measured) in Kingston	MEND: 3 programmes per year, 6 to 8 families per programme, 70% reporting positive change Cook & Eat in Children Centres: 7 programmes per year (to be evaluated and expanded if appropriate), 6 to 8	Q1
		Q2
		Q3
		Q4

	<p>families per programme, 50% reporting positive change</p> <p>Chef's Club: 3 schools running 1 programme each in one academic term (Quarter 4 09/10), 6 to 8 children with 6 to 8 parents/ carers, 50% reporting positive change</p> <p>Weight Management Programmes: 6 programmes per year per age group, 15 children per programme, 70% reporting positive change</p> <p>National Child Measurement Programme: Reception Year 7.6% obesity, 92.14% coverage, Year Six 16.4% obesity, 89.75% coverage</p>		
VSB09 Percentage of children in Reception with height and weight recorded who are obese.	7.61 (March 09)	Q1	
		Q2	
		Q3	
		Q4	8.2%
VSB 09 Percentage of children in Year 6 with height and weight recorded who are obese.	16.38%	Q1	
		Q2	
		Q3	
		Q4	16.0%
<p>Impact on activity and finance (commissioned / decommissioned): Minimum of 3 different organisations commissioned Childhood Obesity: £77K of the total £256K obesity existing budget (MEND is currently Big Lottery funded)</p>			
<p>Impact on workforce: Training given to all programme delivery staff either via commissioned organisation or NHS Kingston</p>			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
MEND attendance low	Low	If programmes are cancelled, funding is not provided by the Big Lottery fund	

		therefore no risk financially, however, low uptake requires potential alternative services to be reviewed that may have higher cost. This funding has already been agreed through 2010/11 financial planning.
Children Centre facilities not provided for Cook & Eat	Low	Cook & Eat required as part of RBK's Children & Young People's Plan, contract currently being agreed with Children's Centre commitment
Schools facilities not provided for Chef's Club	Low	Three schools agreed to commit to pilot to be evaluated for further programme development
New Weight Management programmes not commissioned	Medium	Investigative research already underway with pilot 5-7 year old programme running in Q4 09/10
Strategic initiative 4f:		
Programme: Breastfeeding initiation and maintenance		
This initiative will help deliver the Health for London key themes of reducing health inequalities and improving the health and wellbeing of Londoners. It forms part of the Staying Healthy, Maternity and Children's Service pathways. Support for breast feeding has also identified in the NHS plan 2010-2015 (Section 2.14, p21).		
Linked pledges and targets: VSB11: breastfeeding prevalence at 6-8 weeks and data coverage VSCL4: breastfeeding initiation at birth.		Linked WCC outcome(s): Tackling health inequalities Improving life expectancy CVD and reduction in cancer mortality reduction (prevention in the long term)
Actions:		When will the action be completed? (month)
Increase the number of community based breastfeeding support groups from 3 to 5		December 2010
Introduction of a Breastfeeding Policy for the Community implemented by community providers		December 2010
Provider organisations to have achieved 'Certificate of Intent' for UNICEF Baby Friendly Status		February 2011
Distribution of 'Bump to Breast' DVD to all pregnant women in Kingston via provider organisations		May 2010
All frontline staff working with women and families to have undertaken breastfeeding awareness training		Rolling programme
Appoint a Breastfeeding Co-ordinator for Kingston as per the Operating Plan for 2009/10, which was deferred.		May 2010
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
Training log for frontline staff		
Positive user feedback		

OPT2 Infant Mortality: Breastfeeding initiation rates	86.54 as at Q3	Q1	91.7%
		Q2	91.7%
		Q3	91.7%
		Q4	91.7%
Prevalence of Breastfeeding at 6-8 weeks	74.7 as at Q3	Q1	72.25
		Q2	72.8%
		Q3	73.3%
		Q4	74.1%

Impact on activity and finance (commissioned / decommissioned):

Activity:

Decreased emergency admissions for infant feeding problems.

Potentially: 47% fewer cases of otitis media; 80% fewer cases of gastroenteritis; reduction of 2.5% in cases of asthma.

Finance:

- Increase the number of community based breastfeeding support groups from 3 to 5. Financial impact: £6,000
- Acute & Community provider organisations to have achieved 'Certificate of Intent' for UNICEF Baby Friendly Status: include as part of contract requirement
- Distribution of 'Bump to Breast' DVD to all pregnant women in Kingston via provider organisations: free DVD, provided at face-to-face contact – nil additional cost
- All frontline staff working with women and families to have undertaken breastfeeding awareness training: include as part of contract requirement

Impact on workforce:

Training requirement to meet Baby Friendly level of competency for all staff employed by provider organisations that have contact with women who are pregnant or who have had a baby.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Shortage of Health Visitors to support community breastfeeding support groups	Medium	Utilise skill mix to achieve appropriate level of support to community breastfeeding support groups e.g. nursery nurses with additional training in breastfeeding support
Availability of Maternity Matters funding to provide for Breastfeeding Co-ordinator	Medium	Utilise skill mix to achieve appropriate level of support to community breastfeeding support groups e.g. nursery nurses with additional training in breastfeeding support

Strategic initiative 4g:

Programme: Immunisation

Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Improved performance of immunisation services

Linked pledges and targets:

Achieving immunisation targets contained in:
Healthcare for London

Linked WCC outcome(s):

Proportion of children completing MMR

<p>Childhood Immunisation Programmes in London PCTs: Early sharing of good practice to improve immunisation coverage (The London Regional Immunisation Steering Group September 2009)</p> <p>National Priorities section of the Department of Health (DH) Vital Signs for PCTs for 2008/09, Target.</p> <p>The White Paper “Choosing Health” highlights the need for improved local immunisation rates.</p> <p>As part of the strategy Healthcare for London: a Framework for Action, the Staying Healthy Group identified immunisation as having among the most robust evidence bases in terms of safety, efficacy and cost effectiveness of all healthcare activities.</p> <p>Immunisation is one of our WCC Health Outcomes (proportion of children who complete MMR immunisation by their second birthday) this is included in the CSP.</p> <p>London Assembly: Still Missing the Point Infant Immunisation in London September 2007</p> <p>JSNA September 2008.</p>	
<p>Actions:</p>	<p>When will the action be completed? (month)</p>
<p>Review data sharing systems between GP Practices, community nursing teams, schools and children’s centres and the child health team so that the register of children to be invited is accurate and that details of those who have been immunized are fully captured</p>	<p>End 2010</p>
<p>Develop a consistent, efficient and quality approach to inviting children in for immunization and for the provision of data once an immunization is provided</p>	<p>End 2010</p>
<p>Develop immunization payment system at GP Practice level so that improved data accuracy and performance is rewarded and information is transmitted to the community information system</p>	<p>End 2010</p>
<p>Ensure that any other provider of immunization has a clearly defined process for returning data to ensure that the COVER data is consistent with actual immunization take up</p>	<p>End 2010</p>
<p>Publish an Immunisation Policy, to ensure that GPs and PCT staff follow the same procedures when handling data</p>	<p>July 2010</p>
<p>Provide greater understanding of data requirements</p>	<p>End 2010</p>

Describe uniform data handling throughout PCT Increase the quality of data handling			
Produce Immunisation strategy, including recommendations for targeted work Present better-quality understanding of PCT immunisation needs.Targeting resources Increase uptake of vaccinations Achieve National targets		July 2010	
Increase Senior Public Health Nurse Immunisation hours to cover full time by appointing a part time support role		March 2010	
Continued support for school nurses to assist in HPV acceleration, BCG at risk cohort and other childhood immunisation.		Ongoing	
Continued development of strong links with RBK ensuring that health is an integral component of all children's centres		Ongoing	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Monthly performance reporting of activity through the Child Health system and general practice systems. Performance management of the BCG immunisation programme will be via the regular NHS Kingston performance management arrangements e.g. NHS information Authority Immunisation Programmes return KC50 (Cover Data and Immform) and Board Reports		Q1	
		Q2	
		Q3	
		Q4	
VSB10 Immunisation rate for children aged 1 who have completed immunisation for diphtheria, tetanus, polio, pertussis, Haemophilus influenzae type b (Hib) – (i.e. all 3 doses of DtaP/IPV/Hib) – calculated	92.35% as at Q3	Q1	90.0%
		Q2	90.0%
		Q3	90.0%
		Q4	90.0%
VSB10 Immunisation rate for children aged 2 who have completed immunisation for	82.2% as at Q3	Q1	95.1%

pneumococcal infection (i.e. received Pneumococcal booster) (PCV) – calculated			
		Q2	95.1%
		Q3	95.1%
		Q4	95.1%
VSB10 Immunisation rate for children aged 2 who have completed immunisation for Haemophilus influenzae type b (Hib), meningitis C (MenC) – (ie received Hib/MenC booster) – calculated	83.15% as at Q3	Q1	95.1%
		Q2	95.1%
		Q3	95.1%
		Q4	95.1%
VSB10 Immunisation rate for children aged 2 who have completed immunisation for measles, mumps and rubella (MMR) – (i.e. 2 doses of MMR) – calculated	85.07% as at Q3	Q1	95.1%
		Q2	95.1%
		Q3	95.1%
		Q4	95.1%
VSB10 Immunisation rate for children aged 5 who have completed immunisation for diphtheria, tetanus, polio, pertussis (DtaP/IPV) (i.e. all 4 doses) – calculated	73.88% as at Q3	Q1	90.1%
		Q2	90.1%
		Q3	90.1%
		Q4	90.1%
VSB10 Immunisation rate for children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e. 2 doses) – calculated	79.58% as at Q3	Q1	90.1%
		Q2	90.1%
		Q3	90.1%

		Q4	90.1%
VSB10 Immunisation rate for girls aged around 12-13 years who have completed immunisation for human papillomavirus vaccine (HPV) (i.e. all 3 doses) - calculated	81.12% as at Q3	Q1	90.1%
		Q2	90.1%
		Q3	90.1%
		Q4	90.1%
VSB10 Immunisation rate for children aged 13 to 18 who have been immunised with a booster dose of tetanus, diphtheria and polio (Td/IPV) – calculated		Q1	90.0%
		Q2	90.0%
		Q3	90.0%
		Q4	90.0%

Impact on activity and finance (commissioned / decommissioned):

Additional resource was invested in 2009/10 to improve the recording of data. NHS Kingston will now use contractual frameworks to achieve the uptake in line with our targets.

Impact on workforce:

On going support for school nurses to assist in HPV acceleration, BCG at risk cohort and other childhood immunisation.

Continue to commission Public Health Immunisation data project manager to act as a link between Commissioning and GPs

To ensure increased delivery of services by integrated multi disciplinary based teams, continued commissioning of staff training making certain workforce are suitably qualified / trained to immunise (foundation and update courses)

Produce Immunisation profile, including recommendations for targeted work to ensure that GPs and PCT staff follow the same procedures.

Explore the potential to use patient texting services, in pilots with GP practices

Increase Senior Public Health Nurse Immunisation hours to cover full time by appointing a part time support role

Risks:	High/ Medium/ Low risk	Mitigating actions:
Lack of engagement from trained staff. Failure to achieve all national targets	Medium	Use performance management. Commission services from external providers
Lack of robust systems in primary care for the complete and accurate recording of information	Medium	Targeting practices whose systems are not robust and agreeing action plans for improvement and monitoring these closely.
GP's failing to sign up to LES	Medium	Identify and monitor frequently. Identify practices prepared to take on greater capacity

GP's providing inadequate data	High	Use performance management framework to deal with data issues	
Challenging target which is dependent on real engagement of parents and clinicians	High	Improved marketing and engagement programme, articulated in remedial action plan.	
Strategic initiative 4h:			
Programme: Alcohol & Sensible Drinking			
This initiative will help deliver the Health for London key themes of reducing health inequalities and improving the health and wellbeing of Londoners. It also contributes towards implementation of the Alcohol Strategy for England.			
This programme will be delivered through a variety of care settings including primary care and acute NHS Trust settings. This links to the work undertaken through the strategic partnership for Alcohol and Drugs and will be linked to the review of current service provision. Please see previous initiative for Drug and Alcohol Misuse.			
Linked pledges and targets: VSC26: Rate of hospital admission for alcohol related harm [NI 39 Alcohol Related Hospital Admissions] VSB01: All age all cause mortality rate VSB02: CVD Mortality Rate in < 75s	Linked WCC outcome(s): Implementation of this programme contributes to the achievement of WCC health outcomes including; reducing health inequalities and improving life expectancy. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. Reduce the number of people developing certain cancers.		
Actions:		When will the action be completed? (month)	
Run a Down Your Drink campaign		February 2011	
Continue to commission the locally enhanced service form GPs to identify and support those people consuming alcohol above the recommended levels.		31 March 2011	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
KPIs relating to number of DYD referrals from primary care (DES and systematic screening process), number of facilitated access appointments, number reporting reduced drinking levels in 6 months	DYD: New programme therefore no baseline data available	Q1	100 patients
		Q2	100 patients
		Q3	100 patients
		Q4	100 patients
<i>Alcohol related admissions/</i>	Baseline to be agreed		
Impact on activity and finance (commissioned / decommissioned): DES with GPs may increase referrals to specialist services such as IAPT and CDAT Partnership project leading research and evidence base with NHS Kingston, RBK, UCL, York, MRC and Codeface			
Impact on workforce:			

<p>Training given to all GP practice staff that requires it, facilitated access appointments completed by NHS Kingston staff to ensure quality for research purposes (may need reviewing if demand is too great). Specialist providers may need to ensure they are working to full capacity to cater for extra demand from the increased number of screens in primary care.</p>		
Risks:	High/ Medium/ Low risk	Mitigating actions:
DYD staff capacity unable to cope with demand for facilitated access appointments	Medium	Further admin support has been arranged within the PH admin team but agency staff may be required to cater for appointment demand.
Strategic initiative 4i:		
Improve the uptake of breast screening		
<p>Linked pledges and targets: The NHS Breast Screening Programme will be extended to all women aged 47-73 by 2012. Target for 2010/11: 8% of 47-49 and 71-73 year-old women should be invited for breast screening by March 2011. (VSA-09)</p> <p>Breast screening coverage $\geq 70\%$ of 53-64 year old women (annual) Breast screening coverage $\geq 65\%$ of 65-70 year old women (annual)</p>	<p>Linked WCC outcome(s): Improving life expectancy Tackling Health Inequalities</p>	
Actions:		When will the action be completed? (month)
<p>Focus on awareness raising among women from different social and ethnic backgrounds to increase uptake.</p> <ul style="list-style-type: none"> - A dedicated Cancer Screening Coordinator continues to oversee local Health Promotion activity including the following. - Awareness raising sessions with groups of women from different social and ethnic backgrounds e.g. Korean population, the largest ethnic group in NHSK. - Awareness raising and promotion via Refugee Action Plan voluntary group and with the Kingston Interpreting Service. - Working closely with the Royal Borough of Kingston, in order to raise awareness across local population. 		October 2010
Breast screening nurses to visit GP practices prior to screening		Tri annually
Continue to monitor programme quality (uptake, failsafe, round length etc) at quarterly Breast Cancer screening meetings involving all stakeholders		Quarterly
Re-establish Quarterly pre meet between the Clinical Lead for Breast Screening and screening commissioner		April 2010

once appointed to discuss performance, complaints, compliments, incidents, risks, QA action plan.			
Monthly review of score cards and performance by screening commissioner once appointed.		April 2010	
Penalties to remain in 2010/11 SLA. Round length monitored monthly and escalated if <90% in accordance with SLA.		April 2010	
Breast screening performance data reviewed quarterly in SWL Cancer Network and London Quality Assurance		April 2010	
Benchmark finance and commissioning of breast screening with similar breast screening units		Feb 2010	
Implementation action plan following QA visit recommendations of 2009.		April 2010	
Commence implementation of age extension Commence implementation of digital mammography Commence implementation of family history screening		31 March 2011	
Roll out a SWL-wide initiative of 'GP list cleaning'. This process is likely to result in increased coverage statistics across South West London		Annually	
Cancer Network supporting an initiative to encourage attendance by contacting women on behalf of GP who have not attended and offering a further appointment.		TBC	
Plan for investment to recruit staff to deliver age extension		from April 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
The proportion of women aged 47-49 and 71-73 invited for breast screening by March 2011. Breast screening coverage of 53-64 year old women (measured annually) Breast screening coverage of 65-70 year old women (measured annually)	No women aged 47-49 and 71-73 were invited for breast screening in 2009/10. It is planned to commence age extension from April 2010. Coverage for women aged 53-70 years in 2007/08 across South West London PCTs. KPCT 71.4 coverage	Q1	
		Q2	
		Q3	
		Q4	Over 8% (TBC) of 47-49 and 71-73 year-old women should be invited for breast screening by March 2011. Annual target: Breast screening coverage >70% of 53-64 year old women. Annual target: Breast screening coverage >65% of 65-70 year old women.
OPT04 % of women screened for breast cancer for women aged 53 to 64 years	71.69 (March 09)	Q1-4	70.0%
		Q2	
		Q3	

		Q4	
OPT04 % of women screened for breast cancer for women aged 65 to 70 years	70.66 (March 09)	Q1-4	70.0%
		Q2	
		Q3	
		Q4	
<p>Impact on activity and finance (commissioned / decommissioned): The funding issues of breast screening are complex and relate to age extension, family history screening (combining diagnostic and symptomatic screening), 62-day pathway, Digital mammography and PACS and proposed New Building at St George's.</p> <p>SWL PCTs and the SWLBSS have committed to working towards developing a local tariff for Breast screening mammography. Should this be achieved before April 2010 then the agreed tariff for mammography could be applied across the age extension and family history screening. Discussions are currently underway to establish an agreed eligible population as this figure appears to differ significantly to the figure used for round planning purposes. Resources required to be confirmed.</p>			
<p>Impact on workforce: Increase in clinical and support staff at the screening centre as required. Funded as outlined above. Increase commissioning and public health support in order to effectively monitor and performance manage the Breast Screening Programme. Resources required to be confirmed. Additional funding is required for GP list cleaning work. Resources required to be confirmed.</p>			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Financial commitment of capital build is too expensive. Capital build not being ready to support implementation of age extension.	High	Consider other options of delivering age extension. Eg other NHS breast screening providers, use of chest clinic at St Georges, Private providers. Monitor delivery of capital build.	
Unable to recruit staff to deliver age extension.	High	Plan for delivery of age extension including staffing levels and other capacity in order to maintain round length and coverage.	
Inability to finance digital equipment.	Medium	Identify all purchasing and leasing options for digital equipment.	
At present there is no substantiated commissioner and screening coordinator to oversee the SWL Bowel Screening programme. (Interim arrangements are in place.)	High	SWL PCT CEOs recently considered proposals for the future of screening commissioning in SWL. CEOs referred this to DsPH and DsC for further consideration and implementation. Interim arrangements in place with ACU	

Lack of engagement by local people with negative impact on challenging target	Medium	Engagement with Cancer network social marketing campaign
Strategic initiative 4j:		
Ensure the continued access to bowel screening in the community.		
Linked pledges and targets: Over 30% percentage of adult population aged 70-75 invited for bowel cancer screening by 2011 - (VSA10)	Linked WCC outcome(s): Improving life expectancy Tackling Health Inequalities	
Actions:	When will the action be completed? (month)	
Health promotion specialist to raise awareness of bowel screening and increase uptake.	Annually	
Continue to monitor programme quality (uptake, failsafe etc) at quarterly bowel cancer screening meetings involving all stakeholders	Quarterly	
Re-establish regular discussions between the Director of Endoscopy at St Georges and screening commissioner once appointed	Bi annually	
Health promotion quarterly meetings with bowel screening health promotion specialist and facilitators	Quarterly	
Health promotion initiatives combining five a day message and bowel screening in supermarkets in local community.	Annually	
Primary care awareness sessions on bowel screening being held at the bowel screening service.	Bi annualy	
SLA monitoring and programme funding to be devolved to SWL PCTs.	From April 2010	
Implementation of satellite sites in order to deliver age extension.	March 2011	
Quality Assurance review of the programme	March 2011	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:
Over 30% percentage of adult population aged 70-75 invited for bowel cancer screening by March 2011. Currently 60-69 year old men and women invited for screening every 2 years in order to detect cancers early. By 2010 the programme will expand to invite women and men aged 70-75 years.	No 70-75 year old people have been invited in 2009/10. It is planned to commence age extension from April 2010. The uptake of Bowel Cancer Screening since the implementation of screening is 48% in NHSK.	Q1
		Q2
		Q3
		Q4

VSA10 Percentage of adult population aged 70-75 invited for bowel cancer screening	New – no baseline available	Q1	5.0%
		Q2	10.0%
		Q3	17.5%
		Q4	30.0%

Impact on activity and finance (commissioned / decommissioned):

There are three funding issues: -

- Devolution of central funding,
- Age extension from (70-74 years inclusive) from 2010
- Additional costs relating to polyps surveillance as the programme develops.

1, Devolution of central funding from 2009

For 2009/10 the National Office of the NHS Cancer Screening Programmes holds an SLA with St George's to the value of £1.3m

The programme is currently funded centrally but devolution has been confirmed from April 2010. Based on the initial programme funding (for an eligible population of 60-69 years) the following reflects the indicative budgets for SWL PCTs:

PCT	Indicative Population (Exeter database)	Eligible population (60-69 years) in April 2008	Funding based on 92p per head of population
CPCT	363,708	37,666	£334,611
KPCT	180,952	18,391	£166,476
RTPCT	191,245	20,986	£175,945
SMPCT	396,922	40,130	£365,168
WPCT	322,855	24,783	£297,027

2. Age extension from 2010

Age extension will not be devolved from April 2010 but will be funded centrally from the National Screening Office.

Current available data suggests that the eligible population would increase by 41,000 with the age extension resulting in a 28.3% (overall) increase in activity. Based on current funding this would equate to an additional £385,000 for SWL PCTs broken down as follows:

PCT	Eligible Population (60-69 years)	Indicative funding for current eligible population	Additional population in 2010 with age extension (70-74 years*)	% increase in activity	Potential increase in funding
CPCT	37,666	£334,611	11,220	29.8	£99,714
KPCT	18,391	£166,476	5,040	27.4	£45,614
RTPCT	20,986	£175,945	5,353	25.5	£44,866
SMPCT	40,130	£365,168	11,607	28.9	£105,534
WPCT	24,783	£297,027	7,448	30.1	£89,405
Totals	141,956	1,339,227	40,668		385,133

3. Polyps surveillance

The NHS BCSP recommends that polyps surveillance be part of the screening programme and that surveillance colonoscopy should be undertaken on designated screening lists by accredited screening colonoscopists.

Polyp surveillance in the screening programme is based on current BSG guidelines which advocates that:

patients with high risk polyps are offered annual surveillance
 patients with intermediate risk polyps are offered surveillance every three years
 In 2007/8 a total of 38 high risk polyps and 43 intermediate risk polyps were identified. In 2008/9 the corresponding figures were 46 high risk polyps and 79 intermediate risk polyps. This is based on an average uptake of 49.3% for SWL PCTs in 200/8 and 52.1% uptake in 2008/9.
 An estimated 167 surveillance colonoscopies are expected in 2010/11. At £500 per colonoscopy this creates a cost pressure of £83,500 for 2010/11. NHS Kingston would have to contribute with approx. £15,000 of that cost pressure.

Impact on workforce:
 Increase in clinical and support staff at the screening centre. Funded as outlined above.
 Increase commissioning and public health support in order to effectively monitor and performance manage the Bowel Screening Programme. Resources required to be confirmed.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Low coverage.	Medium	Improved promotion of bowel cancer screening especially among women and minority ethnic groups. A London-wide campaign is planned once bowel cancer screening has been rolled out across London.
At present there is no substantiated commissioner and screening coordinator to oversee the SWL Bowel Screening programme. (Interim arrangements are in place.)	Medium	SWL PCT CEOs recently considered proposals for the future of screening commissioning in SWL. CEOs referred this to DsPH and DsC for further consideration and implementation.

Strategic initiative 4k:

Improve the uptake of cervical screening in primary care

Linked pledges and targets: Cervical screening test results to be received within 2 weeks (VSA15)	Linked WCC outcome(s): Improve Life expectancy Tackling health inequalities Proportion of people screened for chlamydia
---	---

Actions:	When will the action be completed? (month)
Continue to monitor turnaround times at the quarterly Kingston and Richmond District Cervical screening meetings.	Quarterly
Re-establish regular meetings between the Hospital Based Programme Manager and screening commissioner once appointed.	Quarterly
PCSS lead manager to continue to attend quarterly district meeting.	31 March 2011
Re-establish regular meetings between the PCSS lead manager and screening commissioner once appointed	30 April 2010
Laboratory to ensure that turnaround time (sample	From April

taken to report issued) is ≤ 8 working days			
Cancer screening facilitator to raise awareness with GP practices of daily sending of samples to laboratory without delay.		Annually	
Laboratory continue to send daily downloads to PCSS. The PCSS continue to send post daily by first class mail (Mon-Fri).		Routinely	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
All women to receive their cervical screening results within two weeks by 2010.	In Q2 2009 the laboratory turnaround time for (from sample taken to lab report issued) 100% <2 weeks (within current national standard).	Q1	
		Q2	
		Q3	
		Q4	In order to ensure that women receive their cervical screening results within 2 weeks by 2010, laboratory turnaround time (from sample taken to lab report issued) should be no more than 8 working days by December 2010.
VSA15 Percentage of women with an expected date of delivery for their cervical screening test result within 14 days of the test being taken	New target – no baseline data available	Q1	63.2%
		Q2	68.5%
		Q3	100.0%
		Q4	100.0%
Percentage of women receiving cervical screening aged 25 to 49 years	69.25% (Mar 09) 79.24% (Mar 09)	Q1	80.0%
		Q2	80.0%
		Q3	80.0%
		Q4	80.0%
Percentage of women receiving cervical screening aged 25 to 49 years			
Impact on activity and finance (commissioned / decommissioned): None anticipated.			
Impact on workforce: None anticipated.			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Reduction in cytology/pathology staffing. This would adversely affect turnaround time. It is essential to plan for vacancy and recruitment appropriately.	Medium	Laboratory to provide timely updates to NHSK e.g. Quarterly performance monitoring meetings	
At present there is no	High	SWL PCT CEOs recently considered	

substantiated commissioner and screening coordinator to oversee the local cervical screening programme. (Interim arrangements are in place.)		proposals for the future of screening commissioning in SWL. CEOs referred this to DsPH and DsC for further consideration and implementation.
Challenging target to meet	Medium	Improved engagement with clinicians and providers to meet this target.
Strategic initiative 4j:		
<p>HCfL Staying healthy care pathway: 'there should be a greater focus on health protection, with improved sexual health'</p> <p>This initiative will also help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.</p> <p>NHS Kingston has established a Managed Clinical Network to enable the implementation of the revised Sexual Health Specification which was developed collaboratively over the last 18 months.</p>		
<p>Linked pledges and targets: A 40% reduction in the under-18 conception rate (births and abortions) by 2010 (from the 1998 baseline rate). This is one of five lead indicators used to measure progress on the Public Service Agreement increase the number of children and young people on the path to success (PSA14). Commissioners should consider whether more frequent reporting of live births and abortions could help to address progress on this measure.</p> <p>The NHS Operating Frameworks for 2008/09 and 2009/10 include a tier two Vital Signs indicator for reducing the prevalence of Chlamydia. The target includes screening the following proportions of 15–24 year-olds for Chlamydia: 17% in 2008/09, 25% in 2009/10 and 35% in 2010/11, and 50% thereafter.</p> <p>The 48-hour genito-urinary medicine (GUM) access target is included in the Operating Framework for 2009/10 as a standard to be maintained: The target is that 100% offered and 85% seen by 2010/11 and for this level of performance to maintained thereafter.</p>	<p>Linked WCC outcome(s) Tackling inequalities Reducing Mortality Increasing the number of people screened for Chlamydia</p>	
Actions:		When will the action be completed? (month)
Established Managed Clinical Network to lead on the implementation of the agreed new comprehensive sexual health specification.		April 2011

Commission services that apply social marketing principles and approaches relevant to different population segments, providing a range of approaches and materials that support people to be sexually healthy.	Annually		
Commission increased access to Emergency Contraception and long acting methods of contraception to prevent unintended and teenage pregnancies	April 2010		
Establish the local viability of the provision of medical abortion at appropriate GP settings.	March 2011		
Local arrangements for measuring post abortion contraception	April 2010		
To develop a strategy for reducing repeat abortions	May 2010		
Enable convenient access to free condoms through a c-card scheme for all under 25s and students – available from primary care and a range local authority sites.	January 2010		
Increasing the uptake of chlamydia screening by those at highest risk, those under the age of 25.	31 March 2011		
Seek to reduce late HIV diagnoses in GP and acute settings:	April 2010		
Establish schools sexual health drop-in pilot to ensure young people are able to conveniently access appropriate information, Emergency Contraception, Chlamydia screening, condoms.	February 2010 pilots for 1 year		
Ensure mechanisms are in place to measure Patient Experience of sexual and reproductive health services regarding accessibility and quality of services for the whole of Kingston's population.	April 2010		
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
VSB13 Percentage of the population aged 15 - 24 screened or tested for chlamydia	Target for 2009/10 = 25% As at Q3 achieved 16.13%	Q1	15.0%
		Q2	20.0%
		Q3	30.0%
		Q4	35.0%
Percentage offered an appointment to a genito-urinary medicine clinics within 48 hours.	99.98% (as at Jan 10)	Q1	98.0%
		Q2	98.0%
		Q3	98.0%
		Q4	98.0%
VSB08 Conception rate per 1,000 females aged 15-17.	Target for 2009/10: 24.4 Achieved 23.3 in 08/9	Q1	18.4
		Q2	18.4
		Q3	18.4
		Q4	18.4
Impact on activity and finance (commissioned / decommissioned): Agreed funding for the clinical lead and manager of the MCN - £130K per annum for two years.			

Agreed funding for Family Planning Consultant £138K		
Activity flowing into GUM service will be reduced with the implementation of the three tier service with an associated increase in activity in primary care.		
Impact on workforce: Existing roles to enable integrated sexual health services provision as well as aiming for pathways development, adequate skill mix and demand management to enable appropriate and convenient access. Integrated service expansion will warrant local workforce capacity increases to ensure clinical governance.		
Risks:	High/ Medium/ Low risk	Mitigating actions:
Lack of capacity to deliver integrated specification	Medium	Ensure demand capacity analysis and stakeholder engagement at appropriate level.
Financial constraints	High	Business case presentation to PEC is robust - using mechanisms which ensure vfm, cost-saving, and joint commissioning opportunities.
PEC does not choose MCN option 2 of incremental delivery of the integrated spec	low	Business case presentation to PEC is concise and accurate
Strategic initiative 4I:		
Programme: Targeted work with disadvantaged communities targeted at marginalised groups and localities of multiple deprivation This initiative will help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.		
Linked pledges and targets: Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. Reduce the number of people developing certain cancers. Reduce the number of people developing diabetes. VSB01: All age all cause mortality rate VSB02: CVD Mortality Rate in under 75s OPT21: CHD/stroke mortality rates	Linked WCC outcome(s): Mortality, morbidity, inequalities (and the enhanced population health outcome gain in reaching hard to reach groups including through smoking cessation, vascular checks implementation, improving physical activity)	
Actions:	When will the action be completed? (month)	
Participatory Needs Assessments	Rolling programme targeting 4 priority localities of multiple deprivation with community focused solutions to need	

Healthy Living Centre		Prioritisation of recommendations from YouCan Kingston project completed by April 2010 and interventions to be agreed with KSP (in conjunction with Social Entrepreneur in Residence) by July 2010	
BME Needs Assessment		April 2010 (and taking forward recommendations from May 2010)	
Refugee and Asylum Seeker Needs Assessment and Strategy		Strategy implementation from April 2010	
Social Entrepreneur in Residence		Recruitment completed by April 2010 and objectives agreed by June 2010	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
<p>PNA1 medium-term recommendations implementation by March 2011.</p> <p>PNA2 recommendation implementation timetable: April 2010 - March 2011.</p> <p>PNA3 programme from May 2010 -March 2011.</p> <p>Healthy Living Centre - implementation of recommendations prioritised from April 2010.</p> <p>BME Needs Assessment - implementation of recommendations from May 2010</p> <p>Refugee and Asylum Seeker Strategy - implementation of recommendations from April 2010</p> <p>SEiR - Prioritise and implement recommendations of the YouCan Report and establish a minimum of 4 social enterprise projects across Kingston; manage projects; secure new income and forge alliances across organisations and</p>		Q1	<i>To be determined</i>
		Q2	
		Q3	
		Q4	

professions.			
Immunisation uptake by LSOA?(Slope)	TBC - We don't currently collect data by LSOA – but Marjan thinks it may well be possible – if so could use Q1 as baseline with reduction in slope for Q2-4		tbc
Obesity rate by LSOA?(slope)	See above		tbc
Breast Feeding rate by LSOA?(slope)	See above		tbc
<p>Impact on activity and finance (commissioned / decommissioned): Enhanced activity redressing inequalities in localities of need/marginalised groups.</p> <p>The financial impact will be through taking forward needs assessment and YouCan HLC recommendations and interventions of the marginalised group strategies.</p>			
<p>Impact on workforce: To achieve all of the development projects targeted at disadvantaged groups the Equalities and Community Engagement Team have a very stretched programme, especially localities focused work. Chief Executive, Director and AD level time committed support for the SEiR project in both NHS-K and RBK will be required to maximise impact of this project.</p>			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Staff in post in ECET to take forward localities focused work	Low	Hold on implementing PNA3 and refocus individual's objectives	
Retaining SEiR	Medium	Identifying funding for SEiR post beyond 10-11 eg RIF	
Strategic initiative 4m:			
<p>Programme: Mental Health Promotion This initiative will help deliver the Health for London key themes of reducing health inequalities and improving the health and wellbeing of Londoners. It also contributes towards implementation of the 'New Horizons' national mental health Strategy.</p> <p>This programme will be delivered through a variety of settings including primary care, the voluntary sector, local authority and independent contractors.</p>			
<p>Linked pledges and targets: Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death. Reduce the number of people developing cardiovascular disease. VSB01: All age all cause mortality rate</p>		<p>Linked WCC outcome(s): Implementation of this programme will also contribute to the achievement of other WCC health outcomes including; reducing health inequalities, improving life expectancy and increasing the number of people quitting smoking. Engage with public & patients</p>	

VSB02: CVD Mortality Rate in under 75s OPT21: CHD/stroke mortality rates			
Actions:		When will the action be completed? (month)	
Complete training needs analysis for mental health awareness		June 2010	
Develop an anti stigma strategy for Kingston residents in partnership with key partner organisations and mental health service users		Dec 2010	
Implement 2010 – 11 anti stigma strategy action plan		March 2011	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Increased public awareness and better information	There has been some activity on world mental health day in the past but this has been limited and uncoordinated	Q1	
		Q2	
		Q3	
		Q4	
In- Patient Survey – did psychiatrist treat you with dignity & respect?	2009 survey SWL&StG were in worst performing 20% for 2009 survey ¹ Score: 75	Q4	77
In- Patient Survey – did nurses treat you with dignity & respect?	2009 survey SWL&StG were in worst performing 20% for 2009 survey Score: 59	Q4	70
In patient MH Survey – Overall rating of care received in hospital	2009 Survey (SWLStG) score: 43 (worst 20%)	Q4	54
Impact on activity and finance (commissioned / decommissioned): More likely that people in mental distress will seek help, and feel able to disclose and discuss their problems. Reduce the likelihood of relapses in mental health problems.			
Impact on workforce: KPCT Public Health/ RBK: Healthier Communities Manager, with support from the Healthier Communities Officer (mental health promotion), will oversee the planning and implementation of this work and will liaise with other key partners throughout the project.			
Strategic initiative 4n:			
Programme: Mental health, substance misuse (including homelessness)			
This initiative will help to deliver the Health for London key themes of reducing health inequalities and improving health and wellbeing of Londoners.			
Variety of care settings including primary care, specialist providers, voluntary organisations, local authority			

¹ http://www.cqc.org.uk/db/documents/AAB_NHS_MH_survey_2009_ROY.pdf

<p>Linked pledges and targets: VSB14 Number of problem drug users in effective treatment</p> <p>Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas. Target the causes of ill health and premature death.</p>		<p>Linked WCC outcome(s): Improving life expectancy Tackling Inequalities Drug Misusers in effective treatment</p>	
<p>Actions:</p>		<p>When will the action be completed? (month)</p>	
<p>Shared Care Service (including Substance Misuse prescribing LES and Supervised Methadone LES)</p>		<p>March 2012</p>	
<p>BBV Vaccination and Testing Service</p>		<p>March 2012</p>	
<p>Needle Exchange</p>		<p>March 2011</p>	
<p>IAPT Substance Misuse Work</p>		<p>September 2011</p>	
<p>Substance Misuse and Homelessness Prevention Projects</p>		<p>March 2012</p>	
<p>Performance measure(s):</p>	<p>Baseline level of performance:</p>	<p>Target level of performance each quarter:</p>	
<p>KPIs around number of patients on case load of Shared Care Nurses, LES data submissions, number of tests and vaccinations, number of patients on case load of IAPT Substance Misuse Worker, VSB14 data</p>	<p>These programmes are new with many starting in Quarter 4 09/10, therefore no baseline data available</p>	Q1	
		Q2	
		Q3	
		Q4	
<p>VSB14 The number of drug users using crack and/or opiates recorded as being in structured drug treatment in a financial year who were discharged from treatment after 12 weeks or more, or who were discharged from treatment in a care planned way.</p>	<p>284 (as at Sept 09)</p>	Q1	290
		Q2	290
		Q3	290
		Q4	290
<p>Impact on activity and finance (commissioned / decommissioned): LES with GPs may increase referrals to specialist services such as IAPT and CDAT, current shared care nurse at CDAT on secondment (plans for her replacement are as yet unknown). Funding for second additional shared care nurse is now unavailable due to cuts in SPAD Home Office Grant (due to CDAT under performance). Therefore due to the predicted</p>			

unsafe caseloads, a bid for funding will be made to the sum of approximately £45K. Homelessness Strategic Review currently underway will determine more detailed project spend in 2010/11.
Substance Misuse and Homelessness: £180K

Impact on workforce:

Training given to all GP practice staff that require it.. Specialist providers may need to ensure they are working to full capacity to cater for extra demand from the increased number of patients in the system. A bid for further funding for an additional planned shared care nurse is essential to ensure the caseload can be safely managed (funding was planned but is no longer available due to the above mentioned cuts).

Risks:	High/ Medium/ Low risk	Mitigating actions:
Caseload unsafe for Shared Care Nurse at CDAT	High	Bid for further funding for additional nurse, establish alternative provider for the management of the Shared Care Nurse posts if performance remains poor at CDAT
Consultant led BBV service too expensive for long term sustainability	Medium	Move to nurse led model ensuring appropriate professional links are available
IAPT performance remains poor	High	Performance manage this position and disinvest if required, establish potential alternative provider should this be required
Homelessness Strategic Review highlights key gaps and recommendations that incur costs	High	Bid for further funding, prioritise current project costs efficiently and effectively

Strategic initiative 4o:

Programme: Older People: keeping independent

This initiative will help deliver the Health for London key themes of reducing health inequalities and improving the health and wellbeing of Londoners. It also contributes towards implementation of the 'New Horizons' national mental health Strategy.

This programme will be delivered through a variety of settings including primary care, the voluntary sector, local authority and independent contractors.

Linked pledges and targets:

Improve overall life expectancy in Kingston, and reduce the gap between affluent and deprived areas.
Target the causes of ill health and premature death.
Reduce the number of people developing cardiovascular disease.
VSB01: All age all cause mortality rate
VSB02: CVD Mortality Rate in under 75s
OPT21: CHD/stroke mortality rates

Linked WCC outcome(s):

Tackling health inequalities,
Improving life expectancy
Smoking Quitters
Engage with public & patients

Actions:

Develop a programme of mental health awareness for

When will the action be completed? (month)

June 2010

<i>all older people and their families in partnership with key partner organisations and older people</i>			
<i>Implement 2010 – 11 action plan</i>		<i>March 2011</i>	
<i>Recruit older people volunteers to support implementation of plan</i>		<i>Dec 2011</i>	
<i>Appoint Falls Prevention Coordinator</i>		<i>Sep 2010</i>	
<i>Revise services in light of recommendations in falls service review</i>		<i>Mar 2011</i>	
<i>Expand falls awareness activities in Kingston</i>		<i>Ongoing</i>	
<i>Develop a programme of falls awareness for all older people and their families in partnership with key partner organisations and older people</i>		<i>June 2010</i>	
<i>Implement 2010 – 11 falls awareness action plan</i>		<i>March 2011</i>	
<i>Recruit older people volunteers to support implementation of plan</i>		<i>Dec 2011</i>	
<i>Map training needs for falls prevention exercise</i>		<i>June 2010</i>	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Strategy agreed Resources produced Volunteers recruited Awareness raising undertaken Falls Number of referrals to falls service increased Number of falls reported at A&E reduced Number of hip fractures reduced	Recent research 'Positively Affecting Lives' on 'Kingston Older People and Mental Health' identified the need for improved awareness of depression and dementia and made recommendations for the best approaches. Over 1,390 falls were reported at A&E in 2003-2004 (all ages) which was 26% higher than expected compared to national estimates.	Q1	
		Q2	
		Q3	
		Q4	
VSC23 Percentage of practices with PCT validated registers of patients without symptoms of cardiovascular disease with an absolute risk of CVD events greater than 20% over the next 10	100% (March 09)	Q1	89.7%

years.			
		Q2	89.7%
		Q3	89.7%
		Q4	89.7%
No. of falls attending A&E?(Fall on same level from slipping, tripping and stumbling (W01 in ICD-10)		Q1	
		Q2	
		Q3	
		Q4	

Impact on activity and finance (commissioned / decommissioned):

The service will increase activity in the existing falls service (i.e. number of classes offered and numbers attending will increase).

The number of older people suffering falls will decrease which will result in fewer A&E attendances for falls, a reduced number of hip fractures with their associated inpatient and outpatient costs and a reduction in the number of older people requiring placement in nursing or residential accommodation.

Impact on workforce:

KPCT Public Health/ RBK: Healthier Communities Manager, with support from the Healthier Communities Officer (older people), will oversee the planning and implementation of this work and will liaise with other key partners throughout the project.

New human resource requirement:

- Falls Service Coordinator

Staff time of existing posts:

- Ongoing support to project by KPCT/ RBK Public Health team and RBK Community Services

Risks:	High/ Medium/ Low risk	Mitigating actions:
Lack of engagement of partners and older people	Medium	Attend older people meetings
Falls Coordinator not appointed	High	Public Health and RBK to work with Falls Steering group on care pathway Readvertise position or second staff to post on temporary basis
Additional physiotherapy time not obtained	High	Readvertise post
Agreement not reached on new care pathway	High	- Study tours to best practice services - External facilitator can be brought in to assist - Rearrangement of planned budget if different use of funds to support service required

Strategic initiative 5a: End of Life Care

The HCfL End of Life Care pathway - Personalised care is needed for people who are

<p>dying so that they can discuss their preferences, including where they choose to die, with professionals. Patients and carers should have a single point of contact to access professional help. End of Life Care is one of the 8 Local Health World Class Commissioning priorities for NHS Kingston. The World Class Commissioning Data Pack which showed Kingston to be in the bottom 10% in London for the number of deaths that occur at home (14%); it is a Health Care for London priority, this initiative is in direct response to the HfL care pathway and project on End of Life Care; there is inequity of provision between cancer and non cancer end of life services. NHS Kingston considers this target to be challenging</p>										
<p>Linked pledges and targets: VSC10 Delayed Transfers of care VSC15 Proportion of deaths that occur at home</p>	<p>Linked WCC outcome(s): End of life care Delayed transfers of care</p>									
<p>Actions:</p>	<p>When will the action be completed? (month)</p>									
<p>Publication of the Kingston end of lifecare strategy</p>	<p>April 2010</p>									
<p>Introduce a Locally Enhanced Service (LES) and develop a specification for out of hours care in nursing OOH care in nursing / care homes</p>	<p>Sept 2010</p>									
<p>Kingston Hospital Gold standard framework pilot</p>	<p>Pilot complete August 2010</p>									
<p>Redesigned care pathway based on the HCfL commissioning guidance (inc 24 hour arrangements)</p>	<p>August 2010</p>									
<p>Performance measure(s):</p>	<p>Baseline level of performance:</p>	<p>Target level of performance each quarter:</p>								
<p>WCC outcome and vital signs Strategy published April 2010 LES and nursing home initiative complete Sept 2010 Acute pilot complete August 2010 Redesigned care pathway August 2010</p>	<p>14.63% of people die at home</p>	<table border="1"> <tr> <td>Q1</td> <td></td> </tr> <tr> <td>Q2</td> <td></td> </tr> <tr> <td>Q3</td> <td></td> </tr> <tr> <td>Q4</td> <td>17%</td> </tr> </table>	Q1		Q2		Q3		Q4	17%
Q1										
Q2										
Q3										
Q4	17%									
<p>Impact on activity and finance (commissioned / decommissioned): £250,000 year one (part year implementation costs for year one based on a September start). No increase or decrease in activity overall. The result of the development should however be fewer admissions via A/E and a reduction in the number of people who die in hospital.</p>										
<p>Impact on workforce: Redesign community services to support the introduction of care pathway in the community</p>										
<p>Risks:</p>	<p>High/ Medium/ Low risk</p>	<p>Mitigating actions:</p>								
<p>Refer to SCP which summarises the PCTs assessment of risks to delivering its service goals and initiatives.</p>	<p>medium</p>	<p>Finance for redesign is included in the strategy and it is a SWL priority</p>								

Progress dependent on Urgent care and delayed transfer of care JHIP projects	high	Priority given to the JHIP projects by NHS Kingston and Kingston Hospital
Redesign of community services while the provider arm is being externalised	medium	Provider is a full stakeholder in the project and is committed to change
Strategic initiative 6: Planned care		
<p>In line with HCfL and HfSWL, NHS Kingston is planning an ambitious work programme to establish more services closer to people's homes. The following areas will impact on planned care currently provided in secondary care. In order to progress this work, NHS Kingston is working predominantly with Kingston Hospital Trust to review, and redesign services, managing the change through a programme management approach.</p> <p>The strong clinical leadership established through the Professional Executive Committee has allowed us to have named primary care leads who then work with named hospital clinical leads to progress initiatives in a structured and planned way.</p> <p>The recognised collaborative working in primary care, due to the focus on polysystems has also allowed for the wider engagement of practices, pooling and utilising expertise to make the shift of service a viable option.</p> <p>The regular review of performance of the local hospital has been enhanced during the past year to manage improvements in efficiency and increase productivity. In addition, the focus on improved quality of services through the local Clinical Quality Review Group has improved the ongoing monitoring of performance against Key Clinical Indicators. This work is now being led on by the Acute Commissioning Unit for South West London. In line with the units operating plan NHS Kingston will support the focus on emergency care and the reduction in unplanned activity, the focus on improving productivity for elective care and the focus on long term conditions. All these areas are included in the Sector Operating Plan.</p> <p>This initiative overlaps with the work being undertaken to address Long Term Conditions Management, Diabetes and Rehabilitation Services. and the focus on delayed transfers of care.</p>		
<p>Linked pledges and targets: VSA01 MRSA levels VSA03C. Diff levels VSA06 GP Access VSA07 GP extended opening VSB15 Patient Experience Score VSB16 Public Confidence VSA0418 weeks (RTT, audiology and diagnostics) VSA05 Supporting activity lines and 15 diagnostic tests VSA08 Breast Symptoms VSA12 Radiotherapy VSA13 Cancer Extended 62 Day Treatment</p>	<p>Linked WCC outcome(s): Improving life expectancy Tackling health inequalities Delayed transfers of care Percentages of deaths that occur at home Clostridium Difficile infection rate</p>	
Actions:		When will the action be completed? (month)
Implement the redesigned pathway for ophthalmology patients specifically implementing community based glaucoma management and PEARS		June 2010

Establish work stream for the commissioning of additional direct access diagnostic services allowing for greater work up in primary care to reduce unnecessary referrals into acute services. Mainly radiology, phlebotomy, ECG and ambulatory BP monitoring, Ultra sound scanning.		October 2010	
Establish work programme for the redesign of heart failure services to establish care closer to home.		October 2010	
Utilise the National Contract to set challenging Key performance indicators to drive up improvement in planned care – implementing remedial plans when performance trajectory is not achieved.		March 2010	
Ensure the role out of the Ten Partnership Review to enable the Trust to accurately understand demand on services and adapt their capacity accordingly – initially in orthopaedics.		June 2010 and onwards	
Performance measure(s):	Baseline level of performance:	Target level of performance each quarter:	
Quality Hospital mortality: Relative Risk of Mortality (DFI indicator Breast Symptom Two Week Wait Percentage of Patients referred for evaluation/investigation of “breast symptoms” by a PCP who are first seen within 14 calendar days. Incidence of MRSA Incidence of C. Difficile % patients receiving first definitive treatment within 62-days following referral from an NHS Cancer Screening Service. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	100 100% 12 25 90% 100%	Q1	For Completion by 15 March 2010
		Q2	
		Q3	
		Q4	
Efficiency 18 wks RTT Cancelled operations	No more than 0.8% Cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission.		
DNA Rates	To minimise the number of patients who DNA for an Outpatient appointment To minimise the number of patients who DNA for an		

First to Follow up Ratios to be in line with upper quartile	Elective procedure By Specialty – still under negotiation		
Impact on activity and finance (commissioned / decommissioned): For Completion 15 march 2010			
Impact on workforce: The planned care programme will require additional training for primary care clinicians to ensure that they are either equipped to deliver elements of care themselves or to understand revised referral routes into services. The need to ensure that workforce is a key element of all service redesign, this will take into account the role of staff currently working in an acute setting. Roles may need to change, e.g. Consultants utilising freed up capacity to act in a supervisory role to monitor and improve quality of services. Staff may equally need to change the setting in which they work, interacting in different teams or even changing their employer.			
Risks:	High/ Medium/ Low risk	Mitigating actions:	
Lack of engagement by clinicians	Medium	Strong clinical leadership established	
Capacity and capability	Medium	Robust planning using programme management will allow all risks and mitigations to be identified and addressed	
Achievement of key performance indicators namely MRSA rates due to low numbers agreed with main provider. 18 weeks due to inherent backlog at Kingston Hospital	Medium	Regular performance management and ability to support improved performance through the national contract framework	
Emergency preparedness			
NHS Kingston needs to ensure it meets its responsibilities under the Civil Contingencies Act and is adequately prepared for emergencies and major incidents. Comprehensive planning will improve our ability to respond in times of pressure or emergency will support demand surges in urgent care, and our ability to rapidly recover and return to normal services. Our emergency preparedness will be strengthened by: <ul style="list-style-type: none"> • Maintaining a generic emergency plan and specific contingency plans for business continuity, heatwave, flooding and public health incidents. • Continuing to strengthen the mass casualties plan covering Chemical, Biological, Radioactive and Nuclear (CBRN) threats and conventional terrorism. • Working with partners to ensure Kingston can respond to an emerging situation, including triggers, bed management, equipment and stock, staffing implications and communications including a systematic, embedded and resilient approach to mutual aid. • Revising and maintaining a pandemic flu plan building on lessons learned from the 2009/10 swine flu pandemic. • Ensuring key staff and appropriately trained and plans are tested 			
Actions:		When will the action be completed? (month)	
Emergency preparedness <ul style="list-style-type: none"> • Review of local hazards and threats. 		December 2010	

<ul style="list-style-type: none"> • Ensure that acute providers have developed and tested clinically led surge plans including that for adult and paediatric critical care • Review multi-agency plans for emergency and surge management to coordinated escalation levels of each agency • As commissioner, to ensure that provider services maintain levels of emergency preparedness in accordance with the SLA • Building on the lessons learned from this year's response to swine flu review, update test the pandemic flu plan • Maintain a 24/7 on call rota to ensure robust and tested command and control arrangements, which also meet the organisation's obligations under the Civil Contingencies Act • Review of business continuity and associated workforce protection strategies, including appropriate HR policies, to ensure the Business continuity plans for the organization are fit for purpose • Update heatwave plans and conduct pre-heatwave coordination reviews with the health economy • Working with the Local Authority conduct Flood resilience assessments and work with the Local Authority to strengthen multi-agency borough flood plans • Produce a strengthened Mass Casualty plan (CBRNE) incorporating HPA guidance on influx of patients to primary care and NHS Lockdown Guidance & the findings of CBRNE workshop <p>Train key staff in emergency planning and conduct 2 communications exercise and one table top</p>	<p>Annually</p> <p>September 2010</p> <p>October 2010</p> <p>May 2010</p> <p>May 2010</p> <p>June 2010</p> <p>December 2010</p> <p>March 2010</p>
<p>Impact on activity and finance (commissioned / decommissioned): None</p>	
<p>Impact on workforce: Train key staff in emergency planning and conduct 2 communications exercise and one table top.</p>	

SECTION 4: FINANCIAL PLANNING (PCTs only)

Please complete the financial planning spreadsheets attached as Annex A.

4.1 Productivity

Acute

All NHS Kingston's acute and non acute contracts will have the national efficiency target of 3.5% applied to them in 2010/11 and 2011/12. Net tariff inflation is nil so providers will have to absorb pay and non-pay inflation and other costs pressures. Further productivity improvements will be identified as operational plans are developed to deliver the cost improvement plans and as the PCT negotiates its commissioning contracts for 2010/11. The PCT will work closely with acute and non-acute providers to support them in delivering significant productivity savings.

Primary Care

The polysystems development and related pathway redesign will support productivity improvements as the current activity will be undertaken at a lower local tariff.

Community Care and Mental Health

As well as nil tariff inflation, the PCT will be negotiating further efficiencies in these contracts which will mean providers will have to be more productive whilst delivering the same activity.

4.2 Expenditure

Acute

Acute expenditure is forecast to increase by £2.6m each year from 2009/10 to 2011/12 due to estimated growth in demand from population and demographic changes in Kingston. There will also be a £1.2m increase in acute contract expenditure in 2010/11 onwards from additional CQUIN funding requirements, increasing funding from 0.5% in 2009/10 to 1.5%. These increases will be offset by the planned transfer of activity to polysystems and demand management schemes which are covered below.

Acute investments include approximately £0.6m to fund stroke and major trauma pathway redesign in line with Healthcare for London. Locally the PCT is also working with Kingston Hospital to redesign a number of pathways including sexual health, COPD and end of life care which will be funded by the allocation set aside for healthcare investments in both 2010/11 and 2011/12.

Primary Care

The PCT has invested recurring expenditure of £0.8m in 2010/11 and a further £0.5m 2011/12 in a GP led health centre that will open in early 2010/11. In addition £0.5m has been provided for a grant for capital grant to fund the health centre development. The PCT will also continue to invest in staying healthy initiatives using primary care providers, such as Vascular Checks.

Community

The PCT has provided for 1.5% growth in non-acute activity which will be used to fund any required changes to the community contract as polysystems are developed. CQUIN funding is also set aside for schemes to be developed in 2010/11.

There are also a number of healthcare investments in 2010/11 and 2011/12 which will impact on the community contract, including the development of the Stroke and COPD community rehabilitation provision.

Mental Health

The main change to mental health expenditure is provision for growth in activity forecast to be 1.5% (£0.5m) and CQUIN (£0.3m). This is partly offset by cost improvement plan target

allocated to these budgets.

Polysystems

The PCT will continue to develop its polysystems during 2010/11 and the related shift in activity expected from the acute sector into the primary care and community settings are incorporated in the financial plans. This is assumed to be £2.2m in 2010/11 as the pathway redesign projects are developed and implemented, increasing to £4m in 2011/12. The financial plans also have £0.7m of costs assumed for the required changes to the PCT's estate in 2010/11.

4.3 Revenue

The PCT had income of £248m in 2009/10 after the historic debt repayment of £6.7m. This resource limit will increase to £264m in 2010/11 because of 5.1% (£12.8m) growth in the DH allocation. In addition the £6.7m debt repayment funding in 2009/10 will be available to invest in 2010/11 however there will be a reduction of £2m for the PCT's contribution to the NHS London fund in 2010/11. For the purpose of this draft of the operating Plan it has been assumed that the revenue allocation will grow by the base case of 2.5% (£6.6m) in 2011/12. The worst case of 0% and best case of 3.25% additional funding in 2011/12 are covered in the detailed Strategic Plan 5 year financial projections

4.4 Commentary on overall position

NHS Kingston's medium term financial strategy is incorporated in its Strategic Plan 2009-2015 submitted for the World Class Commissioning year two assurance process. It has been developed alongside the PCT's commissioning strategy and invests in its strategic priorities, as shown in the table below.

	2009/10	2010/11	2011/12
	Budget	Budget	Budget
	£000	£000	£000
Care pathways			
Planned Care including Primary Care	747	799	2,078
Staying Healthy	914	1,677	2,497
Maternity	894	944	933
Children's	207	167	684
Acute services	0	765	2,691
Long term conditions	6	157	1,501
End of Life Care	0	200	681
Other	136	210	1,562
Total Investment	2,904	4,919	12,627

The PCT has been working with the South West London ("SWL") PCTs through the Healthcare for South West London (HCfSWL) Affordability Task Force and there are a number of identified cost improvement plans and financial assumptions from this work incorporated in this plan. A summary of the key assumptions is included in the sections below.

The main changes to the financial strategy submitted in December 2009 for World Class Commissioning were in response to the Operating Framework 2010/11. This reduced provider tariff inflation to zero in 2010/11 whilst increasing funding for CQUIN schemes to 1.5%. It also included the requirement to commit 2% of available funding non-recurrently to ensure financial flexibility over the period. The SWL sector PCTs have agreed to hold an additional 0.5% risk contingency and identify a further 1.5% of expenditure in the plans which is to be made non-recurrently.

2009/10 and historical financial performance

NHS Kingston ended 2006/07 with a revenue deficit of £22m. A turnaround plan was implemented which has brought the PCT back into recurrent balance and repaid the debt within three financial years.

NHS Kingston achieved its main financial performance targets in 2008/09, including achieving a small revenue surplus position. This included the repayment of £12.9m of its historical debt leaving £6.7m to repay during 2009/10.

A break even revenue position is currently forecast for 2009/10 but there are a number of financial risks, in particular acute commissioning over performance, which are being managed with the support of the sector Acute Commissioning Unit.

Contingency

The plan includes a contingency of 0.5% of income which is set aside each year for unplanned expenditure and also a 1% surplus target. An additional risk contingency of 0.5% of income has also been included in the financial plan as part of the requirement to spend 2% of expenditure non-recurrently.

Cash

The PCT has repaid its historical loans and projected to have a stable cash position over the next two years.

Other areas

IFRS has been adopted by the PCT in 2009/10 and has had no material impact on the historic or planned financial position.

4.5 Key assumptions included within your financial plan

The financial plan uses the assumptions summarised in the table below to forecast changes in income and the cost base in 2010/11 and 2011/12. The majority of financial planning assumptions are provided centrally by NHS London or the Department of Health.

The financial implications of growth in demand for acute and non-acute services over the period have been modelled using demographic assumptions provided by HCfSWL. All uplifts have been applied to the month 6 forecast outturn for 2009/10, adjusting for non recurrent income and expenditure and the full year effect of any investments which started part way through the year.

Key Planning Assumptions	2009/10	2010/11	2011/12
Income growth	5.2%	5.1%	2.5%
Surplus target	0%	1%	1%
Cost pressures			
Acute growth (% expenditure)		2.6%	2.6%
Non Acute Growth (% exp)		1.5%	1.5%
Healthcare initiatives (% income)		0.5%	0.5%
<i>Central bundle allocation² (%)</i>		0.5%	0.5%
Contingency (% income)		0.5%	0.5%
<i>Risk Contingency (% income)*</i>		0.5%	0.5%
<i>Non recurrent expenditure fund*</i>		1.5%	1.5%
Provider Tariff (acute and non-			

² As per the Operating Framework, this relates to budgets currently held by the DH which will now be devolved to PCTs from 2010/11.

³ Items highlighted * are budgeted for in 2010/11 and rolled forward so have no impact on years 2-5.

<i>Less: Efficiency savings</i>	3.0%	3.5%	4.0%
Net tariff uplift	1.7%	0%	-0.5%
CQUIN funding (% expenditure)*	0.5%	1.5%	1.5%
Prescribing Uplift (Annual)	7.5%	7.5%	7.5%

4.6 Key risks included within your financial plan

Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
Non PBR tariff review	High	Additional cost pressures of £2.5m have been factored in for the 2010/11 "Right Price Review" of non PBR services at Kingston Hospitals. A cost saving has been targeted for the whole amount as the PCT plans to managed any cost pressures within current financial envelope for non PBR services. This will be managed through the acute contracting process with the support of the ACU.
Acute Activity Growth	High	The PCT has used Healthcare for SW London assumptions for growth based on GLA (Low) and historical activity growth. It is expected that the PCT will manage any risks associated with growth within this budget.
Delegation of central budgets	Medium	As per NHS London planning guidance, the PCT costs associated with the devolvement of central budgets from the Department of Health to PCTs, based on the its weighted capitation share of £500m. The final figures are yet to be confirmed

4.7 CQUIN

Describe your proposed CQUIN schemes and how CQUIN payments have been treated in contracts. Where relevant, what is the link to your strategic initiatives and WCC outcomes?

Those being worked up as at 25 January

1. Long Term Conditions (LTC) – emergency admissions and re- admissions across all pathways (combined to be more powerful) and A&E attendances for LTC's (frequent flyers).
 2. LTC's – reducing complications (may need 3- 5 year trend)
 3. Application of the key indicators in the diabetes pathway applied to all LTC's (approx 80% apply to all LTC'S, 20% disease specific)
 4. Effective discharge planning (LOS appropriate to condition), specified timing, content of discharge letters and providing copy to patients. Already in contracts but not performance managed yet
 5. Dementia
 6. Mental Health – what is the system indicator for LOS? Patient's in the appropriate care setting
 9. Rehabilitation. Getting people back to productive life.
 10. Pre-operative work up – as a Regional Indicator – allows for local interpretation of how this is addressed
- KHT specific

Smoking cessation (build upon 2009-10)

Patient experience (focus on a subset of questions; also NHS London thinking)

Improving Delayed Transfer of Care (building on process improvements from JHIP, including

link to Intermediate Care & Social Services
 Improving Early supported Discharges (ditto)

Conditions for coverage in 3 & 4 include COPD, Heart Failure, Diabetes, Stroke and Early Dementia
 Early Dementia pathway within the acute setting was single out a possible separate CQUIN scheme.

4.8 Cost Improvement Programmes (expenditure savings only)

The table below shows the PCT's cost improvement plans for 2010/11 and 2011/12 including the annual reduction in expenditure and the cumulative target reduction over the two year period. The plan mainly uses HCfSWL assumptions to model required savings for 2010/11 and 2011/12. In addition to the challenging targets being identified through the HCfSWL, the PCT has reviewed its own expenditure to identify further opportunities including additional prescribing efficiency of 1% and additional savings from reviewing all major contractual spend including acute, mental health and primary care. The PCT has budgeted for transitional costs likely to be incurred in implementing the HCfSWL and its own efficiency targets.

Savings targets for 2010/11 and 2011/12 have been applied to budgets for 2010/11 and schemes are under development through discussion with operational managers. The PCT's Programme Management Office (PMO) processes will be used to support the development and implementation of the schemes through business cases. The PMO will also be used to report progress in implementing the saving schemes and cost savings achieved during the year. This structure is already effectively used to monitor the delivery of investment projects.

Operational plans are still being developed to achieve the savings targets in 2010/11 and 2011/12. It will require the PCT to work with its providers to identify significant efficiencies in current contract expenditure and may require provider reconfiguration so there is significant risk to achieving the schemes. Achieving a 25% reduction in corporate costs by 2011/12 will require significant change in the management structure of the PCT during 2010/11. The South West London sector PCTs are working together to consider how this could be achieved

Savings Scheme	Implementation Plan	2010/11		2011/12	
		Annual £000	Cum %	Annual £000	Cum %
Corporate Costs (pay and non pay CIP) - Reduction in corporate overheads through pay and non-pay savings	<ul style="list-style-type: none"> A review of corporate budgets is underway as part of the 2010/11 budget setting to identify where these savings can be made. Further work will be undertaken with the SWL Sector PCTs to identify new working practices and structures to support the achievement of the 30% target. 	400	2	1,520	25

Primary Care and Community Services (other CIP) - Reduction in Provider Contract values through efficiency savings	<ul style="list-style-type: none"> National tariff saving plus additional efficiency targets to be built into contracts annually. Review of contract with the Community Provider to identify efficiencies during 2010/11 commissioning process. Review of PMS and other GP contracts to identify further efficiencies – 1% in 2010/11 from list cleansing and renegotiation of contracts. 	410	6	0	9
Polysystems (other CIP) – Transfer of acute activity to a lower cost setting.	<ul style="list-style-type: none"> Pathway redesign work is underway as part of the Polysystems project, as described in section 4. Saving will be made by negotiating a lower tariff for activity undertaken in the primary and community setting. 	330	N/A ⁴	500	N/A
Prescribing (other CIP)	<ul style="list-style-type: none"> Targeted efficiency savings 	380	2	400	4
Non PBR tariff (other CIP)	<ul style="list-style-type: none"> Mitigate additional cost from review of local priced acute activity through 2010/11 contract negotiation. 	2,500			
Mental Health – (other CIP) efficiency savings	<ul style="list-style-type: none"> Local savings target to be achieved through review of contracts to identify further efficiencies. 	500			
Total Cost Improvement Plans		4,520		2,420	

4.9 Demand management schemes

The PCT has identified £1.5m cost savings in its acute expenditure from demand management schemes for 2010/11 (£1m in 2011/12). The detailed schemes are included in the table below. Decommissioning and long term condition management schemes were developed using the HCfSWL assumptions. A further scheme was identified based on utilising contract metrics more effectively. The PCT is working with the Sector Acute Commissioning Unit and its other partners such as GPs and KCAS to implement the plans. The changes to the acute commissioning contracts will be made by 26 February 2010.

Demand Management Scheme	Implementation Plan/Risks	2010/11		2011/12	
		Annual £000	Cum %	Annual £000	Cum %

⁴ Savings calculated using HCfSWL modelling of activity transfer at 10% tariff saving less the costs of developing the polysystem infrastructure.

<p>Decommissioning - Reduction in acute attendances for low priority procedures through referral management and gatekeeping policies.</p>	<ul style="list-style-type: none"> • % reductions identified through benchmarking commissioning HRGs in the SWL Sector. • KCAS manages referrals assessment and will be tasked with supporting the delivery of this saving. • Acute commissioning intentions will also identify the low priority procedures to ensure they are embedded in the contract from 2010/11. • Risks – the PCT is already using KCAS to manage its referrals therefore additional savings may be difficult to achieve. The PCT will have to review pathways currently in use at other SWL Sector PCTs and may need to make significant changes to the services it is commissioning and its contracts. 	490	1	490	1
<p>Long Term Condition (LTC) Management - Reducing the level of acute non-elective admission by better case management in the primary and community setting.</p>	<ul style="list-style-type: none"> • Pathway redesign work is underway on significant areas of expenditure such as COPD and Diabetes. This work will identify activity that should be undertaken in the primary and community setting therefore reducing acute admissions. • The transfer of activity is factored into the polysystem modelling. The savings will require improved case management of patients with LTC by GPs and will be underpinned by acute commissioning contract metrics. • Risks – achievement of this saving is reliant on pathway redesign work identifying a lower cost pathway and having a direct impact on non elective admissions. This work is early in the development stage so the saving for 2010/11 may not be fully realisable. 	520	2	520	3

Contract Management - savings arising from increased use of contract metrics.	<ul style="list-style-type: none"> Work is underway with the ACU to strengthen the use of contract metrics in place with the PCT's main providers for 2010/11, particularly focusing on new to follow up ratios, consultant to consultant referrals and readmission rates. Risks – Demand for acute services may continue to grown and make savings difficult to achieve. The PCT is already using many of the contract metrics to manage acute commissioning expenditure so additional savings will require significant support from the ACU. 	500			
Total Demand Management schemes		1,510		1,010	

4.10 Capital investment and disposal (including sources of funding)

NHS Kingston owns a number of properties, leased to Your Healthcare and GPs, which require capital investment over the period in line with the estates strategy. The PCT will also continue to invest in IT and providing capital grants to GPs to improve premises. The PCT's polysystems development at Surbiton is currently at stage one business case for LIFT so IT and other equipment only is included in the capital forecast below. These investments will be funded through the disposal of surplus estate and DH funding.

Capital Expenditure By Area	2009/10 £000s	2010/11 £000s	2011/12 £000s
Estates	1,000	950	700
Clinical Services	50	550	150
IT	700	1,220	1,050
Primary Care	30	1,800	500
Other inc polysystem	120	380	1,200
Capital grants	300	2,500	300
Transfers from other NHS Organisations	500	1,600	0
Total Capital Expenditure	2,700	9,000	3,900
Capital Income	2009/10 £000s	2010/11 £000s	2011/12 £000s
Income/Sale of Property		(1,900)	(3,600)
Net Total	2,700	7,100	300
Funding from DH		(1,500)	
Capital requirement	2,700	5,600	300

4.11 Key financial risks and opportunities not included in the financial plan (with mitigating actions)

- The main financial risks not included in the plans are:
- PBR tariff inflation may be higher than the 0.5% net saving planned for 2011/12 (£1.6m impact of 0.5% change in tariff inflation).
- The impact of any changes to the existing PBR tariff or extension of PBR to expenditure currently under local tariff or block contracts arrangements. A change in tariff of 1%

could produce a risk of £0.4m or alternatively a positive change to the tariff may produce an opportunity of the same value.

- Operational plans to deliver the HCfSWL savings are under development and require significant change across sector providers to be fully achieved (£1.4m).
- Corporate savings may not be fully realisable in due to resourcing requirements to facilitate the level of change over the period and potential restructuring costs (£0.6m).
- The main financial opportunities not included in the plans are:
- The plan includes growth funding for acute non-PBR and non acute contracts above inflation which may not passed on directly onto providers (£4m).
- The level of savings identified in the polysystems pathway redesign work may fund the increased estates costs as well as realising the ATF assumption of 10% tariff saving (£0.4m).

4.12 Use of Resources – plans to improve your score (where relevant)

Managing Finances – the PCT has improved its score from level 1 in 2006/07 to level 2 in 2008/09, particularly focusing on improvements in financial reporting. It is expected to maintain its score for 2009/10 with improvements in some areas to level 3, particularly around the development of acute commissioning in conjunction with Humana and the SW London Acute Commissioning Unit. . The PCT is developing an action plan to improve its overall scores for 2010/11 to achieve a level 3 rating, including taking forward its work on benchmarking and programme budgeting.

Governing the Business – the PCT has particularly focused its development on its procurement processes linked to its competences under World Class Commissioning.

Managing the Resources – The PCT is working with strategic partners, including the Local Authority, to take this forward.

SECTION 5: WORKFORCE (PCTs and sectors)

5.1 Workforce impact of strategic goals

(PCTs) Please provide a description of the anticipated impact for workforce within local provider Trusts and PCT providers as a result of the PCT's strategic initiatives e.g. describing anticipated increases / decreases for your main providers and services that may see significant change.

(Sectors) Please provide a description of the anticipated impact for workforce within the sector as a result of the sector's strategic initiatives e.g. describing anticipated increases/decreases in workforce and services that may see significant change.

Significant changes :

Investment in maternity workforce and recruitment of community midwifery teams.

Investment in stroke and rehabilitation clinicians – therapists and support staff. Development of integrated teams working across the pathway.

Transfer of skills from secondary care including mental health to primary care and community. Workforce transformation to deliver polysystem programme , promotion of self care and 3rd sector support programmes.

Reduction in or transfer of secondary consultant resource to primary care. Inc in training for GPwSI, primary care and community nursing to deliver polysystem.

5.2 Effective communication with providers

(PCTs) Does your organisation have a process in place by which it can assure the workforce strategies of its provider organisations are fully integrated with service and financial plans, and aligned with the PCT's

Y/N

<p><i>vision as highlighted in its commissioning intentions communicated to its providers?</i></p> <p><i>(Sectors) Are you assured that your PCTs as commissioners have a framework in place to ensure that provider organisation workforce strategies are fully integrated with service and financial plans and aligned to your sector vision?</i></p>	
<p>Key strategic development set out in joint health improvement programme with Kingston Hospital and other providers. Programme is aligned to strategic priorities. Workforce plans are monitored through programme boards PEC and F&C committee sign off all business cases and finance for workforce development Maternity recruitment plan - through monthly maternity improvement board and 3 monthly JHIP board Sexual health network - clinical workforce recruitment and development - through management board and JHIP board. Funding decisions through PEC. Urgent care centre - clinical workforce development monitored through UCC board and JHIP board.</p>	
<p>5.3 Quality of Service / Education considerations</p>	
<p><i>(PCTs) Has the PCT made clear to their provider organisations that their education and training funding should be used to transform their workforce to support the delivery of the PCT's service vision, and does the PCT have mechanisms in place to assess whether provider organisations have appropriate plans to support this objective?</i></p> <p><i>(Sectors) Are there mechanisms in place at sector level to assess whether PCTs have processes in place to ensure provider organisations have appropriate education and training plans to support the service vision for the sector?</i></p>	<p>Y/N</p>
<p>Set out and monitored through joint health improvement programme with Kingston Hospital and other providers. All service developments reviewed by clinical leads group (PEC and KH consultants To be developed further in 2010/11 contracts, development of KPIs and CQUINs.</p>	
<p><i>(PCTs) Does the PCT have processes in place to ensure that provider organisations carry out appropriate workforce risk assessments and address capability or capacity issues ahead of the changes that the PCT's local service vision will require?</i></p> <p><i>(Sectors) Are you assured that your PCTs as commissioners have processes in place to ensure that provider organisations carry out appropriate workforce risk assessments and address capability or capacity issues ahead of the changes your sector service vision will require?</i></p>	<p>Y/N</p>
<p>Set out and monitored through joint health improvement programme with Kingston Hospital and other providers. Contract and clinical quality monitoring arrangements review key risks affecting service delivery. Work in progress to ensure workforce risk is systematically built into all aspects of service planning.</p>	
<p>5.4 Statutory Workforce Obligations</p>	

<p><i>(PCTs) Does the organisation have a process in place by which it can assure statutory workforce obligations (e.g. EWTD, mandatory training, % appraisal rates, quality of appraisals, medical revalidation) are delivered within its provider organisations?</i></p> <p><i>(Sectors) Are you assured that PCTs as commissioners have processes in place by which they can assure statutory workforce obligations (e.g. EWTD, mandatory training, % appraisal rates, quality of appraisals and medical revalidation) are delivered within their provider organisations?</i></p>	<p>Y/N</p>
--	-------------------

Contract and clinical quality monitoring arrangements review statutory workforce obligations. NHSK monitors external assurance, eg declaration to CQC on key training and appraisal requirements.

5.5 Productivity & Efficiency

<p><i>(PCTs) What percentage increase in workforce productivity is the PCT expecting from its providers, and does the PCT have mechanisms to monitor the clinical productivity of provider organisations?</i></p> <p><i>(Sectors) Are there mechanisms in place at sector level to ensure that PCTs as commissioners are monitoring the clinical productivity of provider organisations against expected levels?</i></p>	<p>Y/N</p>
--	-------------------

NHSK is undertaking reviews of clinical productivity but has not reached a position of comparison with others. An overall 5 - 10% increase in productivity is expected to be included in the KPIs according to service area. Performance monitoring is undertaken through the contract monitoring arrangements. Clinical productivity to improve patient outcomes is monitored as part of the development of new clinical pathways. Community Provider services committed to 5% productivity increase 2010/11 (see IBP). This is monitored for DN and HV and performance targets.

5.6 Leadership

<p><i>(PCTs) Does the PCT have a strategy on developing talent and leadership in line with service delivery and financial management?</i></p> <p><i>(Sectors) Are you assured that PCTs can demonstrate that they have focussed on developing talent and leadership in line with service delivery and financial management?</i></p>	<p>Y/N</p>
---	-------------------

This is being implemented as part of the NHSK OD Plan. NHSK commitment to leadership development . ADs seconded to executive development programme and involvement in 'Breaking Through' programme . A range of opportunities have enabled talent to be developed in line with service priorities. Eg Programme management office (PMO) allows project management skills to be developed across sector.

SECTION 6: INFORMATICS (PCTs only)

Please complete the informatics template at Annex B.