NHS Hammersmith and Fulham

NHS Hammersmith and Fulham Trust Board

The next meeting of the NHS Hammersmith and Fulham Trust Board will be held at 2.00pm on Wednesday 19 January 2011 in the Small Hall, Hammersmith Town Hall, W6 9JU

A G E N D A

GENERAL BUSINESS

1	**Introductions**	
2	**Apologies for absence**	
3	**Declaration of interests**	
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6	**Matters arising from the meeting held on 10 November 2010**	
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8	**Chair's report**	
9	**Executive report**	pp 15 – 22

STRATEGY

10	**Update on financial strategy – Jeff Deane**	verbal update
11	**Divesting community services – Tim Tebbs**	verbal update
12	**Public Health White Paper update – David McCoy**	pp 23 – 48
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14	**Planned Procedures with a Threshold – David McCoy**	pp 121 – 170

PERFORMANCE

15	**Finance report – Jeff Deane**	pp 171 – 202
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Chair: Jeff Zitron
Cluster Chief Executive: Sarah Whiting

17	**Performance report – Miles Freeman**	pp 207 – 224
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GOVERNANCE

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INFORMATION

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23	**Minutes of 9 December 2010 meeting of the Equality Strategy Group**	pp 257 – 260
24	**Minutes of 13 October 2010 JCPCT meeting**	pp 261 – 264
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26	**Use of Seal**	p 271

27 ANY OTHER BUSINESS

28 DATE OF NEXT MEETING

Wednesday 16 March 2011 in the Small Hall, Hammersmith Town Hall, W6 9JU

29 RESOLUTION

To exclude the press and public from the second part of the meeting owing to the confidential nature of the business.

NHS HAMMERSMITH AND FULHAM

MINUTES OF BOARD MEETING – Part 1

Wednesday 10th November 2010, 2.00pm
Room 4.1, 1 Hammersmith Broadway, London W6 9DL

Present:

Board Members

Jeff Zitron (JZ)	Chair
Rosie Glazebrook (RG)	Non-Executive Director
Trish Longdon (TL)	Non-Executive Director
Elizabeth Rantzen (ER)	Non-Executive Director (Items 1-19)
Peter Worthington (PW)	Non-Executive Director
David McCoy (DMc)	Acting Director of Public Health
Tim Tebbs (TT)	Interim Director of Finance
Sarah Whiting (SW)	Chief Executive
Cllr Joe Carlebach (JCA)	Associate Board Member

Officers:

Carole Bell (CB)	Programme Director, Children's Commissioning
Josip Car (JC)	Medical Director
Miles Freeman (MF)	Director of Commissioning
Susan McGoldrick (SMc)	GP Consortium Steering Group
James Reilly (JR)	Director of Community Services (Item 5 onwards)
Maureen O'Sullivan (MOS)	Deputy Board Secretary
Tom Stevenson (TS)	Head of Communications
Becky Wellburn (BW)	Assistant Director of Commissioning (Primary Care) (Item 19)
Ben Westmancott (BW)	Associate Director of Strategy & Planning
Kieran Seale (KS)	Company Secretary – Minutes

In attendance
Members of the Public

1.	**Introductions**	
1.1.	The Chairman welcomed members of the public to the meeting.	
2.	**Apologies for Absence**	
2.1.	Apologies were received from Andrew Duguid, Peter Fermie and Geoff Alltimes.	
3.	**Declaration of Interests**	
3.1.	No interests were declared.	
4.	**Minutes of the Board Meeting held on 8th September 2010 and 17th September 2010**	
4.1.	The Minutes of meetings held on 8th September 2010 and 17th September 2010 were approved as accurate records of the meetings.	

5.	**Matters Arising (not included elsewhere on the agenda)**	
5.1.	5.1 (8th September) – a report on the training of practice managers will be brought to the Quality, Performance & Finance Committee.	
5.2.	11.1 (8th September) – the Interim Director of Finance confirmed that an update on the Equality Impact Assessment of the Savings Plan will be brought to the January Board.	**TT**
5.3.	14.2 (8th September) – the Head of Communications agreed to ensure that the PCT's website is clear on how complaints can be made about Primary Care contractors.	**TS**
6.	**Chair's Report**	
6.1.	The creation of an Inner North West London Cluster of PCTs was noted. It was confirmed that this change would not change the legal status of the PCT which will continue in its current form until April 2013. Consideration is being given to the governance arrangements of the Cluster.	
6.2.	It was noted that Sarah Whiting has been appointed as Chief Executive of the Inner North West London Cluster. The Board gave its congratulations to her on this appointment. It was resolved that as a result of this appointment Sarah Whiting will assume Accountable Officer status for the PCT.	
6.3.	The Chair reported that the Minister of State for Health, Paul Burstow MP and Sir David Nicholson, Chief Executive of the NHS, visited the Canberra Centre for Health to see the work the PCT has been doing to integrate activities with the London Borough of Hammersmith & Fulham.	
6.4.	The Chair also reported on his attendance at the White City Well London Open Day where the achievements of local volunteer Health Champions were presented to Commissioners from NHS London and others. He congratulated all those involved in the impressive work at White City.	
7.	**Executive Report**	
7.1.	The Chief Executive, Sarah Whiting, presented the report.	
7.2.	It was reported that the PCT has received a NHS London Health & Social Care Award for the QOF+ programme.	
7.3.	The Chief Executive gave an update on the development of the North West London Cluster. Consultation on Phase II (Director level) began on 18th October and will end on 19th November with interviews in early December. Consultation on Phase III (All staff) began on 22nd October and will run for 90 days. It is expected that functions which will ultimately be taken on by the NHS Board will be run at Sector level in the interim.	
7.4.	The exact extent of resources available to the Cluster is not yet certain and negotiations are continuing as to what will be available. Priority is being given to ensure that the PCT continues to deliver the outcomes in the Commissioning Strategy Plan. In addition, a number of measures have been put in place to provide support to staff through the changes.	
7.5.	Updates to the governance arrangements relating to integration with the local authority are being developed and will be reported to January Board.	
7.6.	The Annual Audit Letter was received and noted by the Board.	

8.	**Practice-Based Commissioning Consortium Update**	
8.1.	Discussions are underway with the members of the GP Consortium Steering Group on their future role in the management of the PCT. It was agreed that a Board meeting should be held on 16th December to consider the outcome of this work.	
8.2.	It was noted that the Consortium in Hammersmith & Fulham will aim to be involved in the "Pathfinder" project for GP consortia.	
8.3.	It was noted that functions that are intended to be carried out by the NHS Board in future arrangements (eg commissioning of ophthalmologists, dentists and maternity services) will be moved to Sector level rather than being dealt with by the Cluster, but that those that will be carried out by GP consortia will continue to be dealt with locally. Thought is also being given as to how a Health & Wellbeing Board will operate. An update on progress on structures will be brought to the January Board.	
9.	**2010/11 Operating Plan Delivery Report – Month 6**	
9.1.	The Associate Director of Strategy & Planning presented progress on the delivery of the operating plan and reported that the PCT is on-track to meet the planned outcomes.	
9.2.	Liz Rantzen asked about progress with the GP Scorecard. It was confirmed that consultation is underway at a London-wide level and that work is also taking place locally.	
10.	**Finance Report**	
10.1.	The Interim Director of Finance reported that the PCT is still forecasting that it will meet its surplus target for the year, but that there are significant cost pressures. The largest area of risk relates to over-performance by Imperial College Healthcare NHS Trust and work is underway to mitigate this risk.	
10.2.	The report was noted.	
11.	**Board Assurance Framework**	
11.1.	The Associate Director of Strategy & Planning presented the latest version of the Board Assurance Framework (BAF). It was noted that the comments made at the last Board meeting on expanding the description of mitigating action had been reflected in the updated BAF.	
11.2.	The Chair asked how the Assurance Framework will be updated to reflect the implications of staffing reductions. The Chief Executive reported that work is underway to ensure that this will be done and that an update on the work will be given at the December Board Seminar.	**SW**
11.3.	The Board agreed to accept the risks as stated and agreed that the actions to provide assurance are satisfactory.	
12.	**Month 6 Performance Report**	
12.1.	The Associate Director of Strategy & Planning, presented the report outlining the PCT's performance in meeting targets.	

12.2.	Responding to a suggestion from Liz Rantzen that receptionists at GP practices be given incentives to promote screening and other services, the Medical Director reported that more innovative use of e-consulting offered a practical and strategic solution to this issue, and that a pilot scheme was planned for early 2011.	
12.3.	Methods of promoting childhood immunisation were discussed and it was suggested that a targeted information campaign could be carried out, possibly in conjunction with London Borough of Hammersmith & Fulham.	
12.4.	The Board noted the report.	
13.	**Capital and Estates Update**	
13.1.	The Director of Commissioning presented the report. He reported that approval of the White City Collaborative Care Centre business case is awaited from NHS London and it is hoped that it can be obtained to enable financial close in January 2011. He agreed to circulate the business case to Board members and give a verbal update on progress at the meeting on 16th December 2010.	**MF**
13.2.	The Director agreed to provide a brief summary of progress on the White City project for Cllr Carlebach to share with the Leader of Hammersmith & Fulham Council.	**MF**
13.3.	The Director agreed to invite Board members to visit some of the new facilities developed by the PCT.	**MF**
13.4.	It is hoped to be possible to bring the business case for the Shepherd's Bush Health Facility to the January Board.	
13.5.	The Board noted the report.	
14.	**Improving Continuity of Care and Integrating Local Services**	
14.1.	The Director of Community Services presented the report. He informed the Board that the report contained the results of feasibility work and that the next stage would be to move towards the design stage, during which engagement would be extended to end-users. He noted comments from the Board and the public on the central importance of the end-user as the focus of design, and the need for an Equality Impact Assessment of the differential effects of the integrated care pilot.	
14.2.	The Director agreed to circulate information on the cost of the integrated care pilot.	**JR**
14.3.	The Board noted the concerns raised in writing by the Chair of the Practice-Based Commissioning Consortium Steering Group and by the Local Medical Committee, about the impact on primary care, and asked that these concerns be addressed in future reports.	**JR**

14.4.	Noting the assurances given in relation to user involvement, the Board: (i) noted that the local Continuity of Care programme and the North West London Integrated Care Pilot were complementary and could be progressed in concert; (ii) agreed to progress the local Continuity of Care programme; (iii) agreed the Integrated Care Pilot in principle, subject to agreement from the Practice-Based Commissioning Consortium Steering Group; (iv) agreed that a business case for full implementation of the Continuity of Care proposals should be prepared for the March 2011 PCT Board meeting.	
15.	**Public Health Annual Report – update**	
15.1.	The Interim Director of Public Health informed the Board that the Public Health Annual Report will be published in January 2011 and circulated to the Board in advance of publication. He agreed to check that this complied with the PCT's legal obligations.	**DMc**
15.2.	The Board noted this verbal update.	
16.	**Safeguarding Children Annual Report 2009/10**	
16.1.	The Programme Director, Children's Commissioning, presented the report, drawing the Board's attention to strengthened safeguarding and assurance arrangements, improvements in the relationship with primary care and the lessons learned from three Serious Case Reviews.	
16.2.	In discussion of the quality of information provided by GPs for case conferences, the Board noted improved arrangements for alerting GPs to conferences and reviews.	
16.3.	In response to a request from Cllr Carlebach, the Director agreed to provide a summary of the child protection training provided by the Local Safeguarding Children Board (LSCB) to share with the Safer Neighbourhoods Team Chief Inspector.	**CB**
16.4.	The Board noted the report and agreed the process for Board assurance, subject to the Audit Committee's approval of the assurance framework set out in Appendix 7.	
17.	**Safeguarding Adults Annual Report 2009/10**	
17.1.	The Director of Community Services presented the report, drawing the Board's attention to a welcome increased awareness of the need to report incidents of harm against vulnerable adults. Despite the increased level of alert, there had been no increase in the incidence of abuse. However, the fact that adults with learning disabilities had the highest level of repeat referral remained a matter of concern.	
17.2.	Asked about the assurance framework, the Director informed the Board that the local authority's multi-agency Safeguarding Adults Committee carried out this duty on behalf of the Board. However, the Committee would raise any relevant concern with the Board.	
17.3.	The Board noted the report and the key priorities for the remainder of the year.	
18.	**Quarterly Untoward Incident Analysis Report**	
18.1.	The report was noted.	

19.	**Dental commissioning**	
19.1.	The Director of Commissioning presented a report giving an update on dental contracts and actions that are being taken to improve the system of dental commissioning.	
19.2.	Liz Rantzen asked about the effect that the CQC registration requirement would have. The Director of Commissioning responded that he did not expect the effect to be great.	
19.3.	Trish Longdon asked about the effect of the opening of the dental facility at White City. It was reported that the level of activity is below target and that a community engagement plan is being developed.	
19.4.	The importance of improving child oral health was noted, both because of its intrinsic importance and because poor oral health is generally an indicator of wider health problems. It was agreed that this should be a priority and that work should be carried out in schools and through working with parents to address it. It was agreed that the Commissioning Executive Team should draw up a timescale for reporting back to the Board on what has been achieved to set up a targeted campaign on child oral health.	**MF**
20.	**Information Governance Review**	
20.1.	The Medical Director updated the meeting on progress being made on information governance. It was agreed that the January Board should be given an update on which areas it will not be possible to give full assurance that obligations are being met.	**JC**
20.2.	It was agreed to note the report and formally delegate responsibility for signing off quarterly updates and statements of compliance to the Information Governance lead.	
21.	**Children's Joint Strategic Needs Assessment**	
21.1.	The Acting Director of Public Health presented the Assessment which gives an overview of child health in Hammersmith & Fulham.	
21.2.	The report was noted and it was agreed that the Commissioning Executive Team should draw up a programme to allow for more in depth discussion of child health and child health services.	**DMc**
22.	**Minutes of Audit & Risk Committee meeting**	
22.1.	The Minutes of the meeting of 17th September 2010 were noted.	
23.	**Draft minutes of Quality, Performance & Finance Committee meeting**	
23.1.	The draft Minutes of the meeting of 21st October 2010 were noted.	
24.	**Minutes of Equality Strategy Group meetings**	
24.1.	The Minutes of the meeting 10th June and 9th September 2010 were noted. It was noted that representatives of the GP Consortium Steering Group have been invited to attend the next meeting.	

25.	**Minutes of NW London JCPCT meetings**	
25.1.	With regards to Item 5 on the Minutes of 5th September, the Board noted that JCPCT members felt there was insufficient analysis of the sector's adverse financial variances, in particular, the reasons for acute sector over-performance and the consequential effects on surpluses and deficits in both PCT and provider trusts.	
25.2.	The Minutes of the meeting of 4th August and 15th September 2010 were noted with the caveat that if, as signalled in the Interim Director of Finance's report, the PCT may be asked to financially support other parts of the sector, the Board would expect to be assured that commissioners and providers in every cluster are applying sufficient rigour to controlling performance and finance.	
26.	**Use of Seal**	
26.1.	The use of the seal as detailed in the report was ratified.	
27.	**Any Other Business**	
27.1.	Rosie Glazebrook reported that the Learning Disability Steering Group has been set up, that regular meetings are being held and that actions are being monitoring against milestones.	

NEXT MEETINGS:

Thursday 16th December, 9.00am (single item meeting): Courtyard Room, Hammersmith Town Hall, King Street, Hammersmith, W6 9JU

Wednesday 19th January 2010, 2.00pm (full meeting), Small Hall, Hammersmith Town Hall, King Street, Hammersmith, W6 9JU

Chair: ……Jeff Zitron……..……

Signature: …… **Date**: ……

NHS HAMMERSMITH AND FULHAM

MINUTES OF BOARD MEETING

Thursday 16th December 2010

Room 4.1, 1 Hammersmith Broadway, London W6 9DL

Present:

Board Members

Jeff Zitron (JZ)	Chair
Andrew Duguid (AD)	Non-Executive Director
Trish Longdon (TL)	Non-Executive Director
Elizabeth Rantzen (ER)	Non-Executive Director
Peter Worthington (PW)	Non-Executive Director
Jeff Deane (JD)	Director of Finance
Sarah Whiting (SW)	Chief Executive
Cllr Joe Carlebach (JCA)	Associate Board Member

Officers:

Dr Ike Anya (IA)	Public Health Consultant
Karen Broughton (KB)	Borough Director, Deputy Chief Executive
Mark Creelman (MC)	Strategy & QUIPP Director
Dr Peter Fermie (PF)	GP Consortium Steering Group
Miles Freeman (MF)	Director of Acute Commissioning
Susan McGoldrick (SMc)	GP Consortium Steering Group
Dr Tim Spicer (TS)	Chair, GP Consortium Steering Group
Tim Tebbs (TT)	Interim Borough Director
Dr Helen Walters (HW) Item 4 on	Director of Public Health, Westminster
Kieran Seale (KS)	Company Secretary – Minutes

1.	**Introductions**	
1.1.	The Chief Executive introduced the new Directors who have been appointed as part of the process of creating the Inner North West London Cluster.	
1.2.	The Chief Executive also gave an update on recent government announcements relating to the Health White Paper and the Operating Framework. Tim Tebbs outlined the current financial position of the PCT.	
1.3.	Liz Rantzen asked about the danger that patients will be sent to A&E to avoid charges relating to re-admission of patients. Miles Freeman said that this issue is being considered by a Sector Clinical Working Group and that he would provide an update on the proposed actions when this work has been carried out.	**MF**
1.4.	James Reilly was congratulated on his appointment as Chief Executive of Central London Community Healthcare and thanked for his work for the PCT in recent months.	
2.	**Apologies for absence**	
2.1.	Josip Car (JC), David McCoy (DMc), James Reilly (JR).	

3.	**Declaration of interests**	
3.1.	Cllr Joe Carlebach declared his interest as a Cabinet Member of the London Borough of Hammersmith & Fulham.	
4.	**Future Governance Arrangements**	
4.1.	The Chief Executive introduced the paper setting out proposals for the development of the governance of the PCT, particularly relating to greater involvement of the GP consortium.	
4.2.	The paper proposed the creation of a Borough Executive Team to be a sub-committee of the Board. This will include the members of the GP Consortium Steering Group, representatives of the local authority and Non-Executive Directors and will meet fortnightly. It will be chaired by the Chair of the GP Consortium Steering Group. Two representatives of the GP Consortium Steering Group will also join the Cluster Integrated Management Team and will sit on the PCT Board.	
4.3.	Trish Longdon asked about how community engagement would be maintained. It agreed that this should be included in the remit of the Borough Executive.	
4.4.	The proposals set out in the paper were approved, with the addition of Non-Executive Director representation on the Borough Executive. It was agreed that the Borough Executive should be put into place as soon as possible.	
4.5.	The importance of maintaining strong links with the local authority was agreed. It was noted that it is proposed to have representatives of the local authority on the Borough Executive and to continue to have a co-opted representative on the Board, as at present. Consideration is being given to how the Health & Wellbeing Board will be constituted.	
4.6.	It was agreed that further proposals relating to governance arising out of the creation of the Inner North West London Cluster and the development of the North West Sector will be brought to the January Board for implementation from 1st April 2011. These proposals will include recommendations relating to ensuring continued local authority and community input, clarification of the time commitment needed from GPs and ensuring consideration of non-GP Primary Care and of Social Care.	
5.	**Standing Orders/Standing Financial Instructions**	
5.1.	An integrated management team for the Inner North West London Cluster came into operation from 13th December. It was agreed that it would be desirable for there to be a common set of Standing Orders and Standing Financial Instructions across the cluster so that Directors are working within a consistent framework. A proposal for putting this in place was outlined.	
5.2.	The Board approved the proposal that the Standing Orders and Standing Financial Instructions for NHS Westminster be adopted for use by the PCT. It was agreed that Chair's action should be taken to approve the Scheme of Delegation.	
6.	**White City Collaborative Care Centre Update**	
6.1.	The Director of Acute Commissioning gave an update on developments with the White City Collaborative Care Centre project.	

6.2.	The Business Case has been submitted to NHS London who have made comments on it. These comments are now being addressed and the Business Case will be re-submitted in early January. It is hoped that final approval will be given in March.	
6.3.	Peter Worthington asked if the Non-Executive Directors could see the Business Case and Miles Freeman agreed to circulate it to them.	**MF**
6.4.	The Board expressed its concern and frustration at the continuing delays and considered whether political-level representations were needed. It was agreed that progress with the scheme should be discussed at the Board meeting on 19th January 2011 and consideration given then to whether further action is needed to ensure that there is no further delay in the scheme reaching financial close and start on site.	
7.	**Annual Public Health Report**	
7.1.	Ike Anya (Public Health Consultant) presented a draft of the Annual Public Health Report. It was noted that the report is independent and in the name of the Director of Public Health, but that the Board's comments on the draft were welcome.	
7.2.	Trish Longdon stressed the importance of basing the conclusions in the report, as far as possible, on evidence rather than supposition.	
7.3.	Tim Spicer said that the report should look at all providers and not focus exclusively on GPs. He identified mental health in particular as needing further attention.	
7.4.	Peter Worthington identified the need to consider the implications of population turnover on meeting targets.	
7.5.	Further comments were requested by 20th December. It was agreed that the final version would be circulated to Board members before publication.	**IA**
8.	**Any Other Business**	
8.1.	None.	
NEXT MEETING: Wednesday 19th January 2010 **Venue: Small Hall, Hammersmith Town Hall, London W6 9JU**		

Chair: ……Jeff Zitron…… **Signature**: ……

Date: ……

EXECUTIVE REPORT

Summary:
The report provides an update on major issues affecting NHS Hammersmith & Fulham. It includes information on:

- Progress with developing the INWL cluster management team
- Next steps for NHS reform
- Operating Framework for the NHS 2011/12
- GP pathfinder applications
- Winter pressures
- Commissioning Support for London (CSL)

Board action required:
The Board is asked to note the contents of the report.

Responsible director:	**Author:**
Sarah Whiting	Sarah Whiting

Date of paper: 10 January 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	Issues raised relate to key strategic priorities
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	n/a
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	Stakeholders have been consulted on relevant items
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	n/a
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	n/a

1. DEVELOPING PCT CLUSTERS IN NORTH WEST LONDON

Work to develop the new PCT Cluster arrangements continues at pace. The consultation with staff across North West London is happening in three phases:

- Phase 1 : CEO consultation and appointment (complete)
- Phase 2 : Executive Directorate structure (complete)
- Phase 3: All staff not included in phases 1 & 2 (22 October 2010 to 25 January 2011)

1.1 Executive Directorate Structure (phase 2)

Following the appointment of Sarah Whiting as Chief Executive of the Inner North West London PCT Cluster in October 2010, the PCT Cluster's Executive Directors were appointed on 13 December 2010. The appointments are:

- Karen Broughton – Deputy Chief Executive/Westminster Borough Director
- Frankie Lynch, Kensington and Chelsea Borough Director
- Tim Tebbs, Interim Hammersmith and Fulham Borough Director
- Jeff Deane, Director of Finance
- Miles Freeman, Acute Commissioning and Performance Joint Director
- Mark Creelman, Strategy and QIPP Implementation Joint Director

All three Directors of Public Health (Helen Walters – Westminster; Melanie Smith – Kensington and Chelsea; David McCoy – Hammersmith and Fulham) will join the Cluster Executive Team until a permanent single Director of Public Health is appointed to the PCT Cluster. This process is now underway.

1.2 All staff consultation (phase 3)

The all staff consultation to design the new cluster structures began on 22 October 2010. All three clusters, and the sector, are consulting to the same timescale (see section 1.5).

Phase 3 has included a design stage (which lasted until 15 December 2010) during which time there were many opportunities for staff to get involved in shaping the structure of functions and posts that will sit below directorate level.

The proposed structure for the integrated management team was published on 16 December 2010 and this confirmed how individual posts are affected by the changes. The PCT Cluster, and each of the three corresponding local authorities have agreed to the creation of a single joint commissioning team across each of the six organisations. This will incorporate mental health; older people; vulnerable adults; and children's services.

We are now undertaking a further 30 days consultation on the detailed proposals and this period of consultation will end on 25 January 2011. The process of applications and appointments to posts set out in the final structure will run from 28 January 2011 to 26 February 2011.

The new structures will be live from 1 April 2011.

2. THE GOVERNMENT'S NEXT STEPS FOR NHS REFORM

The Government published its next steps for NHS reform paper on 15 December 2010. The Government states that the White Paper consultation has bolstered its belief that the reforms are necessary, along with its resolve to follow them through. It acknowledges that the responses received have helped to rectify certain aspects "where we realised our original thinking was flawed".

The paper confirms:

- In an attempt to alleviate concerns around the transition to GP commissioning, there will be a "more phased approach" involving consortia pathfinders. The first tranche of these have already been confirmed (see section 4 for further details).
- A published constitution will be a pre-requisite for all GP consortia.
- The Government has changed its stance on maternity service commissioning with GP consortia now assuming responsibility for this area as opposed to the NHS Commissioning Board as originally envisaged.
- GP consortia will now have a more prominent part to play in supporting the NHS Commissioning Board in the drive to improve primary care quality.
- GP consortia can group together for some purposes with lead commissioner arrangements for contract management.
- The Health and Social Care Bill, expected in January 2011, will provide for membership of GP consortia to flex. The precise size of a consortium is less important than the ability to scale up or down. The only criterion relating to size will be that the NHS Commissioning Board is satisfied that consortia can discharge their functions.
- Health and well-being boards will enjoy an enhanced role within local authorities. Both the NHS and councils must have regard to a joint health and well-being strategy when commissioning services. There will also be an 'early implementer' programme.
- Local authorities will have formal scrutiny powers over all NHS-funded services and benefit from more autonomy over the ways in which they undertake such examinations. Scrutiny will no longer be incorporated into the health and well-being boards as initially proposed.
- The transition process for provider reform will be extended with the economic regulation system now scheduled to be fully in place by 2014. In the meantime, Monitor will continue to exercise some of its present controls over foundation trusts.

- HealthWatch England will be established as a statutory committee within the Care Quality Commission.
- All arms-length bodies will be subject to an explicit duty to co-operate in the delivery of their functions.

The Government's next steps paper can be downloaded from the Department of Health's website at www.dh.gov.uk/en/Aboutus/Features/DH_122686. A hard copy can be sent to you on request by contacting my PA at elizabeth.wright@hf-pct.nhs.uk. The NHS Confederation has also published a helpful summary document of the next steps paper which can also be sent to you on request.

3. THE OPERATING FRAMEWORK FOR THE NHS 2011/12

The Department of Health (DH) also published the Operating Framework for the NHS 2011/12 on 15 December 2010. It states that the overarching goal is to build strong foundations for the new system by:

- Maintaining and improving quality
- Keeping tight financial control
- Delivering on the quality and productivity challenge
- Creating energy and momentum for transition and reform

Key points in the Operating Framework include:

- PCTs will receive, on average, 2.2% recurrent growth with additional 0.8% growth in non-recurrent funding (mainly for investment in social care).
- The £20bn efficiency challenge has now been extended by one year – up to the end of 2014/15. This adjustment follows the Spending Review, the two year pay freeze and the "deeper than originally modelled reductions in management and administration costs".
- The national efficiency requirement in 2011/12 is 4% with an uplift for pay and price inflation of 2.5%.
- The tariff will be reduced by 0.5% to take account of additional efficiencies built into the tariff, while prices for non-tariff services will be reduced by 1.5%.
- Hospitals will no longer be reimbursed for emergency readmissions within 30 days of discharge following an elective admission in 2011/12. All other readmission rates will be subject to locally determined thresholds, with a 25% decrease desired where achievable.
- Providers will now be allowed to offer services below the published mandatory price, if both commissioners and providers concur.
- All PCTs are expected to develop formal cluster arrangements to help mitigate against a risk of "unplanned loss of capacity and capability in the current commissioning system".
- GP consortia will not be responsible for tackling PCT debt that accrued prior to 2011/12. PCTs and PCT Clusters should ensure that "all existing legacy issues are dealt with" between 2011 and 2013.

- GP consortia are expected to having running costs of between £25 and £35 per head by 2014/15.
- The document calls for extra vigilance in relation to: the transition; QIPP; ensuring sustainability of improvements such as waiting times; and delivery of Government priorities in areas such as health visitor recruitment.
- New commitments are announced on health visitors; family nurse partnerships; the cancer drugs fund; military and veterans' health; autism; dementia and carer support.
- Areas recognised as needing improvement include learning disabilities; child health; diabetes; violence; regional trauma networks and respiratory disease.

The Operating Framework can be downloaded from the DH's website at www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Planningframework. A hard copy can be sent to you on request by contacting my PA at elizabeth.wright@hf-pct.nhs.uk. The NHS Confederation has also published a helpful summary document on the Operating Framework which can also be sent to you on request.

We are in the process of responding to the operating framework and the PCT's Operating Plan for 2011/12 will be presented at the Board meeting in March.

4. GP PATHFINDERS UPDATE

The first groups of GP pathfinders were announced on 8 December 2010. Eight groups of GP practices in London are among the 52 from across England that have been selected to be the first to take on commissioning responsibilities. The pathfinders will work together to manage their local budgets and commission services for patients direct with other NHS colleagues and local authorities.

The first eight GP pathfinders in London are Bexley Clinical Cabinet; Ealing Commissioning Consortium (ECC); Great West Commissioning Consortium (Hounslow); Kingston Consortium; Newham Health Partnership; Redbridge; Southwark Health Commissioning (SHC); and Sutton Consortium.

In Inner North West London, all four practice-based commissioning groups in Westminster submitted applications to be GP pathfinders in the first round but these were unsuccessful. Central London Healthcare and the Victoria Commissioning Consortium applied again before Christmas and feedback is expected imminently. The Kensington and Chelsea GP Commissioning Consortium submitted their initial application just before Christmas and the result of this is also expected shortly. The Hammersmith and Fulham Group are planning to submit their initial application later this month.

5. WINTER PRESSURES

The severe snow and cold weather during December 2010 has resulted in an earlier than normal peak in winter pressures. Snow is associated with slips, trips, falls and emergency calls. This escalation was particularly bad during the weekend of 17/18 December 2010 when it snowed in London while many people were attending Christmas parties.

The cold weather subsequently leads to respiratory distress and pneumonia in older people, those with long term conditions and compromised health. This normally occurs about seven to ten days after a cold spell. The over-lay for this year appears to be the strains of seasonal flu encompassing H1N1 which have been severe for patients who would not normally have severe responses to flu. Under 65s and children have been admitted to critical care facilities in acute respiratory distress. The clinical teams suspect that most of these cases are precipitated by flu.

With the predicted poor weather and pressures building in acute capacity, NHS Hammersmith and Fulham instigated a daily conference call for the local health economy from 13 December 2010. This was extended to the rest of the Inner North West London PCT Cluster before Christmas. It was during these calls that decisions were made to implement the winter pressure surge plans.

Acute Trusts provide some seasonal modelling of bed use but this year's critical care beds were at times at 'unprecedented' pressure instead of what is normally seen as 'bad winter' pressure. This is a complex picture which will be emerging as we get month nine data and this will help us to identify the costs of winter pressures.

Every North West London Acute Trust has cancelled or curtailed all non-urgent elective surgery and, in some cases, urgent surgery that would require a critical care bed so that the winter pressure surge could be managed. While this is part of the winter pressure surge plans, the impact will be seen in 18 week wait performance. We cannot currently tell whether any Trusts will breach the 18 weeks target as most of the cancellations have occurred over the last three/four weeks.

Acute Trusts have also struggled with the A&E four-hour target as a result of numbers attending and the severity of the patients who then need to be admitted. Imperial College and Chelsea & Westminster did, however, meet their overall A&E targets over the second half of December. It should also be noted that the Inner North West London PCT Cluster has not been asked to attend emergency meetings to resolved A&E pressures by NHS London who appear to have been confident with the plans we had in place.

The Inner North West London PCT Cluster also appears to have performed more successfully than other areas in terms of managing delays in discharging patients. This is a clear result of the services which we have introduced to treat patients at home as well as our joint working with Central London Community Healthcare (CLCH) and the local authority to manage the impact of winter on our residents.

In terms of flu vaccinations, there has been generally good availability across the Inner North West London PCT Cluster. Our GPs, and other providers, with extra stock have been able to offer some mutual aid although this has not been required. There has, however, been a critical shortage in the supply of the vaccine which is produced without egg (for those with a severe allergy) although this has been the case across the country.

We are currently collecting further detail on the impact of flu in Hammersmith and Fulham which David McCoy will provide at the Board meeting.

6. COMMISSIONING SUPPORT FOR LONDON (CSL)

CSL's Transition Board decided on 29 November 2010 to propose the wind down of the organisation with effect from 31 March 2011 and to transfer certain services to other host organisations. The decision was based on an options appraisal review undertaken with the six London sectors during which they were asked to state which products and services they wished to take from CSL in 2011/12. It was decided that the number of products and services identified were too few to justify CSL remaining as a standalone organisation.

A 90 day consultation process regarding the proposals was initiated with staff and trade union representatives on 1 December 2010. If you would like a copy of the consultation document, please contact elizabeth.wright@hf-pct.nhs.uk.

BRIEFING ON PUBLIC HEALTH WHITE PAPER

Summary:

This paper provides a detailed briefing of:

- the government's White Paper on Public Health: *Healthy Lives, Healthy People*
- the supplementary consultation paper on the funding and commissioning routes for public health
- the supplementary consultation paper on proposals for a public health outcomes framework.

Section A summarises the government's proposals. Section B outlines the key issues created by the proposals. This includes a listing of the formal structured consultation questions as set out by the DH.

The paper also includes a brief update on the local changes to public health.

Board action required:

The Board is asked to take note of the government's proposals for public health development and change in the future; and is invited to comment on the structured consultation questions. It is proposed that a tri-borough PCT response to the White Paper is produced by the three DPHs which could incorporate the views and comments of Board members.

Responsible director: David McCoy	**Author:** David McCoy

Date of paper: 06/01/2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	

The White Paper for Public Health: Healthy Lives, Healthy People

This paper provides a detailed briefing of:

- the government's White Paper on Public Health: *Healthy Lives, Healthy People*
- the supplementary consultation paper on the funding and commissioning routes for public health,
- the supplementary consultation paper on proposals for a public health outcomes framework.

Section A summarises the proposals. Section B outlines the key issues created by the proposals.

SECTION A: SUMMARISING THE PROPOSED REFORMS AND CHANGES

1. The health challenge

Healthy Lives, Healthy People begins by setting out the key challenges facing the public health community. Health inequalities are explicitly referenced, The White Paper presents a set of challenges and solutions for improving health and wellbeing throughout life. There are separate sections dedicated to different parts of the lifecycle, specific sections related to education and schooling; work and employment; housing; and the physical environment.

2. A new approach for public health

Healthy Lives, Healthy People makes the case for a new approach to public health. It aims to establish public health as a government priority and to get a better balance between actions taken nationally and locally, as well as actions taken by individuals, families, communities and business.

Highlighting the importance of the social determinants of health, the government aims to improve population health through actions taken across the NHS and social care services – but also through education, housing, transport and other sectors that impact on health.

It sets out explicitly to minimise government intervention and regulation and proposes to use an 'intervention ladder' to help determine when and how government intervenes. In line with this thinking, a 'Responsibility Deal' has been established with the business sector to drive improvements in healthy living around five areas: food; alcohol; physical activity; health at work; and behaviour change.

A new professionally-led and defined national public health service [Public Health England] will be established. However, the government intends to place localism at the heart of a new system, with devolved responsibilities, freedoms and funding and a heightened emphasis placed on local action by individuals, families, communities and local government. The new system will b e based on principles of empowering people, using transparency to drive accountability, and ensuring that communities lead efforts to improve health wherever possible.

A key element of this effort is the transfer of local public health functions from the NHS to local authorities (LAs)

It is explicitly noted however that the creation of Public Health England and the new public health role of local government should not lead the NHS stepping back from its public health responsibilities. Close partnership working between Public Health England and the NHS at a national level, and between local government, Directors of Public Health (DsPH) and GP consortia at the local level, is expected.

Resources for public health will be ring-fenced and new incentives will be established to improve population health, most notably through a health premium that will reward the reduction of health inequalities in local communities and progress in public health outcomes. The ringfencing of public health budgets acknowledges the fact that prevention has not enjoyed parity with NHS treatment and that public health funds have too often been raided by acute and clinical services.

3. Public Health England – a new national public health service

Public Health England will be established as part of the Department of Health (DH) and will incorporate the existing Health Protection Agency and the National Treatment Agency.

A new Cabinet sub-committee on public health is also proposed to bring together all areas of government which can influence public health

The full scope and remit of Public Health England is still being detailed, but includes the following: health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion including those led by health visiting and school nursing, and some elements of the GP contract such as those relating to immunisation, contraception, and dental public health.

A major remit of Public Health England will be 'health protection', including the control and management of infectious diseases as well as preparedness for public emergencies. Public Health England will therefore have a local presence in the form of Health Protection Units (HPUs).

Public Health England will also be expected to work closely with the NHS Commissioning Board (NHSCB) to ensure that public health and evidence-based policies are reflected in mainstream NHS commissioning.

4. Local public health

At the local level, a new and enhanced role will be established for local authorities (LAs) to lead on health improvement and health inequalities.

Public Health England will allocate ring-fenced public health budgets, weighted for inequalities, to LAs. The independent Advisory Committee on Resource Allocation (ACRA) has been asked to support the development of an approach for allocating budgets to LAs. A new 'health premium' will also be used to incentivize the performance of LAs.

The public health grant to local authorities will be made under section 31 of the Local Government Act 2003. As a ring-fenced grant, it will carry some conditions about how the budget is to be used.

Local authorities already carry out a range of health protection functions and have many wider responsibilities that bear on public health such as leisure, housing, education and social care. For the purposes of funding, these existing functions will not be covered by the public health ringfenced budget, as they are already funded through the existing funding settlement (for example, local authorities health protection activity is funded as part of existing local authority funding).

A new role for local government will be to encourage coherent commissioning strategies and promote the development of joined up commissioning plans across the NHS, social care, public health and other local partners. A central structural innovation of the government's proposed reforms is the establishment of local Health and Wellbeing Boards (HWBs) to enable this vision of integrated and joined-up commissioning and provision.

Existing details about the proposed establishment of HWBs are summarised in Appendix 3. At present, proposed minimum membership of HWBs includes elected representatives, GP consortia, DsPH, Directors of Adult Social Services, Directors of Children's Services and local HealthWatch. However, local areas will be able to expand membership to include local voluntary groups, clinicians and providers, where appropriate. It is envisaged that HWBs will develop joint health and wellbeing strategies and consider the pooling of budgets to enable joined-up commissioning.

To enable this, the government intends to place greater weight on the production and use of the Joint Strategic Needs Assessment (JSNA). GP consortia and LAs will each have an equal and explicit obligation to prepare the JSNA through arrangements made by the HWB. While at present, JSNA obligations extend only to its production, the forthcoming Health and Social Care Bill will place a duty on commissioners to use and apply the findings and recommendations of the JSNA.

In addition to GP Consortia sitting on HWBs and working closely with LAs, they will also be given a more explicit population health remit that will be linked to the national incentive scheme for GPs (the Quality and Outcomes Framework). Furthermore, local public health expertise is expected to inform the local commissioning of NHS-funded services which will require DsPH to advise and work with GP consortia. With the anticipated squeeze in budgets and the proposed changes to the remit of NICE, GP Consortia are likely to want the local PH team to be involved in decisions about prioritising / rationing clinical procedures.

The DH will strengthen the public health role of GPs in the following ways:

- Ensure the public availability of information on the performance and achievement of practices. It is argued that by increasing transparency and information, local communities will be enabled to challenge GPs to enhance their performance.
- New incentives for GP-led activity will be designed with public health concerns in mind. The DH proposes that a sum at least equivalent to 15% of the current value of the Quality and Outcomes Framework (QOF) should be devoted to public health and primary prevention indicators from 2013 (funding for this element of QOF will come from the Public Health England budget).
- Strengthen the focus on public health issues in the education and training of GPs

The White Paper places a heavy emphasis on local transparency and public accountability. Local people are to have access to information about commissioning decisions and how public health money is being spent. Providing people with transparent information on the cost, evidence-base and impact of services will help ensure that the new system is effective and cost-efficient.

In terms of the delivery of services and interventions, local authorities will be encouraged to contract services from a wide range of providers across the public, private and voluntary sectors. As part of building capable and confident communities, local areas may consider grant funding for local communities to take ownership of some highly focused preventive activities, such as volunteering peer support, befriending and social networks.

Healthy Lives, Healthy People allows the development of supra-borough partnerships and arrangements. It does not, for example, preclude the establishment of a single public health structure across the three boroughs of Inner North West London. Similarly, the current proposals do not preclude the possibility of a tri-borough HWB.

Within London, the Mayor also has a statutory responsibility for tackling health inequalities and there is a good rationale for establishment of a pan-London public health resource. The Secretary of State has asked the Mayor and boroughs to agree to an appropriate division of resources and functions to improve health. One proposal currently on the table is for a 3% top slice of the LA public health budget to be allocated to a London-wide public function.

Directors of Public Health are expected to be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. In addition, they are expected to work closely with Directors of Children's Services and Directors of Adult Services.

The critical tasks of DsPH will include:

- promoting health and wellbeing within local government;
- providing and using evidence relating to health and wellbeing;
- advising and supporting GP consortia on the population aspects of NHS services;
- developing an approach to improving health and wellbeing locally, including promoting equality and tackling health inequalities;
- working closely with Public Health England health protection units (HPUs) to provide health protection as directed by the Secretary of State for Health; and
- collaborating with local partners on improving health and wellbeing, including GP consortia, other local DsPH, local businesses and others.

DsPH will be employed by local government and jointly appointed by the relevant local authority and Public Health England. They will be professionally accountable to the Chief Medical Officer (CMO) and be part of the Public Health England professional network. They will discharge their functions in a number of ways, ranging from direct responsibility for achieving public health outcomes to advising colleagues and partners on public health. The White Paper also notes that they will need to be supported by a team with specific public health and commissioning expertise.

5. Funding and Commissioning details

Public Health England will have three principal routes for funding services:

1. through the public health ring-fenced budget to local government;
2. by asking the NHSCB to commission services (e.g. from GPs; and
3. commissioning or providing services directly.

The default position is that, wherever possible, public health activity should be commissioned by local authorities according to locally identified needs and priorities. If a service needs to be commissioned at scale, or is best done at national level, then it should be commissioned or delivered by Public Health England at a national level; and if the activity in question is best commissioned as part of a pathway of health care, or if the activity currently forms part of existing contractual NHS primary care commissioning arrangements, then Public Health England should commission that public health activity via the NHS Commissioning Board (NHSCB). If appropriate, there may also be an option for GP consortia to commission on behalf of Public Health England

As previously mentioned, existing functions in local government that contribute to public health will continue to be funded through the local government grant. The supplementary consultation paper on the funding and commissioning arrangements for public health do however describe the proposed commissioning arrangements for the various elements of a public health programme, as shown in Appendix 1.

6. Transition Plans to 2013

The White Paper sets out a transition period running to 2013. Accountability for delivery in 2011/12 remains with the SHA and PCTs. Public Health England will be established from 2012 and the new enhanced role for LAs will be established in 2013 with 'shadow running' to start in 2011.

There will be 'shadow' allocations to local authorities for each local area for this budget in 2012/13, providing an opportunity for planning before allocations are introduced in 2013/14.

During the transitional year, 2011/12, the forthcoming NHS Operating Framework for 2011/12 will set out the operational arrangements

Milestones for 2011/12

2011/12 will be a period of detailed policy and operational design, while transition to shadow bodies and planning for implementation take shape on the ground.

There will be an overarching human resources framework. One strand will cover all staff in the NHS, including public health staff currently working in the NHS and those that will move to local authorities. Another strand will cover staff in the Department of Health. The third strand will cover staff in arm's-length bodies.

Milestones for 2012/13

Public Health England will come into being in April 2012 as an identifiable part of the Department of Health.

Shadow ring-fenced allocations for local authorities will be published.

SECTION B: KEY ISSUES

The information provided above is drawn from White Papers and consultation documents. There is therefore still some lack of clarity and uncertainty and the possibility of future changes and modifications to the proposals. The White Paper and its accompanying consultation documents have a number of structured questions designed to elicit feedback from all relevant stakeholders. In addition, it is worth considering the White Paper in the light of current and local developments to the public health workforce.

7. Update on local public health

The Public Health Directorates within the PCT has not escaped the downsizing that has been driven by the need to reduce management costs and make cost savings across the health care economy as a whole.

In order to sustain a credible PH capacity and in line with other PCT developments, a merger of the three PH Directorates of inner NW London is underway. The merger involves a reduction in the number of PH posts by about 66%. On top of this, new and additional responsibilities are being placed onto PH Directorates (for example, a number of functions previously managed by the Medical Directorate).

The current proposed organogram for the future PH Directorate has public health functions organised into four teams:

Health Improvement

- Patient and community engagement to influence health seeking behaviour
- Information, education and communication strategies to improve knowledge and influence behaviour
- Support for and commissioning of Health Champions, Health Trainers and Expert Patient Programmes
- Support for and commissioning of third sector organisations to help deliver on PH goals
- Providing a conduit for community intelligence to feed into the planning and commissioning roles of the NHS and LA
- Support to Local Health Watch

Health Protection, Emergency Planning, Clinical Governance and Preventive Medicine

- Clinical governance
- Screening, Immunisations
- Health Checks
- Sexual Health
- Emergency Planning
- Safeguarding
- Infection Control

Health Intelligence and Knowledge Management

- Collate, manage, analyse and use of all data related to NHS and population health

- Management and development of a data warehouse to enable data linkages across the health and social care system
- Disseminate information and analysis about local health needs
- Lead on production of JSNA

Medicines Management

- Control drugs
- Pharmaceutical analysis and needs assessments
- Community Pharmacy contracting and support
- Prescribing support

A lot of time and effort is being spent to determine the precise roles, functions and responsibilities of the proposed new structure in order to ensure that as much of the broad range of public health challenges highlighted in the White Paper can be delivered on.

8. Consultation Questions to Healthy Lives, Healthy People

Role of GPs in public health

Are there additional ways in which we can ensure that GPs will continue to play a key role in areas for which Public Health England will take responsibility?

Public Health evidence

What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

What can wider partners nationally and locally contribute to improving the use of evidence in public health?

Regulation of public health professionals

We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

Cross-cutting issues

What do you think the top 5 issues are in implementing the White Paper vision and related strategy and proposals?

9. Consultation questions on funding and commissioning routes for public health

Funding and Commissioning Flows

Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

Defining Commissioning Responsibilities

Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

Do you consider the proposed primary routes for commissioning of public health funded activity (the third column in Appendix 1) to be the best way to: a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and b) reduce avoidable inequalities in health between population groups and communities? If not, what would work better?

Which services should be mandatory for local authorities to provide or commission?

Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

Allocations

Which approaches to developing an allocation formula should we ask ACRA to consider?

Which approach should we take to pace-of-change?

Health Premium

Who should be represented in the group developing the formula for the proposed health premium?

Which factors do we need to consider when considering how to apply elements of the of the Public Health Outcomes Framework to the health premium?

How should we design the health premium to ensure that it incentivises reductions in inequalities?

Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?
What are the key issues the group developing the formula will need to consider?

10. **Additional Local Issues / Questions**

Transition arrangements

Are the current transition arrangements for PH adequate, appropriate and safe?

Clearly the PH staffing structures for 2011/12 will have a HR consequence for local government when the roles and functions of PH eventually transfer across from the PCTs to LAs. The HR framework to accompany this transfer of functions is however unclear at present, and there are differing opinions as well about whether there should be an automatic transfer of existing NHS staff to LAs. Is there a local view on this issue?

Tri-borough arrangements

Are the proposed governance and accountability arrangements for a tri-borough DPH and PH structure appropriate to the vision outlined in the White Paper?

Funding and commissioning

It is unclear what percentage of the ring fenced budget will be left for LAs to carry out their new and expanded roles and responsibilities. There is a view that too much of the budget is being ear marked to flow through the NHSCB rather than through local structures. In addition, it has been noted that a number of nationally funded data collecting surveys will be abandoned, placing into jeopardy the availability of quality population health information. Is there a local view on this?

Local partnerships

Making the vision of the White Paper work in practice will depend to a large degree on: a) the effective functioning of Health and Wellbeing Boards; b) effective collaboration between GP consortia and public health; and c) the development of an effective and informed Local Health Watch. While appropriate organisational structures and policies are critical to deliver the vision, a culture of collaboration, cooperation and partnership work will be even more important. Is adequate attention paid to these softer aspects of the transition over the coming two years?

Appendix 1: Proposed commissioning arrangements for the various elements of a public health programme

	Activities to be funded from the new public health budget	Proposed commissioning route/s (including direct provision in some cases)	Examples of associated activities to be funded by the NHS budget
Infectious disease	Current functions of the Health Protection Agency and public health oversight of prevention and control including coordination of outbreak management,	Public Health England At a local level, local authorities will need to work closely with Public Health England Health Protection Units (HPUs).	Treatment of infectious disease Co-operation with Public Health England on outbreak control and related activity
Sexual Health	Contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, and outreach and prevention.	Local authority to commission comprehensive open-access sexual health services. In the case of contraception, Public Health England will fund the commissioning by the NHS Commissioning Board of contraceptive provision through primary care commissioning arrangements, and local authorities will fund and commission contraceptive services (including through community pharmacies) for patients who do not wish to go to their GP or who have more complex needs. Local authorities will also be responsible for commissioning fully integrated termination of pregnancy services.	HIV treatment and promotion of opportunistic testing and treatment
Immunisation against infectious disease	Universal immunisation programmes and targeted neonatal immunisations	Vaccine programmes for children, and flu and pneumococcal vaccines for older people, via NHS Commissioning Board (via GP contract) The NHS will continue to commission targeted neonatal Hepatitis B and BCG vaccination provision, funded by Public Health England.	Vaccines given for clinical need following referral or opportunistically by GPs

		Local authority to commission school programmes such as HPV and teenage booster	
Standardisation and control of biological medicines	Current functions of the HPA in this area	Public Health England	
Radiation, chemical and environmental hazards, including the public health impact of climate change	Current functions of the HPA, and public health oversight of prevention and control, including outbreak management co-ordination of	Public Health England supported by local authorities	
Screening	Public Health England will design, and provide the quality assurance and monitoring for all screening programmes	The design and quality assurance of screening programmes will be a direct responsibility of Public Health England, as will funding and managing the piloting and rolling out of new programmes and extending current ones. The NHS Commissioning Board will commission established programmes on behalf of Public Health England, as specified and with funding transferred for that purpose.	
Accidental injury prevention	Local initiatives such as falls prevention services	Local authority	
Public mental health	Mental health promotion, mental illness prevention and suicide prevention	Local authorities will take on responsibility for funding and commissioning mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities. This could include local activities to raise public awareness, provide information, train key professionals and deliver family and parenting interventions.	Treatment of mental ill health, including Improving Access to Psychological Therapies (IAPT), will not be a responsibility of Public Health England but will be funded and commissioned by the NHS

Nutrition	Running national nutrition programmes including Healthy Start Any locally-led initiatives	Public Health England and local authority	Nutrition as part of treatment services, dietary advice in a healthcare setting, and brief interventions in primary care
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity, such as improving the built environment and maximising the physical activity opportunities offered by the natural environment	Local authority	Provision of brief advice during a primary care consultation e.g. Lets Get Moving
Obesity programmes	Local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services	Obesity and physical activity programmes, including encouraging active travel, will be the responsibility of local authorities. Local authorities will be responsible for running the National Child Measurement Programme at the local level, with Public Health England co-ordinating the Programme at the national level.	NHS treatment of overweight and obese patients, e.g. provision of brief advice during a primary care consultation, dietary advice in a healthcare setting, or bariatric surgery
Drug misuse	Drug misuse services, prevention and treatment	Local authority	Brief interventions
Alcohol misuse	Alcohol misuse services, prevention and treatment	Local authority	Alcohol health workers in a variety of healthcare settings
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and communications	Local authority	Brief interventions in primary care, secondary, dental and maternity care
NHS Health Check	Assessment and lifestyle	Local authority	NHS treatment following NHS

Programme	interventions		Health Check assessments and ongoing risk management
Health at work	Any local initiatives on workplace health	Local authority	NHS occupational health
Reducing and preventing birth defects	Population level interventions to reduce and prevent birth defects	Local authority and Public Health England	Interventions in primary care such as pre-pregnancy counselling or smoking cessation programmes and secondary care services such as specialist genetic services
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis via awareness of symptoms	Local authority	Integral part of cancer services, outpatient services and primary care. Majority of work to promote early diagnosis in primary care
Dental public health	Epidemiology, and oral health promotion (including fluoridation)	Public Health England will lead on the co-ordination of oral health surveys while local authorities will lead on providing local dental public health advice to the NHS, as well as commissioning community oral health programmes the NHS Commissioning Board, which will commission dental services. Contracts for existing (and any new) fluoridation schemes will become the responsibility of Public Health England	All dental contracts
Emergency preparedness and response and pandemic influenza preparedness	Emergency preparedness including pandemic influenza preparedness and the current functions of the HPA in this area	Public Health England, supported by local authorities	Emergency planning and resilience remains part of core business for the NHS. NHS Commissioning Board will have the responsibility for

			mobilising the NHS in the event of an emergency
Health intelligence and information	Health improvement and protection intelligence and information, including: - data collection and management; - analysing, evaluating and interpreting data; modelling; - using and communicating data. This includes many - existing functions of the Public Health Observatories, Cancer Registries and the Health Protection Agency	Public Health England and local authority	NHS data collection and information reporting systems (for example, Secondary Uses Service)
Children's public health for under 5s	Health Visiting Services including the Healthy Child Programme for under 5s and the Family Nurse Partnership	Public health services for children under 5 will be a responsibility of Public Health England which will fund the delivery of health visiting services, including the leadership and delivery of the Healthy Child Programme for under 5s (working closely with NHS services such as maternity services and with children's social care); health promotion and prevention interventions by the multiprofessional team and the Family Nurse Partnership. Local areas will need to consider how they join-up with Sure Start Children's Centres to ensure effective links. In the first instance, these services will be commissioned on behalf of Public Health England via the NHS Commissioning Board. In the longer term, health visiting to be commissioned locally.	All treatment services for children (other than those listed above as public health-funded) NHS Partners will need to help to focus on child protection and specifically the early intervention end of support for families through Local Safeguarding Children Boards.

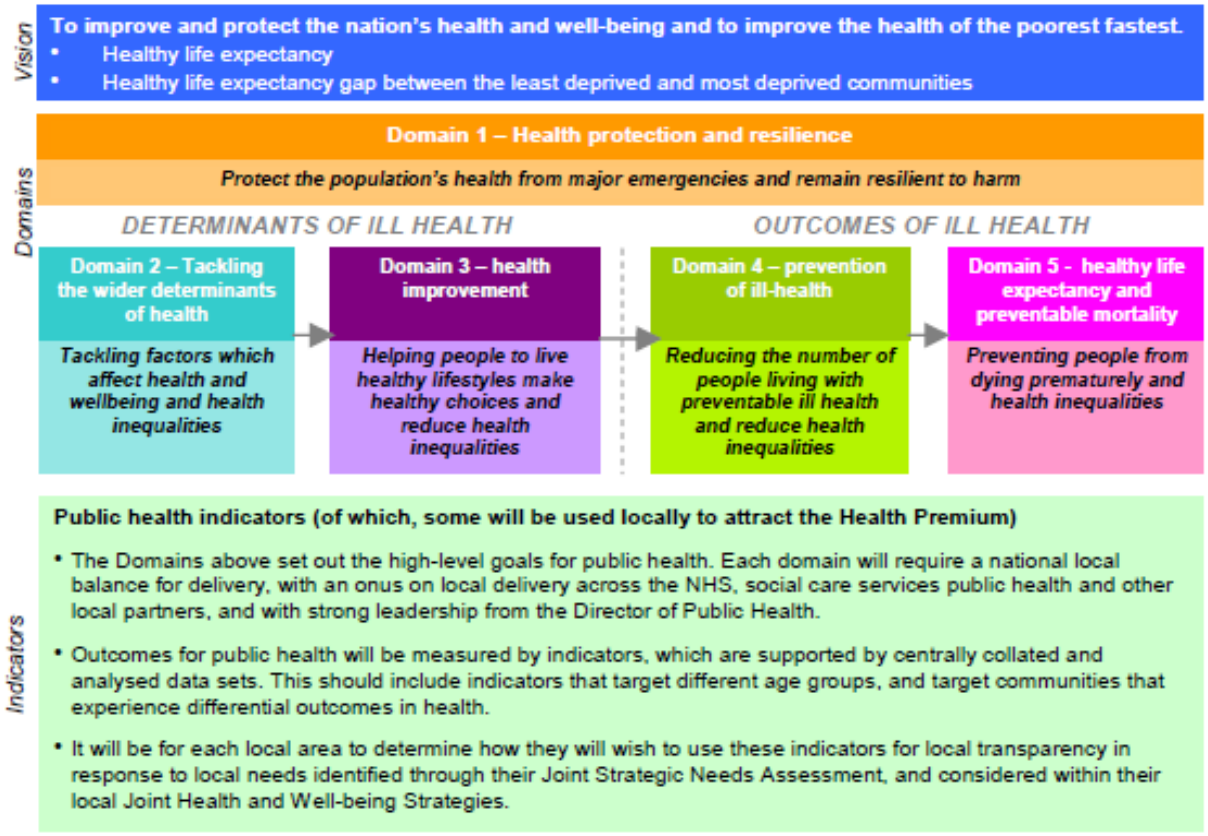
Children's public health 5-19	The Healthy Child Programme for school-age children, including school nurses	Public health services for children aged 5-19, including public mental health for children, will be funded by the public health budget and commissioned by local authorities. This will include the Healthy Child Programme 5-19; health promotion and prevention interventions by multiprofessional teams and the school nursing service.	All treatment services for children (other than those listed above as public health funded, e.g. sexual health services or alcohol misuse)
Community safety and violence prevention	Specialist domestic violence services in hospital settings, and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence, and non-confidential information sharing activity	Local authority	Non-confidential information sharing
Social exclusion	Support for families with multiple problems, such as intensive family interventions	Local authority	Responsibility for ensuring that socially excluded groups have good access to healthcare
Public health care for those in prison or custody	e.g. All of the above	Where public health services are delivered in prison or for those in custody, these interventions will be funded by Public Health England. However, such interventions will be commissioned by the NHS Commissioning Board on behalf of Public Health England	Prison healthcare

Appendix 2: Proposed Framework for Public Health Outcomes

The government is proposing a set of public health indicators that are intended to have three purposes:

- set out the Government's goals for improving and protecting the nation's health and narrowing health inequalities through improving the health of the poorest, fastest;
- provide a mechanism for transparency and accountability across the public health system at the national and local level
- provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

The framework is based on five inter-linked domains as shown below.



Within each domain a set of indicators have been proposed and are now subject to public consultation. These indicators are listed as below.

<u>Domain 1</u>

- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a regular cycle. Systems failures

identified through testing or through response to real incidents are identified and improvements implemented.
- Systems in place to ensure effective and adequate surveillance of health protection risks and hazards.
- Life years lost from air pollution as measured by fine particulate matter
- Population vaccination coverage (for each of the national vaccination programmes5 across the life course)
- Treatment completion rates for TB
- Public sector organisations with a board approved sustainable development management plan.

Domain 2

- Children in poverty
- School readiness: foundation stage profile attainment for children starting Key Stage 1
- Housing overcrowding rates
- Rates of adolescents not in education, employment or training at 16 and 18 years of age
- Truancy rate
- First time entrants to the youth justice system
- Proportion of people with mental illness and or disability in settled accommodation
- Proportion of people with mental illness and or disability in employment
- Proportion of people in long-term unemployment
- Employment of people with long-term conditions
- Incidents of domestic abuse
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- Killed and seriously injured casualties on England's roads
- The percentage of the population affected by environmental, neighbour, and neighbourhood noise
- Older people's perception of community safety
- Rates of violent crime, including sexual violence
- Reduction in proven reoffending
- Social connectedness
- Cycling participation

Domain 3

- Prevalence of healthy weight in 4-5 and 10-11 year olds
- Prevalence of healthy weight in adults
- Smoking prevalence in adults (over 18)
- Rate of hospital admissions per 100,000 for alcohol related harm
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)
- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds
- Number leaving drug treatment free of drug(s) of dependence
- Under 18 conception rate
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth)

- Self reported wellbeing 5 year olds.

Domain 4

- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds.
- Rate of hospital admissions as a result of self-harm
- Incidence of low-birth weight of term babies
- Breastfeeding initiation and prevalence at 6-8 weeks after birth
- Prevalence of recorded diabetes
- Work sickness absence rate
- Screening uptake (of national screening programmes)
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24
- Proportion of persons presenting with HIV at a late stage of infection
- Child development at 2 - 2.5 years
- Maternal smoking prevalence (including during pregnancy)
- Smoking rate of people with serious mental illness
- Emergency readmissions to hospitals within 28 days of discharge
- Health-related quality of life for older people
- Acute admissions as a result of falls or fall injuries for over 65s
- Take up of the NHS Health Check programme by those eligible
- Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed

Domain 5

- Infant mortality rate
- Suicide rate
- Mortality rate from communicable diseases
- Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age
- Mortality rate from cancer in persons less than 75 years of age
- Mortality rate from Chronic Liver Disease in persons less than 75 years of age
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age
- Mortality rate of people with mental illness
- Excess seasonal mortality

Appendix 3: Summary of proposals for establishment of Health and Wellbeing Boards

The government proposes establishing a statutory Health and Wellbeing Board (HWB) within each upper tier local authority. The primary purpose of the Board would be "to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability".

The Government proposes that statutory HWBs would have four main functions:

- assess the needs of the local population and lead the statutory joint strategic needs assessment;
- promote integration and partnership, including through joined-up commissioning plans across the NHS, social care and public health;
- support joint commissioning and pooled budget arrangements where this makes sense;
- undertake a scrutiny role in relation to major service redesign

Whilst responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia, the HWB would give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care.

It is anticipated that HWBs would lead in determining the strategy and allocation of any local application of place-based budgets for health and relate to other local partnerships, including those relating to vulnerable adults and children's safeguarding. But to reduce bureaucracy, local authorities should want to replace current health partnerships where they exist, and work with the local strategic partnership to promote links and connections between the wider needs and aspirations of local neighbourhoods and health and wellbeing. It is proposed that the statutory functions of the overview and scrutiny committee (OSCs) would transfer to the health and wellbeing board.

The government indicates that there would be a statutory obligation for the local authority and commissioners to participate as members of the Board. However, the proposed composition of the Board appears to be broad and includes**:**

- local elected representatives including the Leader or the Directly Elected Mayor,
- social care commissioners,
- GP consortia;
- Director of Public Health;
- relevant local authority directors on social care, public health and children's services;
- a representative of local HealthWatch;
- local representatives of the voluntary sector;

It is also stated that providers may be invited into discussions, and that representation from the NHS Commissioning Board may be requested if required.

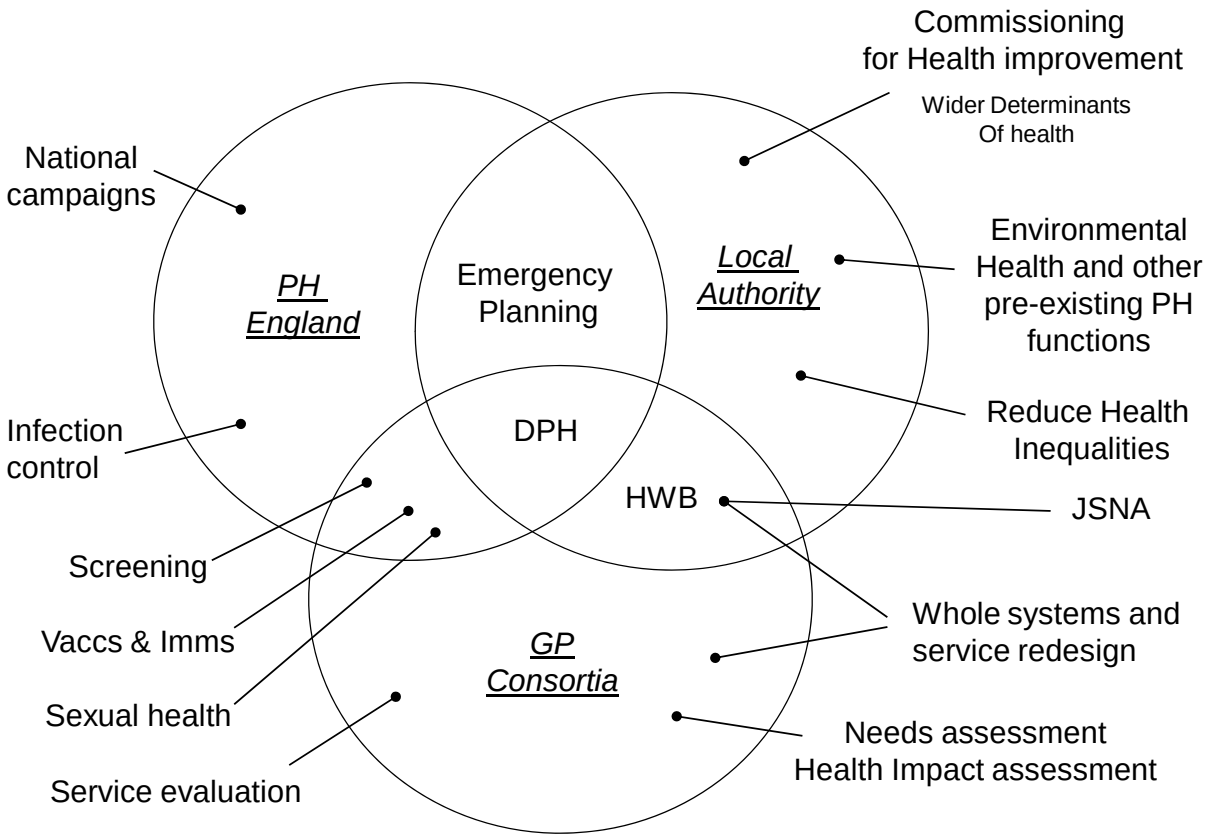
The elected members of the local authority would decide who chaired the board.

Having a seat on the HWB is designed to give HealthWatch a more formal role in commissioning discussions and "provide additional opportunity for patients and the public to hold decision makers to account and offer scrutiny and patient voice".

The government recognises the novelty of arrangements bringing together elected members and officials in this way and is seeking views as to how local authorities can make this work most effectively. But it is hoped that this emphasis on proactive local partnership would minimise the potential for disputes. Where disputes do arise, the Board may "choose to engage external expertise to help resolve the issue, for example a clinical expert, the Centre for Public Scrutiny or the Independent Reconfiguration Panel". But where the dispute is unable to be resolved locally, the Board would have a power to refer the issue to the NHS Commissioning Board.

Neighbouring boroughs may choose to establish a single board covering their combined area.

Appendix 4: Diagrammatic representation



PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

Summary:

The Health Act, 2009, placed a duty on all Primary Care Trusts to develop and publish a Pharmaceutical Needs Assessment (PNA) of a new type. By law this must be published by 1st February 2011.

The objectives of this PNA are:

- to provide a clear picture of the current services provided by H&F community pharmacies and identify gaps in service provision in relation to NHS pharmaceutical services.
- to facilitate planning of future services to address any important gaps.
- to provide robust and relevant information on which to base decisions about applications for new NHS pharmacies. This will become important once the PNA becomes the legislative basis on which applications to provide NHS pharmaceutical services will be assessed.

Appendices to the report are available on request.

Board action required:

The Board is asked to consider the document with a view to approving its publication.

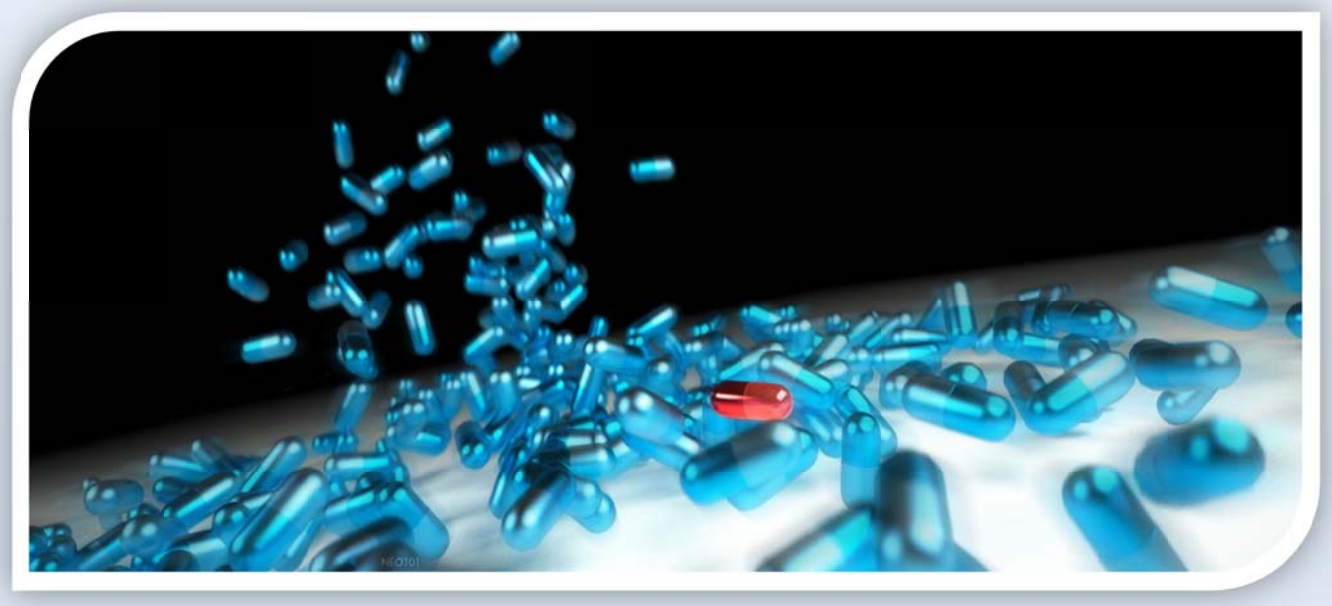
Responsible director: Tim Tebbs	**Author:** Ashfaq Khan

Date of paper: Jan 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	The PNA has regard to key health priorities identified in the Public Health Report and Strategic Plan 2009-14 and examines the potential of commissioned pharmaceutical services to impact on these
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	PCT has a legal requirement to publish a PNA by 1st February 2011
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	The PNA was subject to a 60 day public consultation.
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	The PNA identifies potential to further use pharmacies to help reduce health inequalities.
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	Pending

NHS
Hammersmith and Fulham

Pharmaceutical Needs Assessment



February 2011

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4. Access to Pharmaceutical services

5. Health Priorities in Hammersmith and Fulham

6. Results from the Pharmacy and Public Surveys

7. Recommendations

Appendices

Executive Summary

The Health Act 2009 placed a duty on all Primary Care Trusts to develop and publish a Pharmaceutical Needs Assessment (PNA) that reflects local health needs.

The objectives of this PNA are:

- to provide a clear picture of the current services provided by community pharmacies and identify gaps in service provision in relation to NHS pharmaceutical services.
- to be able to plan for future services to be delivered by community pharmacies and ensure any important gaps in services are addressed
- to provide robust and relevant information on which to base decisions about applications for market entry. This will become important once the PNA becomes the legislative basis on which applications to provide NHS Pharmaceutical services will be assessed (subject to parliamentary approval).

Hammersmith and Fulham is a relatively small borough but is densely populated with 22% of the population from a minority ethnic background. Although parts of the borough are quite affluent, overall Hammersmith and Fulham is the 59th most deprived local authority area in England. An important feature of the borough is the significant gap between the best and worst off wards. On average men living in the most deprived areas die nearly eight years earlier than men in the most affluent areas.

This PNA examines the provision of pharmaceutical services in terms of:

- essential and advanced services. These are mainly core services focused around the dispensing of prescribed medicines
- enhanced services. These are services commissioned locally to meet local health needs and priorities.

Essential and Advanced Services

In general there is adequate provision of essential and advanced pharmaceutical services and there is sufficient capacity to meet the demands from an increasing resident population.

The following gaps, however, have been identified:

(i) provision of pharmaceutical services over extended hours (including Sundays and Bank Holidays) to support the Fulham Centre for Health

(ii) provision of pharmaceutical services over extended hours (including Sundays and Bank Holidays) to support the Hammersmith Centre for Health.

The following would also secure improvements or better access to essential and advanced pharmaceutical services:

(i) commissioning a service to ensure prompt access to end of life care drugs and equipment

(ii) extending availability of language support services to community pharmacies

(iii) commissioning a service which will identify and target Medicines Use Review (MUR) service to key patient groups (eg patients with asthma and chronic obstructive pulmonary disease)

Enhanced Services

Currently 8 enhanced services are commissioned by NHS Hammersmith and Fulham. All these assist in improving access to health services, improving health or minimising harm.

The Stop Smoking, Emergency Hormonal Contraception, Supervised Methadone Consumption and Needle Exchange Services are considered to be necessary. There is currently adequate provision for all these services and no gaps have been identified.

The NHS Heath Checks, Chlamydia Screening, Chlamydia Treatment and H. pylori breath testing services are considered to be relevant services designed to meet local needs and health priorities. We conclude that there is currently adequate provision

of these services. However, it is noted that further developmental work is required in respect of NHS Health Checks and Chlamydia services.

This PNA also looks at the potential to develop and commission pharmaceutical services that would positively impact on the key health priorities identified in the NHS Hammersmith and Fulham's Public Health Report and Strategic Plan 2009-14.

Potential services identified are:

- Chronic Obstructive Pulmonary Disease (COPD) screening service to identify and refer clients with early stage COPD.
- Alcohol misuse service. This would identify higher-risk and increasing-risk drinking and provide brief interventions to motivate individuals to modify their drinking patterns
- Weight management service. Obesity is increasing in the general population and is likely to have significant impact on future health costs. This service would expand the health promotion role of pharmacies.
- Immunisations and vaccinations. A number of pharmacies already have trained staff who provide vaccinations on a private basis. The accessibility and convenience of using pharmacies for NHS vaccination services would have the potential to increase uptake amongst at risk groups.

Pharmacies responding to the survey have overwhelmingly shown the desire of pharmacists to deliver such additional services.

Respondents to the public survey also indicated a keenness to use their local pharmacies to access more services if they were available to them.

1. Introduction

1.1 Purpose of the Pharmaceutical Needs Assessment (PNA)

The Health Act, 2009, placed a duty on all Primary Care Trusts to develop and publish a Pharmaceutical Needs Assessment (PNA) that reflects local health needs. The subsequent NHS (Pharmaceutical Services and Local Pharmaceutical Services) (Amendment) Regulations 2010, which came into force on 24th May 2010, mean that each PCT must publish a copy of its approved PNA on or before 1st February 2011.

This PNA has been prepared at a time of significant change in the NHS: the recent White Paper, *Equity and Excellence*: *Liberating the NHS,* has set in motion a significant programme of change which will have an impact on how we plan and use pharmaceutical services. It is too early to say how this change will affect the PNA or pharmaceutical services.

The proposed consortia of GP practices, working with other health and social care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not be directly responsible for commissioning general pharmaceutical services, which will be one of the roles of the NHS Commissioning Board. However, GP consortia along with public health departments within local authorities will still have influence and may commission enhanced services from community pharmacies.

There is nothing in this White Paper which detracts from the national and local existing vision of an increased contribution from community pharmacies to the promotion and maintenance of good health.

The objectives of this PNA are:

- To provide a clear picture of the current services provided by community pharmacies and identify gaps in service provision in relation to NHS pharmaceutical services.
- To be able to plan for future services to be delivered by community pharmacies and ensure any gaps in services are addressed
- To stipulate the range of enhanced services that may be expected from community pharmacies entering the pharmaceutical list under the exempt category within the Control of Entry Regulations 2005. (e.g. 100 hour pharmacies and wholly internet pharmacies)
- to provide robust and relevant information on which to base decisions about applications for market entry. This will become important once the PNA becomes the legislative basis on which applications to provide NHS Pharmaceutical services will be assessed (subject to parliamentary approval)

In accordance with Part 1A (Regulation 3D[1]) of the Regulations NHS Hammersmith and Fulham will, as a minimum, publish a revised PNA within 3 years of the publication of this document.

In addition, the PCT will make a new assessment of pharmaceutical need sooner than this, should it identify any changes to the availability of pharmaceutical services that have occurred since the publication of this PNA. This will be undertaken only where, in the PCT's view, the changes are so substantial that the publication of a new assessment is a proportionate response.

In accordance with Part 1A (Regulation 3D[3]) of the Regulations, a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of this PNA will be issued whenever:

i. there has been a change to the availability of pharmaceutical services; and

ii. this change is relevant to the granting of applications to open a new pharmacy, to relocate or to provide additional services; and

iii. the PCT is satisfied that the publication of a revised PNA would be a disproportionate response.

1.2 Development of the PNA

The NHS Hammersmith and Fulham PNA has been developed using a mixture of methods drawing on a range of information sources and reinforced through consultation with patients and service providers.

This PNA draws on work conducted for the Joint Strategic Needs Assessment (JSNA), Public Health Report and the Strategic Plan 2009-14. Data was also gathered from the PCT and NHS Business Services Authority around services currently being provided by community pharmacies.

For the purpose of reviewing service provision, the geographical area of the PCT has been divided into localities, based on electoral wards. The electoral wards have also been grouped together into 3 areas: Shepherds Bush & White City; Hammersmith; Fulham (Appendix 1)

The views of pharmacies were obtained through a questionnaire which was made available both on-line and by paper copy (Appendix 2)

The views of residents and service users was obtained through a questionnaire distributed to a broad cross section of the community (Appendix 3)

Paper copies of the public survey were distributed as follows:

Community Pharmacies	1200	(30 copies to each pharmacy)
General Practices	600	(20 copies to each practice)

Older Peoples Forum	50
Children Centres	100
Age Concern	50
H&F Voluntary Centre	50
Community Groups	200
LINKS	100
Expert Patient Graduates	100
Total paper copies distributed	2450

A web link to an electronic version of the survey was also placed on the NHS Hammersmith and Fulham public website.

A draft copy of the PNA was sent out for consultation to the following (Appendix 4 – Consultation Response Form)

Local Pharmaceutical Committee (LPC)

Local Medical Committee (LMC)

All community pharmacies within Hammersmith and Fulham

Hammersmith and Fulham Local Authority

Imperial College Healthcare NHS Trust

NHS Ealing

NHS Kensington & Chelsea

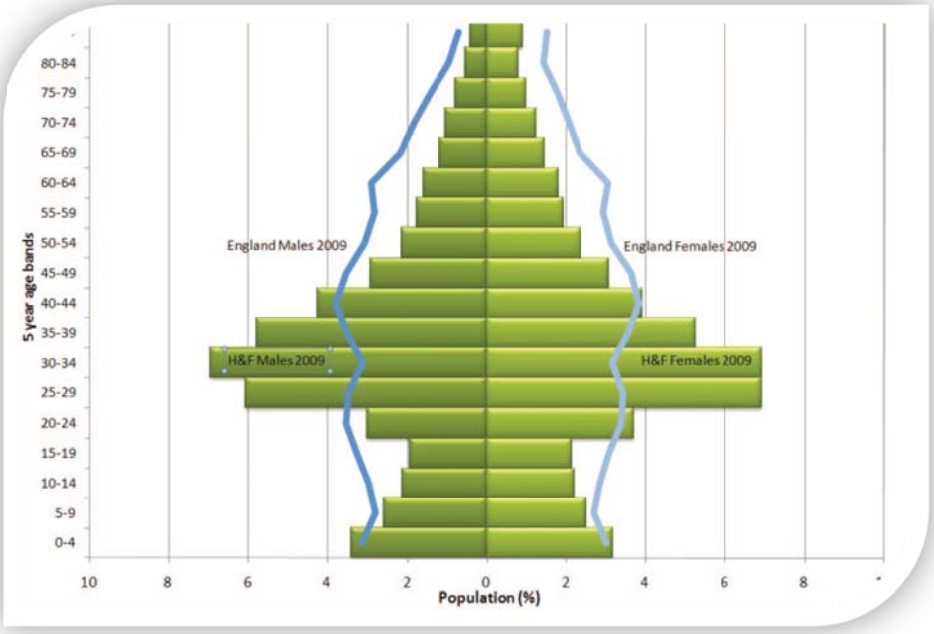
NHS Brent

NHS Hounslow

LINKS

CAVSA

CITAS



2. Hammersmith and Fulham Overview

2.1 The Population

Hammersmith and Fulham is the 5th smallest local authority and the 7th most densely populated in the country.

Hammersmith and Fulham has a young, diverse and mobile population.
There are an estimated 177,000 (GLA estimate 2009) people living in the borough. Nearly half (45%) of the resident population is between the ages of 19 and 40 years old and 36,200 (20.5%) of them are children.

Age profile of Hammersmith and Fulham residents, Compared with England age profile, 2009*

The people

Young population 45% in their 20s and 30s, compared to London average of 35%

Highly mobile 7th highest mobility rate England. 1 in 5 people move address each year.

Small households 40% are one person households, 30% couples, 10% lone parents, 20% families with one or more dependent children

Ethnicity 22% from non-white background, lower than the London average of 33%. Many small minority ethnic communities

Extremes of wealth Half the population classed as well off, but 10,000 (37%) children living in low income homes.

The place

Small densely populated area with limited green space (6.4 square miles and seventh most densely populated area in England)

North generally more deprived though pockets of deprivation across the patch. (ranked 59th most deprived local authority in England and 13th out of 33 in London)

16,000 new homes planned in next decade (with a focus on family sized units)

Wormwood scrubs prison 1,200 adult male prisoners, many with more than one health problem.

Source: Age profile for Hammersmith and Fulham from Greater London Authority 2008 Round of Demographic Projections (Low). England data from the Office for National Statistics 2006-based subnational population projections.

Over the next 20 years the overall population is set to increase substantially. It is projected to increase by over 6% by 2016 and by 12% by 2028, to almost 200,000 residents.

At ward level the largest increases in population will be in Sands End (2,200 people) and Askew (1,300 people).

The increase in population is not uniform across the age groups. The age-group with the greatest expected increase in size is the middle-aged group of 40 to 64 year olds. This group is projected to grow by a third over the next 20 years, from 44,900 to 59,800.

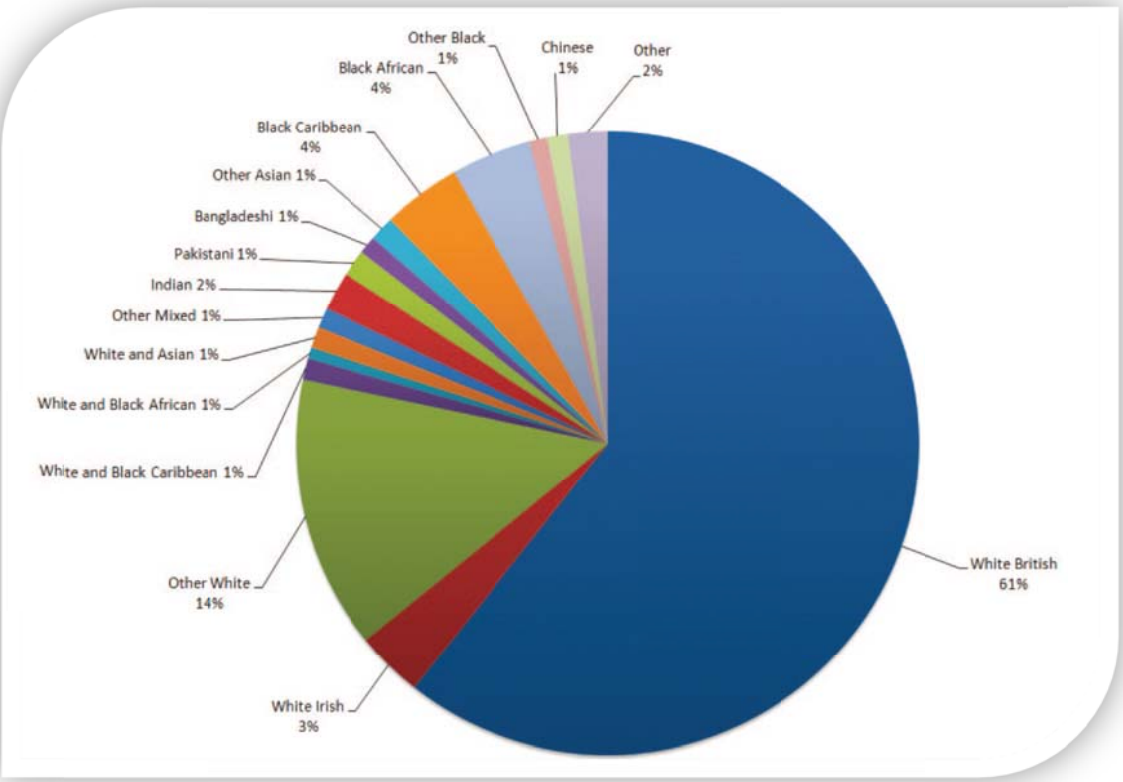
2.2 Ethnic Diversity

As an inner London borough, Hammersmith and Fulham is ethnically diverse. At present around 22% of the borough's population comes from a minority ethnic background.

This is lower than the London average of 33%, but more than twice as high as the national average of around 9%.The ethnic diversity of the population is greatest in younger age groups.

Mixed and black/black British ethnic groups make up a greater proportion of the population aged under 20 than those aged 20 and over.

Recent estimates prepared by the Office for National Statistics (ONS) suggest that around 61% of local residents are White British. The second largest ethnic group is White Other (14%). The White Other group excludes White Irish, who make up 3% of the population. Particularly relevant among the White Other category are people from Poland, Australia and New Zealand, who have significant communities in the area. The largest non-white ethnic groups are Black Caribbean and Black African, each at 4% of the local population.

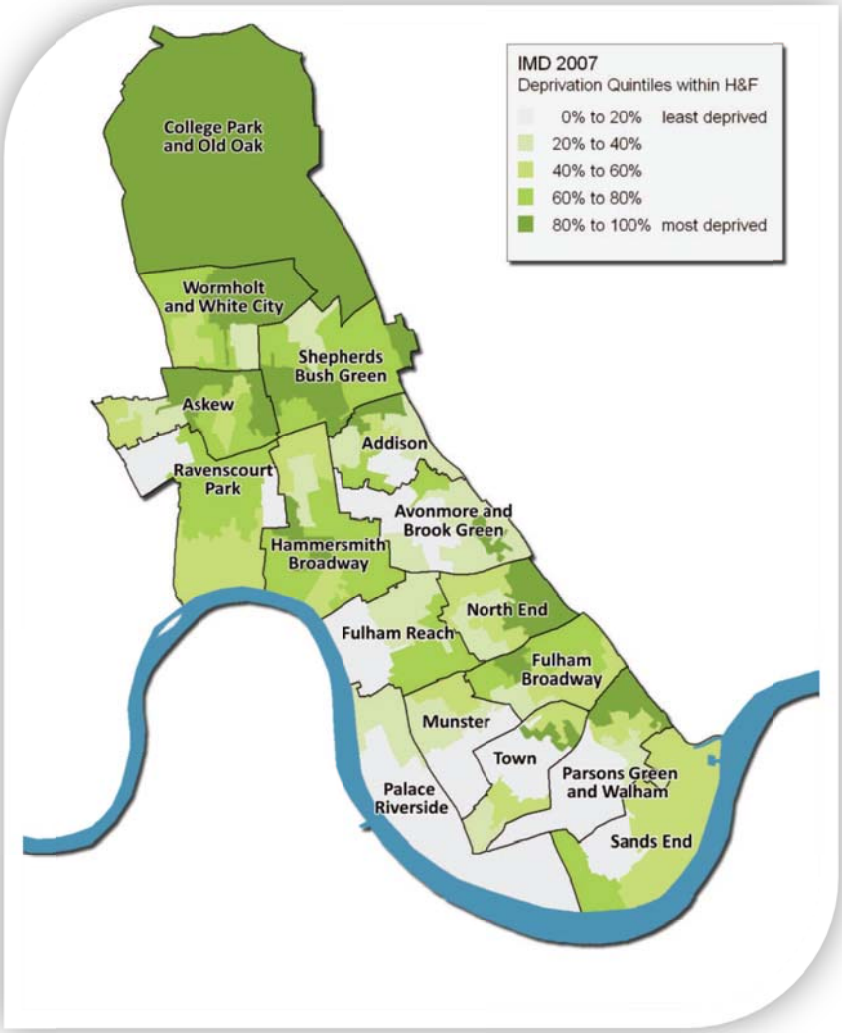


Source: Office for National Statistics, Population Estimates by Ethnic Group Mid-2007

2.3 Deprivation

Using the Index of Multiple Deprivation (IMD, 2007), Hammersmith and Fulham is the 59th most deprived local authority in England (out of a total of 354), and around 30% of the population live in areas that are among the fifth most deprived in England. The map below shows the distribution of affluence and deprivation within Hammersmith and Fulham. Overall, the most deprived wards are College Park and Old Oak, Wormholt & White City and Shepherds Bush Green. The least deprived wards in the borough are Palace Riverside, Munster and Parsons Green & Walham.

Index of Multiple Deprivation 2007 distribution within Hammersmith and Fulham



Source: Department of Communities and Local Government, Index of Multiple Deprivation 2007 by Lower Super Output Area

2.4 Health Inequalities

It is an important feature of Hammersmith and Fulham that wealth and deprivation and consequently health and ill health often sit closely together.

Life expectancy in the borough has been increasing in line with national trends. Mortality rates are also in line with the decreases seen nationally.

However, the figures for the whole borough mask an increasing gap between the best and worst off wards. On average men living in the most deprived areas die nearly eight years earlier than men in the most affluent areas.

	Men	Women
	Life expectancy	
2004/6	78.0	83.5
2006/8	78.3	84.3
	gap between areas (in years)	
2001/05	5.6	2.8
2002/06	6.4	3.3
2003/07	7.8	4.2

2.5 Health Priorities

Compared to national averages Hammersmith and Fulham has high rates of:

- childhood obesity
- child tooth decay
- alcohol & drug misuse
- poor mental health
- HIV
- tuberculosis
- excess winter deaths
- emergency hospital admissions for older people

Uptake of preventive services such as immunisation and screening is improving but is still below national averages. Early diagnosis and treatment of long-term conditions in primary care is below expected levels and varies between individual practices.

Modelling suggests there are tens of thousands of local residents living with undiagnosed diseases: 20,000 with high blood pressure, 2,500 with diabetes, 300 with HIV and as many as one in ten sexually active young people with Chlamydia.

Identifying and treating these conditions can be simple e.g. the use of medicines to control high blood pressure, and reduce the risk of heart attacks and strokes. Every year 110 local people die prematurely from heart attacks, strokes and other circulatory diseases.

3. Current Provision of Pharmaceutical Services

This section describes the range of pharmaceutical services accessed from community pharmacies from within Hammersmith and Fulham.

The Community Pharmacy Contractual Framework (2005) comprises three levels of service:

- Essential Services
- Advanced Services
- Enhanced Services

3.1 Essential Services

All community pharmacies are required to be open a minimum of 40 hours each week and must deliver all the following “essential services”:

3.1.1 Dispensing

The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

3.1.2 Repeat dispensing

The management and dispensing of repeatable NHS prescriptions for medicines and appliances, in partnership with the patient and the prescriber.

3.1.3 Disposal of unwanted medicines

Acceptance, by community pharmacies, of unwanted medicines from households and individuals which require safe disposal.

3.1.4 Public Health

The provision of opportunistic healthy lifestyle advice and public health advice to patients receiving prescriptions who appear to:

• have diabetes; or

• be at risk of coronary heart disease, especially those with high blood pressure; or

• who smoke; or

• are overweight,

and pro-active participation in national/local campaigns, to promote public health messages to general pharmacy visitors during specific targeted campaign periods.

3.1.5 Signposting of patients to other health and social care providers

The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy, on other health and social care providers or support organisations who may be able to assist the person. Where appropriate, this may take the form of a referral.

3.1.6 Support for self care

The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

3.1.7 Clinical governance

Pharmacies have an identifiable clinical governance lead and apply clinical governance principles to the delivery of services. This will include use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development and clinical audit; and assessing patient satisfaction.

3.2 Advanced Services

Community pharmacies may also offer, but are not obliged to offer, Advanced Services. Pharmacies that meet the criteria laid out in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2005 and that are accredited by their Primary Care Trust may provide these services.

Currently only one Advanced Service (Medicines Use Review) is being provided from community pharmacies in Hammersmith and Fulham. There are 2 further Advanced Services (Appliance Use Review and Stoma Appliance Customisation) for which there is currently no provision in Hammersmith and Fulham.

3.2.1 Medicines Use Review and Prescription Intervention Service

This service consists of pharmacists undertaking reviews with patients on multiple medicines. The reviews are designed to help patients understand their therapy, identify any problems and potential solutions.

3.2.2 Appliance Use Review

This service improves a patient's knowledge and use of any specified appliance by:

- establishing the way the patient used the appliance and the patient's experience of such use
- identifying, discussing and helping to resolve poor or ineffective use of an appliance
- advising the patient on the safe and appropriate storage of the appliance
- advising the patient on the safe and proper disposal of appliances that are used or unwanted

3.2.3 Stoma Appliance Customisation

This service involves the customsation of stoma appliances, based on the patient's measurements or a template. Aim of the service is to ensure proper use and comfortable fitting of the stoma appliances.

3.3 Enhanced Services

These services are commissioned locally by PCTs to meet identified needs. NHS Hammersmith and Fulham commissions the following Enhanced Services (August 2010):

(i) Stop Smoking Service

This is an open access service operating on a walk-in basis as well as by appointment. Each pharmacy has one or more accredited stop smoking advisers offering a 6 week support programme to smokers who want to quit. Where appropriate clients are also supplied with nicotine replacement therapies (NRT).

(ii) Emergency Hormonal Contraception ("morning after pill")

This is an open access service offering a convenient and easily accessible location to obtain emergency hormonal contraception. Accredited pharmacists supply levonorgestrel, when appropriate, to clients in line with requirements of a locally agreed Patient Group Direction (PGD). The PGD allows pharmacists to issue the Prescription only Medicine (POM) without the need for the client to obtain a prescription from a doctor.

(iii) NHS Health Checks

The health check is part of the national programme for assessment and management of vascular risk for people aged between 40 and 74. The objectives of the NHS Health Checks programme are to:

- Assess individuals' risks of developing cardiovascular disease (CVD),
- Identify individuals with previously unidentified CVD disease and associated risk factors,
- Encourage and support people to decrease or manage their risk of CVD disease

(iv) H pylori breath test

The H pylori breath test undertaken in a local pharmacy provides a simple and convenient alternative to hospital referral for GPs and patients. The test confirms the presence of gastro-duodenal infection which is linked to gastric and duodenal ulcer disease.

(v) Chlamydia screening

Pharmacies supply Chlamydia screening kits to sexually active males and females under the age of 25. Clients are also offered advice on sexual health where appropriate.

(vi) Chlamydia treatment

Accredited pharmacists provide a single dose antibiotic treatment to clients confirmed with a positive test result for chlamydia.

(vii) Supervised methadone consumption

Accredited pharmacies supervise the consumption of prescribed methadone at the point of dispensing in the pharmacy. This ensures that clients are adhering to their treatment regime and minimises the risk of prescribed methadone being passed onto someone else or being sold on the streets.

(viii) Needle exchange

Pharmacies provide a safe means of disposal of used needles and syringes. Clients can also obtain free packs of sterile needles and syringes. Pharmacies provide advice and support to drug users and, where appropriate, refer clients to other health services and specialist drug and alcohol treatment centres.

Appendix 6 details which of these enhanced services is provided by each of the pharmacies.

4. Access to Pharmaceutical Services

This section will examine the accessibility and adequacy of essential and advanced pharmaceutical services by looking at:

- the location and distribution of community pharmacies
- neighbourhood populations
- opening hours
- provision of dispensing services
- language barriers
- uptake and delivery of advanced services

4.1 Location of Pharmacies

There are currently 40 community pharmacies in Hammersmith and Fulham. The vast majority of the 30 GP Practices have at least one community pharmacy located within 500 metres. Fifteen (38%) of pharmacies are Multiple Contractors (London average 38%; England average 62%).

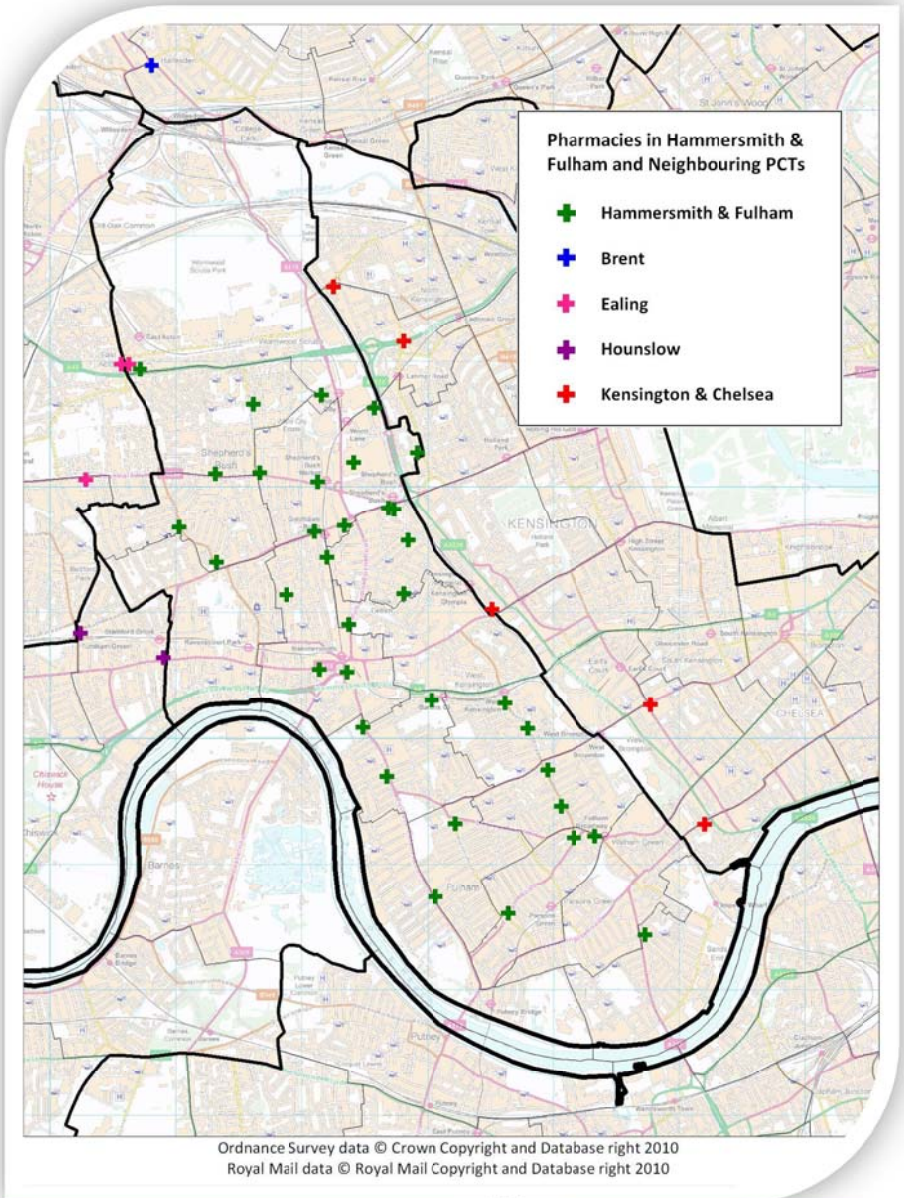
There is only one 100 hour contract pharmacy, located in Fulham Broadway.

Hammersmith and Fulham currently has 22.5 pharmacies per 100,000 population which is higher than the average for England (20 pharmacies/100,000) but slightly lower than the London average (23 pharmacies/100,000). [1]

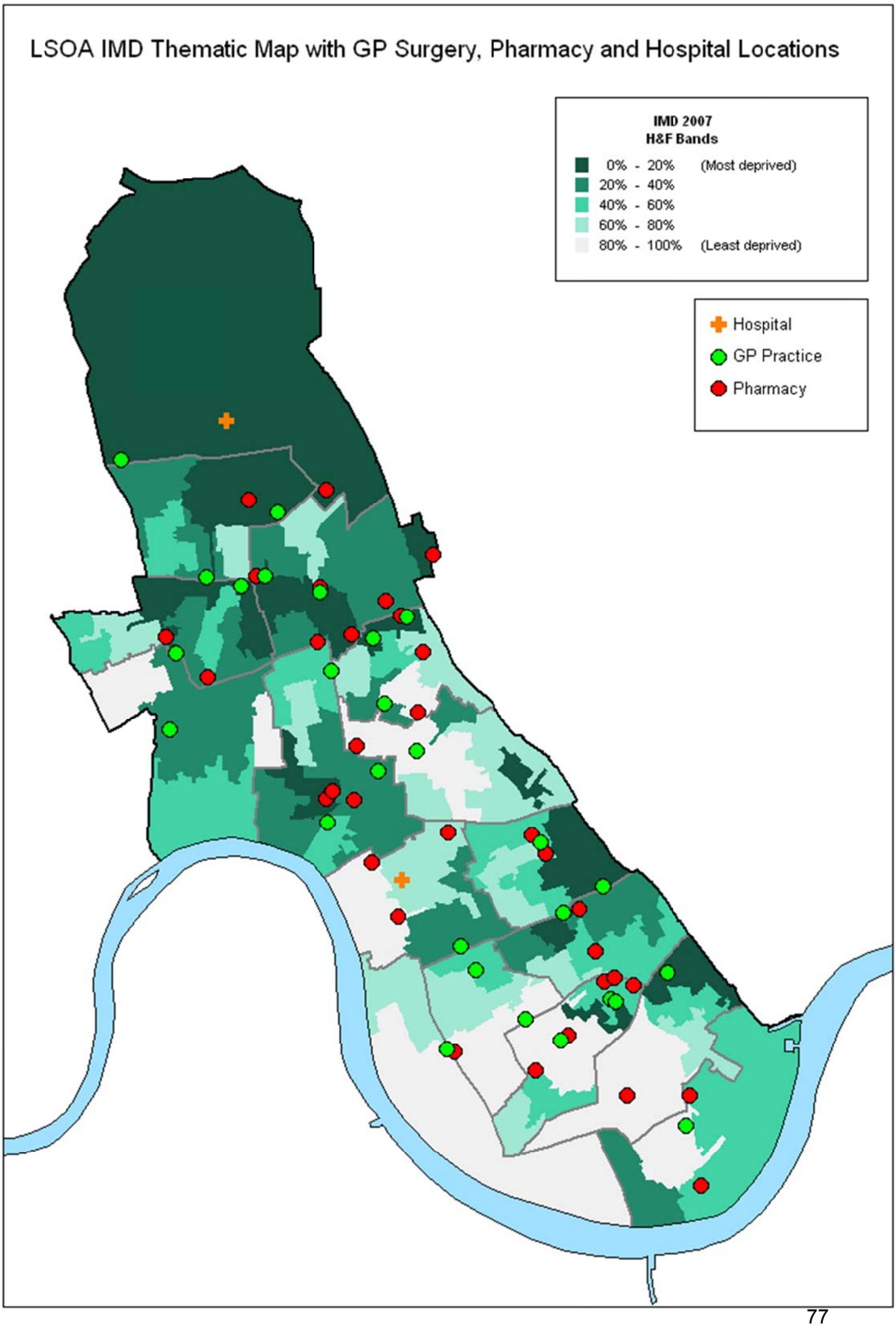
[1] NHS Information Centre: General Pharmaceutical Services In England 1999-2000 to 2008-09

Number of Pharmacies and General Practices by Council Wards

SHEPHERD'S BUSH & WHITE CITY	**No. of Pharmacies**	**No. of General Practices**	**Population (2008 estimate)**
Shepherds Bush Green	10	2	10,249
Askew	2	2	11,886
Wormholt and White City	2	3	11,997
College Park and Old Oak	1	2	7,643
Total Shepherds Bush & White City	**15**	**9**	**41,775**
HAMMERSMITH			
Fulham Reach	3	2	10,197
North End	2	2	10,904
Avonmore and Brook Green	1	2	11,522
Hammersmith Broadway	4	2	11,560
Addison	4	2	11,185
Ravenscourt	0	1	10,791
Total Hammersmith	**14**	**11**	**66,159**
FULHAM			
Sands End	1	2	9,723
Palace Riverside	0	1	7,333
Parsons Green and Walham	1	1	10,280
Town	4	3	9.899
Munster	2	1	8,508
Fulham Broadway	3	2	10,189
Total Fulham	**11**	**10**	**55,932**



LSOA IMD Thematic Map with GP Surgery, Pharmacy and Hospital Locations



The following pharmacies are within other PCT areas but are close to the Hammersmith and Fulham boundaries and are likely to be accessed by residents of Hammersmith and Fulham.

NHS Kensington & Chelsea

My Pharmacy

10 North Pole Road, W10 6QJ

H Lloyd

382 Kensington High Street, W14 8NL

Lloyds

513 Kings Road, SW10 0TX

Zafash Chemist

233-235 Old Brompton Road, SW5 0EA

Pharmaclinix

132 Bramley Road, W10 6TJ

NHS Ealing

Crossbells Pharmacy

131 The Vale, Acton, W3 7RQ

Banks Chemist,

59 Old Oak Common Lane, East Acton, W3 7DD

Marcus Jones Pharmacy

96 Old Oak Common Lane, East Acton, W3 7DA

NHS Brent

Chana Chemist

96-98 High Street, Harlesden, NW10 4SL

NHS Hounslow

Bedford Park Pharmacy

5 Bedford Park Corner, Chiswick, W4 1LS

Pestle & Mortar

10 High Road, Chiswick, W4 1TH

Pharmacies in Hammersmith and Fulham are generally within a comfortable walking distance for most people.

From the public survey, of those who responded:

- 68% (255) had a pharmacy within a 10 minute walk
- 23% (87) could walk to a pharmacy within 10-20 minutes
- 9% (35) stated that it took more than 20 minutes to walk to a pharmacy. However, only 4.5% (17) of the total respondents had a postcode within Hammersmith and Fulham.

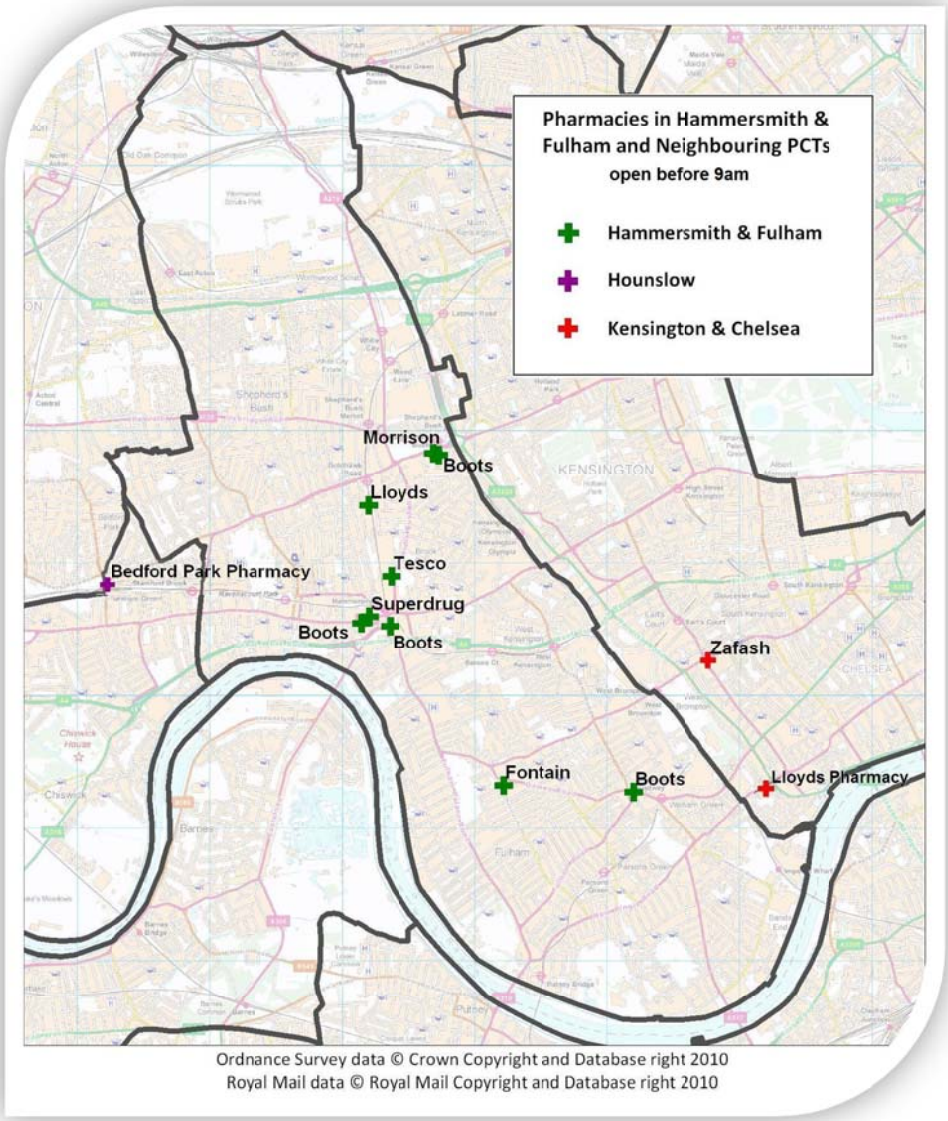
4.2 Opening Hours

During weekdays (Mondays to Fridays) 9 pharmacies in Hammersmith and Fulham open before 9am:

- 4 pharmacies opening at 8.30am
- 3 Pharmacies opening at 8am
- 1 pharmacy opening at 7.30am
- 1 pharmacy opening 7am

These 9 pharmacies are spread across the borough from Shepherds Bush to Fulham Broadway.

Zafash Pharmacy, which is located in Kensington and Chelsea, is open 24 hours a day every day of the year. This pharmacy is within a short walking distance from a tube station.



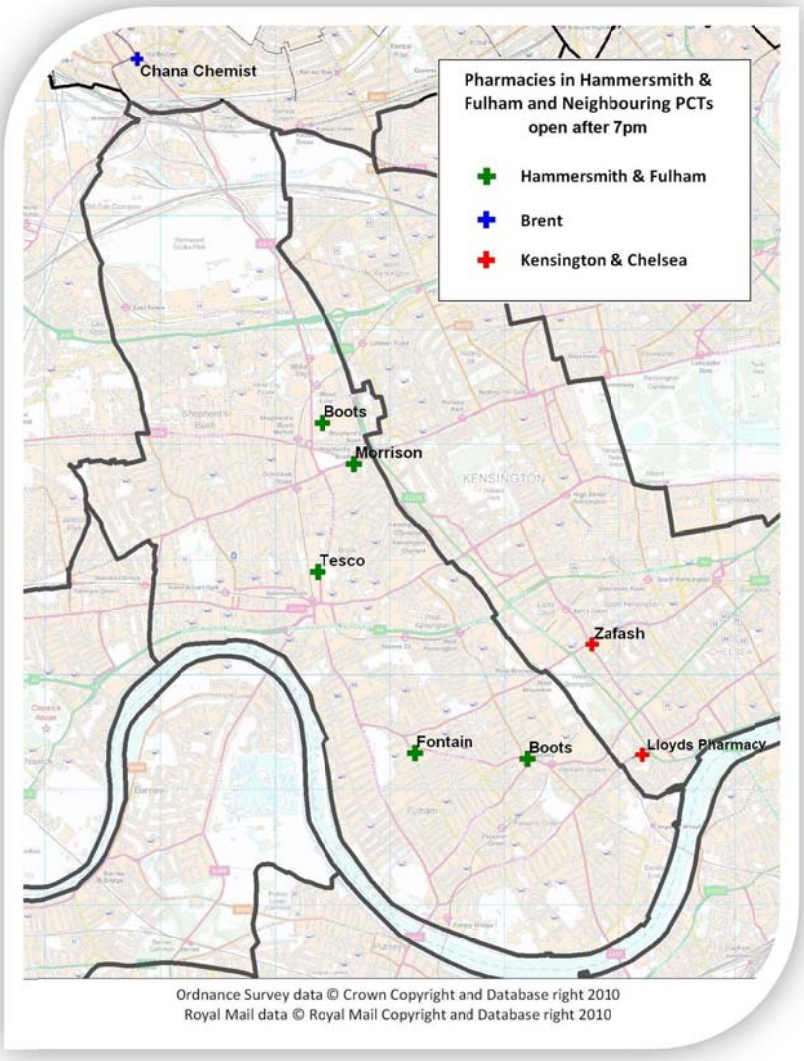
Map: Location of pharmacies opening before 9am Mondays to Fridays

During weekdays (Mondays to Fridays) 5 pharmacies in Hammersmith and Fulham close after 7pm:

- 2 pharmacies close at 8pm
- 1 pharmacy closes 8pm Thursdays and Fridays and 9pm Mondays, Tuesdays and Wednesdays

- 1 pharmacy closes at 9pm Mondays, Tuesdays and Wednesday and at 10pm on Thursdays and Fridays
- 1 pharmacy closes at 11pm

Zafash Pharmacy, which is located in Kensington and Chelsea, is open 24 hours a day every day of the year. This pharmacy is within a short walking distance from a tube station.

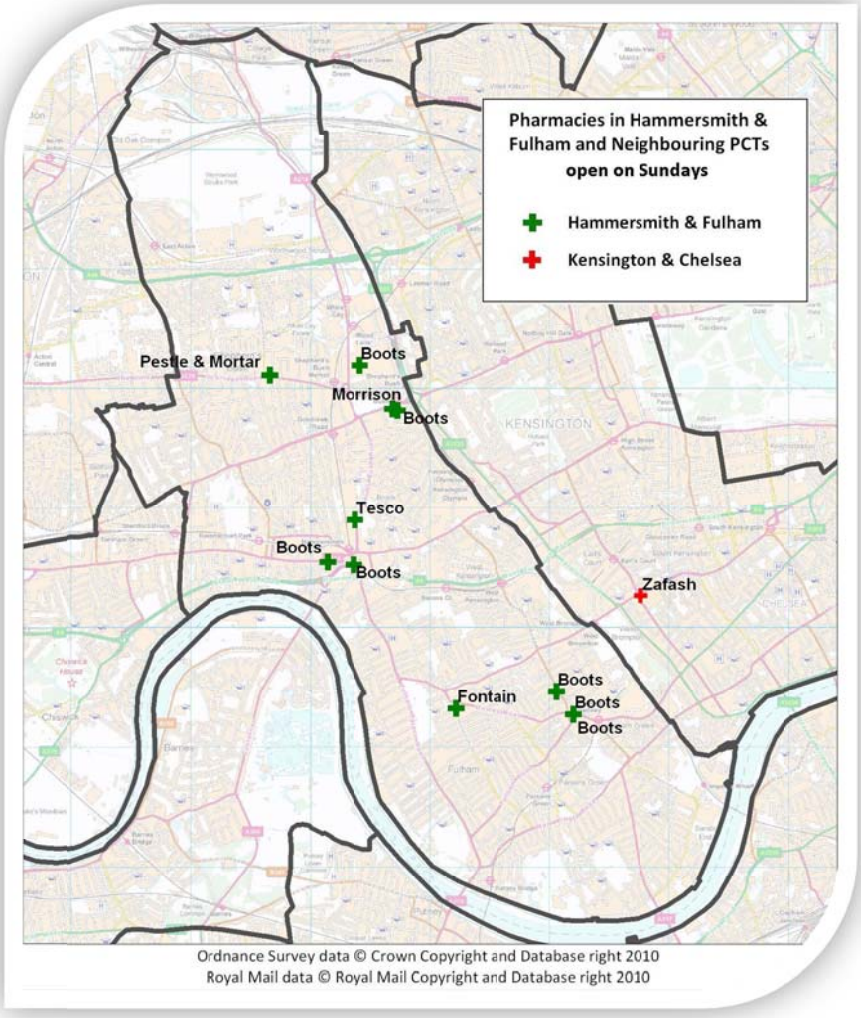


Map: Location of Pharmacies closing after 7pm Mondays to Fridays

These late closing pharmacies are spread across the borough. The pharmacy closing at 11pm is a 100 hour contract pharmacy. This pharmacy is located next to a tube station (Fulham Broadway) and is well served by a number of bus routes.

On Saturdays 38 pharmacies in Hammersmith and Fulham are open with most providing a service for more than 4 hours. One Pharmacy in the north of the borough is open until 9pm and one pharmacy in the south of the borough closes at 10pm.

There is also good provision on Sundays with 11 pharmacies in Hammersmith and Fulham opening, covering between them the hours from 10am to 6pm. However, there are no pharmacies in Hammersmith and Fulham open from Sunday 6pm through to Monday 7am.



Map: Location of Pharmacies open on Sundays

From the public survey 48 (12.4%) respondents had not been able to access a pharmacy because the pharmacy they normally used was closed at the time.
On 31 occasions this was after 6pm and on 26 occasions it was on a weekend or bank holiday.

4.3 Centres for Health

There are two Centres for Health within the borough located within Hammersmith Hospital and Charing Cross Hospital. Both Centres for Health have Urgent Care Centres and a General Practice which operate from 8am to 8pm 7 days a week every day of the year. The General Practice operates across both sites and started from a zero patient base when the Centres opened in 2009. In July 2010 a total of 1874 patients were registered with the General Practice across the 2 sites and patient numbers are expected to increase at a rate of 200 a month.

The Hammersmith Centre for Health has no community pharmacy within half a mile. The closest pharmacy (Marcus Jones Pharmacy, W3 7DA) is located within Ealing PCT and is 0.58 miles away. The nearest pharmacy within Hammersmith and Fulham (Westway Pharmacy, W12 0PT) is 0.7 miles away. Neither pharmacy opens before 9am or beyond 6.30pm on weekdays nor do they open on Sundays.

The Fulham Centre for Health (located within Charing Cross Hospital site) has 2 pharmacies located within 0.3 miles. Neither pharmacy opens before 9am or beyond 6pm on weekdays and Saturdays. One pharmacy opens 11am to 5pm on Sundays.

A total of 2136 prescription items (representing 12.4% of all prescriptions issued and dispensed from both Centres for Health for the period April 2009 – March 2010) were dispensed at 2 pharmacies with extended opening hours. One pharmacy is located within Hammersmith & Fulham and the other is in Kensington & Chelsea. Both pharmacies are more than one mile from the Centres for Health. This is further

indication that pharmaceutical services provision may be required for longer hours than is currently available closer to both Centres for Health.

NHS Hammersmith and Fulham has already procured premises for a pharmacy to be based within Charing Cross Hospital alongside the Urgent Care Centre and the General Practice. The intention is to commission a new pharmacy to operate within these new premises by way of a Local Pharmaceutical Services (LPS) contract. The LPS Pharmacy would operate extended hours to reflect the opening hours of the Urgent Care Centre and the neighbouring General Practice. A neighbourhood around this site has been designated for an LPS Pharmacy.

4.4 Prescribing Data

In the year 1st April 2009 to 31st March 2010 Hammersmith and Fulham pharmacies dispensed 1.97 million prescription items.

During this period GPs in Hammersmith and Fulham issued 2 million prescriptions items that were dispensed. The vast majority of these (82%) were dispensed by pharmacies within Hammersmith and Fulham. The remaining 18% of prescription items were dispensed by pharmacies outside the Hammersmith and Fulham area. The number of prescription items issued by GPs in Hammersmith and Fulham that were never dispensed is not known. Although Hammersmith and Fulham has a higher number of pharmacies per 100,000 population than the national average, the average number of prescription items dispensed per pharmacy was significantly lower (38% lower than the national average) in 2008-09.

	Mean No. of prescription items/month/pharmacy
Hammersmith and Fulham	3790
London	4510
England	6129

NHS Information Centre: General Pharmaceutical Services in England 1999-2000 to 2008-09

4.5 Languages

Language may be a barrier to accessing pharmaceutical services and in particular with understanding how to use prescribed medication. Hammersmith and Fulham has an ethnically diverse population where there may be a significant number of residents who do not speak English or have access to someone who can interpret for them.

Pharmacies employ staff from a wide section of the community as indicated by the variety of languages spoken. The Pharmacy survey highlighted that 35 different languages were spoken by staff members across 38 of the pharmacies. (Appendix 5)

From the public survey 16 (4.4%) of respondents said they used a member of the pharmacy staff for interpreting support. However, the public survey was only available in English and it is therefore likely that people who require interpreting support were not able to complete the survey.
Data from the use of the interpreting service (1st April 2010-29th September 2010) provides a good indication of language support required in the community. The top 5 languages requested were as follows.

Somali	17.9%	(1 Pharmacy)
Arabic	17.6%	(11 Pharmacies)
Farsi	11.6%	(2 Pharmacies)
Polish	9.1%	(8 Pharmacies)
Spanish	7.9%	(5 Pharmacies)

Total number of requests for language support was 2053.

Also shown above (in brackets) is the number of pharmacies who have speakers of each language. Somali is only spoken in one pharmacy and further work with the Somali community may be needed to determine if this is a particular problem when accessing pharmaceutical services. Pharmacies currently do not have access to the

interpreting service utilised by other local health services. A review should be undertaken to determine how best to support communication between pharmacy staff and the public.

4.6 Access to Medicines Use Reviews

Of the 40 pharmacies, 35 have a consultation room meeting standards required to undertake MURs. Wheelchair users are able to access 23 of these consultation rooms. Hand washing facilities are also present in 22 consultation rooms. Over half the pharmacies in Hammersmith and Fulham are, therefore, well placed to deliver a range of enhanced services.

Each pharmacy can undertake 400 MURs in a year. In the period April 2009-March 2010 there were a total of 5140 MURs which represents 39% of the maximum number of MURs that could have been performed by the 33 accredited pharmacies.

	Accredited Pharmacies	**No. of MURs**
Shepherds Bush & White City	13	1756
Hammersmith	9	1720
Fulham	11	1664

23 of the 33 pharmacies carried out less than 100 MURs each.

4.7 Access to end of life care drugs

An agreed range of end of life care drugs are held in stock at the 100 hour contract pharmacy (Boots Fulham Broadway Retail Centre). Although this pharmacy has good transport links consideration may need to be given to provision of a similar service in the north of the borough so as to minimise delays in obtaining medicines and impact on healthcare staff.

4.8 Summary

In general there is adequate provision of essential and advanced pharmaceutical services and there is sufficient capacity to meet the demands from an increasing resident population.

The following gaps, however, have been identified:

(iii) provision of pharmaceutical services over extended hours (including Sundays and Bank Holidays) to support the Fulham Centre for Health

(iv) provision of pharmaceutical services over extended hours (including Sundays and Bank Holidays) to support the Hammersmith Centre for Health

The following would secure improvements or better access to essential and advanced pharmaceutical services:

(iv) commissioning a service to ensure prompt access to end of life care drugs and equipment

(v) extending availability of language support services to community pharmacies

(vi) commissioning a service which will identify and target MURs to key patient groups (eg patients with asthma and chronic obstructive pulmonary disease)

5. Health Priorities in Hammersmith and Fulham

This section of the PNA focuses on key health priorities identified in the JSNA, Public Health Report 2008-09 and the Strategic Plan 2009-14 and explores how pharmaceutical services could and do meet identified needs.

5.1 NHS Hammersmith and Fulham's Vision

NHS Hammersmith and Fulham's overall corporate vision is to **improve the health of the local population**.

We have four strategic goals against which we plan and prioritise initiatives to deliver improvements in local people's health and wellbeing.

- Enable and support health, independence and well-being
- Give people more control of their own health and healthcare
- Offer timely and convenient access to quality, cost effective care
- Proactively tackle health inequalities

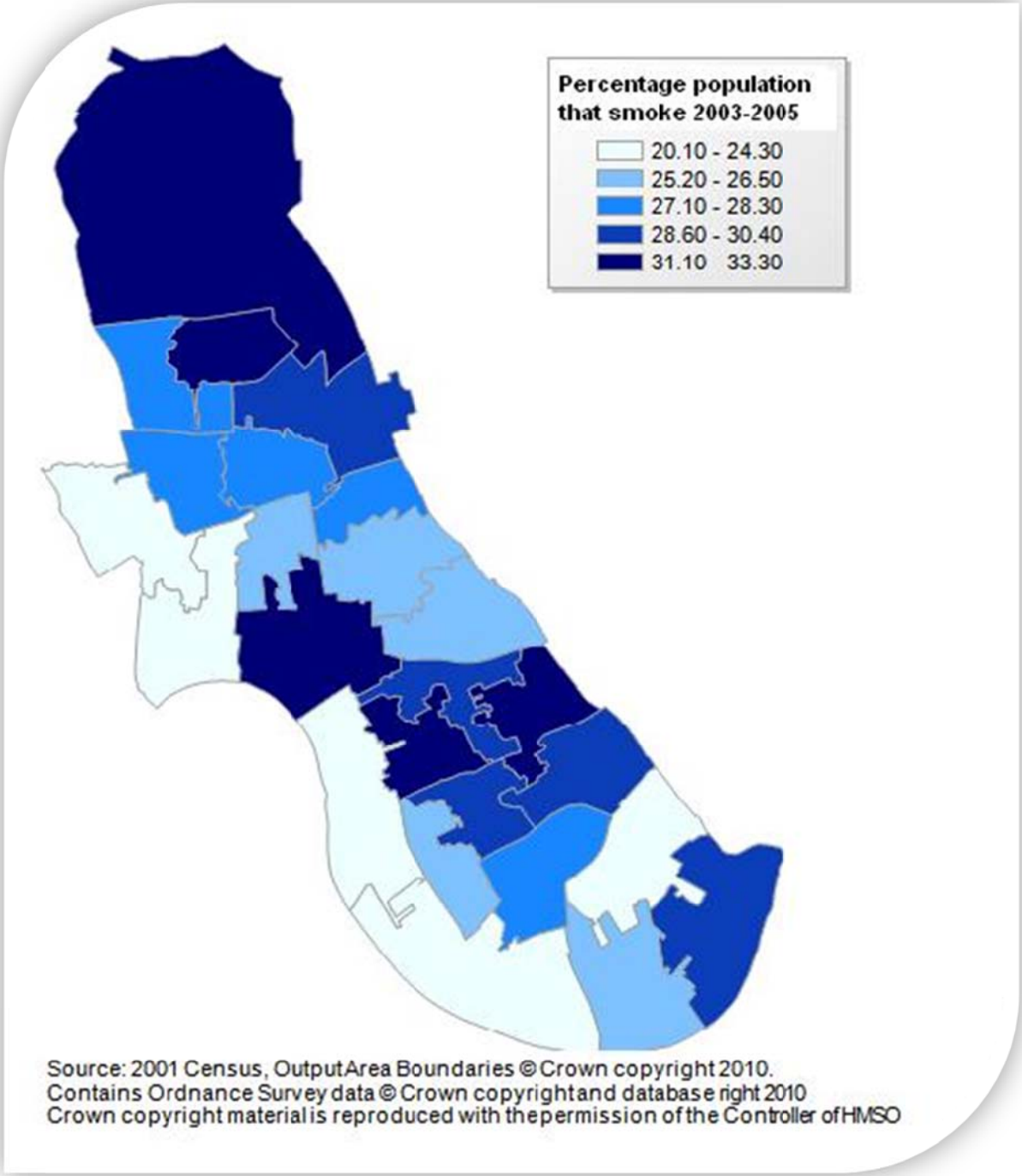
These are broad goals which have been shaped by several years of engagement with local residents, clinicians, and other partners. They reflect national priorities such as patient choice, timely access to care, a shift to provide more care in convenient settings and a greater focus on supporting people to live healthy lives.

The goals also address specific local needs identified in our Joint Strategic Needs Assessment (JSNA). In particular the vital work to remove the unacceptable variation in quality and availability of services related to who you are and where you live within the borough.

5.2 Smoking

Smoking is the most important risk factor for ill health and remains the major cause of preventable morbidity and premature death in England. It is also the principal reason for the gap in healthy life expectancy between rich and poor. The three leading causes of death in the borough are all smoking-related – respiratory disease, cancer and cardiovascular disease. Half of all who continue to smoke for most of their lives die of the habit, and smoking therefore remains a key public health priority.

The estimated smoking prevalence for Hammersmith and Fulham is 27.8% (London Boost of the Health Survey of England, 2009). This equates to around 49,000 current smokers and places Hammersmith and Fulham among the top 5 boroughs in London with the highest smoking rates.


Percentage population that smoke 2003-2005
20.10 - 24.30
25.20 - 26.50
27.10 - 28.30
28.60 - 30.40
31.10 33.30
Source: 2001 Census, Output Area Boundaries © Crown copyright 2010.
Contains Ordnance Survey data © Crown copyright and database right 2010
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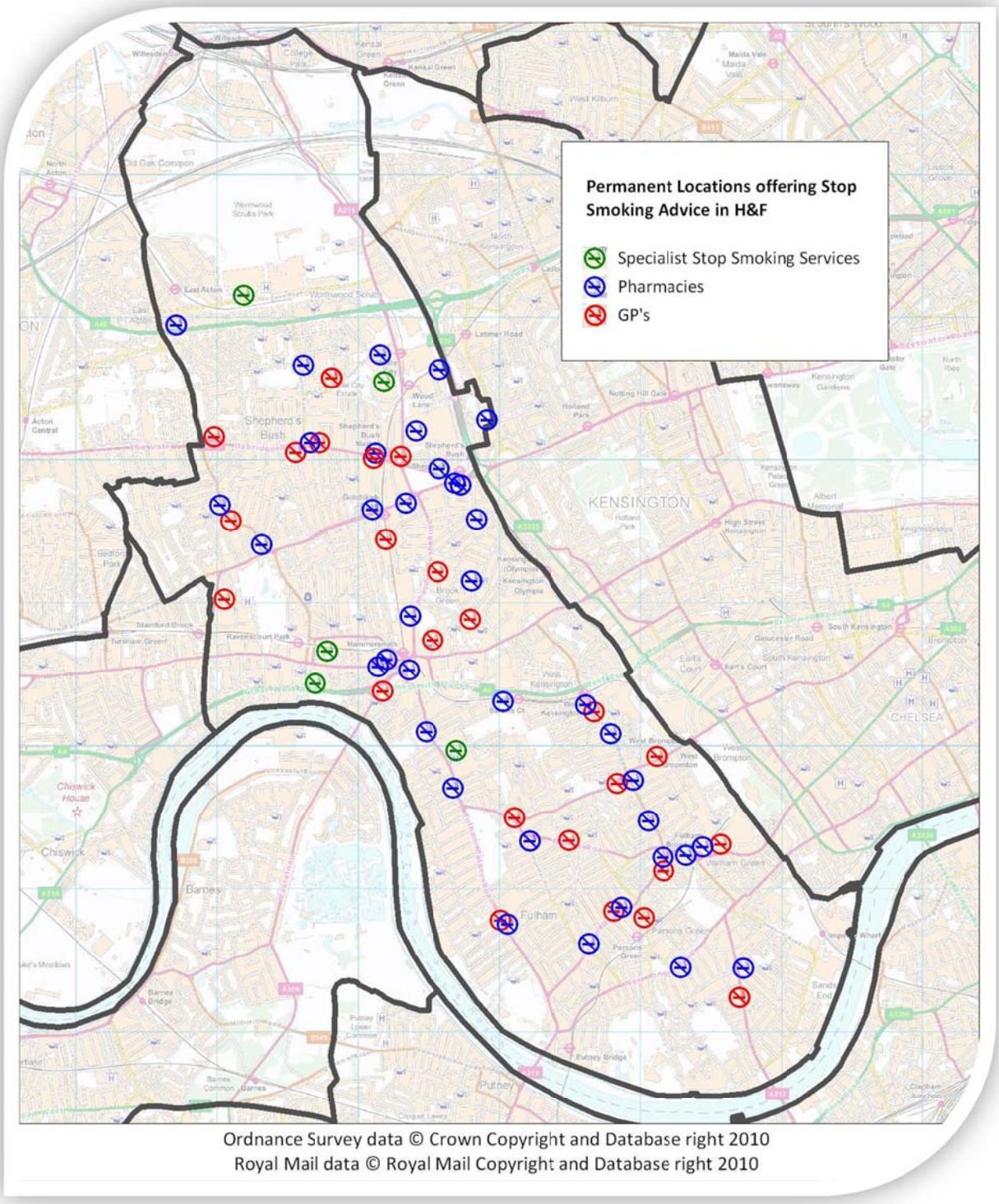


Trained Stop Smoking advisers are available in 37 pharmacies. In 2009/2010 pharmacies helped a total of 568 smokers to quit, contributing 33% towards the total achieved in that year.

Pharmacies have proved to be an important part of the Stop Smoking Service providing an easily accessible and convenient option for smokers seeking advice, support and nicotine replacement therapies.

We consider the pharmacy based stop smoking service to be a necessary service. These pharmacies along with all the other providers of the stop smoking service meet the needs of the population. We conclude that there are no gaps in service provision.

5.3 Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is an incurable but largely preventable disease which leads to damaged airways in the lungs.

COPD is the UK's fifth biggest killer disease and also the second most common cause of emergency admission to hospital.

There are an estimated 3.7 million people in the UK with COPD yet only 900,000 people have been diagnosed and receiving care and treatment. The local situation is expected to mirror the national picture with a sizeable cohort of undiagnosed cases of COPD.

There were 1900 people on the COPD disease register in H&F in November 2009, representing a borough level prevalence of around 1.0%. Modelled estimates of COPD prevalence in H&F suggest that the expected prevalence is 3.2% (all ages) meaning that around 4000 people remain undiagnosed.

With early diagnosis and the right care, the progression of the disease can be slowed down allowing people to live healthy and active lives for longer. The most important risk factor for COPD is smoking.

Pharmacies are well placed to promote and offer simple, convenient screening for COPD using hand held spirometers. Smokers already access pharmacy services through the Stop Smoking Service, over the counter purchases of nicotine replacement products as well as a variety of other reasons.

Consideration should be given to utilising pharmacies to identify those with an early stage of COPD, provide advice and signpost or directly refer to respiratory services.

5.4 Sexual Health

5.4.1 Emergency Hormonal Contraception

Eighteen pharmacies are commissioned by NHS Hammersmith and Fulham to provide an Emergency Hormonal Contraception (EHC) service through a Patient Group Direction (PGD). Pharmacists also offer advice on safe sex, contraception and signpost clients to other services where appropriate. Pharmacies offer convenient, confidential access to the service without the need for an appointment.

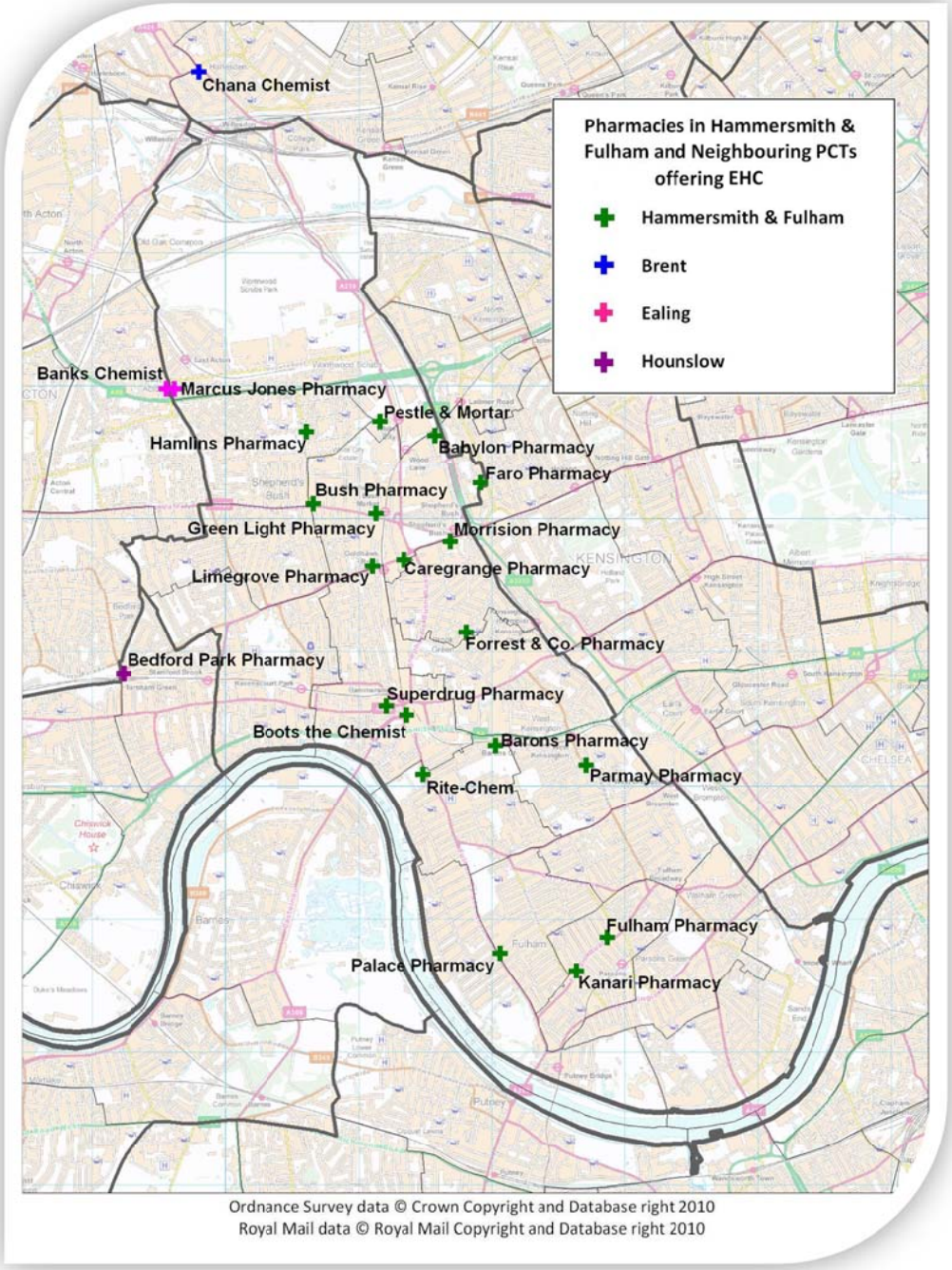
Data for teenage conceptions in 2005-2007 highlighted that rates were significantly higher in 3 wards: Askew; Wormholt & White City; College Park & Old Oak.
The highest numbers for EHC consultations in pharmacies is also in the Shepherds Bush locality.

The pharmacies providing an EHC service are spread throughout the borough with more pharmacies located in the Shepherds Bush and White City areas where the need is likely to be the greatest.
Emergency hormonal contraception can also be accessed through GP surgeries and family planning clinic. Family Planning Clinics operate from the following sites in Hammersmith and Fulham:

- Parsons Green Centre, 5-7 Parsons Green, SW6 4UL
- Charing Cross Hospital, Outpatients Clinic, Fulham Palace Road, W6 8RF

- White City Health Centre, Australia Road, W12 7PH
- Milson Road Health Centre, 1-13 Milson Road, W14 0LJ

We consider the Pharmacy EHC service to be a necessary service. Across the borough there is sufficient choice of providers and access to the service including late evenings on weekdays and also on Sundays. We conclude that there are no gaps in service provision.


Pharmacies in Hammersmith & Fulham and Neighbouring PCTs offering EHC
Hammersmith & Fulham
Brent
Ealing
Hounslow
Chana Chemist
Banks Chemist
Marcus Jones Pharmacy
Pestle & Mortar
Hamlins Pharmacy
Babylon Pharmacy
Faro Pharmacy
Bush Pharmacy
Green Light Pharmacy
Morrision Pharmacy
Caregrange Pharmacy
Limegrove Pharmacy
Forrest & Co. Pharmacy
Bedford Park Pharmacy
Superdrug Pharmacy
Boots the Chemist
Barons Pharmacy
Parmay Pharmacy
Rite-Chem
Fulham Pharmacy
Palace Pharmacy
Kanari Pharmacy
Ordnance Survey data © Crown Copyright and Database right 2010
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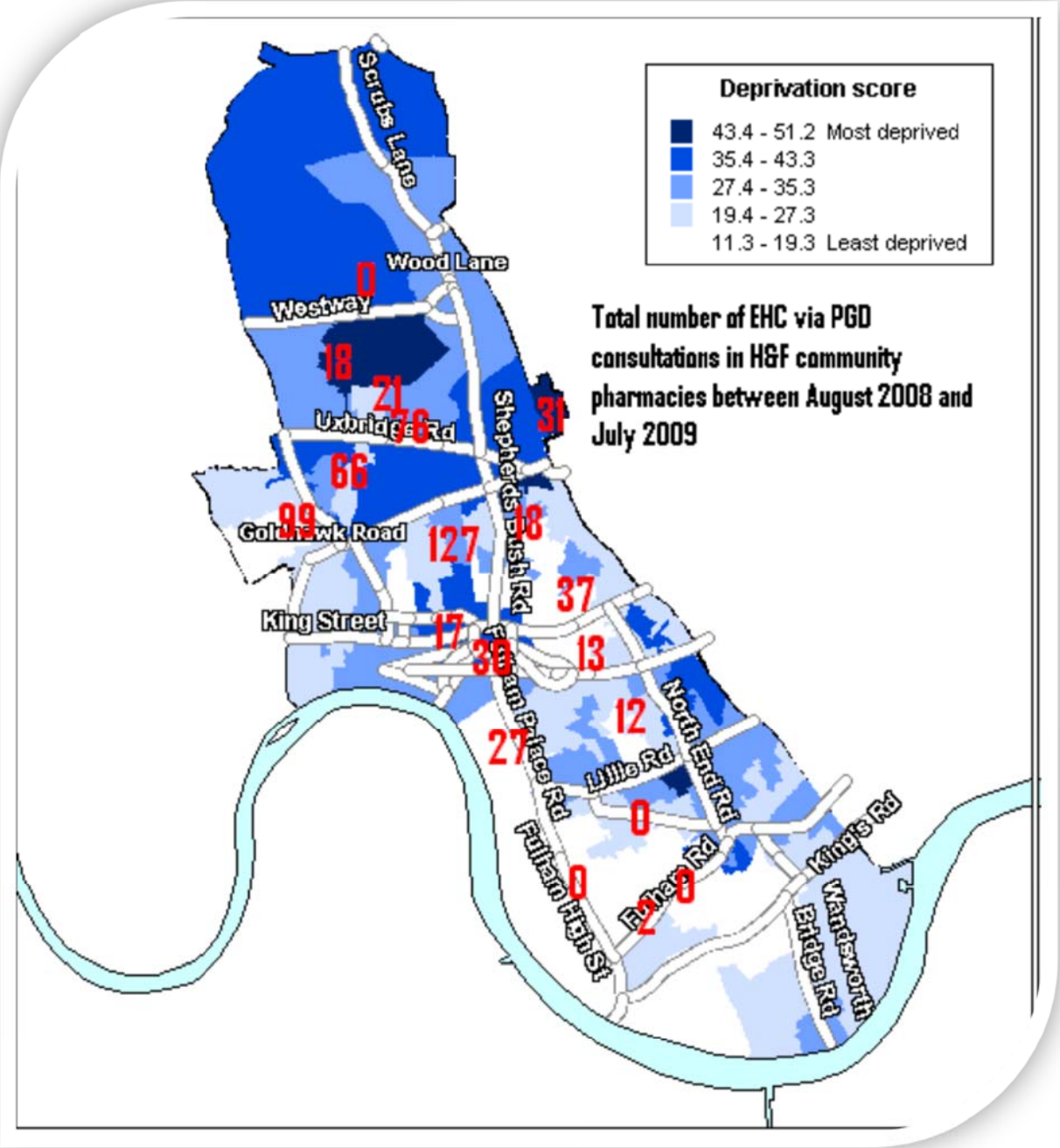

Deprivation score
43.4 - 51.2 Most deprived
35.4 - 43.3
27.4 - 35.3
19.4 - 27.3
11.3 - 19.3 Least deprived
Total number of EHC via PGD consultations in H&F community pharmacies between August 2008 and July 2009
Scrubs Lane
Wood Lane
Westway
Uxbridge Rd
Goldhawk Road
King Street
Shepherds Bush Rd
Fulham Palace Rd
Fulham High St
Lillie Rd
North End Rd
Finlay Rd
King's Rd
Wandsworth Bridge Rd
0
18
21
76
31
66
99
127
18
37
17
38
13
12
27
0
0
2
0

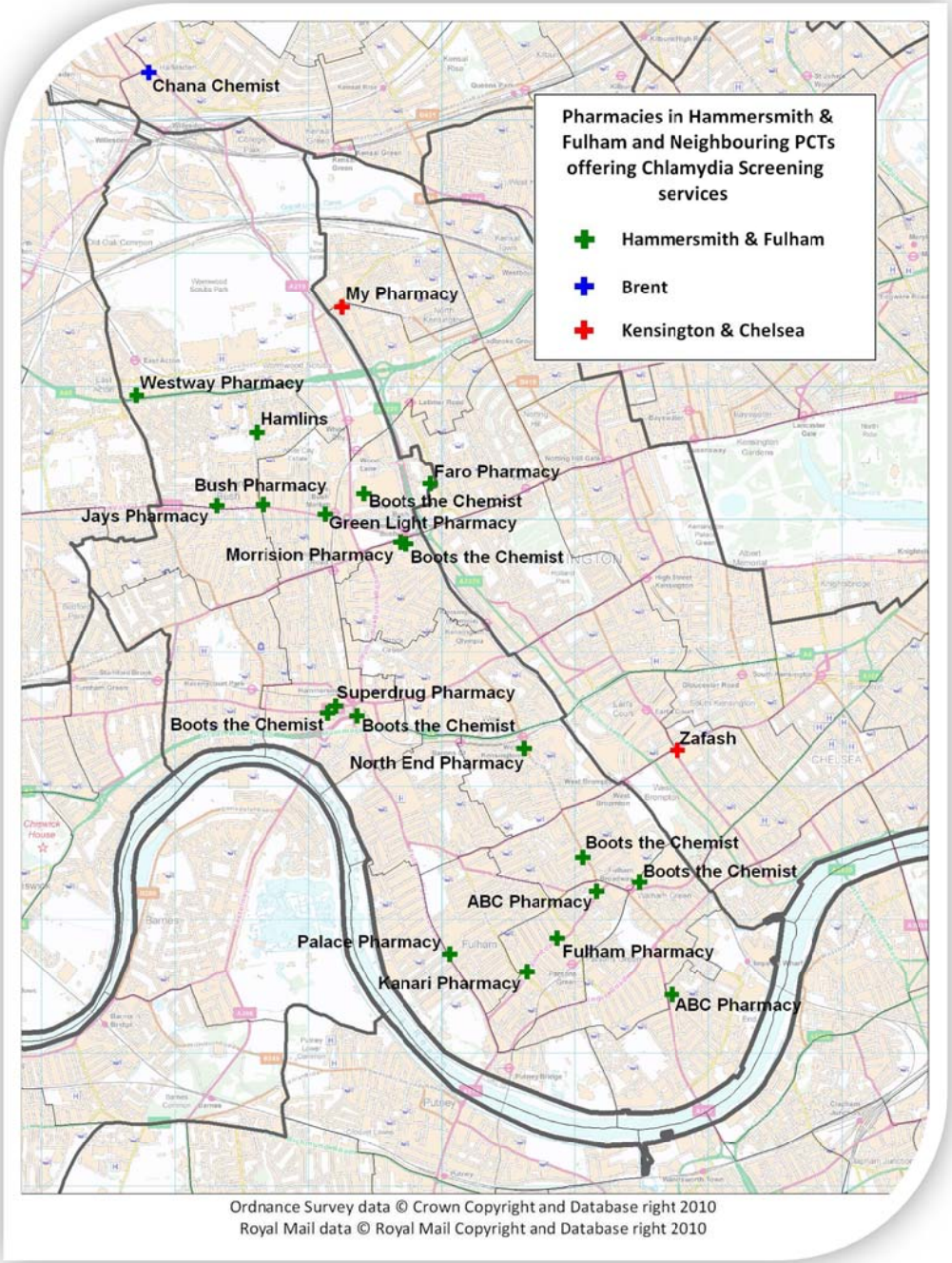
5.4.2 Chlamydia Screening and Treatment

As many as one in ten young people in Hammersmith and Fulham have Chlamydia. Often there are no symptoms and the person is unaware they have the infection. However, there are longer term health consequences as well as risks in spreading infection to others. Young persons are more likely to be affected but they are also a group that are less likely to access health services such as their GP surgery.

A pharmacy based Chlamydia screening and treatment service has been operating since April 2009 with 19 accredited pharmacies. There are adequate numbers of pharmacies offering the service across the borough. Although the processes and operational models have worked well, the activity levels have remained low.

Pharmacies provide an easily accessible point for screening, however, the service needs to be reviewed to determine how best the pharmacy model can provide a cost effective service and improve activity levels.

The pharmacy based Chlamydia screening and treatment service is a relevant service for our population. We conclude that there no gaps in provision.


Pharmacies in Hammersmith & Fulham and Neighbouring PCTs offering Chlamydia Screening services
Hammersmith & Fulham
Brent
Kensington & Chelsea
Chana Chemist
My Pharmacy
Westway Pharmacy
Hamlins
Faro Pharmacy
Bush Pharmacy
Boots the Chemist
Jays Pharmacy
Green Light Pharmacy
Morrision Pharmacy
Boots the Chemist
Superdrug Pharmacy
Boots the Chemist
Boots the Chemist
Zafash
North End Pharmacy
Boots the Chemist
Boots the Chemist
ABC Pharmacy
Palace Pharmacy
Fulham Pharmacy
Kanari Pharmacy
ABC Pharmacy
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5.5 Alcohol Misuse

Hammersmith and Fulham has more alcohol related problems (including high rates of hazardous harmful and binge drinking, alcohol specific hospital admissions and alcohol related mortality) than London and England.

Alcohol misuse not only harms the individual but also their family (e.g. domestic violence), their community (e.g. crime and disorder, road traffic collisions) and society as a whole (e.g. healthcare costs).

A local Alcohol Harm Reduction Strategy 2008 – 2011 and an action plan were developed addressing prevention, early detection and improved treatment. During 2009 a number of new projects were started, including the Older People Alcohol Project and the introduction of two alcohol nurse specialists, one at Hammersmith Hospital and the other at Charing Cross Hospital.

Other initiatives include the development of low threshold community alcohol services and initiatives related to the prevention agenda, including reducing and preventing harms in under 18s and encouraging licensed premises to promote responsible drinking.

26 (6.6%) of respondents from the public survey said they would use an alcohol screening service in a community pharmacy if it was available. 27 (67.5%) of the pharmacies stated that they would be willing to provide an NHS commissioned alcohol screening service with most (17) requiring further training.

Pharmacies may have a role to play in alcohol screening and brief interventions in primary care. However, there is currently limited evidence and experience of such programmes nationally and further work is needed to explore the potential.

5.6 Substance Misuse

The number of Problem Drug Users in Hammersmith and Fulham is estimated to be nearly 3,000, which equates to a rate of 22 per 1,000 of the population aged 15-64. This ranks Hammersmith and Fulham as the eighth highest in London (out of thirty three Drug Action Team [DAT] areas), and eighth again in Inner London (out of twelve). The Hammersmith and Fulham rate is similar to the Inner London average (22), and significantly higher than the London average (14).

For users of opiates only, Hammersmith and Fulham has a rate of 14 per 1,000. This is above the London average of 10, but below the Inner London average of 16. Approximately 51% of H&F's opiate users are 'treatment naïve' (i.e. not known to treatment system), similar to the London rate (50%). Hammersmith and Fulham has 13 crack users per 1,000, more than the London average of 10 and less than the Inner London average of 15.

Pharmacies in Hammersmith and Fulham provide two services to support drug treatment services

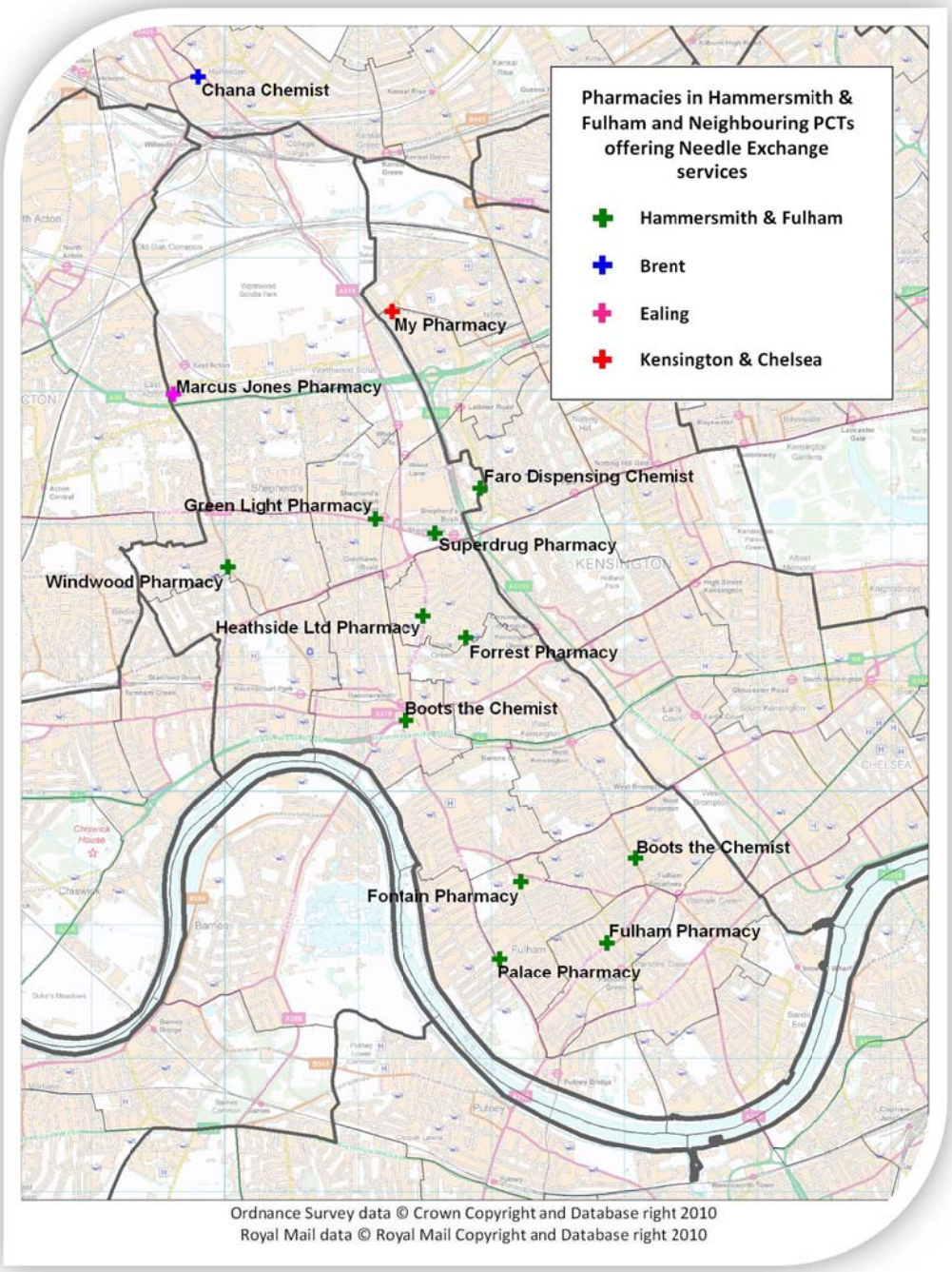
5.6.1 Needle Exchange Service

The needle exchange service is focused on ensuring that injecting drug users have access to clean injecting equipment, are able to safely dispose of used equipment and have access to advice from pharmacists. Clients can access a needle exchange service from 11 pharmacies as well as Druglink based in Shepherds Bush.

Pharmacy needle exchange activity for the period 30th July 2009 to 30th June 2010 in H&F:

- 8,138 needle exchange packs given out
- 3,057 packs returned (an average return rate of 37.6%).

	Needle exchange packs distributed	Needle exchange packs returned
FULHAM		
Town	49	17
Munster	1235	705
Fulham Broadway	697	247
Fulham Total	**1981**	**969**
HAMMERSMITH		
Avonmore & Brook Green	71	36
Hammersmith Broadway	643	129
Addison	293	68
Hammersmith Total	**1007**	**233**
SHEPHERDS BUSH & WHITE CITY		
Shepherds Bush Green	4144	1581
Askew	1006	274
Shepherds Bush & White City Total	**5150**	**1855**



There is adequate availability and capacity for the service with access to the service late evenings and Sundays across the borough.

We consider the pharmacy needle exchange service to be a necessary service. We conclude that there are no gaps in service provision.

5.6.2 Methadone supervised consumption

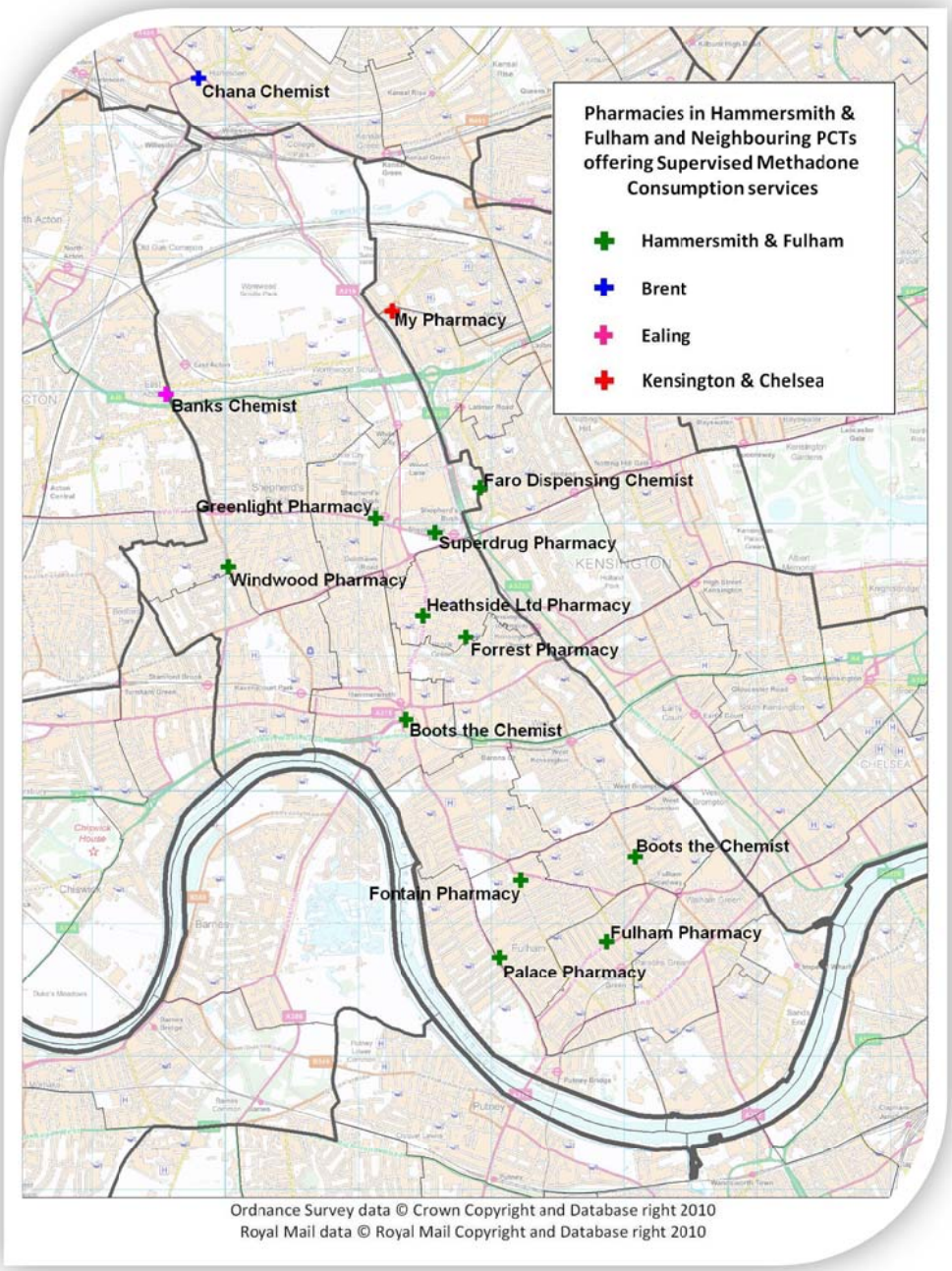
This service is focused on ensuring that clients in drug treatment programmes take their treatment as prescribed and to provide an opportunity for the pharmacist to make interventions as appropriate.

In the period 1st July 2009 to 30th June 2010, 14 Pharmacies carried out a total of 18,566 supervisions of methadone consumption. A further 2 pharmacies are accredited to provide the service but have had no patients during this period.

Locality	No. of Pharmacies	No. of supervisions
Shep. Bush & White City	7	9955
Hammersmith	4	2332
Fulham	3	6279

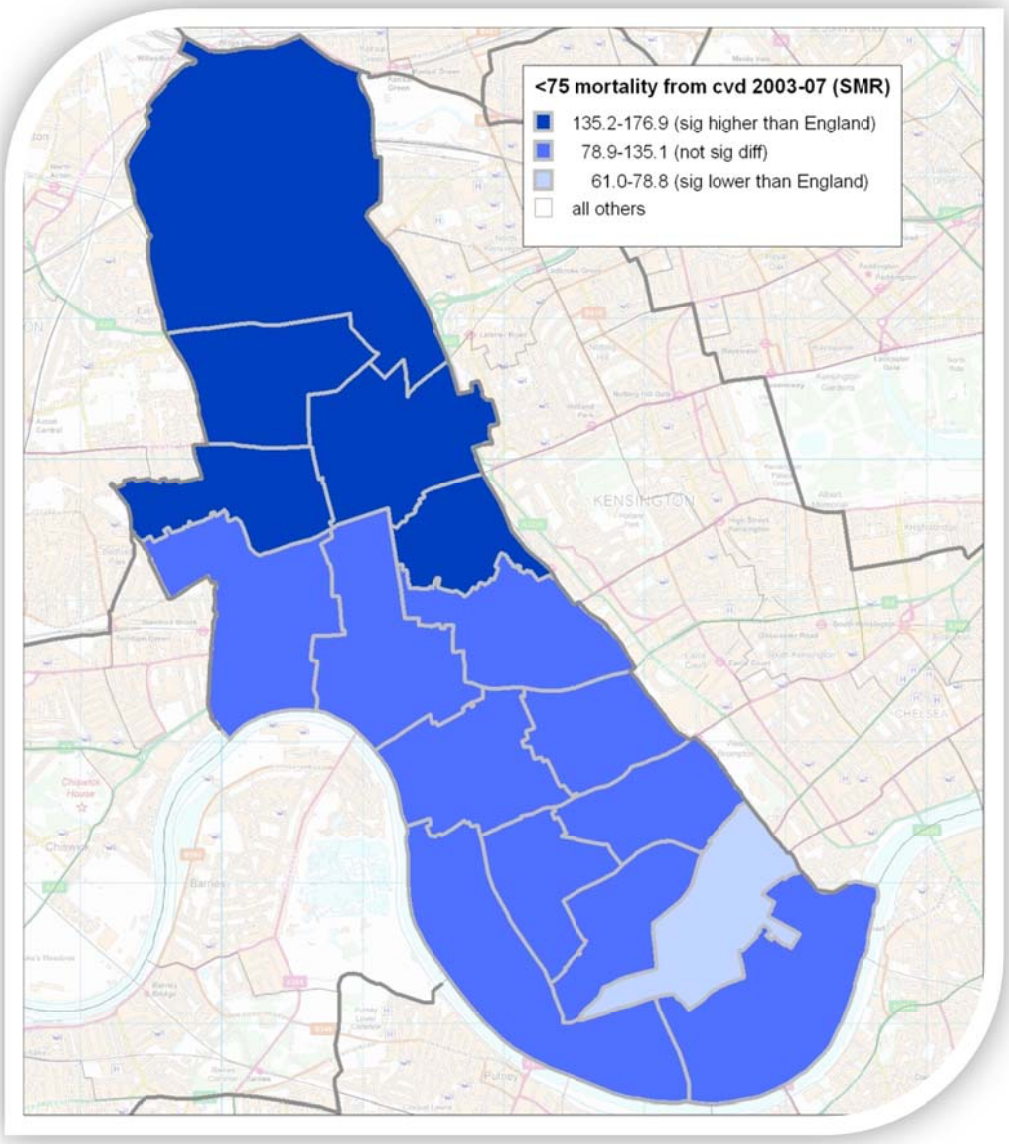
The pattern of provision is consistent with the needs of the population.
There are currently sufficient pharmacies spread across the borough to meet the demand and provide choice to patients.

We consider the supervised methadone consumption to be a necessary service. We conclude that there are no gaps in service provision.



5.7 NHS Health Checks

Cardiovascular disease (CVD) is one of the major causes of death in Hammersmith and Fulham accounting for around 110 deaths each year. The premature mortality rates are similar to those in London and in England. However, there are stark inequalities between wards. 79% of the gap between wards can be explained by deprivation.



It is estimated that there are around 20,000 people with undiagnosed hypertension and 2,500 with undiagnosed diabetes, both of which are risk factors for CVD. Nationally the incidence of diabetes is expected to rise by 70% by 2050, in line with the increase in prevalence of adult obesity.

Early identification of those at risk of CVD and treatment and/or changes to lifestyle can prevent later complications and reduce the levels of premature deaths.

The NHS Health Checks program in Hammersmith and Fulham is designed to:

- Assess individuals' risks of developing cardiovascular disease (CVD)
- Identify individuals with previously unidentified CVD and associated risk factors
- Encourage and support people to decrease or manage their risk of CVD

While some NHS Health Checks take place in general practice, pharmacies are also well placed to play a key role. The aim of the risk assessment and management programme is to identify the risk of vascular disease in the population early and then to help people reduce or avoid it.

Pharmacies offer an excellent point of contact with the general population, and also offer a place of access to services for groups who may not be registered with GPs.

6 Pharmacies have been commissioned to provide a NHS Health Checks Service initially for a period of 12 months from September 2010. The project will be evaluated during the 12 month period and recommendations made on how the programme should proceed beyond the initial period.

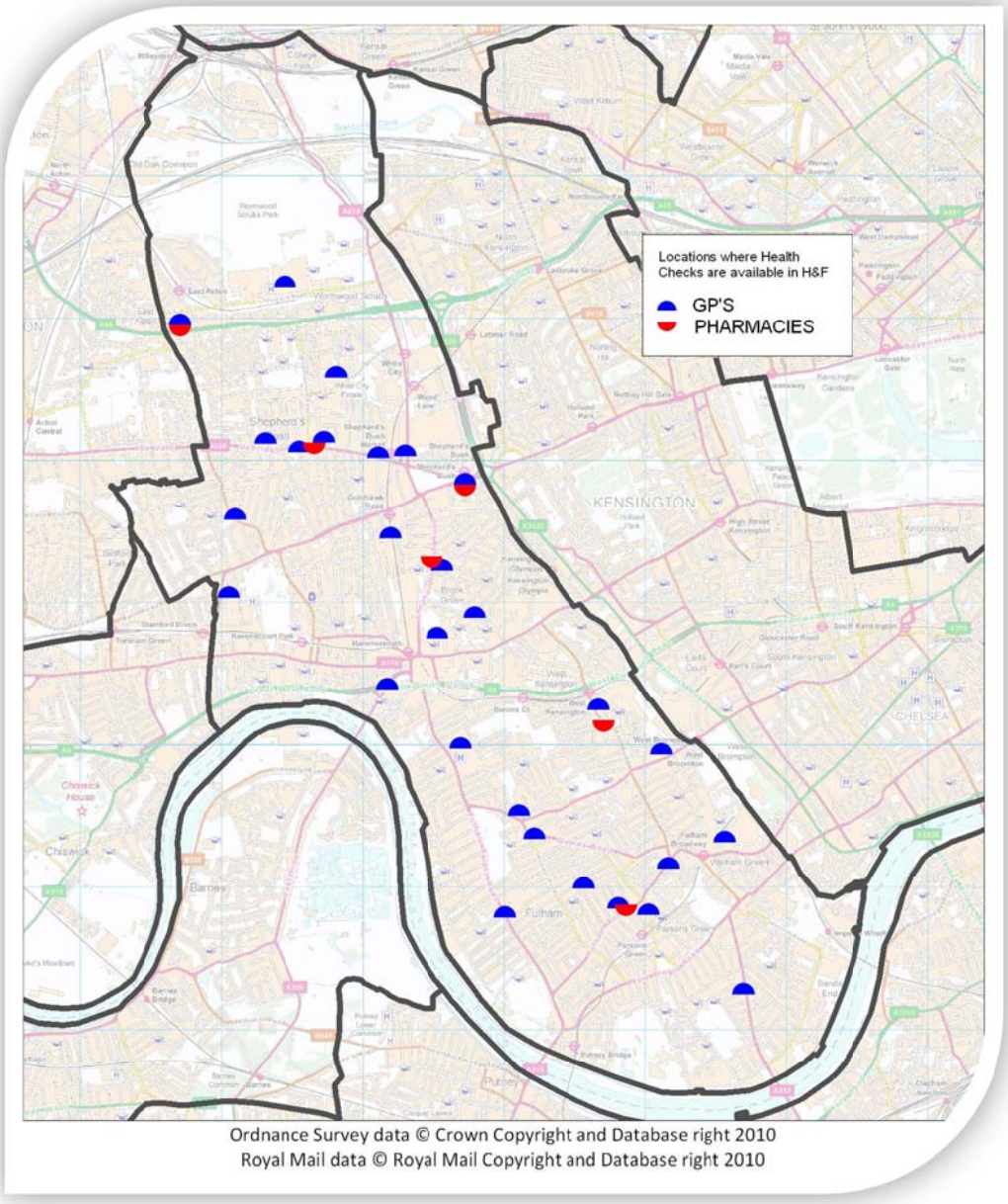
The Pharmacies are all located in or close to areas of high deprivation where the incidence of CVD is likely to be the greatest

The pharmacies are expected to:

- Increase choice, convenience and accessibility of the service especially for those who haven't registered with a GP or would prefer to receive an NHS Health Check outside of a GP setting

- Offer an opportunity to reduce health inequalities by targeting the service in the deprived areas of the borough

- Engage individuals who may not access other services or are infrequent users of GP services.



Map: Location of GP's and Pharmacies providing NHS Health Checks Service

5.8 Health Lifestyle – Weight Management

15.4% of adults in Hammersmith and Fulham are estimated to be obese which equates to about 27,000 people. The prevalence of obesity in children is currently measured via the annual National Child Measurement Programme in reception (aged 4-5) and year 6 (aged 10-11).The risk of childhood obesity in the borough, for both reception and year 6, is significantly higher than the England average but comparable to London.

There is evidence of a link between deprivation and the prevalence of obesity. In Hammersmith and Fulham around 30% of the population live in areas ranked within the fifth most deprived in England.

Failure to bring down levels of obesity will result in a major impact on healthcare services and resources in the future.

82 (21.0%) of the respondents in the public survey said they would use a weight management service if it were available as an NHS service in their local pharmacy.
6 (15%) of the pharmacies are already providing a private weight management service.

There is potential to utilise pharmacies to tackle the ever increasing problem of obesity. Further work should be undertaken to learn from experiences of PCTs who have developed pharmacy weight management services and to explore the potential impact pharmacies could have on this issue in Hammersmith and Fulham.

5.9 Immunisations and Vaccinations

NHS Hammersmith and Fulham does not currently commission any immunisations and vaccinations from community pharmacies.

However, a number of pharmacies are providing these services on a private basis through private Patient Group Directions (PGD).

10 (25%) of pharmacies are providing seasonal flu vaccinations. 2 pharmacies also provide a HPV vaccinations against cervical cancer.

11 (2.8%) of respondents in the public survey had received vaccination in a pharmacy in the past 12 months. 70 (17.9%) said they would like to receive vaccinations in a pharmacy if they were available on the NHS.

Further work is needed to establish if there is unmet need for vaccination programmes and whether pharmacies could be developed to meet that need.

5.10 Long Term Conditions

Most people with long term health conditions take one or more prescribed medicines. However, evidence suggests that as much as 50% of medicines are not taken as intended or not taken at all. This is not only a waste of NHS resources but is also likely to have a negative impact on the health of the patients.

Medicines can also have adverse effects which in some cases results in admissions to hospital. On discharge from hospital patients medication is often altered but the changes may not be fully implemented in primary care or the patient has difficulty adapting to the new regime.

Pharmacies have a role to play in ensuring that patients can get the maximum benefit from the medicines they are prescribed. Medicines Use Reviews (MURs) are designed to achieve this but, as highlighted earlier, currently only 39% of the potential maximum number of MURs are being undertaken.

Consideration should be given to targeting MURs to impact on the key health priorities identified locally. MURs should also be targeted at those patients prescribed new medicines and those recently discharged from hospital.

6. Results from the Pharmacy and Public Surveys

6.1 Public Survey

Some of the results from the survey are already highlighted in the main body of the report.

A total of 391 members of the public responded to the survey.

Many of the respondents stated that they had one or more long term health conditions, an indication that they are likely to be frequent users of pharmacy services.

	No. of respondents
High blood pressure	128
Diabetes	93
Arthritis	92
Asthma	66
Heart disease	43
COPD	20

The main reasons for choosing to use a particular pharmacy were cited as:

	No. of respondents
Convenient location	272
Friendly and helpful staff	240
Good quality service	235
Staff knowledge	188
Closes after 6pm	100
Opens before 9am	65

Most of the respondents visited a pharmacy for health services at least once every 3 months with the most common reasons being purchases of medicines and prescription dispensing. 115 (67.6%) responding to the question said they used a pharmacy to get advice on health issues. 280 (71.6%) also stated they read the posters and leaflets displayed in pharmacies.

	No. of respondents
To buy medicines	220
To get a prescription dispensed	279
To get advice on health issues	115
For other health services	81

We also asked what services they had used in a pharmacy in the last 12 months. As expected prescription dispensing was the most common reason. Despite the high levels of chronic health conditions amongst the respondents only 42 (10.7%) have had a Medicines Use Review with a pharmacist. This corresponds with the low levels of MURs that are currently taking place – only 39% of the maximum potential number of MURs were undertaken by the 33 accredited pharmacies in 2009-10.

	No. of respondents
Prescription dispensing	292 (74.7%)
Prescription collection	148 (37.9%)
Advice about medicines	139 (35.5%)
Consultation about health	128 (32.7%)
Disposal of unwanted medicines	62 (15.9%)
Medicines Use Review	42 (10.7%)
Stop Smoking Service	41 (10.5%)

The services that respondents would most like to access if available as a NHS service from a pharmacy were as follows:

	No. of respondents
Cholesterol measurement	171 (43.7%)
Blood sugar measurement for diabetes	135 (34.5%)
Diabetes screening	104 (26.6%)
Weight management service	82 (21.0%)
Management of minor ailments	80 (20.5%)
Vaccinations	70 (17.9%)

6.2 Pharmacy Survey

39 of the 40 pharmacies responded to the pharmacy survey.

The survey highlights both the number and variety of services, both NHS and private, that community pharmacies are delivering.

To supplement the dispensing service 39 pharmacies provide a free prescription collection service and 29 pharmacies also offer a free home delivery service.

Pharmacies show a willingness to provide a greater range of NHS services which include:

	No. of pharmacies
Minor ailment service	30
Obesity management	29
Anticoagulant monitoring	24
End of life drugs service	23
Supplementary prescribing	22

Over 60% of the pharmacies would be willing to provide a medicines management service with more than half the pharmacies also looking to deliver a vaccinations

service. 10 pharmacies are already administering seasonal flu vaccinations on a private basis.

However, most have also stated that additional training would be needed in order to deliver these additional services.

When asked if they felt their skills were being fully utilised, 29 said partly or not all. This is further indication that the pharmacies themselves feel that they have more to offer to the NHS than is currently being utilised.

This was also reflected in the comments made in the surveys:

"Embracing new services and developing a portfolio of services for the local community in addition to dispensing prescriptions and providing the current core pharmaceutical services. Greater integration with the NHS but maintaining our independence with a fairer remuneration structure. To deliver these services we will need to acquire new skills both at a professional & commercial level"

"Shift more services from the GPs to the pharmacy and work more closely with the GPs and utilise the clinical skills of the pharmacist in providing professional services to the community."

Pharmacies, on the whole, do have good relationships with their locals GPs and the PCT with 65% saying they were totally satisfied.

7. Recommendations

7.1 Access to Essential Pharmaceutical Services

Hammersmith and Fulham has more pharmacies per 100,000 population than the national average. These pharmacies dispense significantly fewer prescriptions than both the London and national averages. Generally there is good access to pharmaceutical services including early mornings, late evenings and on Sundays. However, the following points raised in this PNA require further consideration:

7.1.1 Centres for Health

There are 2 Centres for Health which have opened recently. Both centres have on site an Urgent Care Centre and General Practice operating from 8am to 8pm 365 days a year. The number of patients registered with GPs across the 2 sites is expected to grow at the rate of 200 a month over the next 3-5 years.

At the Fulham Centre for Health (located on the Charing Cross Hospital site) the PCT has acquired space for a community pharmacy. The intention is to tender for a Local Pharmaceutical Services (LPS) contract. The LPS contract pharmacy would be required to open extended hours.

At the Hammersmith Centre for Health (located on the Hammersmith Hospital site) there are no pharmacies within half a mile. The 2 nearest pharmacies do not open beyond 6.30pm and neither opens on Sundays. Consideration should be given to addressing any gaps in access to pharmaceutical services early mornings, late evenings, Sundays and Bank Holidays.

7.1.2 Language

Data from the interpreting service and from the public survey suggests that language may be a barrier to fully accessing pharmaceutical services for some patients from

ethnic minorities. The public survey has limitations since it was only distributed in the English language.

Language support services that are available to other NHS services should be extended to include community pharmacies.

7.1.3 Drugs for End of Life Care

Healthcare professionals providing end of life care often require a number of medicines at short notice. This is important to ensure patients are kept comfortable, pain free and to avoid unnecessary admissions to hospital.

The 100 hour contract pharmacy in Fulham Broadway carries a minimum stock level of a range of agreed drugs. Although there are good transport links to this pharmacy, it is located in the south of the borough.

Consideration should be given to extending this service to at least one pharmacy in Hammersmith and one in Shepherds Bush & White City. This would reduce delays in obtaining urgent medicines, reduce impact on the time of healthcare professional and also reduce the risk of out of stocks.

7.2 Medicines Use Reviews

Pharmacies have an important role in ensuring that patients gain the maximum benefit from the medications they are prescribed. There is evidence that upto 50% of patients with long term conditions do not take medicines as prescribed which is not only a waste but could also have a negative impact on health.

There is potential to make better use of MURs to achieve reductions in medicines waste and improve health outcomes by:

- targeting MURs at patients who have specific long term health conditions reflecting local health priorities

- targeting MURs at patients discharged from hospital with new medication
- strengthening professional relationships between pharmacists and GPs to ensure feedback is given on MUR recommendations and that they are implemented where appropriate
- promoting awareness of this service amongst the general public

7.3 Screening Services

7.3.1 COPD Screening

Around 4000 people in Hammersmith and Fulham have undiagnosed COPD. With early diagnosis the progression of the disease can be slowed down allowing people to live healthy and active lives for longer. The most important risk factor for COPD is smoking.

37 of the 40 community pharmacies provide a Stop Smoking Service and all sell nicotine replacement products. Pharmacies present an excellent opportunity to screen for COPD and refer suspected cases to a respiratory service.

7.3.2 Alcohol misuse

Hammersmith and Fulham has more alcohol related problems (including high rates of hazardous harmful and binge drinking, alcohol specific hospital admissions and alcohol related mortality) than London and England.

Pharmacies are not currently commissioned to provide alcohol services but there is potential to commission a screening and brief intervention service in pharmacies.

The National Treatment Agency's *Review of the Effectiveness of Treatment for Alcohol Problems* (2006) showed that opportunistic brief interventions delivered to hazardous and harmful drinkers in primary healthcare are effective in reducing alcohol consumption to lower-risk levels. The public health impact of widespread

implementation of brief interventions in primary healthcare is potentially very large. Additionally, the effects of brief interventions persist for periods of up to two years after intervention and perhaps as long as four years.

A potential community pharmacy based service could:

- identify higher-risk and increasing-risk drinking and provide brief interventions to motivate individuals to modify their drinking patterns

- provide referral to specialist services where appropriate

7.3.3 Cardiovascular Disease

It is estimated that there are around 20,000 people with undiagnosed hypertension and 2,500 with undiagnosed diabetes, both of which are risk factors for CVD.
The evaluation of the current NHS Health Checks project in 6 pharmacies should be used to determine how pharmacies can be best utilised to reduce incidence of cardiovascular disease as well as identify and improve outcomes for those at risk.

7.4 Weight management service

Pharmacies provide advice and support for healthy lifestyles as part of their core contract. Community pharmacies are also well placed to provide a weight management services on a one-to-one basis, particularly those who may not be accessing any other health services.
For example, pharmacies in Coventry have offered a comprehensive weight management service since 2006 which includes a risk assessment and motivational interviewing to support people to lose weight. The service is successful in attracting men who are often more difficult to reach through traditional weight management services.

Further work is required to explore the potential of utilising pharmacies to reduce levels of obesity and Hammersmith and Fulham.

7.5 Immunisations and vaccinations

10 community pharmacies in Hammersmith and Fulham are already providing immunisation and vaccination services on a private basis. There is potential to use community pharmacy to improve performance on meeting national targets such as ensuring all eligible people receive seasonal flu vaccinations.

PLANNED PROCEDURES WITH A THRESHOLD (PPwT)

Summary:
In 2009, the NHS North West London (NWL) Sector developed an Interventions Not Normally Funded (INNF) policy which included 37 procedures which would not be funded, except where clinical evidence and criteria had been met. This policy has not been systematically applied by all North West London PCT's to all acute contracts (highlighted in the Finance section of the attached policy).

With the development of the NHS North West London Sector and the inception of the Acute Commissioning Vehicle, a piece of work developed where the North West London Public Health Network reviewed and refreshed the current list of Planned Procedures with a Threshold (PPwT) (previously referred to as innfs') and their associated referral criteria. This work will inform planning for 2011-12, evaluate potential savings and inform current and future contract management. This work is not part of the current contractual innf monitoring which NWL Acute Commissioning Vehicle manages, although this will have a significant impact on both current contract management, future contract setting and ongoing monitoring.

The revised policy will be incorporated, implemented and monitored into all North West London Sector acute contracts for 2011/12.

The paper attached is the revised and refreshed NHS North West London Planned Procedures with a Threshold (PPwT) Policy (previously referred to as Interventions Not Normally Funded (INNF)).

The updated and new policy procedures are included as appendices within the policy document.

The draft policy has taken into account the feedback from Clinical Strategy Group (CSG) and has been subsequently endorsed by the North West London Joint Committee of PCT (JCPCT) at the meeting on the 1 December 2010 and the CSG at their meeting on 8 December 2010 subject to the next steps:

- The PPwT policy paper to be submitted to each PCT for formal board approval in January 2011 as they remain the statutory body; and
- Public and Stakeholder Engagement to be ongoing.

Board action required:
The Board is asked to ratify JCPCT and CSG endorsement of and formally approve the NHS NW London Planned Procedures with a Threshold (PPwT) Policy.

Responsible director:
Nick Relph, Planned Care Project SRO

Author:
Mark Creelman, Director of Strategic Commissioning, NHS Kensington and Chelsea;
and Dr Cyprian Okoro, Consultant in Public Health Medicine, NHS Ealing, Honorary Senior Lecturer, Imperial College Medical School

Date of paper: December 2010 v3.0

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	n/a
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	n/a
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	Refer to Appendix 4
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	Refer to Appendix 3
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	Refer to section 6 and Appendix 3

NHS
North West London

Planned Procedures with a Threshold

Version 3.0
December 2010

Document Control

Version	Date	Author	Reviewed by	Comments/Changes
V0.1 draft	05/11/10	Mark Creelman	Mark Creelman (MC)	Initial draft
V0.2 draft	05/11/10	Revision AW	Amanda Ward (AW)	Formatting, editing and minor amends
V0.3 draft	05/11/10	Revision CO	Cyprian Okoro (CO)	Bariatric, Cataracts and EqIA sections
V0.4 draft	08/11/10	Revision AW	Amanda Ward	Editing and amends following comments from CO, MS, AW
V0.5 draft	09/11/10	Revision AW	Amanda Ward	Tables updated; Financial section update
V0.6 draft	10/11/10	Revision AW	Amanda Ward	Formatting
V0.7 draft	10/11/10	Revision (MC)	Mark Creelman	Update to finance section
V0.8 draft	10/11/10	Revision (CO)	Cyprian Okoro	Table procedure title updates
V0.9 draft	11/11/10	Revision (AW)	Amanda Ward	Policy Procedures – zipped files uploaded to the appendices
V0.10 draft	11/11/10	Revision (MC)	Mark Creelman	Amendment to finance table narrative
V0.11 draft	24/11/10	Revision (CO and MC)	Cyprian Okoro and Mark Creelman	Amendments following feedback from CSG; and inclusion of IVF policy procedure in appendix 2
V0.12 draft	26/11/10	Revision (AW)	Cyprian Okoro	IVF procedure minor amends –red narrative changed to black font Commissioning Principles section removed and replaced with Guiding Principles section Amended page 5 (4.1) 94 to read 84.
V1.0	26/11/10	Revision (AW)	Amanda Ward	Tracked changes accepted for document to be submitted to JCPCT for meeting on 01/12/10
V2.0	02/12/10	Revision (AW)	NWL JCPCT	Policy endorsed by NWL JCPCT at their meeting on 01 December 2010, subject to next steps – see section 8 'Recommendations'
V2.1	14/12/10	Revision (AW)	NWL CSG	Policy endorsed by NWL CSG at their meeting on 08 December 2010
V2.2	17/12/10	Revision (AW)	Amanda Ward	Document title amended from Interventions Not Normally Funded to now be know as 'Planned Procedures with a Threshold'
V2.3	17/12/10	Revision (AW)	Amanda Ward	Addition - Appendix 4
V3.0				

Contents

1. Background

PCTs are required to improve and care for the health of their populations within a limited and increasingly challenged financial envelope. It is therefore appropriate that PCTs ensure that the most effective use is made of the resources available, particularly as they prepare to handover commissioning budgets to GP Consortia. This implies a priority setting culture where the access to some treatments or procedures, of low clinical effectiveness or cost effectiveness, is limited. These treatments are normally referred to as "Planned Procedures with a Threshold" (PPwT) or Procedures of Limited Clinical Effectiveness (PoLCE). For the sake of clarity, this paper will refer to the collective procedures as PPwT's.

In 2009, the NHS North West London (NWL) Sector developed a PPwT policy which included 37 procedures which would not be funded, except where clinical evidence and criteria had been met. This policy has not been systematically applied by all North West London PCT's to all acute contracts, highlighted later in the Finance section of this paper.

With the development of the NHS North West London Sector and the inception of the Acute Commissioning Vehicle, a piece of work developed where the North West London Public Health Network reviewed and refreshed the current list of PPwTs' and their associated referral criteria. This work will inform planning for 2011-12, evaluate potential savings and inform current and future contract management. This work is not part of the current contractual PPwT monitoring which NWL Acute Commissioning Vehicle manages, although this will have a significant impact on both current contract management, future contract setting and ongoing monitoring.

2. Purpose

The purpose of this paper is to secure Clinical Strategy Group (CSG) agreement and recommendation for the refreshed list of procedures and associated referral criteria to be presented to the North West London Joint Committee of PCT (JCPCT) for approval and agreement. The revised policy will then be incorporated, implemented and monitored into all North West London Sector acute contracts.

The purpose of the work carried out in the North West London Sector has been:

- To review and refresh the existing procedures within the 2009 policy
- Review national guidance and clinical evidence in determining any procedures which have limited clinical effectiveness, are not cost effective or are outside the remit of the National Health Service
- Engage clinicians in agreeing a new list of PPwT's with the associated referral criteria and thresholds
- To identify the current levels of activity of these procedures carried out by acute Trusts and using SUS and SLAM data, quantify the expenditure associated with the procedures
- To ensure that the revised policy is incorporated, implemented and monitored into all acute contracts
- To harmonise practice and application across the North west London PCTs

3. Guiding Principles

> *"I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much the cost, particularly when a life is potentially at stake.*
>
> *It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. Difficult and agonising judgements have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients".*
>
> *Sir Thomas Bingham*[1]

The NHS North West London Sector is responsible for the health of our entire population. Demand for health and healthcare has always outstripped available resources. If we provide a treatment for one group of people, then these resources cannot be used for other people. We are simply unable to provide everything to everyone. Therefore, we have to make decisions over which treatments or services to prioritise over others.

The treatments and services listed in this document are of a lower priority than others. This is usually because the evidence for their clinical and/or cost-effectiveness is limited. However, they can provide benefit in certain groups of patients. For these interventions, we have decided on criteria to ensure that those who receive it are those who will benefit the most from it.

In drawing up these criteria, we applied a number of principles to guide our decisions. This document outlines these principles. All of these are consistent with our aim to use our finite resources to provide the greatest benefit to the greatest number of our population.

Clinical effectiveness

This is the extent to which specific interventions do what they are intended to do in real life conditions, i.e. in a particular patient rather than in experimental conditions.

In drawing up this policy, we have sought the best available evidence for clinical effectiveness of the listed interventions. It would be a poor use of resources to fund treatments/services where there was weak or no evidence of clinical effectiveness. It would also be irresponsible to promote treatments which have been shown to be ineffective.

Evidence for clinical effectiveness will be assessed according to the hierarchy of evidence[5,6], with greater weight given to randomised controlled trials and clinically relevant outcome measures. Patient satisfaction does not necessarily correlate with clinical effectiveness.

For rare conditions, we will consider the best evidence available.

Even when there is good evidence of clinical effectiveness for an intervention, this has to be balanced against the other principles in this framework, including cost-effectiveness, affordability and equity.

Cost-effectiveness

This concerns value for money. If there are two treatments for the same condition which produce similar outcomes, but one is less expensive than the other, then it is a better use of resources to fund the cheaper one.

The evidence for cost-effectiveness comes from analyses of the costs and benefits of two or more interventions for the same condition. In general, there is less evidence available for cost-effectiveness than clinical effectiveness. However, it is important to note that an intervention cannot be cost-effective unless it is also clinically effective. Also a low price alone does not necessarily mean an intervention is cost-effective. The National Institute for Clinical Effectiveness (NICE) produces guidance on cost-effectiveness of certain treatments on a national level.

Affordability

We are required by law to keep within the resources allocated to us. This means that we cannot spend more money each year than we have been given by the government.

If we spend money on one service or treatment, then we will have less to spend on others, which may provide greater benefit to our population. This is called opportunity costs. In addition, if we fund a treatment for one person, then other people in similar circumstances can expect to receive the same treatment. So one funding decision can have resource implications beyond that individual and, because there are opportunity costs, for the whole population.

Therefore, even if a service/treatment is judged to be clinically and cost-effective, we may still not be able to fund it as the money may not be available or we consider other interventions to be of higher priority for our population.

Equity

Equity concerns the fair distribution of benefits across the population. We will aim for a service or treatment to be accessible to all those in the population who could benefit from it. We will also seek not to directly or indirectly discriminate between people on the grounds of personal characteristics or lifestyle.

However, if there is good evidence that a particular characteristic (e.g. age) or lifestyle (e.g. smoking) affects the clinical and/or cost-effectiveness of a particular treatment, then we will prioritise those who will benefit from the treatment most. This is a responsible use of resources and does not affect individuals' rights under the Human Rights Act 1998 (article 14).

Primary care trusts may also prioritise some treatments according to guidance and/or directives issued by the Department of Health, or to address health inequalities to their own populations.

Quality and Safety

We have a responsibility to only provide healthcare which is safe and of high quality.

We will follow guidance given by authorities such as the Medicines and Healthcare products Regulatory Agency, the British National Formulary, and NICE.

Primary care trusts are sometimes asked to fund treatments or services which will be provided in non-NHS institutions. We will need to be satisfied that any service provider has adequate quality and clinical governance mechanisms in place, and all standards set by regulatory bodies are met fully.

Exceptionality

Individual patients may feel that they will benefit from a treatment or service even if they fall outside its referral criteria. In these cases, the patient and/or their clinician can apply to their

responsible primary care trust for “exceptional” status. These requests will be heard by an individual funding panel, who will consider the evidence presented by the clinician or patient. All decisions will be balanced against the principles outlined in this document.

For funding to be agreed, the patient must be:

i) Significantly different to the general population of patients with the condition in question

AND

ii) Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

It is for the requesting clinician (or patient) to make the case for exceptional status. The fact that a treatment is likely to be effective in a patient is not, in itself, a basis for exceptional status.

Accountability

We will be accountable for our funding decisions[7], through:

i) Transparency

We will make publicly available, the rationale/criteria supporting the decision making process and the processes through which they are made.

ii) Relevancy

Priorities and criteria will be set against evidence and principles that reasonable parties agree are relevant to the matter in hand.

iii) An appeal process

Individuals who disagree with the funding decisions made by their PCTs will be able to appeal these decisions. This process will be through the responsible PCT.

iv) Enforcement

Individual PCTs will ensure that these processes are monitored and regulated so that the above conditions are met.

Ethical considerations

We will take account of the following ethical considerations in our decision-making[8]: These need balancing and none necessarily take precedence.

i) Respect for personal autonomy

We will help capable individuals to make informed decisions (e.g. by being transparent and providing important information) and we will respect those decisions.

ii) Beneficence

This means “doing or bringing about good”, such as providing clinically effective treatments for individual patients or making the best use of our resources for our population.

iii) Non-maleficence

This means the avoidance of doing harm, such as not providing ineffective or unsafe treatments.

iv) Distributive justice

This concerns distributing healthcare fairly and justly, and incorporates the principles of equity and opportunity costs, as set out above.

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This document, together with all the policy procedures, were sent to all CSG members on 11 November 2010. Feedback has been received and this has been included in the relevant policy(ies). The policy was endorsed by the JCPCT (subject to 'next steps' outlined in section (8) Recommendations) at their meeting on 1 December 2010 and subsequently endorsed by the CSG at their meeting on the 8 December 2010.

This document was previously know as 'Interventions Not Normally Funded (INNF)' but it has been agreed to change this to be now know as 'Planned Procedures with a Threshold (PPwT)'.

4. Procedures

4.1 Summary

As previously mentioned there are currently 37 procedures in the current PPwT policy. Of these 7 remain unchanged, with 30 being updated. In addition to these, 47 new procedures are being recommended for inclusion in the policy which have either referral criteria attached or require individual funding requests. The total number of procedures recommended for inclusion in the new policy is therefore 84. The majority of these have been agreed at the sector workshop.

4.2 Existing procedures

The six procedures in Table 1 are those which have remained unchanged from the existing PPwT policy including any referral criteria. These are not included in this paper for agreement, although some were discussed at the workshop which are denoted by an *.

Table 1

	Procedure	**Not funded/IFR Route/Criteria**
1	Blepharoplasty	IFR route/criteria stated

2	Face lift or brow lift	Not funded
3	Inverted nipple correction	Not funded/IFR route
4	Therapeutic use of ultrasound	Not funded/IFR route
5	Thigh lift, buttock lift and arm lift, excision of redundant skin or fat	IFR route
6	Revision mammoplasty	IFR route
7	*Drug treatment for erectile dysfunction	IFR route

4.3 Updated procedures

The procedures in Table 2, are also in the existing PPwT policy, but have been updated and were all agreed at the sector workshop, denoted again by an *. The policies have been updated and can be found in Appendix 1 and Appendix 1.1. The Clinical Strategy Group is asked to agree the updated policies.

Table 2

	Procedure	**Not funded/IFR Route/Criteria**
1	*Abdominoplasty or Apronectomy	IFR route/criteria stated
2	*Breast augmentation (breast enlargement)	IFR route/criteria stated
3	*Breast prosthesis removal or replacement	IFR route/criteria stated
4	* Breast reduction	IFR route/criteria stated
5	*Gynaecomastia - Male Breast reduction	IFR route/criteria stated
6	*Hair grafting – Male pattern baldness	Not funded
7	*Hyperhidrosis treatment with Botulinum Toxin	IFR route/criteria stated
8	*Liposuction	Not funded/IFR route if exceptional
9	*Mastopexy	Not funded/IFR route if exceptional
10	*Pinnaplasty	Not funded/IFR route if exceptional
11	*Removal of Tattoos	Not funded/IFR route if exceptional
12	*Removal benign skin lesions	Not funded/IFR route if exceptional
13	*Repair of lobe of external ear	Not funded/IFR route if exceptional

14	*Resurfacing procedures: dermabrasion, chemical peels and laser	Not funded
15	*Rhinoplasty	Not funded
16	*Grommet insertion	Criteria/Threshold included
17	*Tonsillectomy	Criteria/Threshold included
18	*Circumcision	Criteria/Threshold included
19	*Ganglia	Criteria/Threshold included
20	*Gender reassignment surgery/Gender Dysphoria (appendix 1.1)	Criteria/Threshold as per specialist commissioning arrangements
21	*Varicose veins	Criteria/Threshold included
22	*Caesarean section for non-clinical reasons	Criteria/Threshold included
23	*Dilatation and curettage	Criteria/Threshold included
24	*Laser surgery for short sight	Not funded/IFR route
25	*Apicectomy	IFR route/criteria
26	*Dental implants	IFR route/criteria
27	*Orthodontic treatments of essentially cosmetic nature	IFR route/criteria
28	*Laser Hair depilation (Replaced by Electrolysis of the hair)	Criteria/Threshold included
29	*Reversal of female sterilisation	Not funded/IFR route
30	*Reversal of male sterilisation	Not funded/IFR route

4.4 New Treatment/intervention Policies

The following 47 interventions in Table 3, which are not included in the current 'Interventions Not Normally Funded' (INNF) Policy, 37 procedures, have been recommended as additional procedures which will not be funded or will have referral criteria applied. The CSG is asked to agree these interventions and approve their associated policies. The related policies are included in Appendix 2 and Appendix 2.1

Table 3

	Treatment/Procedure	**Not funded/IFR route/Thresholds**
1	*Anal procedures (haemorrhoidectomy)	Criteria/threshold included
2	Uncomplicated hernia	Criteria/threshold included

3	*Asymptomatic gall stones	Criteria/threshold included
4	*Cataracts	Criteria/threshold included
5	*Bariatric surgery	Criteria/threshold included
6	*Unified IVF Policy	Criteria/threshold included
7	*Hysterectomy for menorrhagia	Criteria/threshold included
8	*Hip Replacement	Criteria/threshold included
9	*Knee replacement	Criteria/threshold included
10	*Knee Arthroscopy/wash out	Criteria/threshold included
11	*Revision hip surgery	Criteria/threshold included
12	*Revision knee surgery	Criteria/threshold included
13	*Carpal tunnel surgery	Criteria/threshold included
14	*Penile implants	Criteria/threshold included
15	*Pain management programmes	Criteria/threshold included
16	*Wisdom teeth removal	Criteria/threshold included
17	*Occlusal Splints	Criteria/threshold included
18	*Dental extraction for non impacted tooth	Criteria/threshold included
19	*Alternative/Complimentary therapies – homeopathy, osteopathy, acupuncture, biofeedback, etc	Homeopathy – not funded. Criteria specified for relevant therapies e.g. acupuncture, biofeedback etc.
20	*Polysomnography	IFR Route
21	Rhinophyma	Not funded – IFR route if exceptional
22	*Adenoidectomy	Not funded per se but possible if combined with grommets – IFR route
23	*Refashioning of scars and keloids	Not funded – IFR route if exceptional
24	*Skin grafts for scars	Not funded – IFR route if exceptional
25	*Plastic operations on umbilicus	Not funded - cosmetic
26	*Repair of traumatic clefts	Not funded – IFR route if exceptional

27	*Magnetic resonance focused ultrasound for uterine fibroids	Not funded – IFR route if exceptional
28	*Open MRI scan	Criteria/threshold included
29	*Cyberknife surgery (appendix 2.1)	Criteria/threshold included
30	*Pulmonary Arterial Hypertension (appendix 2.1)	Criteria/threshold included
31	*Chronic Fatigue Syndrome	NWL Pathway specified
32	*Functional Electrical Stimulation	Criteria/threshold included
33	*Spinal Cord Stimulation	Criteria/threshold included
34	*Limb Prosthesis	Criteria/threshold included/ IFR Route
35	*Trigger Finger	Criteria/threshold included
36	*Dupuytren's Disease/Contracture	Criteria/threshold included
37	*Acne Scarring	Criteria/threshold included
38	*Cochlear implants	Criteria/threshold included/ IFR Route
39	*Dermatology – light and laser therapy	Not funded – IFR route if exceptional
40	*Hyperbaric Oxygen Therapy	Criteria/threshold included
41	**Chalazia	Criteria/threshold included
42	**Lymphoedema	Criteria/threshold included/ IFR Route
43	**Upper GI Endoscopy	Criteria/threshold included
44	**Prostate cancer – both Robotic procedure (DaVinci) and Cryotherapy	Criteria/threshold included
45	**Hysteroscopy**	Criteria/threshold included
46	**Closure of patent foramen ovale	Not funded
47	** Pelvic organ prolapse	Criteria/threshold included

Those donated with an * were discussed at the workshop on the 29th October 2010. All policies were agreed with the majority requiring minor amendments, clarifications or adjustments. For a minority, there was general consensus which required further action which has now been completed.

Those donated with an ** were not discussed at the workshop. The CSG were asked to review these procedures and provide comments.

The following three procedures warrant additional comment and steer from the CSG:

4.5 IVF

There was broad agreement on the IVF policy in principle with a few final changes agreed. There were two main issues:

I. There is wide variation in existing IVF policies across the Sector and as such some PCT's may see an increase in their current PCT offer and thus associated expenditure. However there are many other regions who have a single sector/regional IVF policy. The proposal to fund one cycle (I fresh and 1 frozen blastocyst) will represent an overall reduction in activity across the sector.

II. There was debate about the social and ethical factors within the provision of IVF. None of the so called social factors are new. They are all covered in legislations such as the HFEA Act (and subsequent 2009 amendments), Equalities Act etc. There are also clear HFEA and NICE guidance and agreed national standards on best practice for commissioners which are reflected in the policy. The renowned local provider units have given an input into the policy and have agreed it.

It was agreed that the policy would be submitted to the CSG for a steer and a further sector workshop to be organised to debate the issues further.

The policy procedure was sent on 11 November 2010 to all CSG members and the delegates of the Clinical Event workshop. Feedback has been received and this has been included in the policy.

4.6 Bariatric

A new approach to commissioning bariatric surgery was widely discussed with specialist providers and an amended criteria is proposed.
The key issues to note are itemised below.

1. Previous NICE based criteria not thought to be focused enough and may actually increase activity.
2. Evidence base for weight loss through non-surgical treatments is limited.
3. Not always appropriate to consider bariatric surgery as the end stage of a clinical pathway for obesity management.
4. Presence of co-morbidities should determine speed at which a patient is referred for bariatric surgery, not just BMI. Similarly, stipulation of a 6-month structured primary care based weight management programme may not be appropriate.
5. Secondary care management of obesity must include elements of non-surgical care that links into primary care. Not all eligible patients are willing to have surgery, so proper counselling/assessment with GP and Specialist is necessary. This aspect of pre - and post bariatric care pathway will need to be developed either at cluster or sector level. Currently weight management programmes are commissioned separately from the bariatric service.
6. In terms of impact on bariatric activity, there are about 1300 referrals /year for bariatric surgery from NWL PCTs. Capacity for this procedure is limited – Imperial can only do 650 procedures per year. So even if current referral rates are reduced by 50%, there will be no reduction in current spend on bariatric surgery. Ophthalmologists advised against immediate sequential cataract surgery (ISCS) on the grounds that it was not good clinical practice
7. A strategy that focuses on bariatric surgery for people with established diseases (e.g. CHD, diabetes, apnoea etc) for now is likely to reduce referrals by 41.7% and lead to most population health gain and greater reduction in health care costs.

4.7 Cataracts

Following discussion of the evidence base and implications for population visual health it was accepted that:

- Cataract surgery is effective for first and second eyes
- Surgery is offered for symptomatic cataract and is not based on visual acuity
- There are no patient related outcome measures that are currently suitable for use in *routine* clinical practice.
- Visual acuity represents a quantifiable *indicator* of visual function that could be used for audit purposes and monitoring surgical activity
- Projected demographic trends are likely to necessitate current surgical rates

The following criteria for surgery were agreed:

1. Cataract surgery to be considered for patients with a best corrected visual acuity of 6/9 or worse in either the first or second eye

AND

2. Have impairment in lifestyle such as substantial affect on activities of daily living, leisure activities, risk of falls

3. Surgery is indicated for management of ocular comorbidities e.g. control of glaucoma, view of diabetic retinopathy

4. Patients with visual acuity of 6/9 or better in both eyes should not normally be referred for cataract surgery

5. Financial Analysis

Financial analysis is underway to identify the expenditure associated for all procedures, However as an indication of the levels of funding involved, we have carried out analysis, focussing on the 10 interventions with most expenditure across the sector. Three of these cannot yet be quantified and need further analysis, however for the remaining seven, there is a potential of £5.4 million to £7.7 million saving.

Public Health analysed the top ten interventions by value to identify procedures which were miscoded or would not fall under referral protocol.

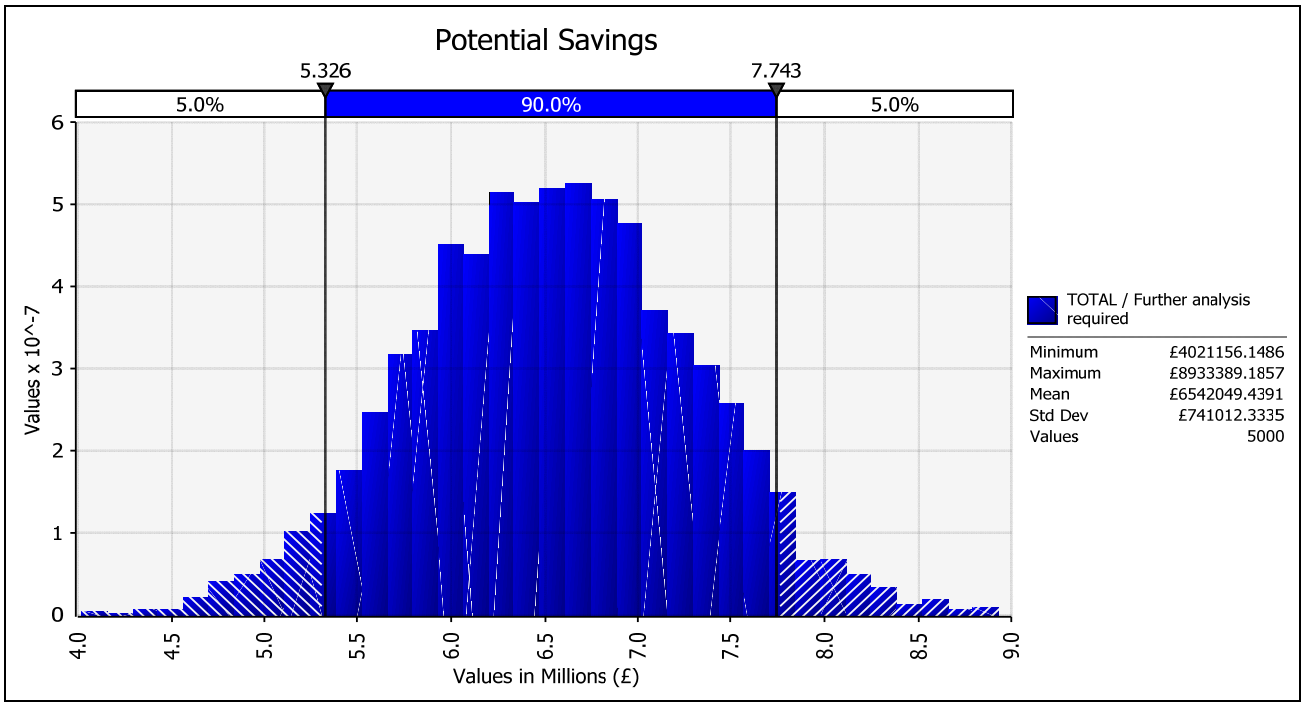
Of the remaining interventions, Public Health attributed the activity into three funding categories (“funded”, “possibly funded” and “not funded”) based on the available information.

This enabled us to determine a range of funding scenarios which is summarised in the table below.

Source: SUS data from ICAPS Partnership Live, 1 September 2009 to 31 August 2010, prices adjusted to PbR 2010-11 tariffs

Procedure	A Sector Expenditure Total (£)	B Clinically Challengeable Expenditure(£)	Funding Scenarios Maximum	Likely	Minimum	C Likely Expenditure Total (£)	(A-C) Potential savings (£)
WISDOM TEETH REMOVAL	1,878,552	1,878,552	100%	65%	31%	1,227,404	651,149
DENTAL (UNSPECIFIED)	2,296,146	2,295,346	100%	93%	86%	2,129,620	165,726
EXCISION/DESTRUCTION OF SKIN LESION (potentially REMOVAL BENIGN SKIN LESIONS)			Further analysis required				
TONSILLECTOMY	2,411,801	2,382,035	100%	68%	36%	1,614,986	767,050
EXCISION OF GALL BLADDER (potentially ASYMPTOMATIC GALL STONES)	2,785,190	2,785,190	100%	76%	52%	2,114,333	670,857
UNCOMPLICATED HERNIA			Further analysis required				
EXCISION OF UTERUS (potentially hysterectomy due to menorrhagia)	2,651,419	1,327,067	100%	50%	0%	663,534	663,534
CATARACT SURGERY			Further analysis required				
KNEE PROCEDURES – ARTHROSCOPY	2,758,889	2,753,012	94%	51%	8%	1,406,840	1,346,172
VARICOSE VEINS	2,369,194	2,358,384	7%	3%	0%	80,819	2,277,566
TOTAL	17,151,191	15,779,586				9,237,533	6,542,052

Based on the funding scenarios, a Monte Carlo simulation was run in order to be realised. The figure below illustrates that there is a potential savings of between £5.3 million and £7.7million.



6. Equality Impact and Risk Assessment

An Equalities impact assessment is currently being undertaken by the North West London Public Health Network to ensure that the recommended policies will not discriminate between individuals or groups on the basis of age (except where clinically necessary), sex, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual/cognitive functioning or physical functioning. However where treatments have a differential impact as a result of the age, sex or other characteristics of the patient it is legitimate to take such factors into account.

Once agreed, a risk analysis will be undertaken on the policy as a whole. This will include clinical, legal and implementation risk and have associated action to mitigate. (See Appendix 3).

7. Next Steps

Following the agreed recommendation of the JCPCT and the CSG, Table 5 summarises the actions which need to be completed for the work stream to achieve its purpose. Timelines are included.

Table 5

Area	Action	Deadline
Policy	Ratified policies to be consolidated into one document	Dec 2010
Policy	Issues log developed for each policy	Dec 2010
Contracts	Feedback to ACV on current PPwT list contractual application	Dec 2010
Governance	Approval from JCPCT of new policy	Dec 2010
Policy	Development of systems to support the implementation of the dental policies e.g. dental referral management centre	Dec 2010
Governance	Agreement and Implementation of a single Individual Funding Request/Extra Contractual Referral (IFR/ECR) Panel	Dec 2010
Finance	Analysis of activity, applying appropriate intervention thresholds and inclusion of non PbR activity and expenditure, e.g. IVF	Dec 2010
Engagement	Communication and Engagement Strategy drafted	Dec 2010
Engagement	Stakeholder engagement Ongoing	Jan 2011
Governance	The PPwT policy paper to be submitted to each NWL PCT for formal board approval	Jan 2011

8. Recommendation

The CSG is requested to agree and make recommendation to the NWL JCPCT to approve the updated and new policies presented. Following the CSG comments and recommendations, JCPCT are asked to approve the process and the revised procedure contents. On approval, this will be unified into a single policy document.

At their meeting on the 1st December 2010, the JCPCT endorsed the policy document subject to the following next steps:

- The PPwT full policy paper to be submitted to each NWL PCT for formal board approval in January 2011 as they remain the statutory body
- Stakeholder Engagement to be ongoing

At their meeting on the 8 December 2010, the CSG endorsed the policy and agreed the next steps as outlined by the JCPCT above.

Appendices

Appendix 1 – Updated Procedures

Appendix 1.ZIP

Available on request

Appendix 1.1 - National/Regional Specialised Commissioning Policies

Appendix 1.1.ZIP

Available on request

Appendix 2 – New Treatment/Policies

Appendix 2.ZIP

Available on request

Appendix 2.1 – National/Regional Specialised Commissioning Policies

Appendix 2.1.ZIP

Available on request

Appendix 3 – Equality Impact Assessment

NHS
North West London

Equality Impact Assessment

Equality Impact Assessment is a useful tool to ensure compliance with the Equality Act 2010. Under the Act a public authority must, in the exercise of its functions, have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Act stipulates nine 'protected characteristics': age, disability, gender reassignment, pregnancy and maternity, marriage or civil partnership, race, religion or belief, sex, and sexual orientation

Stage 1 - Initial Assessment
This stage is to assess the service, policy or strategy to identify possible areas where service users or staff may experience a positive or negative impact.

What is the policy, service or strategy being assessed?	
Planned Procedures with a Threshold and Treatments with Clinical Thresholds	
What is the main aim or purpose of the policy, strategy or service?	
To agree across North West London sector interventions that will not normally be funded by the NHS or where a clinical threshold for access is desirable because they confer limited or no health benefit.	
Lead Manager	Cyprian Okoro, Consultant in Public Health Medicine
What are the issues relating to equality and diversity within this policy, strategy or service?	
If interventions are not normally funded because they do not confer benefit then all people are excluded from the intervention on account of lack of need. Exceptional decisions will be made according to needs of individuals, regardless of any personal characteristics not related to their health needs. There may be potential for discrimination related to people's differing levels of awareness about the policy and their ability to advocate their need for exceptional benefits.	
Which groups of the population are affected?	
The policy applies to the whole population. Some of the interventions that will not normally be funded would (if they were funded) be used differentially by equality groups. Male circumcision would probably be used by patients from certain faith groups, for example, Jewish and Muslim patients. 'Non-core' interventions for gender dysphoria would be used only by trans people.	

Please provide an explanation for your answer and evidence as appropriate

Characteristics	Positive Impact – it could benefit	Negative Impact – it could disadvantage	Reason
Sex: differential impact on women and / or men	none	none	
Age: differential impact on particular age groups	Women aged 23 – 39 age group	Women under 23 or over 39 years of age seeking IVF treatment.	Age criterion may not take account of individual clinical need but is national policy based on clinical evidence of benefit and falling fertility rate with increasing age.
Disability: differential impact on disabled people, including people with long term conditions.	none	none	
Race: differential impact on people of a particular race or ethnic group	none	none	
Religion or belief: differential impact on people with a particular religion or belief.	none	Lack of access to male circumcision	Patients from particular may make use of unsafe alternatives outside the NHS.
Sexual orientation: differential impact on gay men, lesbians, heterosexuals or bisexuals	none	none	
Gender reassignment: differential impact on trans people.	none	Lack of access to non-core interventions	Trans patients may disagree with the judgement that non-core interventions will not benefit their health.
Pregnancy and maternity: differential impact on women who are pregnant or have children.	none	none	
Marriage or civil partnership: differential impact on people who are married or in a civil partnership.	none	none	

How does the policy, strategy or service affect the different groups? For example, in the way it is framed, or targeted, delivered or communicated. Provide the details and evidence of the impacts identified. These might include communication, information, physical access, location, cultural sensitivity etc
• By making a positive contribution to the equality of opportunity/inclusion
The policy will indirectly promote equality of opportunity by saving costs on interventions that do not confer benefit.
By causing a negative impact. For example, are there any requirements or criteria that could contribute to inequality?
Lack of access to male circumcision and to non-core gender dysphoria interventions may be perceived as unfair and so may cause harm to community relations, unless the reasons for this are clearly explained and relevant communities are engaged in discussion about issues that are relevant to them.
Does the policy, strategy or service give all groups the same access relative to their need? Please provide evidence for your answer.
The policy is designed to limit access to interventions which confer no benefit. There is no need for the interventions and so it is appropriate for remove access for all.
1. Does the policy, strategy or service have measures designed to promote equality of opportunity? How will the policy, service or strategy meet the needs of different communities or groups? 2. Are the aims consistent with other Trust policies on Equality, Diversity and Human Rights? 3. Are there examples of good practice that can be built on? Do you have measures in place already to tackle discrimination?
1. The policy is designed to ensure that no-need entails no-intervention. It is about ensuring that resources are not diverted to interventions that confer little or no benefit. 2. The PPwT policy is consistent with the Single Equality Scheme. 3. We are considering possible examples of good practice to ensure that circumcision can be done safely and cost-effectively.

What evidence has been used to make these judgements? Please tick one or more. Please provide evidence for your answer that may be appropriate.	
Demographic data and other statistics, including census findings	No
Research findings and literature	Yes
Results of recent consultations or surveys with staff and clinicians	Yes
Results of recent consultations or surveys with patients	No
Data from the local authority or joint services.	No
Engagement with groups and agencies that work with NHS NWL	Yes
Comparisons between similar functions or policies	Yes
Analysis of PALS, complaints and public enquiries information	No
Analysis of audit reports and service reviews	No
Information from other health and social care organisations	Yes
Data about service use	Yes
What further information might be required?	
We need to consult with representatives of relevant faith groups and with trans groups to ensure that denying access to male circumcision and to non-core gender dysphoria interventions can be justified in the light of any concerns they may have.	

Who have you consulted? Other teams, services, users, community groups, carers, partnership board, advocacy service etc.		
Name	Designation/Organisation	Method of Consultation
Sector colleagues: clinicians and commissioners	NWL Sector PPwT and treatments with clinical thresholds.	Working group to develop PPwT policy

In light of the above, do you consider that this policy, strategy or service requires a full impact assessment? Yes

Signed	
Name and Designation	

Stage 2 – Full Equality Impact Assessment

If the initial screening shows that a policy could have a negative impact, or has the potential to have a positive impact, or both, it is necessary to conduct a full assessment.

Detailed Questions – Further Assessment

This section sets out more detailed questions that can help you to decide on the appropriate actions, which you will outline below. This section should only be completed after completing Stage 1.

What do the available data and results of consultation tell about the negative or positive impact on different groups?
Lack of access to male circumcision and to non-core gender dysphoria interventions may be perceived as unfair and so may cause harm to community relations, unless the reasons for this are clearly explained and relevant communities are engaged in discussion about issues that are relevant to them.
What are the key messages which have come from the consultation with service users, carers or other stakeholders? Do you need to consult further? What conclusions have you drawn from these consultations?
We need to find appropriate ways to consult with relevant faith communities and with trans groups in order to validate the decision not to fund male circumcision and non-core gender dysphoria The Equality Act service provisions relating to age discrimination will be phased in over a period of time, but no date has been set for these. We will need to monitor the introduction of Age Equality provisions for health and social care and ensure that the IVF policy is updated as necessary to take account of these.

Actions – Please give details of the actions that you will take to address the issues highlighted in this assessment and when you will complete them by.			
Equality Target Group	**Action**	**Lead Person**	**By When**
Faith groups	Discuss suitable consultation strategy with Southall Community Alliance	Stephen James	End December 2010
Trans	Discuss suitable consultation strategy with West London LGBT Forum	Stephen James	End December 2010
Women under 23 or over 39 years seeking IVF	The Equality Act service provisions relating to age discrimination will be phased in over a period of time, but no date has been set for these. We will need to monitor the introduction of Age Equality provisions for health and social care and ensure that the IVF policy is updated as necessary to take account of these.	Stephen James	Monitor as necessary.

Please provide any information you think may be relevant to the Equality Impact Assessment.

Please send the completed templates to Stephen James, stephenjames@nhs.net

Appendix 4 – Communication and Engagement Strategy

NHS
North West London

Planned procedures with a threshold

Communications and engagement strategy

22 December 2010

Document control sheet

Document Title	**Planned procedures with a threshold communications and engagement strategy**
Version	3
Status	
Reference	
Author	Nick Worner
Date	22 December 2010

Quality assurance by:	• Ian Adams, Director of Communications, NHS North West London

Document history			
Version	Date	Author	Comments
1	14-Dec-10		Review and comments by IA
2	17 Dec-10		Review and comments by LB
3	22 Dec-10		Review and comments by JC

Contact details			
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Contents

1 Introduction

This communications strategy is intended to support stakeholder communications and engagement on how NHS North West London intends to manage planned procedures with a threshold (PPwT). This strategy and the associated communications and engagement plan need to be ready to deploy from mid January 2011 when papers are presented to the eight PCT boards in North West London. From this time, papers about the PPwT policy will be publicly available via PCT websites across North West London.

The approach recommended blends proactive communications, especially among key NHS partners (e.g. local GPs, trusts and PCT PALS teams) and more reactive communications (e.g. prepared lines in the event of media enquiries being received about this new policy).

It is also intended to offer patients seeking information about these planned procedures with guidance about this policy, in order to help explain the rationale for future decision-making by the NHS in North West London and to align our policy with that across the wider NHS in England & Wales.

The key communications message is that the majority of treatments available in the NHS continue to be free at the point of delivery. But sometimes we have to make choices around treatments which are very costly or where there is limited evidence of clinical benefit or cost effectiveness. A new system for planned procedures with a threshold will ensure equity of access to treatments in North West London, subject to PCT board approval in January 2011.

NHS in North West London is seeking to implement a sector-wide PPwT. This single approach will give greater capacity and breadth of expertise to reduce variation in decision making, thus improving fairness for patients and simplifying the process for secondary and tertiary care. This updated policy is expected to go live across NWL in April 2011.

1.1 Background

PCTs are required to improve and care for the health of their populations with limited and increasingly challenged funding. PCTs, through clusters and the sector, will continue to ensure that the most effective use is made of the resources available, particularly as they prepare to hand over commissioning budgets to GP Consortia.

This implies a priority setting culture, where consistent access to some treatments or procedures, of low clinical effectiveness or cost effectiveness, is applied. These treatments have variously been referred to as Interventions Not Normally Funded (INNF) or Procedures of Limited Clinical Effectiveness (PoLCE) or Achieving Consistent Thresholds (ACT). For the sake of clarity, we will refer to Planned Procedures with a Threshold (PPwTs) in this document.

Dealing with individual funding requests (IFRs) is one of the important and often difficult functions that PCTs undertake. The volume of requests has steadily increased across the country in recent years and the Department of Health last year published directives on what PCTs must do to comply with robust processes for local decision making about funding of new medicines and other treatments.

Currently, not many PCTs have sufficient capacity to establish robust systems to cope with the increasing volume and complexity of requests, and this increases the risk of

challenge and adverse findings at Judicial Reviews. It also leads to inequalities in access to treatment between neighbouring PCTs. However, it is possible to have uniform processes that ensure consistent and robust decision making in this area, and there are examples of where this has worked across the country.

1.2 Planned procedures with a threshold

The priority of the NHS is to pay for medicines and treatments that are clinically effective**,** can demonstrate they improve people's health and offer good value for money.

There are other treatments where there is limited evidence about whether they are clinically effective or the treatment is considered to be cosmetic, rather than necessary on health grounds, for example removal of excess skin following weight loss surgery, or treatments for varicose veins. There treatments are not normally funded by the NHS.

GPs can make a request for these kinds of procedures to be carried out on the NHS, on a patient's behalf, because they are very rare or they can be demonstrated that there are exceptional clinical circumstances. If this is the case, a special panel that includes clinicians would carefully consider the case against the latest medical evidence and other criteria to decide whether or not the treatment can be approved.

1.3 Progress to date and future plans

In 2009, the NHS North West London developed a single policy for PPwT, then known as INNF, which included 37 such treatments. This policy was intended to be sector-wide, but has not been systematically applied by all PCTs to all acute contracts.

There is now a proposal to establish a single process with greater capacity and breadth of expertise to reduce variation in decision making, thus improving fairness for patients and simplifying the process for secondary and tertiary care. A further 47 procedures, making 84 in total, will be added. A further three are being considered to add to this list in early 2011.

The sector IFR Team will carry out all the preparation and the sector IFR Panel meetings (including appeals) to make the funding recommendation to the appropriate PCT Cluster of GP Consortia. Each PCT Cluster or GP consortia could delegate responsibility to the Executive (Borough Director), but in some areas, e.g. IVF, the PCT/Cluster Board may wish to review the recommendation, and review it in light of issues such, as financial balance, NHS reputation, population impact. This model is suitable for Cluster PCTs and will also be applicable to future GP consortia.

1.4 Benefits

This single approach will ensure:

- equal access to treatments
- a consistent single process and set of criteria
- more robust and uniform decisions that can stand challenge and Judicial Reviews
- more efficient use of scarce resources
- consistent priority setting across the sector
- continuity of approach with new GP consortia and their patients

1.5 Target audience

Demand-side	Supply-side
• GP Consortia leads and other GPs • Cluster Borough Directors • Sector Medical Director • Public Health Directors • PALs • Patients and the public • LINk • Overview and Scrutiny • Local Medical Committee • Council Leaders/Chief Executives/Lead Members for Health • MPs, London Assembly Members • Voluntary groups	• Hospital clinicians (consultants, nurses) • Sector Acute Commissioning Vehicle (ACV) • Former provider arms of PCTs

1.6 Objectives of this strategy

- to raise stakeholder understanding and awareness of why some treatments are not normally funded by the NHS
- to show that there is a fair system for assessing whether a patient would benefit from a treatment not normally funded
- to show GPs and public health specialists the designed and agreed criteria
- to increase confidence in the process of making funding decisions
- to show that the NHS in North West London is efficient in using scarce resources and releasing more money for frontline care
- to reassure stakeholders about equity of access to treatments across the sector
- to show that decisions are being made on a clinical as well as cost effectiveness basis
- to manage any adverse media coverage and mitigate negative reactions

2 Messages

The core communications messages are proposed as:

- the majority of treatments available in the NHS continue to be free at the point of delivery
- But sometimes we have to make choices around treatments which are very costly or where there is limited evidence of clinical benefit or cost effectiveness
- we make these choices, using the best available evidence about the effectiveness and relative costs of different treatments
- our priority is to pay for medicines and treatments that are clinically effective**,** can demonstrate that they improve people's health, and offer good value for money
- there are some treatments that the NHS doos not normally fund
- this is where there is limited evidence about whether they are clinically effective or it could be because the treatment is considered to be cosmetic, rather than necessary on health grounds
- the new system for planned procedures with a threshold will ensure equity of access to treatments in North West London, subject to PCT board approval in January 2011
- one sector-wide approach will mean better use of resources when administering planned procedures with a threshold
- a unified approach will serve GP consortia and their patients better by applying decisions more consistently and fairly across North West London
- North West London is following many other parts of the NHS in England & Wales in adopting a consistent and transparent system for managing planned procedures with a threshold

2.1 Communications resources

- media holding statements
- news items to cascade within PCTs, clusters and GP Consortia
- letters about the new policy to stakeholders from Cluster CEOs and/or Borough Directors
- cascade briefings to GPs
- educational events for GPs and clinicians
- patient leaflet on the new PPwT process to be available across NWL
- properly briefed and prepared spokespeople and media lines for the planned procedures that are anticipated to cause the most contention
- template letters for GPs to give to patients explaining the new policy

3 Timetable of communications activities

The Clinical Strategy Group is holding discussions with GPs, providers and stakeholders on commissioning intentions, and part of these discussions concern PPwT, these meetings are not included in this planner.

Month	Week starting	Milestone	Internal communications	Stakeholder engagement	Media, including handling
December 2010	6				
	13	Draft communications and engagement strategy ready for review			
	20			Plan programme of engagement with GPs, hospital doctors, LINK, MPs, Council Leaders/Lead Member for Health	
	27				

Month	Week starting	Milestone	Internal communications	Stakeholder engagement	Media, including handling
January 2011	3	PPwT paper at NHS Harrow Board (11-Jan)	Inform ACV team about the changesto ensure aware and are preparing for the single IFR and the 84 treatments	Letter to local LMC, OSC, LINk, Council leader,CEO, Lead for Health and MPs, giving advance notice of decisions to be taken at individual PCT board meetings during January about PPwT	Holding statements ready to use Develop and secure supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place
	13			News item in the sector stakeholder bulletin News item in the sector GP bulletin and through existing communications channels at PCTs	

	17	PPwT paper at NHS Hammersmith and Fulham Board (19-Jan) PPwT paper at NHS Ealing Board (20-Jan) PPwT paper at NHS Hillingdon Board (21-Jan)			
	24	PPwT paper at NHS Westminster Board (25-Jan) PPwT paper at NHS Kensington and Chelsea Board (25-Jan) PPwT paper at NHS Brent Board (27-Jan) PPwT paper at NHS Hounslow Board (27-Jan)			
	31				

Month	Week starting	Milestone	Internal communications	Stakeholder engagement	Media, including handling
February 2011	**7**			Further letters to local stakeholders, confirming PCT board decisions about PPwT policy and including information about the workings of the new policy	
	14	Announcement of the PPwT Policy and single IFR launching in Apr-11	Briefing cascaded by PCT	Briefing cascaded through established GP communications at PCT level	Holding statements ready to use with supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place
	21				
	28				

Month	Week starting	Milestone	Internal communications	Stakeholder engagement	Media, including handling
March 2011	7	Pre-launch briefing		News item in the sector GP bulletin	Holding statements ready to use, including supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place.
	14	Mobilisation briefing (the treatments, criteria and process)		Briefing or training session for clinicians (specialist nurses, GPs and hospital consultants) and PCT PALS teams – not a communications activity per se, but shown here to provide complete overview of planned activity	Holding statements ready to use, including supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place.
	21			Letters to patient support groups and/or charities with an interest in the more contentious treatments (bariatric	Holding statements ready to use, including supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place.

				surgery, knees, cataracts and varicose veins). Plus LINks	
	28	Leaflet on new IFR process and patient letter template for GPs ready	Standardised news article for PCT/cluster intranets	PDF of leaflet distributed to GPs and hospitals Standard patient letter for GPs PDF of leaflet added to PCT/Cluster/Sector website	Holding statements ready to use, including supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place.

Month	Week starting	Milestone	Internal communications	Stakeholder engagement	Media, including handling
April 2011	4	Go live of the service	Announcement of new service to PCTs, Clusters and ACV	News item in the sector stakeholder bulletin	Holding statements ready to use, including supportive quotes and statements from GPs and a range of clinicians explaining why the policy is in place.
	11				Proactive sell-in news and case studies with clinical spokespeople
	18				
	25				

4 Pre-prepared draft statements and draft FAQs

4.1 Background on PPwT?

Most treatments are freely available on the NHS to anyone registered in England and Wales who needs them. But sometimes the NHS has to make choices around treatments which are exceptionally costly or where there is limited evidence of benefit.

PCTs currently make these choices, using the best available evidence about the effectiveness and relative costs of different treatments.

Our Individual Funding Request Panel considers individual requests and decides whether or not to fund the requested treatment for each patient, and we have an appeals panel that considers appeals against Individual Patients Funding Panel decisions.

4.2 Q&As for media and informs patient information

Why is this important?	We have seen a substantial rise in referrals for non-urgent or low priority procedures. In addition, there is increasing evidence that for some procedures significant numbers of patients report little or no clinical benefit. By stopping doing things which are not clinically necessary, we can safeguard and continue to do what is clinically essential or urgent, such as cancer referrals and life-threatening trauma cases in A&E. Medical needs will always be at the heart of decisions about our priorities. Going forward it is clear that the NHS cannot continue to offer treatments where there is no or very limited clinical evidence or which are predominately cosmetic, rather than necessary on health grounds.
I feel I could benefit from the treatment that is not normally funded?	If your GP feels that you would benefit from one of the treatments that PCTs in North West London does not routinely pay for and therefore you would like to apply for funding, your GP will need to get in touch with the IFR panel.
How can you ensure decisions are fair and equitable if you are looking at each case individually?	By having one panel reviewing the same criteria will make sure that the 1.8m people living in the NHS in North West can be sure that decisions are fair and equitable. The panel members have the expertise to assess the clinical information and evidence provided by your doctor. The panel operates under an agreed ethical framework to ensure any decisions are fair, consistent and equitable

Why change the current arrangements?	At the moment each PCT runs their own IFR, with different criteria and funding. The single IFR will make the most of scarce resources and ensure that there is a fair and consistent approach across NW London.
How is my case considered?	Panel members have the expertise to assess the clinical information and evidence that your doctor has provided. The panel operates under an agreed ethical framework which states that any decisions must be fair, consistent and equitable. The panel consists of a mix of clinically qualified and managerial members, including: • GPs • public health representative(s) • commissioning representatives • lay member(s) • head of pharmaceutical commissioning (drugs panel only)
Why have you chosen over 80 treatments?	A panel of GPs and public health experts reviewed procedures where significant numbers of patients report little or no clinical benefit. By stopping doing things which aren't clinically necessary, we can safeguard and continue to do what's clinically essential or urgent, such as cancer referrals and life-threatening trauma cases in A&E.
I thought the NHS funded all hip operations?	Most treatments are freely available on the NHS to anyone who needs them but sometimes we have to make choices around treatments which are exceptionally costly or where there is limited evidence of benefit. Some hip treatments are among these.
Why is there a postcode lottery of funding?	The single PPwT panel will ensure that everyone in North West London is considered and reviewed in the same way at the same time. So we are stopping variation and therefore actually helping to reduce the likelihood of a so-called postcode lottery across NHS North West London.
Will all the cost and time of panels outweigh any savings?	No. By creating a single PPwT process we can make savings and ensure consistency of process and outcome. At the moment we run eight panel processes and decision making bodies, which is expensive to run and means that there are inconsistent outcomes.
When will this new system start?	1 April 2011

What happens to patients in the system waiting for treatment?	There will be a transition from the existing borough-based IFR panels from January to the end to March 2011. The new process is planned to go live on 1 April 2011. It is anticipated that patients in the system will be managed through by the new panel.
What does ineffective or non-cost effective treatments mean?	For some treatments there is evidence of their not being clinically effective; for others, there is lack of evidence of their being clinically effective. Hip replacements are seen as clinically effective but due to demand and high expense they are not cost-effective; by contrast most agreed that there is no evidence for homeopathy being clinically effective
Will this new process save money?	Yes. Financial analysis is underway to identify the expenditure associated for all procedures. However as an indication of the levels of funding involved, we have carried out analysis, focussing on the 10 interventions with most expenditure across the sector. Three of these cannot yet be quantified and need further analysis, however for the remaining seven, there is a potential of £5.4 million to £7.7 million saving.
A single PPwT panel seems remote from my borough?	The single PPwT panel will use the same criteria to make a decision for all 8 boroughs in NWL. It is more cost effective to run one IFR panel than continue to run 8 borough based panels, who would anyway use the same criteria.

4.3 Q&A for PPwT for key treatments

Treatment	Threshold	Why
Bariatric surgery	Any patient with a BMI > 35 and at least of one of the following: • stage 2 or 3 Diabetes • stage 2 or 3 Apnoea / Airway complications • state 2 or 3 cardiovascular disease • stage 3 gonadal/ sexual complications	BMIs can be a poor indicator of clinical need or functionality. A person with a BMI of 30 with co-morbidities could benefit more from surgery than a patient with a BMI of 50.
Cataracts	Cataract surgery to be considered for patients with a best corrected visual	NHS NW London has determined that people with a visual acuity of 6/9 or better in

	acuity of 6/9 or worse in either the first or second eye and • have impairment in lifestyle such as substantial affect on activities of daily living, leisure activities, risk of falls • surgery is indicated for management of ocular comorbidities • patients with visual acuity of 6/9 or better in both eyes should not normally be referred for cataract surgery	both eyes are a low priority for cataract surgery
Knees	Immediate referral to orthopaedic services is indicated when there is evidence of infection in the joint. Patients with body mass index (BMI) of greater than 40 should not be referred for knee replacement surgery but should have access to patient-specific exercise and weight loss programmes before surgery. Where the patient complains of intense or severe symptomatology (see definition below) not adequately relieved by an extended course of non surgical management AND • has radiological features of severe disease AND • has demonstrable disease in one or more compartments. Where the patients complains of intense or severe symptomatology not adequately relieved by an extended course of non surgical management AND	Any comorbidities, including obesity, should be managed to their optimum level prior to referral. Patients who meet the criteria before having knee replacement surgery are thought to have greater quality of life improvements.

	• has radiological features of moderate to severe disease AND • is troubled by limited mobility or instability of the knee joint	
Varicose veins	Referral for varicose vein surgery should be considered only if the following criteria are met: If they are bleeding from a varicosity that has eroded the skin If there is acute thrombophlebitis progressing up to the groin If they have bled from a varicosity and are at risk of bleeding again If they have an ulcer which is progressive and/or painful despite treatment If there is recurrent superficial thrombophlebitis. Where it is felt that the extent, site, and size (> 3mm) of the varicose veins are having a severe impact on quality of life. Progressive skin changes If the patient has venous skin problems and significant arterial insufficiency (ankle-brachial pressure index less than 0.8)	Varicose veins are an area where intervention rates vary across NW London. There are some cases where evidence shows it is clinically and cost effective. The criteria listed aims to prioritise these cases.

5 Measuring communications success

This communications and stakeholder engagement strategy and plan will be monitored as follows:

- Positive/neutral vs negative media coverage

- Support gained for the new policy from among key target audiences – e.g. local GPs acting as local spokespeople to promote the new policy

- Level of patient complaints and enquiries received by PCT PALS and Complaints teams about the new policy compared with historic levels relating to the former policies operating across individual PCTs

6 Risk assessment

The table below sets out the key risks to delivery of this strategy going forward and mitigating actions to reduce risk:

Risk	Mitigation
PPwT is seen just as a cost cutting exercise	Need to demonstrate that most treatments are freely available on the NHS to anyone, registered with a GP in England and Wales, who needs them but sometimes we have to make choices around treatments which are exceptionally costly or where there is limited evidence of benefit. Need to prepare reactive lines and have prepared supportive quotes and statements from GPs. Need to engage with patient representative groups with where we anticipate there will be the most contention. Will also have supporting quotes from a range of clinicians explaining why the policy is in place.
Confusion over Government statements about NHS funding being protected but the local NHS refusing funding for a range of treatments, especially for hip, knee, IVF and cataracts	Need to demonstrate that most treatments remain freely available on the NHS to anyone who needs them but sometimes we have to make choices around treatments which are exceptionally costly or where there is limited evidence of benefit. Need to prepare reactive lines and have prepared supportive quotes and statements from GPs.
Confusion among the public with NHS jargon (PPwT, IFR/INNF/PoLCE) and what the NHS does and does not routinely fund	• Simple messages on the reasons why • Use plain English in patient communications and media • Use consistent language and terminology elsewhere
Lack of consistency of message between PCTs on why there is a single PPwT and IFR panel	Standardised lines are prepared and shared. This will ensure there is sharing of messages on the process across all PCTs in the sector. Make sure that all stakeholders, especially referring GPs and hospital consultants, are briefed on the process and progress.

People perceive that NHS pays for all treatments for, bariatric surgery, knees, cataracts and varicose veins?	Develop and share standardised lines on why these treatments will not routinely be funded. Need to develop statements from GPs and clinicians as to why the criteria were agreed on and how certain patients can be eligible for treatment.
Hospitals not fully aware of the criteria and treatments not normally funded and carry out the treatment. This maybe seen as unfair as those going through IFR are rejected, but those going via another route get treated	Make sure that hospitals and the ACV understand and are aware of the new system and process. Otherwise patients may perceive the system unfair and we continue to pay for some treatments that should have gone through IFR This can be overcome by regular communications using lines to cascade Will also have supporting quotes from a range of clinicians explaining why the policy is in place.
By standardising the criteria for funding there will be a perception of some winners and losers in the new system	Develop standard lines and patient leaflets to show the new IFR system will be fairer. There needs to be engagement with GPs, hospital doctors, LINK, MPs, Council Leaders/Lead Member for Health
National announcements contradict local decisions (Andrew Lansley urged PCTs to “take note” of guidelines recommending infertile women are entitled to three cycles of IVF treatment on the NHS, 7 Dec-10)	Seek clarification from Department of Health Develop lines to take in the meantime while awaiting response from DH
Why have you decided to include treatments in your PPwT that are available on the NHS in other parts of the county? Is not this a post code lottery?	We have reviewed and selected treatments where are residents would most benefit. This the new approach means that all 1.8m residents in North West London are evaluated on the same criteria so will have consistent access to healthcare.
Lack of continuity of communications capacity. The current communications teams at PCT will in this time become a smaller sector team	Need to be mindful that transition process is happening and this could impact. Standardised messages to cascade and use of sector channels (GP emails and stakeholder bulletins)

INTEGRATED FINANCE REPORT 2010/11 (Month 8)

Summary:

This report is to provide an update to the Board of the financial position at month 8 and of the forecast for the year end. The report highlights the risks and the actions being taken to mitigate these risks.

Please note this is the first attempt at an integrated finance report that provides financial information at both a cluster and individual PCT/borough level. It is the intention that one report will go to all three PCT Boards and therefore your feedback on the content, style and format is sought.

The Board is asked to note the achievement of a year to date surplus of £11.8m across INWL (H&F £2.35m) and the cluster is forecasting a £14.4m (H&F £3.5m) surplus at year end, which is £0.5m above plan due to K&C.

All statutory financial duties are forecasted to be delivered at year end and all other financial targets (with the exception QIPP in K&C and Westminster and K&C Better Payments Practice Code) are expected to be met in 2010/11.

Overheating of Acute SLAs remains the main risk to the financial forecast and action is being taken to both reduce the value of overperformance and mitigate the financial risk. A deal for 2010/11 has been agreed between Imperial and the Sector although the impact on individual PCTs is still to be negotiated and will be reported in next month's report.

Negotiations are ongoing with NWL on INWL providing additional sector support in 2010/11, which are also linked to discussions around the Imperial deal.

Board action required:

- To note the financial position of H & F to month 8.
- To note the risk to the achievement of a year end surplus of £3.5m for H&F and consider the actions being taken to mitigate this risk.
- To review and provide feedback on the content and format of the integrated finance report.

Responsible director:	**Author:**
Jeff Deane Director of Finance (INWL)	Jeff Deane Director of Finance (INWL)

Date of paper: 6th January 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	The financial plan is key to the delivery of the PCTs key priorities
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	The PCT has statutory financial duties to remain within approved funding levels
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	

Inner North West London Cluster (INWL)
(Hammersmith & Fulham, Kensington & Chelsea and Westminster PCTs)

INTEGRATED FINANCE REPORT 2010/11 (Month 8)

Contents

1. Executive Summary

1.1 This report provides a summary of the financial performance for INWL as at 30 November 2010.

Description of Duty or Target in 2010/11	Target	Actual / Forecast	Variance	Direction of Travel	Comment
Statutory Duties:					
Meet Revenue Resource Limit (Forecast) £000s:					
NHS Hammersmith & Fulham (H&F)	0	(3,510)	(3,510)	→	All three PCTs are on target to deliver break-even or better in 2010/11.
NHS Kensington & Chelsea (K&C)	0	(4,718)	(4,718)	↓	
NHS Westminster (W)	0	(6,179)	(6,179)	→	
Inner North West London PCT Cluster (INWL Total)	0	(14,407)	(14,407)	↓	
Meet Capital Resource Limit (Forecast) £000s:					
H & F	3,137	3,137	0	→	The PCTs have been successful in their bid for additional capital. Capital resources have been increased by over £3m and all PCTs are on track to operate within their revised limits.
K & C	4,030	4,030	0	→	
W	4,450	4,450	0	→	
INWL Total	11,617	11,617	0	→	
Meet Cash Limit (revenue and capital) (Forecast) £000s:					
H & F	351,702	351,702	0	→	All PCTs are forecasted to operate within their cash limits and no cash issues are anticipated.
K & C	371,874	371,874	0	→	
W	550,130	550,130	0	→	
INWL Total	1,273,706	1,273,706	0	→	
Other Selected Targets:					
Meet Revenue Surplus Target / NHSL Control Total (Year to Date) £000s:					
H & F	(2,320)	(2,350)	(30)	↓	All PCTs are ahead of their year to date surplus plan at month 8.
K & C	(3,233)	(3,581)	(348)	↑	
W	(5,701)	(5,858)	(157)	↓	
INWL Total	(11,254)	(11,789)	(535)	↓	
Meet Revenue Surplus Target / NHSL Control Total (Forecast) £000s:					
H & F	(3,510)	(3,510)	0	→	H&F and Westminster are forecasting to deliver their original surplus plan. K&C is forecasting a surplus that is £0.5m higher than originally planned, discussions are ongoing with NWL.
K & C	(4,209)	(4,718)	(509)	↓	
W	(6,179)	(6,179)	0	→	
INWL Total	(13,898)	(14,407)	(509)	↓	
Deliver QIPP Plan - (Forecast) £000s:					
H & F	(15,732)	(15,732)	0	→	All 3 PCTs are forecasting large QIPP delivery. H&F is on target to deliver 100% of their target. K&C are forecasting 79% delivery and W 76%. The financial risk of any QIPP underperformance has been mitigated and is included in forecasts.
K & C (Commissioning only excluding CLCH)	(10,836)	(8,582)	2,254	↓	
W	(21,677)	(16,544)	5,133	↓	
INWL Total	(48,245)	(40,858)	7,387	↓	
Operate within management cost ceiling (Forecast) £000s:					
H & F (£1.55m / 15% reduction from 09/10 levels)	8,801	8,699	(102)	→	All 3 PCTs are forecasting to operate within the management cost ceiling for 2010/11 and a 15% reduction in management costs will be delivered across the cluster this year.
K & C (£1.7m / 15% reduction from 09/10 levels)	9,714	9,699	(15)	↑	
W (£1.9m / 15% reduction from 09/10 levels)	11,098	10,746	(352)	↑	
INWL Total (£5.15m / 15% reduction from 09/10 levels)	29,613	29,144	(469)	↑	
BPPC to pay non-NHS trade creditors within 30 days (Year to date - Volume) %:					
H & F	95.0%	94.0%	-1.0%	↓	In terms of the year to date volume target H&F is almost meeting the 95% target, K&C is well below target and W is exceeding the target.
K & C	95.0%	86.5%	-8.5%	→	
W	95.0%	96.7%	1.7%	↓	
BPPC to pay non-NHS trade creditors within 30 days (Year to date - Value) %:					
H & F	95.0%	94.0%	-1.0%	→	In terms of the year to date value target H&F and K&C are just below the 95% target and W is exceeding the target.
K & C	95.0%	92.8%	-2.2%	→	
W	95.0%	98.1%	3.1%	↑	

Key:

Variance singing for financial values: (Underspend) / Overspend

Variance colour against duty or target:
Low risk of failure; existing management effort should deliver success
Medium risk of failure; requiring significant management effort to deliver success
Significant risk of failure; additional actions need to be identified

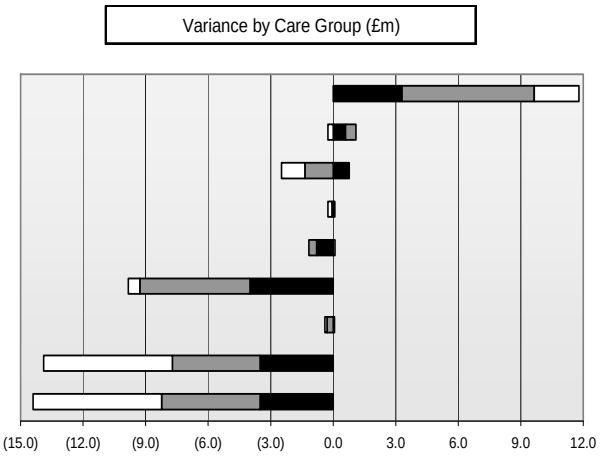
Direction of travel against duty or target since previous report	
↑	Performance improving
↓	Performance deteriorating
→	Consistent

2. Revenue Resource Limit

Summary Overview - Inner North West London Cluster

2.1 The INWL PCT cluster is forecasting to deliver a £14.4m surplus against its original £13.9m surplus plan. The illustration below shows forecast performance by budget group (**see Annex A for detail by PCT**).

Total INWL by Care Group (£m)	Budget INWL	Forecast INWL	Variance INWL	Variance H&F	Variance K&C	Variance W
Acute Care (incl. Ambulance)	483.7	495.4	11.8	3.3	6.3	2.1
Non Acute Services	379.9	380.7	0.8	0.6	0.5	(0.3)
Primary Care (incl.Prescribing)	212.0	210.2	(1.7)	0.8	(1.4)	(1.1)
Specialist & Other Services	57.8	57.6	(0.2)	0.1	(0.1)	(0.2)
Corporate Services	56.0	54.9	(1.1)	(0.8)	(0.4)	0.1
Reserves,Contingency & Other	45.3	35.4	(9.8)	(4.0)	(5.3)	(0.6)
Hosted Services incl.NWLS	24.4	24.0	(0.3)	0.1	(0.3)	(0.1)
Surplus Budget (Original Plan)	13.9	0.0	(13.9)	(3.5)	(4.2)	(6.2)
Grand Total	1,272.8	1,258.4	(14.4)	(3.5)	(4.7)	(6.2)



2.2 The main overspend against budget is in Acute Care which is forecasting a £11.8m (2.4%) pressure in 2010/11. This cost pressure has been mitigated through management of reserves & contingency and additional savings being delivered to ensure the PCTs deliver the surplus plan.

2.3 All statutory duties are forecasted to be met by year end and all other financial targets (with the exception of K&C and Westminster QIPP and K&C BPPC) are expected to be met in this financial year.

2.4 The risk assessed forecast range is between a £9.4m and £18.9m surplus. This £9.5m range (£4.4m H&F, £1.6m K&C and £3.5m W) is driven mainly by acute, primary care, corporate services and reserves.

Forecast Risk Assessment - By PCT 2010/11 (Underspend)/Overspend	Highest Case £000s	Most Likely Case £000s	Lowest Case £000s
Hammersmith & Fulham	(5,189)	(3,510)	(757)
Kensington & Chelsea	(5,105)	(4,718)	(3,554)
Westminster (including NWLCP/Sector)	(8,638)	(6,179)	(5,130)
Total INWL Cluster	**(18,932)**	**(14,407)**	**(9,441)**

Forecast Risk Assessment - By Budget Group 2010/11 (Underspend)/Overspend			
Acute Services (including Ambulance)	9,083	11,791	13,573
Non Acute Services	354	838	2,077
Primary Care Services (including Prescribing)	(2,549)	(1,713)	(185)
Specialist & Other Commissioned Services	(601)	(179)	(3)
Corporate Services	(2,273)	(1,076)	(238)
Reserves & Contingency	(12,550)	(10,838)	(8,534)
NWLCP/Sector and other hosted Services	(500)	(335)	(235)
Surplus Budget / Plan	(13,898)	(13,898)	(13,898)
Other (including NHSW central risk adjustment)	4,002	1,003	(1,998)
Total INWL Cluster	**(18,932)**	**(14,407)**	**(9,441)**

Summary Overview (Revenue) – Hammersmith & Fulham

2.5 The year to date financial position at month 8 is an actual surplus of £2.350m – which is in line with the year to date plan. A surplus of £3.5m is forecast for the year end. There remains some risk to the delivery of the year end position – and the issues and actions are outlined below.

2.6 The summary financial position and risk assessed forecast for H&F is attached as Annex A1.

2.7 There have been a number of small but notable movements from the month 7 position. The forecast overspend on acute has deteriorated by £484k to £3.3m – mainly due to a significant increase in the overspend on C&W. The forecast overspend on primary care services has increased by £465k to £0.8m – with pressures evident on GMS contracts and primary care prescribing. These adverse movements in the forecast, totalling £949k, have been offset by an improvement of £262k on corporate expenditure, and by releasing the balance of contingency reserves of £637k.

2.8 There remain a number of risk areas which may impact on the delivery of the control total surplus of £3.5m.

- It is assumed that settlement will be reached with Imperial at no more the £1m above contract value. The current forecast per the Trust's data is £1.8m.
- There is the risk of further deterioration on acute expenditure generally – with particular risk on C&W, non-local contracts and NCA's.
- The Urgent Care Centre Contract is forecast to breakeven – with demand pressures offset by the imposition of contract penalties. These have yet to be agreed and are likely to be disputed.
- A forecast overspend of £0.5m has been factored in for offender health – bed watches & escorts. The actual value could be as much as £1m – and a settlement needs to be reached with CLCH to limit the in year exposure.
- It is assumed that the full benefit of pricing adjustments for prescribing have not yet been factored into the prescribing forecasts provided to the PCT. An improvement of £250k has been assumed within the PCTs own forecast.

Whilst all of these risks may not materialise – a downside forecast would see the PCT control total being under achieved by as much as £2.5m.

2.9 All contingency reserves are now factored in fully to the forecast position. The PCT is therefore fully exposed to the risks outlined in paragraph 2.7 above. Actions to protect the position are limited but urgent consideration needs to be given to:

- Negotiating a cap on the C&W contract to reduce exposure to further deterioration in the current financial year, or to agree a reduction in activity in the latter part of the year.
- To negotiate a cap with CLCH on offender health expenditure.
- A further review of all budgets not fully spent – with a view to suspending payments for any non clinical service where this is possible.

In addition, a detailed review is being undertaken of all NHS creditors – to challenge all disputed items with a view to agreeing a settlement at below the current creditor value.

2.10 The overall assessment of the financial position is that a year end surplus of £3.5m remains achievable – but with an increased risk of under achievement compared to the position reported at month 7. Achievement remains critically dependent on reaching agreement with Imperial to cap over performance, the management of other pressures to within or below the current forecast, and the identification and delivery of further mitigating actions.

Summary Overview (Revenue) – Kensington & Chelsea

2.11 As at 30 November 2010 the PCT is reporting an in-year surplus of £3.58 million; this is £348,000 higher than planned. Commissioning budgets are reporting a surplus of £2.30 million. The PCT's overall position also includes the surplus (£1.28 million) generated by Central London Community Healthcare during the first seven months of the year.

2.12 The summary financial position and risk assessed forecast for K&C is attached as Annex A2.

2.13 We are expecting that the PCT's control total will be adjusted downwards to £4.21 million to take account of the transfer out of Central London Community Healthcare. This is the subject of discussions with NHS London and we expect to have this finalised for the Month 9 report.

2.14 The PCT continues to forecast that it will exceed its adjusted control total by £0.5 million. The North West London sector has indicated that they may be looking to increase the PCT's control total as result of financial pressures elsewhere in the sector.

2.15 There has, however, been a further deterioration in the position on acute commissioning budgets. This has partially been offset by reduced expenditure on specialist commissioning and primary care budgets.

2.16 We have previously reported that the Sector were looking to the PCT to make an advance payment of £2 million in respect of our 2011/12 contribution to the Sector's Challenged Trust Board; this was possible because the PCT received additional capital funding which reduced the value of the revenue-to-capital transfer required. The current forecast assumes that the PCT will only be able to transfer £1.5m to the Sector if we are to achieve the surplus forecast at Month 7.

Acute Commissioning:

2.17 Acute commissioning budgets are currently overspent by £3.99m (4.5%) and are forecast to overspend by £6.34m at the year-end. Expenditure is based on projections from seven months' activity data.

2.18 Whilst the main areas of overperformance remain accident and emergency attendances, non-elective spells, critical care and outpatient follow-up attendances, there has been a sharp increase this month in critical care costs at Imperial College Healthcare Trust. This appears to be partly the result of a double-charge and this is being investigated.

2.19 As previously reported, one of the causes of the overperformance on acute SLAs is slippage on demand management schemes that form part of the PCT's QIPP programme. In the short-term a number of steps are being taken to mitigate the overspend. The PCT is working with NW London Commissioning Partnership to ensure that all activity caps on outpatient follow-up attendances are being applied correctly. It is also expected that the opening of the Urgent Care Centre at Chelsea & Westminster Hospital will lead to a reduction in non-elective admissions. Finally the PBC Consortium is working with practices that have high levels of referrals relative to their peers.

2.20 In the longer term, the PCT will need to ensure that a more robust QIPP plan is in place for 2011/12. Plans are fairly well advanced to develop this plan.

HIV and Non-acute Commissioning:

2.21 HIV and non-acute commissioning budgets are underspent by £180k at the end of November, but are forecast to overspend by £519k at the year-end. This reflects an increase in the monthly level of expenditure on learning disabilities and physical disabilities services.

2.22 The budgets for individual placements are overspent by £350k and this is forecast to increase to £465k by the year-end. Actions are being taken to mitigate the cost pressure arising from these placements, including a review of certain cases to establish whether patients can be treated as part of existing service level agreements.

Primary Care:

2.23 Primary Care budgets are currently underspent by £650k and are forecast to underspend by £1.35m at the year-end. The forecast out-turn variance is £374k lower than at the end of October. The main reason for this improvement is a reduction in the cost of Category M drugs with effect from 1 October. The part-year effect of this reduction is to reduce expenditure on practice prescribing budgets by £250K in 2010/11.

Corporate Services and Estates & Facilities:

2.24 Corporate Services budgets are overspent by £27k to date, but are forecast to underspend by £360k at the end of the year. The forecast underspend is £20K lower than at the end of October. This is attributable to additional legal costs relating to the work undertaken to establish Central London Community Healthcare as an independent NHS Trust. The forecast underspend is entirely attributable to slippage on the Fit for Work pilot project. Excluding this, corporate budgets are forecasting an overspend of £40k at the year-end.

2.25 Estates and Facilities budgets are underspent by £341k and are forecast to underspend by £300k at the year-end.

Summary Overview (Revenue) – Westminster

2.26 NHS Westminster is reporting year to date under spend of £5.86m and is forecasting a year end surplus of £6.179m which is in line with plan.

2.27 The summary financial position and risk assessed forecast for Westminster is attached as Annex A3.

2.28 The main area of risk to achieving the planned surplus relates to acute SLAs overheating further and in particular at Imperial and some contingency for this has been built into the reserve position. All reserves are currently fully committed.

2.29 Following discussions with NWL sector NHS Westminster is to receive funding from NHS London for any redundancies in 2010/11, therefore the contingency of £3m being held to cover contingencies has now been released to the sector plan. Negotiations are also ongoing about NHS Westminster providing additional funds to support the sector position in 2010/11 linked to the challenged board contributions.

2.30 A summary of the forecast position by budget group is provided below:

Community & Intermediate Services:

2.31 There has been a small increase in the forecast underspend in month, mainly due to Older peoples services – savings here are due to a delay in the start of projects and reduction in cost of bedded services where

clients have passed away. However there has been a reduction in MSK underspend and the St John and Elizabeth contract continues to over perform in the Hospice at Home service.

Mental Health, Pooled or Jointly Funded:

2.32 The improvement in month is due to newly identified underspends, Sexual Health Services are reporting an underspend of £150k rather than previously reported overspend of £102k; this is due to the delays in start of projects/tendering process. Children's services are also reporting new underperformance on CAMHS ECR £103k as a result of lower than expected packages of care being agreed, and Maternity Service Improvements are forecasting break even rather than previously reported overspend of £108k. The consortia budgets within this category remained unchanged as no revised information was available at the time of reporting.

Secondary Care:

2.33 Acute SLAs are forecasting an overspend of £2,299k, this is a reduction of £1,127k on previous month, mainly a result of the improvement in the Imperial position, their overperformance has reduced by £849k. Previously reported overperformance at other Trusts has also reduced this month; Brompton's position improved by £65k, Bart's by £93k, Marsden £24k St George's £40k and UCLH by £57k. Looking at where the pressures are across our SLAs we are still seeing significant overperformance in Non Elective inpatients £1,623k, outpatient first and follow-up £1,232k and A&E c. £733k. Other secondary care contracts which are forecasting variances are; NCI £129k, TOP Services £84k, Assisted Conception £100k, NCA £567k. The adverse NCA movement is a result of funds transferred as part a contribution to the cost of Overseas Visitors. Pressures reported are mitigated by underperformance in some out of sector Trusts and in Clinicenta c. £375k under.

Primary Care:

2.34 GMS/PMS/APMS, a broadly consistent position with month 7, underspends reported are anticipated in the QOF and Out of Hours budgets. £720k dental underspend anticipated in relation to an over-recovery in patient charge revenue and claw-backs for contract underdelivery, there is also a forecast slippage in DPO Development c. £55k and community ophthalmic budget of c. £24k.

Prescribing:

2.35 Practice Prescribing - Prescribing information April-Oct (the latest available), suggests an underspend for GP prescribing. The underspend is anticipated as a result of savings from the Medicines Management team's work on specials and our share of the national price reduction of £120m Cat M drugs.

2.36 Misc Prescribing - Underspend is mainly due to a forecast slippage in the compliance AIDS scheme; the future of the scheme is being reviewed.

2.37 Acute Drugs - The movement in month relates to UCLH, the Trust has issued a credit note for all HCD's because it is part of the SLA. The full value of these drugs has been charged within the secondary care budgets this month.

Corporate Services:

2.38 Corporate services are forecasting a slight overspend of £84k a £116k adverse movement from the previous month's year end forecast. The overspend mainly relates to organisational development spend pressure in Integrated Governance following withdrawal of investment funding and un-budgeted use of agency/consultancy spend in Borough Commissioning to support Polysystem system at the start of the year.

QIPP Performance

2.39 Year to date and forecast performance against the PCT QIPP plans are included in Annex B (Annex B1 for H&F, B2 K&C and B3 for W).

Hammersmith & Fulham

2.40 Following the write-off of high risk savings schemes in month 7 the total of active savings schemes is now £15.7m, of which £11.9m are risk rated as green [76%] and £3.8m [24%] as amber.

2.41 The main Amber risks identified relate to acute contract management and prescribing.

2.42 Acute contract over-performance, particularly at Imperial College and Chelsea & Westminster, continues to negatively impact initiatives. Whilst an agreed settlement with Imperial will mitigate the risk of further deterioration, further actions need to be considered with respect to Chelsea & Westminster.

2.43 A significant element of the prescribing savings relate to national category M price reductions and to drug switches, both of which will be realized during the latter half of the year.

2.44 As at month 8 it is estimated that £7.4m of the £15.7m planned in year savings have been delivered and it is forecast that the full £15.7m will be delivered by the year-end.

Kensington & Chelsea

2.45 K&C is forecasting savings of £8.6m against the original QIPP Plan of £10.7m (Commissioning schemes only). The shortfall has been covered by additional in-year schemes and deferring non-recurrent investments. 72% of schemes are RAG rated as green and 3% as amber.

Westminster

2.46 The month 8 returns to NHSL forecasted a variance of £4.9m against the £9.2m planned demand management schemes. This variance forms part of the acute SLA over performance and is built into the overall financial forecast position. The shortfall has been met by action taken earlier in the year to reduce investment plans and other mainstream budgets.

2.47 Against the cost improvement schemes NHSW is forecasting to deliver the majority of the £12.5m plan of which £5m is cost reduction from 09/10 actual levels per original operating plan and £7.2m is the action taken to reduce expenditure on our original operating plan investment to enable NHSW to make the contribution to the NWL sector financial plan.

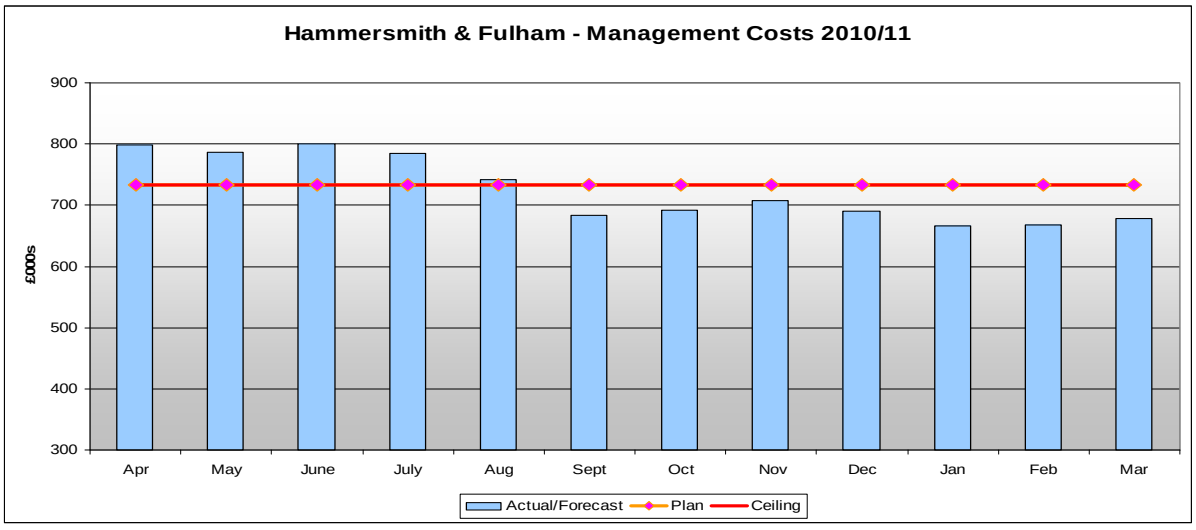
Management Costs

2.48 All three PCTs are on target to deliver their management cost saving targets in 2010/11 and the INWL cluster is forecasting to operate within its £29.6m management cost ceiling this year. It is possible that the cluster arrangements may provide opportunities to reduce management costs further this year at all three PCTs where functions can be shared.

Hammersmith & Fulham

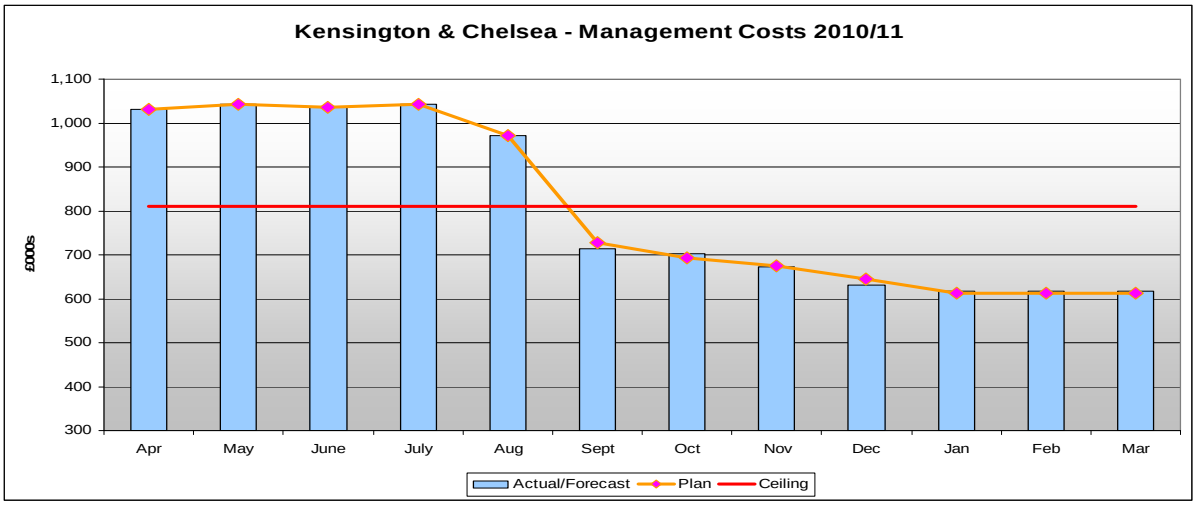
2.49 H&F remains on course to meet its management cost target for the year. The year-to-date management cost is at £6.68m against a budget of £6.60m. The year-to-date overspend of £80k will be recovered as the current monthly run-rate is producing an average monthly saving of £62k (£186k by the end of the financial year).

2.50 The total year end management cost is forecasted at £8.67m against a target of £8.8m (£100k headroom). The forecast will be further adjusted for redundancy costs (MARS and VRS) which do not fall into the definition of management costs, this is expected to produce an improved headroom position, however, it must be noted that these deductions from management costs have no real impact on the PCT total corporate costs.



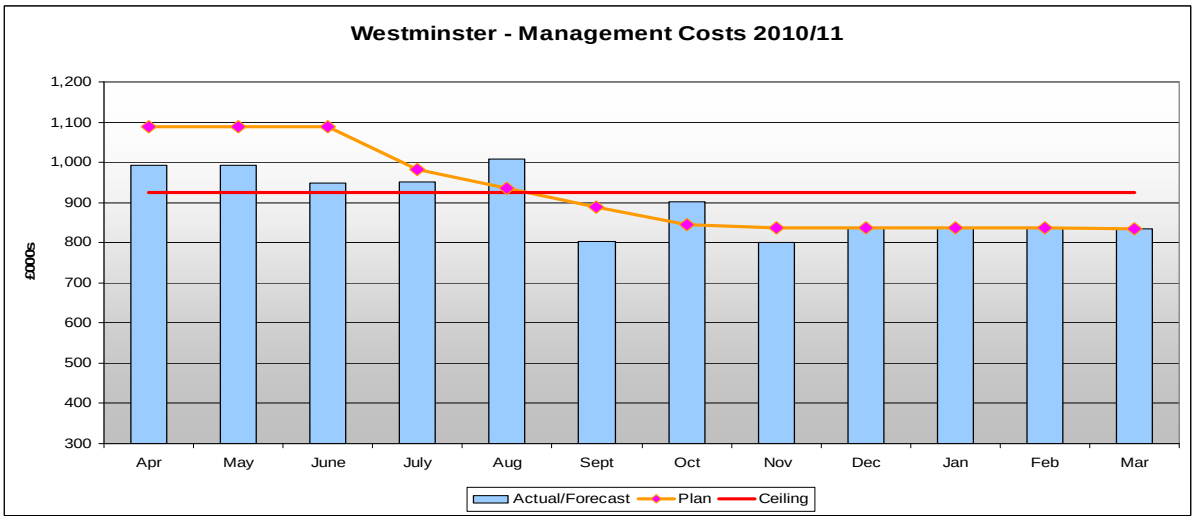
Kensington & Chelsea

2.51 K&C has been set a target to reduce its commissioning management costs by 15% in 2010/11 to £9.71 million. Management costs in the first eight months were £7.21m and the year-end forecast is that these costs will total £9.70m. Management costs in November were £673k, £1k lower than the planned figure.



Westminster

2.52 The commissioner management cost ceiling is £11.098m in 2010-11 and the revised forecast is to contain costs at £352k below the ceiling. There has been a reduction in the November run rate due to the impact of planned staff reductions over the summer. It is possible that further reductions in staff costs by March 2011 will arise from integrated management arrangements supported by the Mutually Agreed Resignation and Voluntary Redundancy Schemes. It should be noted that only strategic functions in Public Health are currently counted as management cost by the PCT.



3. **Capital Resource Limit**

3.1 Year to date and forecast performance against the PCT Capital plans are included in Annex C (Annex C1 for H&F, C2 K&C and C3 for W) and is summarised in the table below.

Capital 2010/11	Annual Plan £000s	YTD Actual £000s	Forecast Actual £000s	Forecast Variance £000s
Hammersmith & Fulham	3,137	1,994	3,137	0
Kensington & Chelsea	4,030	960	4,030	0
Westminster	4,450	189	4,450	0
Total INWL Cluster	**11,617**	**3,143**	**11,617**	**0**

Hammersmith & Fulham

3.2 A summary of the capital expenditure is attached as Annex C1. This shows full commitment of the PCTs total capital allocation of £3.1m. With 3 months left in the financial year budget-holders are now increasingly being monitored to ensure all funds are utilized and the capital control total met. Year-to-date spend is £2m with an additional £0.4m already committed. The PCT does not foresee any risk to the outstanding £0.7m remaining to spend for the year.

Kensington & Chelsea

3.3 A summary of capital expenditure is attached at Annex C2. This now shows full commitment of the PCTs capital budget of £4.71m (£4.03m CRL and £0.68m grants). The main scheme in the 2010/11 capital programme is for the development of a new health centre in Earl's Court. Tenders received have now been evaluated and a letter of intent issued to the preferred bidder. The project is on track for completion in the summer of 2011.

Westminster

3.4 Following a successful bid process NHSW has been awarded additional capital resource of £2.7m for 2010/11. It has received an additional £0.55m for polysystem IT, £0.65m for supporting the development of the NWL IC pilot and £1.5m for estates and facilities projects (DDA and H&S works). Additionally £0.27m of the original Soho centre allocation has been re-profiled to the polysystem IT scheme (which in total is now a £1m scheme).

3.5 Although year to expenditure is relatively low (£0.2m), now additional funds have been confirmed, plans are in place to deliver the programme by year end and operate within the revised Capital Resource Limit of £4.450m.

4. Cash, Balance Sheet and Working Capital

4.1 None of the PCTs are anticipating any cash issues in 2010/11 and a year to date and forecast cash flow at individual PCT and consolidated INWL cluster is included in Annex D.

4.2 The table below illustrates how much cash resource has been consumed to date compared to what cash is available for the remainder of the year, both in terms of time passed and average per month. H&F has currently drawn down more cash than time passed, whereas K&C and W need to spend considerably more cash in the final four months of the year. Cash plans are in place to ensure PCTs deliver the cash targets at year end.

Cash Limit	Annual Cash Limit Forecast £000s	Cash drawn down YTD (M1-M8) £000s	Left to draw down (M9-M12) £000s	Time Passed (8/12ths) %	Cash Drawn down YTD %	Average per month YTD (M1-8) £000s	Average per month (M9-12) £000s
Hammersmith & Fulham	351,702	245,270	106,432	67%	70%	30,659	26,608
Kensington & Chelsea	371,874	232,809	139,065	67%	63%	29,101	34,766
Westminster	550,130	329,775	220,355	67%	60%	41,222	55,089
Total INWL Cluster	**1,273,706**	**807,854**	**465,852**	**67%**	**63%**	**100,982**	**116,463**

4.3 Annex E shows individual PCT and consolidated INWL cluster balance sheets as at the end of month 7. These include the year to date movement from the closing balance sheet as at the 31st March 2010.

4.4 The table below shows a £14m reduction in debtors from last month and includes balance at the start of the year together with the current age profile of debtors by individual PCT and cluster total. Across the cluster there is currently £3.3m of debt over 6 months old and action is being taken to reduce this long term debt by year end.

Debtors Current Aged Profile	Income not invoiced yet	<91 Days £000s	91-180 Days £000s	181-360 Days £000s	361+ Days £000s	Total Debtors £000s
Hammersmith & Fulham	1,602	2,425	201	374	220	**4,822**
Kensington & Chelsea	4,613	1,397	393	74	36	**6,513**
Westminster	6,423	1,467	212	1,322	1,267	**10,691**
Total INWL Cluster	12,638	5,289	806	1,770	1,523	**22,026**
Total INWL profile last month	18,764	11,569	1,572	2,271	1,395	**35,571**
Total INWL profile 31/03/10	13,798	16,223	2,386	631	962	**34,000**

4.5 A similar table to that in 4.4 above will be provided for creditors in the new financial year when all three PCTs are on the same financial ledger system.

5. Conclusion and Recommendations

5.1 The Board is asked to note the financial position to month 8 and that each of the PCTs is forecasting to achieve its planned surplus target at year end, whilst acknowledging the risks in this forecast and the actions being taken to mitigate this risk as outlined in the report.

5.2 The Board is requested to note that all statutory financial duties are expected to be met in 2010/11 and all PCTs are on target to reduce management costs and operate within their management cost limits in 2010/11.

5.3 The Board is asked to note that K & C is now likely to be in a position to transfer only £1.5m of revenue resource to the NW London sector to provide support to PCTs at risk of under-shooting their control totals. However, if the mitigating actions being taken to address acute overperformance are successful, then it may still be possible to provide the full £2m previously envisaged.

5.4 The Board is asked to note that there has been an increase in capital budgets for 2010/11 following successful bids for additional capital.

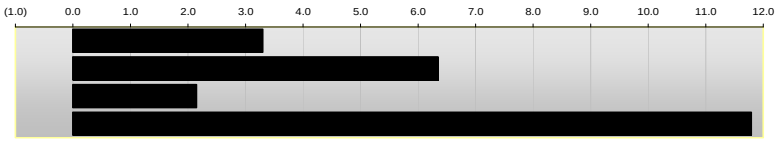
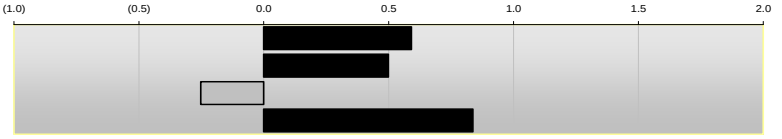
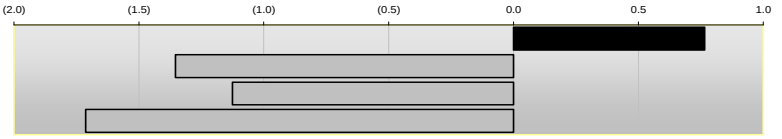
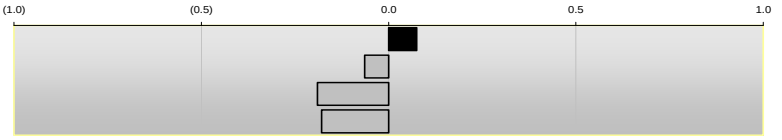
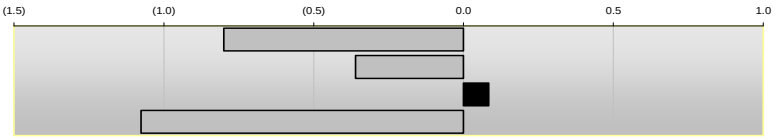
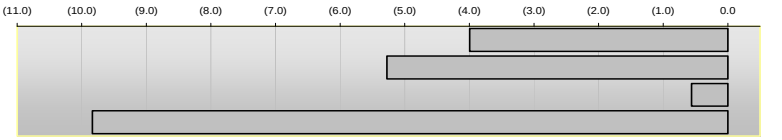
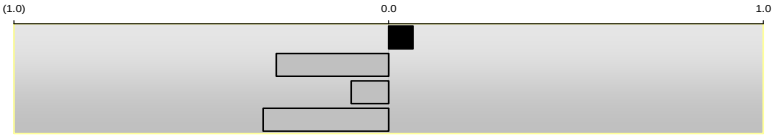
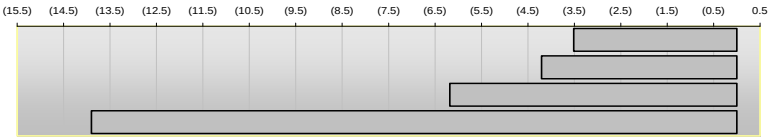
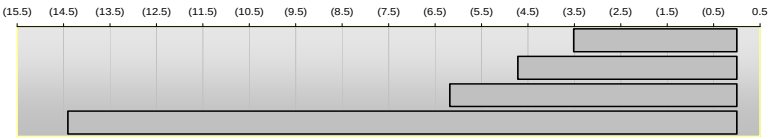
Jeff Deane

Director of Finance (INWL Cluster)

11th January 2011

Revenue Budgets – INWL Summary

Annex A

Care Group	Budget (£m)	Forecast (£m)	Variance (£m)	Variance %	Variance by Care Group (Various Scales) (£m)
Acute Care (incl.Ambulance)					
Hammersmith & Fulham	170.2	173.5	3.3	1.9%	
Kensington & Chelsea	131.2	137.6	6.3	4.8%	
Westminster	182.2	184.4	2.1	1.2%	
Total INWL Custer	483.7	495.4	11.8	2.4%	
Non Acute Services					
Hammersmith & Fulham	103.3	103.9	0.6	0.6%	
Kensington & Chelsea	113.7	114.2	0.5	0.4%	
Westminster	162.9	162.6	(0.3)	(0.2%)	
Total INWL Custer	379.9	380.7	0.8	0.2%	
Primary Care (incl.Prescribing)					
Hammersmith & Fulham	60.1	60.8	0.8	1.3%	
Kensington & Chelsea	64.2	62.8	(1.4)	(2.1%)	
Westminster	87.7	86.6	(1.1)	(1.3%)	
Total INWL Custer	212.0	210.2	(1.7)	(0.8%)	
Specialist & Other Services					
Hammersmith & Fulham	2.8	2.9	0.1	2.6%	
Kensington & Chelsea	18.1	18.0	(0.1)	(0.4%)	
Westminster	36.9	36.7	(0.2)	(0.5%)	
Total INWL Custer	57.8	57.6	(0.2)	(0.3%)	
Corporate Services					
Hammersmith & Fulham	16.8	16.0	(0.8)	(4.8%)	
Kensington & Chelsea	16.6	16.2	(0.4)	(2.2%)	
Westminster	22.7	22.8	0.1	0.4%	
Total INWL Custer	56.0	54.9	(1.1)	(1.9%)	
Reserves, Contingency & Other					
Hammersmith & Fulham	3.5	(0.5)	(4.0)	(113.0%)	
Kensington & Chelsea	7.8	2.5	(5.3)	(67.8%)	
Westminster	33.9	33.4	(0.6)	(1.7%)	
Total INWL Custer	45.3	35.4	(9.8)	(21.7%)	
Hosted Services incl.NWLSector					
Hammersmith & Fulham	1.3	1.4	0.1	4.9%	
Kensington & Chelsea	6.0	5.7	(0.3)	(5.0%)	
Westminster	17.1	17.0	(0.1)	(0.6%)	
Total INWL Custer	24.4	24.0	(0.3)	(1.4%)	
Surplus Budget (Original Plan)					
Hammersmith & Fulham	3.5	0.0	(3.5)	(100.0%)	
Kensington & Chelsea	4.2	0.0	(4.2)	(100.0%)	
Westminster	6.2	0.0	(6.2)	(100.0%)	
Total INWL Custer	13.9	0.0	(13.9)	(100.0%)	
Grand Total Forecast					
Hammersmith & Fulham	361.5	358.0	(3.5)	(1.0%)	
Kensington & Chelsea	361.7	357.0	(4.7)	(1.3%)	
Westminster	549.5	543.4	(6.2)	(1.1%)	
Total INWL Custer	1,272.8	1,258.4	(14.4)	(1.1%)	

Key: Light Grey = Underspend Black = Overspend

Annex A1

Revenue Budgets and Risk Assessed Forecast – Hammersmith & Fulham

NHS Hammersmith & Fulham

Summary Finance Report - to November (month 8) 2010-11

	Annual Budget £000s	Year to date			Forecast @ Month 8 £000s	Forecast @ Month 7 £000s	Change m8 v m7 £000s
		Budget £000s	Actual £000s	Variance £000s			
Acute Services							
Imperial College Hospital	89,802	59,653	59,653	0	0	0	0
Urgent Care Centre Contract	3,180	2,120	2,120	0	0	0	0
Chelsea And Westminster	35,595	23,728	24,641	913	1,172	769	403
Acute -Non-Local Commissioning	11,580	7,720	8,672	952	1,249	1,374	(125)
Foundation Trusts	6,460	4,307	4,750	443	666	754	(88)
ASV / Acute contract leverage	(1,928)	(1,285)	0	1,285	1,928	1,928	0
Acute Contingency	1,716	1,144	0	(1,144)	(1,716)	(1,716)	0
Additional Activity	399	266	97	(169)	(250)	(250)	0
Marginal Rate Benefit Reserve	(1,021)	(582)	0	582	774	873	(99)
Acute Consortia	16,164	10,776	10,776	0	178	0	178
Other Acute Commissioning	2,358	1,669	1,098	(571)	(658)	(873)	215
Ambulance Services	5,873	3,916	3,920	4	(43)	(43)	0
Total Acute Services	**170,179**	**113,432**	**115,727**	**2,295**	**3,300**	**2,816**	**484**
Non Acute Services							
CLCH Provider Services	35,954	23,142	23,671	529	707	668	39
Mental Health Commissioning	39,238	26,202	26,035	(167)	(335)	(301)	(34)
Childrens Commissioning	6,327	4,202	4,183	(19)	(13)	(13)	0
Older People Commissioning	5,551	3,718	3,799	81	68	133	(65)
HIV Commissioning	2,837	1,933	1,943	10	75	100	(25)
LD Commissioning	9,340	7,511	7,573	62	168	168	0
Phys Dis Commissioning	708	472	484	12	18	18	0
Substance Misuse Commissioning	5,116	3,437	3,386	(51)	(77)	(77)	0
Offender Health Commissioning	1,034	689	726	37	55	55	0
Total Non Acute Services	**106,105**	**71,306**	**71,800**	**494**	**666**	**751**	**(85)**
Primary Care Services							
General Ophthalmic Services	940	627	744	117	178	154	24
GMS Discretionary	21,754	13,657	13,636	(21)	164	(115)	279
Pms Practices	1,985	1,183	1,141	(42)	(49)	(116)	67
Prescribing	20,614	14,091	14,594	503	542	482	60
Pharmacy Contract	3,901	2,601	2,584	(17)	(75)	(26)	(49)
Primary Care Dental	10,471	6,995	6,976	(19)	(20)	(129)	109
Primary Care Development	418	282	296	14	26	51	(25)
Total Primary Care Services	**60,083**	**39,436**	**39,971**	**535**	**766**	**301**	**465**
Corporate Services							
Directorate totals	18,073	12,566	11,947	(619)	(735)	(473)	(262)
Total Corporate Services	**18,073**	**12,566**	**11,947**	**(619)**	**(735)**	**(473)**	**(262)**
Surplus & Savings							
Misc	(27)	0	0	0	27	0	27
Pass Through Funding	576	84	84	0	0	0	0
General Contingency	2,285	575	0	(575)	(2,285)	(1,648)	(637)
Other allocation adjustments	(373)	0	0	0	373	373	0
Specific Reserve	1,177	900	722	(178)	(92)	(100)	8
Balance Sheet / Contingency Savings	(2,120)	(1,425)	(1,425)	0	0	0	0
FIMS Phasing adjustments	0	(216)	(728)	(512)	0	0	0
Savings Slippage Reserve	2,020	1,470	0	(1,470)	(2,020)	(2,020)	0
Total Surplus & Savings	**3,538**	**1,388**	**(1,347)**	**(2,735)**	**(3,997)**	**(3,395)**	**(602)**
TOTAL EXPENDITURE	**357,978**	**238,128**	**238,098**	**(30)**	**0**	**0**	**0**
REVENUE RESOURCE LIMIT	**(361,489)**	**(240,448)**	**(240,448)**	**0**	**0**	**0**	**0**
SURPLUS / (DEFICIT)	**3,511**	**2,320**	**2,350**	**30**	**0**	**0**	**0**

(continued)

Revenue Budgets and Risk Assessed Forecast – Hammersmith & Fulham

Summary Finance Report – to November (month 8) 2010/11 – Scenarios

The Risk Assessed Forecast Annex not available in time for month 8 report.
Will be provided from month 9 onwards

Annex A2

Revenue Budgets and Risk Assessed Forecast – Kensington & Chelsea

KENSINGTON & CHELSEA PRIMARY CARE TRUST

Financial Outlook 2010/11
Eight Months to 30 November 2010

Line ref		Budget 2010/11	RLA changes	Budget changes	Budget 2010/11	Periods to date: Budget 2010/11	Periods to date: Actual 2010/11	Periods to date: Var 2010/11	Full year forecast (variance): Best	Likely	Worst
1	Opening Resource Limit	359,994			359,994	237,116	237,116	0	0	0	0
2	In-year Resource Limit Adjustments	0	835		835	557	557	0	0	0	0
3	Notified Resource Limit	359,994	835	0	360,829	237,673	237,673	0	0	0	0
4	Revenue to Capital transfer	-3,500		500	-3,000	-500		500	3,000	3,000	3,000
5	Other anticipated Resource Limit Adjustments	371	1,771		2,142	1,428	1,428	0	0	0	0
6	Adjustment for non-elective threshold				0		-668	-668	-1,002	-1,002	-1,002
7	Contribution to Challenged Trust Board				0				-2,000	-1,500	-1,000
8	**INCOME**	**356,865**	**2,606**	**500**	**359,971**	**238,601**	**238,433**	**-168**	**-2**	**498**	**998**
	EXPENDITURE										
	Acute Commissioning										
9	Acute SLAs (NWLCP)	120,945	0	0	120,945	81,830	86,212	-4,382	-6,506	-6,506	-7,406
10	Acute SLAs (Other)	8,147	0	0	8,147	5,346	4,999	347	0	0	0
11	NCAs / ECRs / Other budgets	2,448	0	0	2,448	1,632	1,391	241	160	160	160
12	Acute activity reserves	-300	0	0	-300	-200	0	-200	0	0	0
13	**Total PBC Commissioning Budgets**	**131,241**	**0**	**0**	**131,241**	**88,608**	**92,602**	**-3,994**	**-6,346**	**-6,346**	**-7,246**
	Non-acute and Specialist Commissioning										
14	Specialist Services SLAs	5,670	0	0	5,670	3,781	3,651	130	110	110	110
15	HIV	12,385	0	0	12,385	8,257	8,232	24	-46	-46	-46
16	Children's Services	3,240	0	0	3,240	2,160	2,085	75	21	21	21
17	Learning Disabilities	7,751	0	0	7,751	5,167	5,118	50	-113	-113	-113
18	Mental Health	43,507	0	-250	43,257	28,613	28,572	41	3	3	-77
19	Older People	13,214	0	0	13,214	8,809	8,976	-167	-374	-374	-374
20	Physical Disabilities	3,974	0	0	3,974	2,649	2,635	14	-80	-80	-80
21	Substance Misuse	5,635	0	0	5,635	3,757	3,700	57	0	0	0
22	Vol Sector/Interpreting	1,733	0	-200	1,533	1,022	970	52	43	43	43
23	Community Services	31,351	0	0	31,351	20,958	20,979	-21	0	0	0
24	Other non-acute	3,765			3,765	2,510	2,455	55	0	0	0
25	**Total non-PBC Commissioning Budgets**	**132,224**	**0**	**-450**	**131,774**	**87,683**	**87,373**	**310**	**-435**	**-435**	**-515**
26	**Total Secondary Care Commissioning**	**263,465**	**0**	**-450**	**263,015**	**176,291**	**179,974**	**-3,684**	**-6,781**	**-6,781**	**-7,761**
	Primary Care Commissioning										
27	GMS / PMS / QOF	25,378	0	0	25,378	17,242	17,084	158	190	190	56
28	Enhanced services	3,117	0	-100	3,017	1,952	2,002	-50	-72	-72	-135
29	Other primary medical services budgets	2,556	0	1,283	3,839	1,839	1,911	-72	-21	-21	-21
30	Community Pharmacy Contracts	3,394	0	151	3,545	2,329	2,306	24	120	33	-41
31	Dental Services Contracts	7,828	0	0	7,828	5,248	4,821	427	900	600	600
32	Primary Care Investment Fund	885	0	0	885	609	524	86	129	129	95
33	Prescribing budgets	19,710	0	0	19,710	13,160	13,082	78	495	495	116
34	**Total Primary Care**	**62,868**	**0**	**1,334**	**64,202**	**42,380**	**41,730**	**650**	**1,741**	**1,354**	**670**
35	**Corporate Services**	**16,525**	**835**	**-791**	**16,569**	**11,018**	**11,045**	**-27**	**360**	**360**	**360**
36	**Estates & Facilities**	**5,978**			**5,978**	**3,723**	**3,382**	**341**	**300**	**300**	**300**
37	**Corporate Services - restructuring**								**-1,500**	**-1,500**	**-1,500**
38	**Contingency**	**0**	**1,771**		**1,771**	**231**	**0**	**231**	**1,771**	**1,771**	**1,771**
39	**Investment Reserve - recurrent**	**1,000**			**1,000**	**0**	**0**	**0**	**0**	**0**	**0**
40	**Investment Reserve - non-rec - committed**			**4,507**	**4,507**	**3,005**	**0**	**3,005**	**4,507**	**4,507**	**4,507**
41	**Investment Reserve - non-rec - uncommitted**	**4,100**		**-4,100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**Total Applications**	**353,936**	**2,606**	**500**	**357,042**	**236,648**	**236,132**	**516**	**398**	**11**	**-1,653**
43	**In Year (Deficit)/Surplus (Commissioning)**	**2,929**	**0**	**0**	**2,929**	**1,953**	**2,301**	**348**	**396**	**509**	**-655**
44	**In Year (Deficit)/Surplus (Provider Servs)**				**1,280**	**1,280**	**1,280**	**0**	**0**	**0**	**0**
45	**In Year (Deficit)/Surplus (PCT)**				**4,209**	**3,233**	**3,581**	**348**			
46			**Forecast surplus for year**			**4,209**	**4,718**	**509**	**396**	**509**	**-655**

Annex A3

Revenue Budgets and Risk Assessed Forecast – Westminster

NHS Westminster Revenue Budgets

NHS Westminster

Month 8
2010-11
NOTE **Variance Signing : (Favourable) / Adverse**

		Annual budget £000's	Budget YTD £000's	Actual YTD £000's	Variance YTD £000's	Forecast yearend £000's		*Forecast Prior Month £000's*	*Forecast Movement £000's*
	COMMISSIONING (CLC)								
CLC100	**SERVICE DEVELOPMENT**								
CLC110	Community & Intermediate Services*	57,416	38,277	37,730	(547)	(437)		*(423)*	*(14)*
CLC120	Mental Health, Pooled or Jointly Funded	105,466	70,311	70,154	(157)	185		*723*	*(539)*
CLC130	Secondary Care	169,644	113,096	114,779	1,683	2,804		*3,644*	*(840)*
CLC135	PBC	1,721	1,147	1,165	18	26		*26*	*(0)*
CLC140	Ambulance Services	11,755	7,837	7,837	(0)	(0)		*(0)*	*(0)*
CLC150	Specialist Commissioning via LSCG	27,960	18,640	18,689	49	(173)		*(296)*	*123*
CLC160	Tertiary & Other Specialist Commissioning	1,625	1,083	1,132	49	65		*65*	*(0)*
CLC170	Public Health Commissioning	7,280	4,853	4,485	(368)	(82)		*(163)*	*81*
CLC180	GMS/PMS	37,761	25,174	25,127	(48)	(72)		*(59)*	*(13)*
CLC190	Other Primary Care Com	21,782	14,521	13,964	(557)	(827)		*(835)*	*8*
	Totals	**442,412**	**294,940**	**295,062**	**122**	**1,490**		***2,683***	***(1,193)***
CLC200	**PRESCRIBING**								
CLC210	Practice Prescrib Budgets	25,523	17,015	17,075	60	(150)		*0*	*(150)*
CLC220	Misc Prescribing Budgets	888	592	528	(65)	(101)		*(102)*	*1*
CLC230	Acute Drugs Budgets	834	556	37	(519)	(659)		*56*	*(715)*
	Totals	**27,245**	**18,163**	**17,640**	**(524)**	**(911)**		***(46)***	***(865)***
CLC300/600	**CORPORATE**								
CLC610	Chief Executive Office	1,097	731	756	25	0		*0*	*(0)*
CLC620	Integrated Governance	3,425	2,277	2,108	(169)	39		*75*	*(36)*
CLC630	Borough Commissioning Corp	3,861	2,574	2,902	328	221		*102*	*119*
CLC640	Public Health (Corp)	2,104	1,403	1,308	(95)	(3)		*2*	*(5)*
CLC650	Finance & Investment	12,444	8,296	7,651	(645)	(219)		*(206)*	*(13)*
CLC660	Strategy & Performance	1,534	1,023	1,221	198	220		*235*	*(15)*
CLC670	ICE	1,905	1,270	1,098	(171)	(29)		*(95)*	*66*
CLC375	NHSW NWLCP Contract	1,260	840	743	(97)	(146)		*(146)*	*(0)*
CLC380	Corporate Serv Recharges	(4,930)	(3,286)	(3,286)	(0)	(0)		*1*	*(1)*
	Totals	**22,701**	**15,127**	**14,501**	**(626)**	**84**		***(33)***	***116***
	RESERVES								
E67779	Savings Identified	3,841	0	(104)	(104)	(3,945)		*(3,875)*	*(70)*
E67780	Contingency Reserve & Surplus	3,060	0	179	179	0		*0*	*0*
E67781	High Labour Cost Reserve	1,163	775	775	0	0		*0*	*0*
E67853	GP Min Improve Grant Pro	0	0	0	0	0		*0*	*0*
E67905	Cost Pressure Reserve	24,512	16,347	17,142	795	3,382		*1,270*	*2,112*
E67906	Investment Reserve	1,362	908	908	0	0		*0*	*0*
	Totals	**33,938**	**18,030**	**18,901**	**870**	**(563)**		***(2,605)***	***2,042***
E67904	**2009/10 Surplus Plan Budget**	**6,179**	**5,701**	**0**	**(5,701)**	**(6,179)**		***(6,179)***	***0***
CLC400	**OTHER BOARD**								
CLC420	Hosted Services	788	525	525	0	0		*0*	*(0)*
	Totals	**788**	**525**	**525**	**0**	**0**		***0***	***(0)***
CLC500	**NWLCP**								
CLC50A	ACV	4,484	2,989	2,989	0	0		*(0)*	*0*
CLC50B	LAS	1,239	826	826	0	(100)		*0*	*(100)*
CLC50C	NWLCP Other	10,548	7,032	7,032	0	0		*(0)*	*0*
	Totals	**16,271**	**10,847**	**10,847**	**0**	**(100)**		**(0)**	**(100)**
	GRAND TOTAL NHS WESTMINSTER	**549,534**	**363,334**	**357,476**	**(5,858)**	**(6,179)**	**0**	**(6,179)**	**0**
	Variance from Plan				**(157)**	**(0)**			

(continued)

Revenue Budgets and Risk Assessed Forecast – Westminster

Forecast Risk Assessment 2010/11 (Underspend)/Overspend	Highest Case £000s	Most Likely Case £000s	Lowest Case £000s
SERVICE DEVELOPMENT			
Community & Intermediate Services	(577)	(437)	(259)
Mental Health, Pooled or Jointly Funded	(136)	185	496
Secondary Acute Care	2,374	2,804	2,874
PBC	27	26	27
Ambulance Services	0	0	0
Specialist Commissioning via LSCG	(163)	(173)	(107)
Tertiary & Other Specialist Commissioning	58	65	71
Public Health Commissioning	(200)	(82)	(50)
GMS/PMS	(200)	(72)	0
Other Primary Care Com	(1,000)	(827)	(800)
Totals	**183**	**1,491**	**2,252**
PRESCRIBING			
Practice Prescrib Budgets	(300)	(150)	(50)
Misc Prescribing Budgets	(220)	(102)	110
Acute Drugs Budgets	(750)	(659)	(600)
Totals	**(1,270)**	**(911)**	**(540)**
CORPORATE			
Chief Executive Office	(150)	0	25
Integrated Governance	(250)	39	100
Borough Commissioning Corp	300	221	400
Public Health (Corp)	(50)	(3)	50
Finance & Investment	(950)	(219)	100
Strategy & Performance	150	220	300
ICE	(100)	(29)	(75)
NHSW NWLCP Contract	(100)	(146)	50
Corporate Serv Recharges	0	0	0
Totals	**(1,150)**	**84**	**950**
RESERVES			
Savings Identified	(3,945)	(3,945)	(3,945)
Contingency Reserve & Surplus	0	0	700
High Labour Cost Reserve	0	0	0
GP Min Improve Grant Pro	0	0	0
Cost Pressure Reserve	1,923	3,382	3,882
Investment Reserve	(500)	0	250
Totals	**(2,522)**	**(563)**	**887**
2009/10 Surplus Plan Budget	**(6,179)**	**(6,179)**	**(6,179)**
OTHER			
Hosted Services	0	0	0
NWLCP / Sector	(200)	(100)	0
Totals	**(200)**	**(100)**	**0**
SUB-TOTAL - Bottom up Risk Analysis	**(11,138)**	**(6,179)**	**(2,630)**
Central Risk Adjustment	**2,500**	**0**	**(2,500)**
GRAND TOTAL Risk Assessed Forecast	**(8,638)**	**(6,179)**	**(5,130)**

Annex B1

QIPP – Hammersmith & Fulham

Savings Ref	Initiative	Cost Centre	Initiativ e Lead	Target Savings	YTD savings	Forecast Out-turn	RAG	Status	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Comments
W1	**ACUTE**		MF					target	342	685	1,026	1,368	1,710	2,053	2,395	2,908	3,421	3,842	4,355	4,962	UCC - Applying contractual performance penalties - Imperial deal
								Actual	23	38	79	148	219	288	494	1,402					
								Variance	- 319	- 647	- 947	- 1,220	- 1,491	- 1,765	- 1,901	- 1,505	- 3,421	- 3,842			
S1	UCC	CXA082	MF	1,098	220	1,098		In progress													Rehab - Ward closed - Imperial SLA adj &
S5	Rehab	CXA082	MF	243	49	243		In progress													srv re-provision costs still being finalised -re
S7	NWLCP Claims mngm	ASV001	MF	822	164	822		In progress													ablement funds
S76	NWLCP Contract mg	ASV001	MF	1,106	221	1,106		In progress													Negogiating overall Imperial position [vai NWLCP]
S2	Respiritory carepathway	CXA082	MF	262	52	262		On target													Service went live Oct 2010 - CLCH Savin
S6	Diabeties	CXA082	MF	350	70	350		On target													Service went live Oct 2010 - CLCH Savin
S3	MSK	CXA082	MF	796	569	796		In progress													MSK operational but current volumes
S4	Pain mngmt	CXA082	MF	285	57	285		In progress													not as high as expected
W2	**CORPORATE**	TT						target	55	110	165	486	1,462	2,899	3,267	3,685	4,103	4,521	5,584	6,002	
								Actual	55	110	165	478	1,457	2,895	3,215	3,594					
								Variance	-	-	-	- 8	-	- 3	- 52	- 91					
				6,002	3,594	6,002															
S18	Capital to rev flexibilities	CFS180	TT	550	-	550		In progress													Capital loan from HPCT secured - other BS adj complete
S17	Bal sheet provisions	CFS180	TT	825	825	825		Completed													
S79	BS write off [C&W]	CFS180	TT	145	-	145		In progress													C&W provision being reviewed per month 6 Aof B
S80	Hydropool grant	CFS180	TT	600	600	600		completed													Broadly on track
S10	Internal mgnt costs	VARIOUS	TT	2,318	1,288	2,318		In progress													
S12	Ealing SS mngmnt costs	CFS001	TT	70	40	70		In progress													Revised SLA agreed
S57	Polysystems engagement	PMX152	JR	48	32	48		In progress													OK
S55	Development funds	PMX150	JR	250	167	250		In progress													OK
S60	Intergration	PMX099	TT	100	67	100		In progress													OK
S56	Proritsation Board CSL / NWLCP	PMX151	JR	66	44	66		In progress													OK
S12/13	mngmnt	PMX098	TT	165	110	165		completed													Lower SLA values agreed
S9	Estates HQ relocatio	CFS042	MF	250	-	250		In progress													On track
S66	Self care Mngr	PMX25M	DM	80	53	80															OK - post £60k non pay £20k
S14/15	Healthgain ABG	PMX102	DM	285	285	285		In progress													Budget set at £972k but SLA at £1087k?
S77	Income gains		JC	0	-	-		In progress													Non pay restrictions / budget changes t
S78	Non pay restrictions	VARIOUS	TT	250	83	250		In progress													be effective from Nov 2010
W3	**PRIMARY CARE**		MF					target	151	303	454	605	938	1,146	1,454	1,762	2,070	2,411	2,753	3,098	
								Actual	127,917	256	384	512	814	990	1,208	1,483					
								Variance	- 23	- 47	- 70	- 93	- 124	- 156	- 246	- 279					
				3,098	1,483	3,098															
S71	Dental srvs	CDP200	MF	298	200	298		In progress													OK
S63	Childs Oral Health	PMX130	MF	125	83	125		In progress													OK
S67	GP Registrations	PMX119	MF	33	22	33		In progress													OK
S100	GMS list cleansing	CFS101	MF	100	-	100		In progress													Need to look at Jan List size adj
S101	GMS Descretionary	CFS101	MF	150	50	150		In progress													Budget underspend to date
S102	GP Locums	CGM004	MF	30	10	30		In progress													Budget underspend to date
S103	Freed up resources mngmt	CGM006	MF	-	-	-		In progress													Budget underspend to date
S104	Flu Vaccs Nursing Support	CFL009	MF	20	7	20		In progress													OK
S106	IM&T DES - defer to 11/12	CFS101	MF	100	100	100		In progress													OK
S68	QOF+ Redirection	CGM001	MF	850	567	850		In progress													OK - BIU to produce report?
S69	QOF+ Slippage	CGM001	MF	400	267	400		In progress													OK
S70	Cassidy Rd	CGP130	MF	60	20	60		In progress													OK
S72	PMS rent Maystar	CPM012	MF	100	67	100		In progress													OK
S73	Homeless LES	CFS101	MF	25	25	25		In progress													OK
S99	Canberra staffing costs	CGP132	MF	100	48	100		In progress													OK
S64	Community pharmacy	PMX010	MF	27	18	27		In progress													
S74	Prescribing intiatives	CPR001	MF	280	-	280		In progress													PPA reports forecast considerable drugs cost pressures negating any savings
S75	Prescribing M Class drugs	CPR001	MF	400	-	400		In progress													

Savings Ref	Initiative	Cost Centre	Initiative Lead	Target Savings	YTD savings	Forecast Out-turn	RAG	Status	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Comments
W4	**Community & Non acute SRVS**		JR					target	105	211	316	422	546	671	835	1,002	1,169	1,335	1,502	1,670	
								Actual	105.375	211	316	422	527	653	810	961					
				1,670	961	1,670		Variance	-	-	-	-	- 19	- 18	- 25	- 41					
S29	SMS CNWL 3% Block SLA reduction agreed	CXV905	JR	93	62	93		In progress													
S32	SMS DAT rehab team	CXV905	JR	10	7	10		In progress													Budget underspend - mngr meetings
S31	SMS Data project worker	CXV865	JR	17	11	17		In progress													[PC] outstanding for SMS - CNWL main concern
S34	SMS Dual diagnosis post	CXV901	JR	21	14	21		In progress													OK
S33	SMS Finance data mgnmt charge	CXV865	JR	12	8	12		In progress													OK
S35	SMS Social marketing budget	CXV867	JR	5	3	5		In progress													OK
S51	Older End of Life	PMX055	JR	181	121	181		In progress													OK
S44	Older Acton placements	CXS200	JR	64	50	64		In progress													OK
S45	Older Equipment	CXS199	JR	59	30	59		In progress													OK
S43	SH family planning sessions	CXA205	JR	-	-	-		In progress													
S40	SH Chlamydia Screening	CXA205	JR	-	-	-		In progress													FP savings plan being re-worked to
S42	SH Budget savings	CXT215	JR	139	40	139		In progress													incorporate Chlymidia screening target
S98	SH budget mngmt savings	CFP001	JR	25	8	25		In progress													spend & issue with 0910 bills needs resolving
S87	Childrens - WLMHT post	CXP014	CB	50	-	50		In progress													
S88	Childrens - Failsafe	PMX021	CB	35	-	35		In progress													
S90	Childrens School nurse		CB	20	-	20															
S92	Childrens - Kaleidoscope	CXP007	CB	26	17	26		In progress													Overall the service has an underspend
S95	Childrens C&W vacant post	CXP016	CB	20	7	20		In progress													that should deliver sufficient savings even if some individual measures do not deliver
S96	Childrens - con care	CXP150	CB	130	87	130		In progress													
S59	Childrens - Maternity srvs - Peri natal	PMXO4A	CB	70	47	70		In progress													OK
S62	Childrens centre Obesity	PMX089	CB	112	75	112		In progress													OK
S28	CLCH SLA CQUINS / mngnt costs		JR	-	-	-		In progress													OK
S38	LD Agency consultant usage		JR	-	-	-		In progress													No provider agreement yet
S24	MH Mind contribution	CXX888	JR	12	9	12		In progress													No provider agreement yet
S83	MH Assertive Out reach		JR	-	-	-		In progress													OK
S84	MH C&W Patients		JR	-	-	-		In progress													No provider agreement yet
S21	MH Citizens advice Bureau	CXE033	JR	19	13	19		In progress													No provider agreement yet
S25	MH SLAM		JR	-	-	-															OK
S26	MH SWLSTG		JR	-		-															Dis-continued - no provider agreement
S46	MH CNWL patients		JR	-	-	-		In progress													
S20	MH Contiuing Care	CXF100	JR	251	167	251		In progress													OK - Based on mngrs forecast
S27	MH Dementia srvs	CXH117	JR	148	99	148		In progress													OK -
S23	MH Expert patient prog	CXH109	JR	30	20	30		In progress													OK
S22	MH Hestia Day worker	CXH107	JR	44	29	44		In progress													OK
S58	MH IAPTS		JR	-	-	-		In progress													No savings actions in place yet
S86	MH Third Sector Provision	CHX107	JR	40	13	40		In progress													?
S47	MH WLMHT 75% beds		JR	-	-	-		In progress													No provider agreement yet
S50	PH TB Post	PMX60B	DM	37	25	37		In progress													OK
	TOTAL			**15,732**	**7,440**	**15,732**		target	654	1,308	1,961	2,881	4,657	6,768	7,951	9,357	10,762	12,110	14,194	15,732	
								Actual	311	615	944	1,559	3,016	4,826	5,727	7,440					
								Variance	- 343	- 693	- 1,017	- 1,321	- 1,640	- 1,942	- 2,224	- 1,917					

Colour code

- Savings on track to delivier
- Issues with full delivery of savings
- Risk of non-delivery
- Savings not yet started
- Savings measure dis-continued

(continued)

QIPP Plan 2010/11 - Position as at Month 8

QIPP – Kensington & Chelsea

Ref	Initiative	Initiative Lead	Planned savings	YTD savings	FOT savings	RAG	Status	Comments
1	Management cost savings	DR	1,736	1,157	1,736		In progress	
2	IS Diagnostics	MC	189	126	189		In progress	
3	Referral incentive scheme & outpatient caps	GM	1,890	0	0		Delayed	Revised scheme to be presented to PBC Steering Group
4	St Charles UCC	FL	228	152	228		In progress	
5	C&W UCC	FL	250	42	208		Now in progress	
6	Sexual Health (incl screening)	PD	272	0	0		Delayed	Local tariff deferred to 2011/12
8	Prescribing	AMcC	558	372	558		In progress	
9	Mental Health	CL	1,167	778	1,167		In progress	
10	Cardiology	GM	448	299	448		Delayed	Business case not approved
11	Community skin health	KG	101	67	101		In progress	
12	Community older peoples service	HC	351	234	351		In progress	
13	District nursing case management & rapid response	HD	316	211	316		In progress	
14	COPD	HD	614	409	614		In progress	
15	Diabetes	KT	54	36	54		In progress	
17	Musculo-skeletal	GM	593	395	593		In progress	
18	End of life care	PE	30	20	30		In progress	
20	Imperial SLA review	DR	1,227	818	1,227		In progress	
21	Non tariff drugs review	MC	200	133	200		In progress	
22	Non tariff medical devices review	MC	200	133	200		In progress	
23	Homeopathic treatment review	MC	200	0	150		In progress	
25	Primary care contracts	DR	212	141	212		In progress	
	Total		**10,836**	**5,523**	**8,582**			

Savings Ref	Initiative	Cost Centre	Initiative Lead	Target Savings	YTD Savings	Forecast Out-turn	RAG	Status	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Comments
	DEMAND MANAGEMENT							**Target**	**366**	**949**	**1,639**	**2,334**	**3,142**	**3,955**	**4,768**	**5,581**	**6,394**	**7,314**	**8,236**	**9,208**	
								Actual	**9**	**73**	**201**	**334**	**418**	**484**	**759**	**1,154**	**1,666**	**2,533**	**3,404**	**4,325**	
				9,208	**1,154**	**4,325**		**Variance**	**-357**	**-876**	**-1,438**	**-2,000**	**-2,724**	**-3,471**	**-4,009**	**-4,427**	**-4,728**	**-4,781**	**-4,832**	**-4,883**	
	Major Health Campaigns - Elective	Various	HW	45	0	45		Yet to start	0	0	0	0	0	0	0	0	0	15	30	45	Schemes yet to start
	Major Health Campaigns - Non Elective	Various	HW	72	0	72		Yet to start	0	0	0	0	0	0	0	0	0	24	48	72	
	Major Health Campaigns - Total			117	0	117			0	0	0	0	0	0	0	0	0	39	78	117	
	Family Recovery - Non Elective	Various	CA	522	44	198		In progress	0	0	0	0	0	0	22	44	66	110	154	198	See integrated performance report
	Family Recovery - A & E	Various	CA	43	10	26		In progress	0	0	1	2	3	3	6	10	14	18	22	26	
	Family Recovery - Total			565	54	224			0	0	1	2	3	3	28	54	80	128	176	224	
	Urgent Care Centre - A & E	Various	SH	726	212	576		In progress	0	0	0	0	25	32	121	212	303	394	485	576	See integrated performance report
	Urgent Care Centre - Total			726	212	576			0	0	0	0	25	32	121	212	303	394	485	576	
	Polysystem/Pathway - MSK Outpatients	Various	SH	1,099	55	361		In progress	0	0	14	14	24	32	40	55	85	177	269	361	See integrated performance report
	Polysystem/Pathway - ENT Outpatients	Various	SH	206	0	0		Stopped	0	0	0	0	0	0	0	0	0	0	0	0	ENT procurement stopped
	Polysystem/Pathway - Dematology Elective	Various	SH	4	0	4		Yet to start	0	0	0	0	0	0	0	0	0	0	0	4	
	Polysystem/Pathway - Dematology Outpatients	Various	SH	521	128	321		In progress	0	0	0	17	32	56	92	128	164	216	268	321	See integrated performance report
	Polysystem/Pathway - Gynaecology Outpatients	Various	SH	547	98	218		In progress	0	0	27	52	53	53	68	98	128	158	188	218	
	Polysystem/Pathway - Total			2,377	281	904			0	0	41	83	109	141	200	281	377	551	725	904	
	GP led - consume local primary care growth	Various	KC	129	8	45		In progress	0	0	0	0	0	0	3	8	15	24	35	45	Delay in locating to correct premises
	GP Led Healthcare - Total			129	8	45			0	0	0	0	0	0	3	8	15	24	35	45	
	Tackling Cancer - Elective	Various	AB	35	0	35		Yet to start	0	0	0	0	0	0	0	0	0	11	23	35	Schemes yet to start
	Tackling Cancer - Non Elective	Various	AB	173	0	173		Yet to start	0	0	0	0	0	0	0	0	0	57	115	173	
	Tackling Cancer - Total			208	0	208			0	0	0	0	0	0	0	0	0	68	138	208	
	Community Cardiac - Non Elective	Various	AB	25	4	13		In progress	0	0	0	0	0	0	2	4	6	8	10	13	
	Community Cardiac - Outpatients (cardiology)	Various	AB	2,028	113	719		In progress	0	7	40	82	82	82	83	113	163	347	531	719	
	Community Cardiac - Outpatients (resp med)	Various	AB	137	6	53		In progress	0	0	3	3	3	3	3	6	12	24	36	53	Delays in premises frustrated progress
	Community Cardiac - A & E	Various	AB	87	22	53		In progress	0	0	2	4	7	8	15	22	29	36	43	53	on the cardiology schemes in the first
	CHD/MyAction/CVD - Elective	Various	AB	77	9	38		In progress	0	0	0	6	6	6	6	9	15	21	27	38	half of the year.
	CHD/MyAction/CVD - Non Elective	Various	AB	207	29	100		In progress	0	0	0	0	0	0	12	29	46	63	80	100	
	CHD/MyAction/CVD - Outpatients (cardiology)	Various	AB	156	91	143		In progress	0	13	26	39	52	65	78	91	104	117	130	143	
	CHD/MyAction/CVD & Community Cardiac - Total			2,717	274	1,119			0	20	71	134	150	164	199	274	375	616	857	1,119	
	Transforming Community Nursing - Elective	Various	SH	507	136	313		In progress	7	43	57	68	76	87	105	136	179	222	265	313	
	Transforming Community Nursing - Non Elective	Various	SH	1,376	115	581		In progress	2	10	27	38	38	38	61	115	222	335	448	581	See integrated performance report
	Transforming Community Nursing - A & E	Various	SH	274	65	157		In progress	0	0	4	9	17	19	42	65	88	111	134	157	
	Transforming Community Nursing - Total			2,157	316	1,051			9	53	88	115	131	144	208	316	489	668	847	1,051	
	End of Life - Non Elective	Various	UD	212	9	81		In progress	0	0	0	0	0	0	0	9	27	45	63	81	See integrated performance report
	End of Life - Total			212	9	81			0	0	0	0	0	0	0	9	27	45	63	81	
	COST IMPROVEMENT PROGRAMME							**Target**	**368**	**741**	**1,835**	**2,953**	**4,071**	**5,189**	**6,319**	**7,449**	**8,704**	**9,959**	**11,214**	**12,469**	
								Actual	**368**	**741**	**1,835**	**2,953**	**4,071**	**5,189**	**6,319**	**7,449**	**8,641**	**9,833**	**11,026**	**12,219**	
				12,469	**7,449**	**12,219**		**Variance**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**-63**	**-126**	**-188**	**-250**	
	Personal Medical Services Review	Various	KC	500	0	250		Stopped	0	0	0	0	0	0	0	0	62	124	187	250	PMS Review not happening
	Local Enhanced Services Review	Various	KC	675	448	675		In progress	56	112	168	224	280	336	392	448	504	560	616	675	
	NWLCP Contract Management	Various	KB	1,691	1,128	1,691		In progress	141	282	423	564	705	846	987	1,128	1,269	1,410	1,551	1,691	Savings expected to deliver
	Corporate Services Review / Mgt Cost Reduction	Various	JD	2,395	1,547	2,395		In progress	171	347	523	723	923	1,123	1,335	1,547	1,759	1,971	2,183	2,395	
	NWL Sector Additional Efficiency Contribution	Various	JD	7,208	4,326	7,208		In progress	0	0	721	1,442	2,163	2,884	3,605	4,326	5,047	5,768	6,489	7,208	
	CIP - Total			12,469	7,449	12,219			368	741	1,835	2,953	4,071	5,189	6,319	7,449	8,641	9,833	11,026	12,219	

	TOTAL QIPP							**Target**	**734**	**1,690**	**3,474**	**5,287**	**7,213**	**9,144**	**11,087**	**13,030**	**15,098**	**17,273**	**19,450**	**21,677**	
				21,677	**8,603**	**16,544**		**Actual**	**377**	**814**	**2,036**	**3,287**	**4,489**	**5,673**	**7,078**	**8,603**	**10,307**	**12,366**	**14,430**	**16,544**	
								Variance	**-357**	**-876**	**-1,438**	**-2,000**	**-2,724**	**-3,471**	**-4,009**	**-4,427**	**-4,791**	**-4,907**	**-5,020**	**-5,133**	

Colour code

- Savings on track to deliver
- Issues with full delivery of savings
- Risk of non-delivery
- Savings not yet started
- Savings measure dis-continued

Annex C1

Capital Budget – Hammersmith & Fulham

NHS H&F CAPITAL 2010/11

Main Headings	Original Budget	Revised Budget	Actual Spend YTD	Forecast	Variance
INFORMATION TECHNOLOGY					
Charing Cross Polyclinic phase 2 IT equipment	29	29	19	29	0
GP Extranet Licences	16	16	0	16	0
Maystar GP premises IT and diagnosis equipment	58	58	18	44	(14)
Business Intelligence server and software for Data Warehouse	27	27	27	27	0
Business intelligence developing	0	174	112	174	0
Extension of community rehab -Farm Lane server upgrade & license	19	19	19	19	0
Encompass Software Installation	0	90	90	90	0
Sub Total IT	**149**	**413**	**285**	**399**	**(14)**
ESTATES					
Repositioning of Shepherds Bush professional fees	15	15	5	15	0
Lift Wandsworth Bridge Rd Fit-out	630	630	283	630	0
Cassidy Rd Gp Surgery Renovation 2010	369	340	340	340	0
2009/10 Over accrual of capital costs from prior year	(50)	(19)	0	(19)	0
Mandatory estates compliance works	295	295	194	310	15
Professional Fees - White City	65	100	55	100	0 0
Subtotal - Estates maintenance projects	**1,324**	**1,361**	**877**	**1,376**	**15**
GRANTS					
GP - Maystar setup costs for new GP premises	97	97	97	97	0
GP premises improvement works	25	230	0	230	0
LBHF - Refurbish clinical rooms at Wormwood scrubs Prisons	15	15	15	15	0
LBHF - Office move CNWL Addictions & Offender Care Directorate	12	12	12	12	0
Council - Hydro Therapy Pool	650	650	650	650	0
LBHF Additional Grant	116	300		300	0
Refurbishment cost for HQ move to 1HB	0	50	58	58	8
IT Link to Town Hall Extension for commissioning HQ move	10	10	0	0	(10)
Subtotal - Grants	**925**	**1,364**	**832**	**1,362**	**(2)**
TOTAL AMOUNT ALLOCATED TO PROJECTS	**2,397**	**3,137**	**1,994**	**3,137**	**(0)**

Capital Programme 2010/11

Project Ref	Scheme	2010/11 Original Capital Prog	2010/11 Revised Capital Prog	Year to Date Actual 30/11/10	2010/11 Forecast Spend Dec-Mar 2010	2010/11 Total Actual and Forecast	Variance Against Revised Capital Prog	Comments
		£'000	£'000	£'000	£'000	£'000	£'000	
002	Earls Court Polyclinic (Hogarth Road)	1,950	1,500	120	1,350	1,470	30	
003	St Charles Central Core and Western Pavilion	1,537	737	696	41	737	0	
004	Carbon Reduction Measures	124	124		124	124	0	
005a	Dental Access Programme - Colville HC		144	144	0	144	0	
005b	Dental Access Programme - Violet Melchett HC	570	570		570	570	0	
007a	IT - server replacement	200	200		200	200	0	
007b	IT - St Charles Community Hospital	50	50		50	50	0	
007c	IT - Other hardware purchases	82	82		82	82	0	
Additnl	IT - CLCH infrastructure		300		300	300	0	
	Unallocated	-13	323		353	353	-30	
	Total Capital Resource Limit	**4,500**	**4,030**	**960**	**3,070**	**4,030**	**0**	
	Capital Grants							
006	Dental - Boots High Street Kensington	300	300		300	300	0	
008	GP - Om Sai Practice	150	150		150	150	0	
	Dental - Other unallocated	50	50		50	50	0	
	Acorn House refurbishment (Blenheim CDP)		180		180	180	0	
	Total Capital Grants	500	680	0	680	680	0	
	Grand Total Capital Budgets	**5,000**	**4,710**	**960**	**3,750**	**4,710**	**0**	

Annex C3

Capital Budget – Westminster

Capital Programme 2010/11			Original Full year Plan £000s	Revised Full year Plan £000s	Actual Capital Expenditure Year to Date £000s	Actual Capital Expenditure Forecast to M12 £000s	Actual Capital Expenditure Forecast Variance £000s
CAPITAL FUNDING:							
Initial capital resource allocation confirmed (£700k poly systems/£900k maintenance DDA)			1,600	1,600		1,600	0
Refurbishment and IT equipment for Hungerford drugs Project.			75	75		75	0
Refurbishment and IT equipment for North Westminster Services.			75	75		75	0
Additional bids approved (17/11/10) (£550k poly system IT/£517k maintenance and DDA)				1,067		1,067	0
Additional bids approved (15/12/10) (£650k ICO scheme)				650		650	0
Additional bids approved (15/12/10) (£983k maintenance and DDA)				983		983	0
Total Capital Funding			**1,750**	**4,450**	**0**	**4,450**	**0**
CAPITAL EXPENDITURE:							
Estates and Facilities schemes:							
Project No	**Location**	**Project**					
CLCN E67801 7391 E8010	Woodsfield Medical Centre		371	645		645	0
CLCN E67801 7391 E8007	Queens Park		16	71		71	0
CLCN E67801 7391 E8006	Lisson Grove		104	285		285	0
CLCN E67801 7391 E8005	Linnett House		5	50		50	0
CLCN E67801 7391 E8008	Soho Centre		167	490	39	490	0
CLCN E67801 7391 E8283	Great Chapel Street		8	88		88	0
CLCN E67801 7391 E8009	South Westminster Centre		17	97		97	0
CLCN E67801 7391 E8004	Garside		60	200		200	0
CLCN E67801 7391 E8011	Athlone House		72	215		215	0
CLCN E67801 7391 E8284	Carbon reduction/Waste compliance		30	30		30	0
	291 Harrow Road		0	95		95	0
	Lanark Medical Centre		0	70		70	0
CLCN E67801 7391 E	Contingency		50	64		64	0
		Subtotal Estates & Facilities	**900**	**2,400**	**39**	**2,400**	**0**
Polysystem schemes:							
CLCN E67801 7391 E8286	SWC	Polysystem hub (E&F)	200	200		200	0
CLCN E67801 7391 E	Soho Centre	Polysystem hub (E&F)	320	50		50	0
CLCN E67801 7354 E		Polysystem IT	180	1,000		1,000	0
		Subtotal Polysystems	**700**	**1,250**	**0**	**1,250**	**0**
NWL Sector schemes:							
		ICO Scheme		650		650	0
				0			0
		Subtotal NWL Sector	**0**	**650**	**0**	**650**	**0**
Information Technology and Other schemes							
Project No	**Location**	**Project**					
CLCN E67801 7354 E8287		Hungerford Drugs Project refurb and IT equipment	75	75	75	75	0
CLCN E67801 7354 E8288		North Westminster services refurb and IT equipment	75	75	75	75	0
				0			0
		Subtotal IT and Other	**150**	**150**	**150**	**150**	**0**
Total Capital Expenditure			**1,750**	**4,450**	**189**	**4,450**	**0**
Over/(under) spend against Capital Resource Limit			**0**	**0**		**0**	**0**

Annex D

Cash Flow Statement – Year to Date and Forecast

Cash Flow Statement	H & F		K & C		W		Total INWL (Indicative)	
	YTD Actual £000s	2010/11 Forecast £000s	YTD Actual £000s	2010/11 Forecast £000s	YTD Actual £000s	2010/11 Forecast £000s	YTD Actual £000s	2010/11 Forecast £000s
Total net operating cost	(238,098)	(357,978)	(237,237)	(357,031)	(357,476)	(543,355)	(832,811)	(1,258,364)
Net other adjustments	(613)	959		(12,903)	(12,508)	364	(13,121)	(11,580)
Net Operating Cost & Other Adjustments - Cash Outflow	(238,711)	(357,019)	(237,237)	(369,934)	(369,984)	(542,991)	(845,932)	(1,269,944)
Less non-cash cost items (including Depreciation and Cost of Capital)	1,246	1,529	4,026	6,040	909	1,590	6,181	9,159
Less non-cash cost item: Impairment	0	0					0	0
Movement in working capital:								
(Increase)/decrease in Debtors	(501)	10,543	6,299	2,000	6,176	217	11,974	12,760
Increase/(decrease) in Creditors	(1,825)	(2,062)	(4,037)	(5,000)	35,756	(1,742)	29,894	(8,804)
Use of provisions	(1,115)	(1,556)	(215)	(450)	(1,714)	(2,754)	(3,044)	(4,760)
Net cash (outflow) from operating activities	**(240,906)**	**(348,565)**	**(231,164)**	**(367,344)**	**(328,857)**	**(545,680)**	**(800,927)**	**(1,261,589)**
Net cash inflow/(outflow) from capital expenditure	(844)	(3,137)	(1,652)	(4,530)	(189)	(4,450)	(2,685)	(12,117)
Net cash (outflow) before financing	**(241,750)**	**(351,702)**	**(232,816)**	**(371,874)**	**(329,046)**	**(550,130)**	**(803,612)**	**(1,273,706)**
Financed By:								
Net Parliamentary Funding - Discretionary Cash drawdown	222,000	316,797	215,000	344,974	301,300	507,418	738,300	1,169,189
Net Parliamentary Funding - PPA drugs reimbursement (Central Charge)	16,697	25,243	14,223	21,400	20,264	30,396	51,184	77,039
Net Parliamentary Funding - Dentistry Recharge (Central Charge)	6,573	9,662	3,586	5,500	8,211	12,317	18,370	27,479
Net cash inflow from financing	**245,270**	**351,702**	**232,809**	**371,874**	**329,775**	**550,130**	**807,854**	**1,273,706**
TOTAL INCREASE / (DECREASE) IN CASH DURING PERIOD	**3,520**	**0**	**(7)**	**0**	**729**	**0**	**4,242**	**0**
Cash - Opening Balance at start of the period	13	13	59	59	32	32	104	104
Total Increase / (decrease) in cash during period	3,520	0	(7)	0	729	0	4,242	0
Cash - Closing Balance at the end of the period	3,533	13	52	59	761	32	4,346	104

Annex E

Balance Sheet – Year to Date

Balance Sheet	H & F			K & C			W			Total INWL (Indicative)		
	2009/10 Closing Actual £000s	2010/11 YTD Actual £000s	2010/11 YTD Movement £000s	2009/10 Closing Actual £000s	2010/11 YTD Actual £000s	2010/11 YTD Movement £000s	2009/10 Closing Actual £000s	2010/11 YTD Actual £000s	2010/11 YTD Movement £000s	2009/10 Closing Actual £000s	2010/11 YTD Actual £000s	2010/11 YTD Movement £000s
Fixed Assets	22,730	22,236	(494)	80,617	79,212	(1,405)	43,945	43,282	(663)	147,292	144,730	(2,562)
Current Assets/(Liabilities):												
Stock and work in progress	0	0	0	0	0	0	0	0	0	0	0	0
Debtors	4,321	4,822	501	12,812	6,513	(6,299)	16,867	10,691	(6,176)	34,000	22,026	(11,974)
Cash at bank and in hand	13	3,533	3,520	59	52	(7)	32	761	729	104	4,346	4,242
Creditors due within one year	(27,954)	(26,129)	1,825	(41,647)	(37,610)	4,037	(33,004)	(68,760)	(35,756)	(102,605)	(132,499)	(29,894)
Net Current Assets/(Liabilities)	(23,620)	(17,774)	5,846	(28,776)	(31,045)	(2,269)	(16,105)	(57,308)	(41,203)	(68,501)	(106,127)	(37,626)
Creditors due after more than one year	(2,423)	(2,768)	(345)	0	0	0	(1,670)	(1,670)	0	(4,093)	(4,438)	(345)
Provisions for liabilities and charges	(5,055)	(3,940)	1,115	(2,302)	(2,087)	215	(12,245)	(13,639)	(1,394)	(19,602)	(19,666)	(64)
TOTAL ASSETS EMPLOYED	**(8,368)**	**(2,246)**	**6,122**	**49,539**	**46,080**	**(3,459)**	**13,925**	**(29,335)**	**(43,260)**	**55,096**	**14,499**	**(40,597)**
Financed By:												
General Fund	(13,849)	(7,215)	6,634	23,696	20,237	(3,459)	946	(42,290)	(43,236)	10,793	(29,268)	(40,061)
Revaluation Reserve	5,469	4,957	(512)	22,654	22,654	0	12,979	12,955	(24)	41,102	40,566	(536)
Other Reserves	12	12	0	3,189	3,189	0	0	0	0	3,201	3,201	0
TOTAL TAXPAYERS EQUITY	**(8,368)**	**(2,246)**	**6,122**	**49,539**	**46,080**	**(3,459)**	**13,925**	**(29,335)**	**(43,260)**	**55,096**	**14,499**	**(40,597)**

SAVINGS AND EQUALITY IMPACT ASSESSMENTS

Summary:
Since the need to generate £15million of savings was identified during the summer of 2010, work has been in progress to consider the impact of planned savings on health inequalities. Equality Impact Assessments have already been completed for many savings initiatives, despite the challenges presented by in-year implementation timescales and reductions in staff resources.

At this time, no significant adverse impact on equalities has been identified.

Board action required:
The Board is asked to:

- Note that many savings were achieved by halting planned investment or expenditure before commencement, rather than reducing on-going expenditure.
- Note that the Equalities Steering Group considered progress in completing Equality Impact Assessments for 2010-11 savings initiatives.
- Agree that Equality Impact Assessments should be completed for the QIPP Plan commencing in 2011/2012, taking on board the lessons learnt from the Savings Programme in 2010/11, and that Equality Impact Assessments for the remaining 2010/11 savings initiatives should be completed, while recognising the constraints due to reductions in management capacity

Responsible director: Tim Tebbs, Interim Borough Director	**Authors:** Nick Day, Programme Manager Jonathan McInerny, Equalities and Human Rights Manager

Date of paper: 4th January 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	Reducing Health Inequalities is a key element of our strategy.
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	None identified.
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	Equalities Impact Assessments are carried out by the Equalities Manager with commissioning leads.
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	Equalities Impact Assessments consider how policies may affect communities and whether they reduce or increase inequalities.
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	The report considers the Equalities Impact of savings measures.

Introduction and Background

Though the new Government committed to increasing the NHS budget in real terms over the course of this parliament, the NHS is seeking to make savings of £20 billion over the next 5 years. This is to keep pace with changes in demography, technology and costs, and is to be achieved primarily by eliminating waste and inefficiencies, particularly management costs, and refocusing on front line, clinical services.

NHS Hammersmith and Fulham's previous spending plans for 2010/11 required savings of £11 million. The impact of the NHS London short-term financial strategy was to increase the in-year savings target to £15million, and required rapid identification of additional savings of £4m.

How savings were prioritised and determined

Over the summer, the Commissioning Executive Team (CET) identified potential savings initiatives. It made decisions using the prioritisation framework set out in the Strategic Plan. Almost 100 different savings initiatives were initially identified.

The savings plan includes a number of one-off schemes, but also some recurrent costs for services. Some of these will deliver a part year benefit in 2010-11. Some savings have been relatively easily achieved – for example some new projects that were being developed in 2010/11 have been halted. Early decisions were also made to restrict expenditure in, for example, corporate areas which did not adversely affect services.

Out of hospital, non-acute budgets were reviewed with the aim of achieving 3% savings in 2010/11. These actions were supplemented by a review of all expenditure to identify areas where expenditure could be reduced in-year with minimal impact.

CET have continued to review and revise the savings plan as further information about progress in delivering savings becomes available. Other factors taken into account included fortuitous savings, the viability of achieving savings targets, and adverse impact on services. In consequence of information that became available after implementation started, some proposed savings initiatives were scaled back or dropped.

Savings in 2010/11 - Equality Impact Assessments

In July 2010 the Board noted that Equality Impact Assessments were being carried out on savings proposals. The overwhelming majority (82% by value) of savings initiatives were for acute services, primary and community care services and capital/staff savings. It is difficult to gauge how these savings will impact directly on groups such as Black and Other Ethnic Minority people, the Lesbian Gay and Bi-sexual community, or people of diverse religion or faith. The only project specifically catering for the Black and Other Ethnic Minority community was the Hestia Day Worker (Mental Health).

Analysis of the overall Savings Programme showed that people with mental health problems faced the greatest reduction in service when compared to other client groups. This was followed by older people and children. However, it should be noted that a larger proportion of expenditure by NHS Hammersmith and Fulham is devoted to Mental Health than other, similar London PCTs. Reductions in spend for this group therefore start from a position of above average expenditure. In addition, all service areas were initially expected to achieve the same level of savings (3%). For this reason savings identified for mental health services would be expected to be of greater absolute value. In contrast, savings identified for disabled people (including people with learning disabilities) and offender health/substance misuse were of lower value.

At this time, no significant adverse impact on equalities has been identified. However, Equality Impact Assessments have not yet been completed for all individual initiatives within the Saving Programme.

In November 2010, the Equalities Steering Group considered progress in assessing the Equalities impact of the savings plan. The Group agreed that work should continue both to consult with communities, and to assess the equalities impact of savings in 2010-11 and future years.

Prioritisation and consultation process for 2011/12 Savings Programme – QIPP

Real terms budget growth over the next 4 years for the NHS is expected to be minimal, while financial pressure remains from the growing elderly population, advances in treatments and rising patient expectations. It is anticipated that to keep pace with these challenges, across the North West London sector we will need to deliver £1bn in efficiency savings by 2014/15.

A four year strategic plan will address Quality, Innovation, Productivity and Prevention (QIPP). The strategy will set out commissioning intentions covering priority areas of healthcare across the eight boroughs. It will include savings initiatives to be implemented over the four-year lifetime of the strategy.

Commissioners in the NW London Sector have looked at quality and cost across a broad range of health services. Priority areas set out in the draft QIPP plan are:

- Mental health
- Urgent care
- Planned care
- Prescribing
- Acute contracting/procurement
- Primary care
- Long term conditions

In addition, it is recognised that major clinical quality improvements are necessary in paediatrics, maternity and preventative health.

Consultation has commenced with communities across the Borough to feed into the development of the QIPP programme, including a LINks/PCT event in November. About 50 residents discussed priorities in five service areas: Mental Health, Long Term Conditions, Public Health, Children Services, Older People and Community Services. The concerns, ideas and suggestions that were highlighted by the local community will feed into the future prioritisation of savings in QIPP. The Equalities Steering Group agreed in November that work to engage with local communities should continue, to feed into the QIPP strategy.

It is expected that a draft strategy for QIPP will be completed in December. This will be followed by further consultation with stakeholders, with final sign off expected in January 2011. An important element of QIPP will be to carry out Equality Impact Assessment on further savings initiatives that directly affect patients.

MONTH 8 PERFORMANCE REPORT

***Key areas of improving performance**:*

- 2 cases of **MRSA** cases were identified in November and the year to date position remains in line with trajectory at 6.
- **Clostridium difficile** cases remain below trajectory with 8 in November, totalling 69 since April against a trajectory of 88.

***Key areas of worsening performance**:*

- **Cancer 2ww breast symptomatic** showed 8 breaches in November and continues to perform below the target of 93% (90.1% year to date)
- **All other cancer waits targets** Cancer waits are showing an increase in breaches with 12 breaches of the 2ww target, one breach of the 31 day target and one breach of the 62 day target. Although this increase in breaches is of concern, performance still remains above the overall year to date trajectories. A new General Manager for Cancer has been appointed at ICHT and a meeting is being arranged in January to investigate the causes of the increased breaches and put in place a plan of action.

Action required:
The Board is asked to note the report and agree the actions to improve performance.

Responsible director:	**Author:**
Miles Freeman, Director of Acute Commissioning and Performance, INW London Cluster	Ben Westmancott, Associate Director Margaret Gilroy-Smith, Performance Manager

Date of paper: 6th January 2011

A dashboard showing current monthly performance and RAG rating and year-end forecast RAG rating.

National priorities

Title	Previous	Most recent	RAG Change	Year-to-date Target	Year-end forecast
MRSA (cumulative)	4	**6**		6	GREEN
C. diff. (cumulative)	61	**72**		99	GREEN
18 weeks					
Primary care satisfaction (access)					
Cancer waits - 2 weeks (excl breast)	92.7%	**89.6%**		93%	GREEN
Cancer waits - 2 wks (breast)	91.5%	**90.5%**		93%	AMBER
Cancer waits - 62 days	88.9%	**80%**	▼	87.1%	GREEN
Cancer waits - 31 days	100%	**100%**		96%	GREEN
Breast Cancer screening	59.9%	59.8%		70%	AMBER
Bowel Cancer Screening					
Stroke care (stroke unit)	96.4%	**95.2**		90%	GREEN
Stroke care (TIA) (cumulative)	58.3%	**100%**	▲	91.7%	RED
Cervical Screening (25-49yrs) & (50-64yrs)	59% & 68%	60.4% & 70.1%		80%	RED
All-age all-cause mortality (m & f)	701 & 424	647 & 398	▲	563 & 377	RED/AMBER
CVD mortality		84 (07-09)	▼	66	RED
Cancer mortality	109	118 (07-09)	▼	107	AMBER
Smoking quitters	612	**776**		548	GREEN
Maternity	81.5%	**88.2%**	▲	90%	AMBER/GREEN
Teenage conceptions		42.4		38.5	GREEN
Childhood obesity reception year	12.01%	10.31%	▲	12.6%	GREEN
Childhood obesity year 6	22.4%	23.92%	▼	22.8%	AMBER
Immunisation (no. targets achieved)	10 pts	**12 pts**	▲	18 pts	RED/AMBER
Breastfeeding	83%	83.4%		82.1%	GREEN
CAMHS	4	4		4	GREEN
Chlamydia screening (cumulative)	3601	**3908**		4937	AMBER
Drugs misuse (2007/08)	927	**930**		899	GREEN
Patient experience				81.2%	AMBER
Staff satisfaction	3.5	3.53		3.54	AMBER
Dental access	**105,954**	**106,219**		109,509	AMBER

Existing commitments

Title	Previous	Current	RAG Change	Year-to-date Target	Year-end forecast
A&E 4-hour waits	98.05%	**98.15%**		95%	GREEN
Outpatient 13-week waits					
Inpatient 26 week waits					
Revascularisation 13 week waits					
GUM waits	100%	100%		98%	GREEN
Delayed transfers of care	7.3	5.1		15	GREEN
Ambulance response – Cat. A 8 mins	73.6%	**71.9%**	▼	75%	GREEN
Ambulance response – Cat. A 19 mins	99.2%	**98.8%**		95%	GREEN
Ambulance response – Cat. B 19 mins	92.2%	**90.4%**		95%	AMBER
Diabetic retinopathy screening	94.2%	110%	▲	95%	GREEN
Crisis resolution	212	**252**		248	GREEN
Early intervention in psychosis	13	**26**		18.50	GREEN
Data quality on ethnic group	92.9%	**92.6%**		85%	GREEN

NB: Amber rating is given where current/projected performance is within 10% of the target (except All Age All Cause Mortality which has been rated as amber by NHS London for Q1)

Headlines:

Indicator	Reason for below par performance	Key activities to improve performance
Cancer waits – 2 weeks (breast)	• Patient choice. • Some GP practices have higher levels of breaches	• GP patient leaflet raising awareness has been launched • Primary Care is progressing a programme with GPs with higher breach levels to improve communication.
Cancer – all targets	• Performance in several of the cancer waits targets has shown reduced results • The reasons for the reduction in performance are not yet known	• New General Manager for Cancer at ICHT has been appointed • Cancer Lead has requested meeting during January to review cancer performance at ICHT, establish reasons for reduced performance and form improvement plans
Breast cancer screening	• Poor list and data quality (inflated lists) • Poor primary care engagement • Lack of public awareness • Ethnicity and deprivation • SLA with ICHT did not incentivise them to improve performance	• Adult Screening Task Force engages with primary care to improve list and data quality and to raise awareness of screening programme and benefits • Community's engagement strategy for patients developed. • ICHT SLA was revised from April 2010 to incentivise improved performance.
Stroke care: TIA	• Low numbers cause variability. Q2 was 100% but year-to-date is below target.	• Lead Manager is investigating the cause of the below target performance and prepare a recovery action plan
Cervical Screening	• Poor list and data quality (inflated lists) • Variable levels of performance in primary care. • Ethnicity and deprivation • Accessibility e.g. out-of-hours • Poor primary care engagement • Lack of public awareness	• New leaflets designed and sent to practices and libraries • Primary Care supporting practices to raise awareness • GP and health professional training • Comms and engagement strategy for patients developed. • Improvement strategy is being developed by Adult Screening Task Force. Second meeting taking place on 1st December.
All-age all-cause mortality (incl CVD and cancer)	• Linked to the demographic profile of the population of H&F.	• Staying Healthy programme. • Analysing types of cancer that are causing premature death to inform future planning
Maternity access	• Late referrals by GPs • Late initial contacts • Lack of awareness and cultural influences	• Referral forms have been improved. • Self-referral system in place. • Public Health promotion and information Campaign.
Childhood obesity Y6	• Provisional 2009/10 data has revealed that obesity in reception year pupils has reduced whilst in Y6 pupils obesity has increased. Data to be ratified in December	• Routine data quality checks to be carried out. • Data considered at Healthy Weight Healthy Life Task group in October • Analysis taking place to examine development from Yr R to Y6 and revise action plan
Childhood Immunisations	• Over-reliance on the Failsafe Team. • Awareness of importance of immunisations not optimal.	• Failsafe activity is now being coordinated by the Children's team at NHS H&F • Proactive plan to locate all 0-5 yrs children in borough and try to ensure they are immunised • Training programme for GPs and CLCH • Maintain current performance and improve one target to full achievement by year end.

Indicator	Reason for below par performance	Key activities to improve performance
Chlamydia screening	• Chlamydia Screening office was not providing satisfactory coordination role	• New provider Metrosexual has taken over the coordination role • Westside continues to provide clinical role
Patient Experience	• Target construction	•
Staff Satisfaction	• Changes to the NHS have an impact on staff satisfaction. • Achieving the management cost target has an impact on workload.	• Staff Engagement Group • Staff briefing • Support to staff during period of change
Primary Dental Services	• Target raised by DH in July from 62% to 66% by 2013. • New service at Canberra is not performing to target.	• Canberra service is being closely monitored to ensure continued increase in activity. Some activity has already been removed from Canberra. • Community Engagement strategy in White City • Remedial action may be taken with Canberra in the event of continued breach of contract. • Trajectory is challenging since it requires performance to hit target two years ahead of deadline

Existing commitments

Indicator	Reason for below par performance	Key activities to improve performance
Ambulance Cat B calls 19 mins	NWL monitor performance and provide a monthly performance report.	

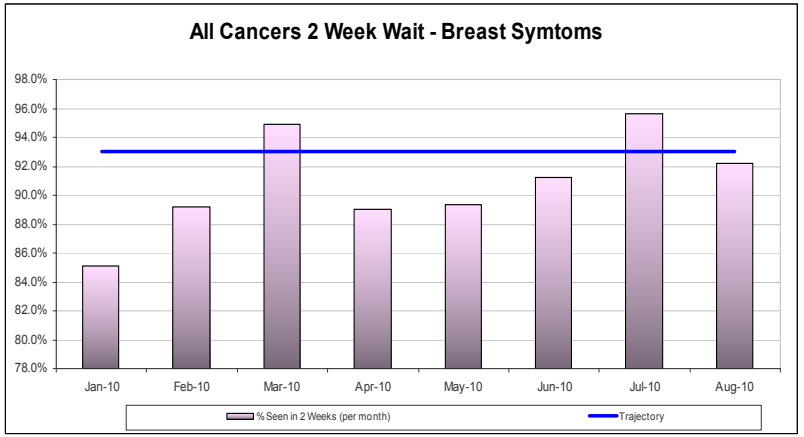
PERFORMANCE IMPROVEMENT PLANS

Cancer 2ww Breast Symptoms ▼	Lead Director – Miles Freeman	Target : 93%	Latest data 92.7% (August)

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
Results against the target will be closely monitored on a monthly basis during 2010/11 to address issues.	Results against the target will be closely monitored on a monthly basis during 2010/11 to address issues.	Results against the target will be closely monitored on a monthly basis during 2010/11 to address issues.	Results against the target will be closely monitored on a monthly basis during 2011/12 to address issues.	**Performance was again below the target of 93% with results in October at 90.5% leading to a year to date performance of 90.1%. The Lead manager is investigating the cause of recent breaches that influenced this reduction and will address any issues identified.**
Joint planning meeting to investigate difference in results from St Mary's compared with Charing Cross will lead to action plan.	Actions taken through Joint Planning meeting with ICHT will lead to achievement closer to that of K&C and W where target is being met.	Joint Planning meeting will continue to identify areas with potential to improve this target and to initiate work with GP practices whose patients have been shown to breach the target		**A member of the Primary Care team is progressing a programme with 9 GP practices with greatest number of breaches of the target, to improve communication with patients.**
Most breaches of this target relate to patients cancelling or postponing their appointments. NWLCN is preparing a GP Patient Leaflet to address this issue.	GP Patient Leaflet will be designed to reduce number of patients cancelling or postponing their appointments.	GP Patient Leaflet launched in October will lead to improvements in GP communication with patients		**The GP Patient leaflet has been launched**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, service in place as well as joint planning group	**Green, The effect of interventions can be measured**	**Green, milestones are on track**	**Red, Results show that performance continues to reduce and is below the target**	**Green, no current quality issues**	**Green, plans are reviewed monthly**	**Green, stakeholders both internal and external are included in planning meetings**



Breast Cancer Screening ▶	Lead Director – David McCoy	Target : 70%	KPI Lead: Adrian Mayers

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
Adult Screening Task Force to generate action plan to improve all adult screening Primary Care to support GP practices to raise awareness of breast screening programme and benefits	Review of pilot outcomes to inform future commissioning intentions based on most effective initiatives	Primary Care to support GP practices to raise awareness of breast screening programme and benefits	Primary Care to support GP practices to raise awareness of breast screening programme and benefits	**Breast Screening operational group meeting every three weeks to monitor action plan progress.** **Adult Screening Task Force is meeting regularly and an action plan is being monitored and progressed. Primary care were engaged to support GP practices to raise awareness.**
Phone and text messages to patients of H&F GP Practices scheduled for screening. Development of long term plan for pathway involving iPLATO and EHS	Refinement of long term plan for appointment uptake improvement with iPLATO and EHS	Continued improvement of uptake through iPLATO and EHS initiatives	Continued improvement of uptake through iPLATO and EHS initiatives	**Information governance concerning text and phone pilot were addressed initially and pilot through iPLATO commenced in September. For one GP Practice of 336 patients who DNA'd, 147 texts have been sent. Feedback on success is awaited. Patients of GP practices scheduled for screening in December and January are currently receiving reminder texts.**
Monthly SLA review meetings with ICHT Expected coverage 67.4% @ December 2010.	Monthly SLA review meetings with ICHT Expected coverage 69.9%@ March 2011.	Monthly SLA review meetings with ICHT Expected coverage 70%@ June 2011.		**3 yr SLA from April 2010 to incentivise ICHT to meet this target by 2011, by average across the Consortium. ICHT have also committed to provide data on "reason for attendance" to enable measurability of interventions but have not yet provided this**
Communities and engagement strategy will be developed	Open Day for patients with learning disabilities and possibly other groups at Charing Cross including breast screening awareness			**Initial Communities Engagement plan has been developed and will be further refined. Mailout has been sent to 125 organisations including 20 Housing Associations and to 42 Faith organisations. Community Engagement will follow up to check whether posters are visible.**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, SLA is in place. WOLBSS is working to achieve SLA	**Amber, effect of some interventions is not easily measured**	**Amber,**	**Amber, interventions are likely to improve performance but may not hit target**	**Green, No current issues**	**Green, regular reviews are in place**	**Green, stakeholders are engaged**

As data is only available annually, no meaningful graph can be created. The NWL Cancer Network has committed to provide quarterly or monthly data. A graph will be prepared as soon as this is available.

Stroke Care (TIA) ▲	Lead Director – Miles Freeman KPI Lead – Adrian Mayers	Target : 91.7%	Latest position: 64.3%

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
				Performance in Q1 was 58.3%. There were only 2 cases in Q2 and both were treated within 24 hours with the result that performance was 100%. The very low numbers of cases have meant that the CQC did not assess this part of the Stroke target in both of the last years. However NHS London continue to monitor our performance.
				Established TIA clinics on the HASU at CXH and at the SU at SMH – all referrals triaged upon receipt by Consultant or SpR and booked to come to the ward for clinic appointment same day (or at weekends – via A&E). Direct CNS support for each patient – from booking, managing all tests and imaging and session with Consultant = "one stop shop". Follow up via general neurology or stroke clinics. Admission to wards where necessary. Weekend service via A&E.
				Achieved 94% for quarter as an organisation (96% for CXH/HH and 90% for SMH).

Assessment of Progress against Improvement Plan

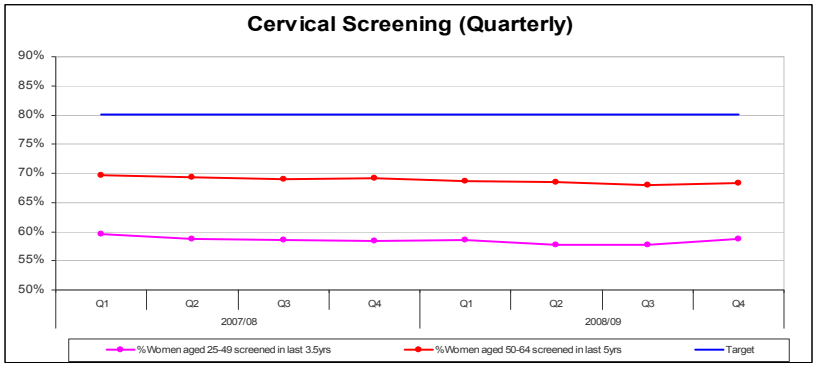
Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, No identified resource issues	Red, milestone interventions have not yet been identified	Amber, new milestones are yet to be identified	Amber, milestones are not yet identified so benefits cannot be realised	Amber, quality of milestones is not yet visible	Green, monthly reviews are set up	Green, stakeholders are engaged

Cervical Screening ▲	Lead Director – David McCoy KPI Lead – Clare Graley	Target : 80%	Latest performance: 2008/09 25-49 yrs: 60.4%, 50-64 yrs: 70.1%

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
List validation and removal of patients who have had returned letters continuing. Task Force in place to implement an action plan to improve performance	List validation and removal of patients who have had returned letters continuing. Task Force will continue to implement action plan to improve performance	List validation and removal of patients who have had returned letters continuing. Task Force will continue to implement action plan to improve performance	List validation and removal of patients who have had returned letters continuing. Task Force will continue to implement action plan to improve performance	**List validation is ongoing but practices are showing good co-operation with this scheme**
Start of a public health campaign for cervical screening taking place in community pharmacies. Production of new promotional materials linked to cervical screening to support this.	Increased examination of why people do not attend for cervical screening with focus groups. More work on the problems in different areas of the borough. Campaign involving hairdressers in health promotion	Engage with faith groups in the area to increase education and knowledge about cervical screening.	Look for other sources of community engagement and continue to engage with those already in place. Evaluation of work with pharmacies.	**The pharmacy campaign has started, new materials have been produced and training is completed. Visits to pharmacies have shown good performance.**
Roll out of project of inviting women for cervical screening through different methods of communication. Project evaluation will look at why women attended at CC4H and impact on uptake has been increased.	Write up of findings and agreed actions of visits and review contact. Intensive support to the 5 lowest performing practices (not including those in White City Health Centre)	Follow up of actions from the 5 lowest performing practices to see changes in practice and impact. Invite patients have cervical screening done at Canberra centre for health as a targeted catch up campaign.	Work with more practices in the borough more intensively. Evaluation of catch up campaign at Canberra.	**Communication project and evaluation have been postponed due to funding issues**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Amber, Funding issues and reduced staff	**Amber, effect of some interventions is not easily measured**	**Green, Milestones are being completed on schedule**	**Amber, milestones are on track. Performance is steadily improving but not sufficiently to meet target in 2010/11**	**Green, no quality issues identified**	**Green, monthly reviews are taking place**	**Green, stakeholders are engaged in the PCT and in GP practices**

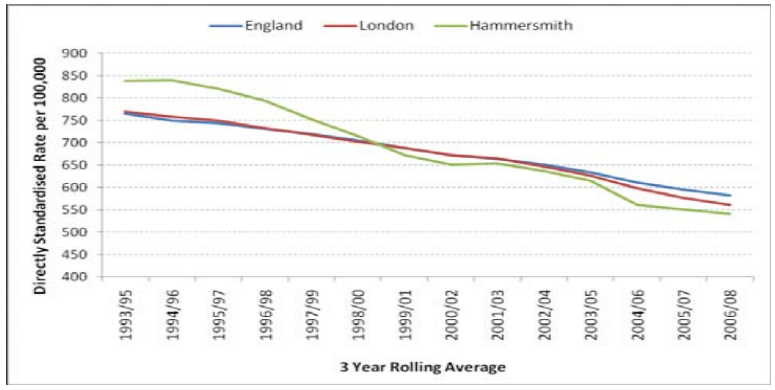


All Age All Cause Mortality ▼	Lead Director – David McCoy KPI KPI Lead: Alide Petri	Target : 563 (males) 377 (females)	Latest position: (2007-9) 647 (males) 398 (females)

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M7 (to October 2010)
The three main causes of AAACM in LBHF are CVD (34%), cancer (28%) and respiratory conditions (13%). Key in reducing CVD mortality is the NHS Health Checks programme.	NHS Health Checks take place in GP practices, pharmacies and at community events. Uptake will be reported and equity profile provided	NHS Health Checks programme: Uptake will be reported and equity profile provided	NHS Health Checks programme: Uptake will be reported and equity profile provided	**In 2009/10 3012 health checks were carried out in LVHF. Further health checks were launched in September to run in pharmacies and at various community events, to check people who do not normally attend GP surgeries. The aim is to check every LBHF resident aged 40-75 over the next five years. People identified as higher risk are referred to preventative services or given treatment to reduce their risk**
Improving quality of care for people with long term conditions	Reporting on: - Uptake and coverage of EPP (Expert Patient Programme) - Lung cancer awareness campaign	Reporting on: - Uptake and coverage of EPP - Lung cancer awareness campaign	Reporting on: - Uptake and coverage of EPP - Lung cancer awareness campaign	**Programmes include:** - **Service redesign** - **Increase uptake of EPP** - **Increasing lung cancer awareness among males 40-60 years**
Data finalised in August showed that the rate for premature cancer mortality increased to 117.5 (target 110)	Analysis of cancer mortality by BIU			**BIU is analysing cancer mortality. Action plans will be based on this report.**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, no resource issues identified	**Green, Effect of interventions can be measured/ observed**	**Amber, milestones are on schedule but some milestones not yet defined**	**Amber, Interventions are not guaranteed to meet target**	**Amber, some milestones are not yet defined, pending further analysis**	**Green, plan is reviewed monthly**	**Green, stakeholders are engaged**

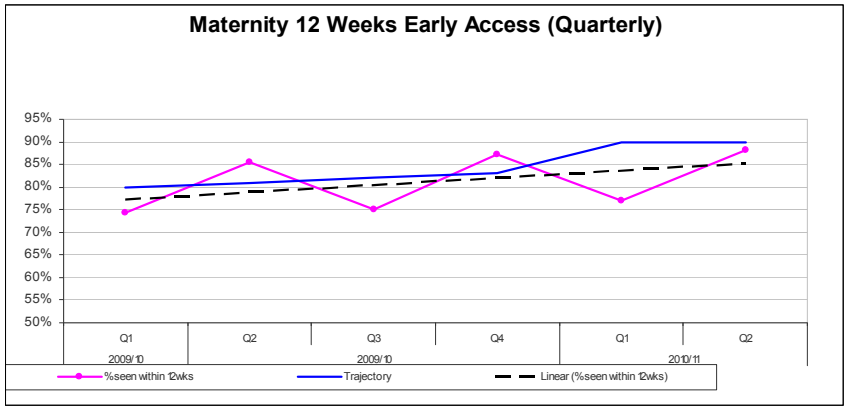


Maternity 12 wk ▲	Lead Director – Carole Bell Lead Manager – Julia Mason	Target : 90% Latest data: 88.2% (Q1+2)	End of year forecast: AMBER/GREEN

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
Monthly review of maternity provider performance and PCT 12 week access action plan. Submit refreshed VSMR data to DH in January	Review of Q1-Q4 data completeness and quality. Continued review of provider performance.	Continued monthly review of maternity provider performance and update of action plans	Continued monthly review of maternity provider performance and update of action plans	**The NHS London Performance Report gave a 'green' assessment for Q2. Year to date and forecast remains 'amber'. Providers continue to see >93% of women who are referred within 12 weeks and show steady improvement.**
Targeted health promotion and information campaign on early access to antenatal services. Includes briefings and campaign sessions with Health Champions and Trainers	Promote access to caseholding midwifery and community midwifery service. Health promotion campaign is continuing	Deliver and evaluate public health campaign and communication strategy	Deliver and evaluate public health campaign and communication strategy	**Some women present later than 12 weeks for their initial appointment with their GP, due to lack of awareness, apathy or cultural influences. Strategy to improve through public health campaign. Health promotion is running in parallel with the launch of the ICHT maternity helpline in December.**
Revised standardised antenatal form to be agreed by NHS London & amended on Map of Medicine	Primary Care communications will obtain feedback from the GPs on the new antenatal form			**Standardised antenatal forms have been agreed by NHS London and are now included in the Map of Medicine**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, No resource issues	**Green, effective-ness of intervene-tions will be measured**	**Green, milestones are robust and on schedule**	**Green, no current issues**	**Green, no current quality issues**	**Green, regular reviews are scheduled**	**Green, attending MSLC and working with Primary Care, stakeholders are engaged**



Childhood Obesity ▲	Lead Director – Carole Bell KPI Lead: Marie Trueman	Target : 12.6% (Reception) 22.8% (Yr 6)	Latest: 10.31% (Reception) 23.92% (Yr 6)

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
• Ensure review recommendations are implemented • Review of 2 schools with higher than average rates of obesity	• Improve understanding of local cultural and ethnic picture • Monitor "green" targets and focus on "amber/red" ones • Receipt and analysis of ratified NCMP data	Review CLCH dietetic contract to see whether any scope to provide support to H&F children		**Public Health has completed comprehensive review of local picture of child obesity. This has been incorporated into the JSNA for children and will influence commissioning intentions for 11/12** **2 schools with higher than average rates have been reviewed – good practice initiatives in place to target unhealthy behaviours**
• Quarterly task group meetings • Quarterly progress update against plan	• Quarterly task group meetings • Quarterly progress update against plan	• Quarterly task group meetings • Quarterly progress update against plan	• Quarterly task group meetings • Quarterly progress update against plan	**October (Quarter 3) task group delivered with action plan to be updated by Qtr 4 meeting**
• Review of membership and progress made • Share briefings with CET/DMT as appropriate to ensure buy in	• Involvement of GPs in task group and wider leadership/ governance arrangements to be explored	• Invite C3SP member to join task group (children's voluntary sector rep) • Identify local strategic lead/champion for child obesity		**GP attended Qtr 3 Healthy Weight Healthy Lives Task Group**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, No identified resource pressures	**Amber, effect of some interventions is not easily measured**	**Green, Projected milestone dates are OK**	**Green, No current issues.**	**Green, No current quality issues**	**Green, Plan is reviewed monthly**	**Green, Stakeholders are engaged**

Childhood Immunisations ▲	Lead Director – David McCoy Lead Manager – Ike Anya	Target: various (75-95%)	End of year forecast RED/AMBER

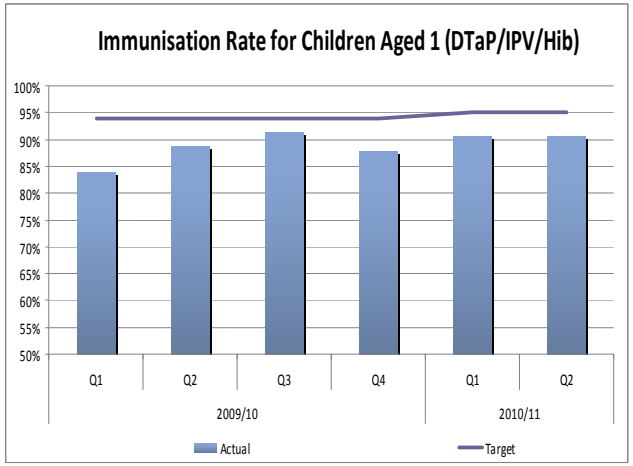
Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M7 (to October 2010)
Child Health Team will continue to collate records and provide call/recall service to GP Practices	Effectiveness of Child Health Team will be monitored and analysed. Any issues will be addressed	Monthly report provided by Child Health Team and monitored and analysed. Issues will be addressed	Monthly report provided by Child Health Team and monitored and analysed. Issues will be addressed	**Child Health Team at CLCH continues to provide a call/recall service to all GP practices including :** • **Scheduling of children due for imms** • **Lists to GPs and letters being sent out** • **Monthly reports identifying and addressing issues**
Failsafe Team will provide lists of any repetition, people who have moved away or wrong recording to the GP Practice Nurse Liaison (Gale Reece) who will liaise with GPs to ensure that lists are cleansed of these patients, to ensure that denominator of target is not inflated.	NHSH&F Children's Team will take over coordination of Failsafe function, liaising with Public Health through the monthly Turnaround Team meeting and ensuring continued improvement through Action Plan	NHSH&F Children's Team will take over coordination of Failsafe function, liaising with Public Health through the monthly Turnaround Team meeting and ensuring continued improvement through Action Plan	NHSH&F Children's Team will take over coordination of Failsafe function, liaising with Public Health through the monthly Turnaround Team meeting and ensuring continued improvement through Action Plan	**Agency nurse contracts will end by Dec 2010. Failsafe activity now being coordinated by the Children's Team at NHSH&F. An Action Plan has been produced to:** • **capture all 0-5 yrs children in the borough who are due for immunisations, whether registered with GP or not, and ensure immunisation as far as possible** • **clarify training requirements for GPs and CLCH** • **plan activity in relation to other immunisations eg school leaver booster** • **liaison with primary care to continue improvement of patient lists and poor performing practices**
Monthly turnaround team meetings continue to monitor progress on refreshed action plans	Focus on specific targets to have the greatest benefit for all immunisations and to achieve improved result against target at end of year	Monthly turnaround team meetings will continue to monitor progress and refresh action plans	Monthly turnaround team meetings will continue to monitor progress and refresh action plans	**Minimum performance to achieve amber for this target overall is 6 ambers and 1 green assessment. Performance in Q2 was amber for all targets. Decisions on which targets to give additional focus will be made at the next meeting.**

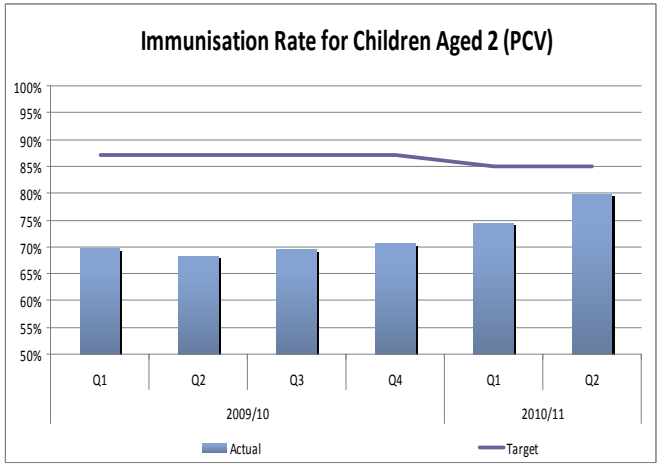
Assessment of Progress against Improvement Plan

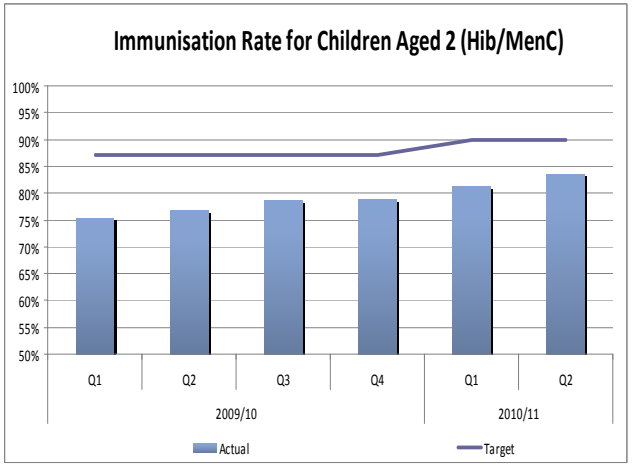
Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Amber, Plans in place to continue work of failsafe team through existing resources	**Green, Milestones that have been put in place are proving effective**	**Green, Milestones are robust provided failsafe Team responsibilities are continued**	**Amber, failsafe activity is effective but possible lack of continuity in future**	**Green, no quality issues**	**Green, Regular reviews of plans are in place**	**Green, stakeholders are fully engaged**

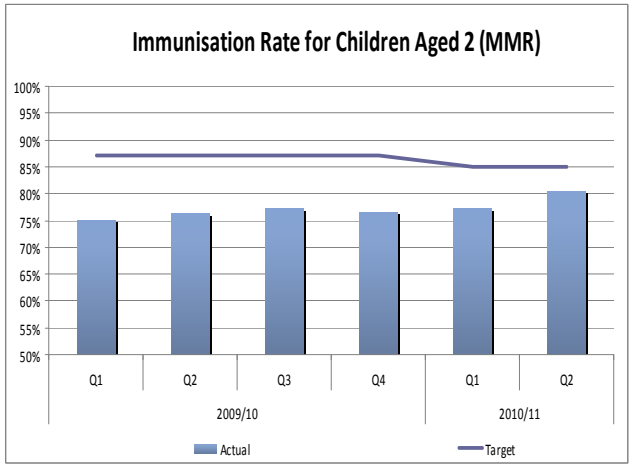
Graphs for childhood immunisation KPIs are included on the next page. Quarterly data for the 2 remaining immunisations targets are not available.

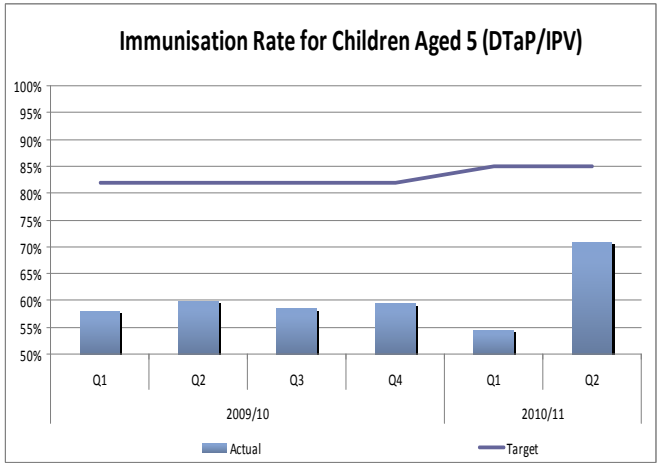
Childhood Immunisations ▲	Lead Director – David McCoy Lead Manager – Ike Anya	Target: various (75-95%)	End of year forecast RED/AMBER

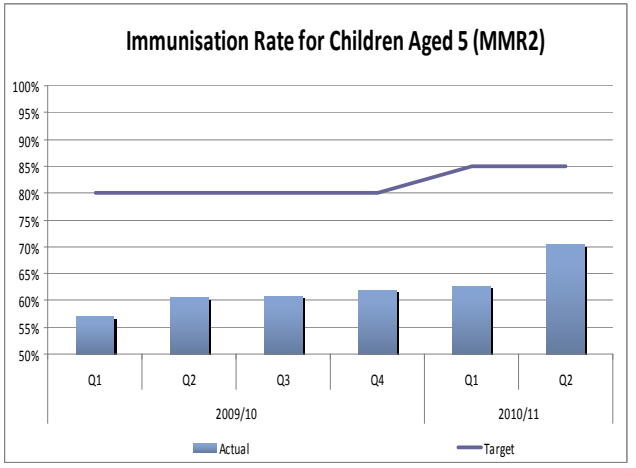










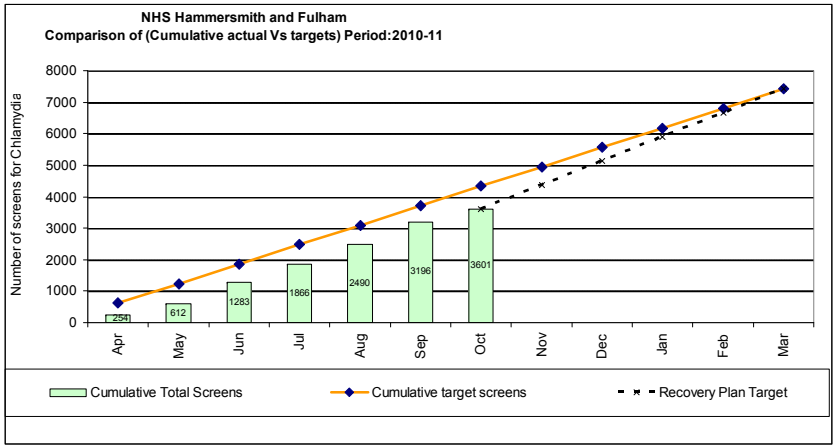


Chlamydia Screening ▼	Lead Director – Miles Freeman	Trajectory: (Oct) 4328 Latest YTD position: (Oct) 3601	End of Year Forecast AMBER

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
				Performance is now behind trajectory and would require 764 screens per month to recover. Forecast is amber.
A new structure for the Chlamydia Screening Office and possibly a new provider will be in place. Screening rates and data quality will continue to be addressed	Work with new contractor to ensure quality service	The continuation of the Chlamydia Screening programme is being reviewed and the National Chlamydia Screening Programme will advise		**The Chlamydia Screening Office contract has been divided between two providers: Metrosexual Health now provide the coordination role and Westside continue to provide the clinical element. The Sexual Health lead works three days a week with Metrosexual in a developmental role to ensure continuity of the programme.**
Continued work and monitoring screening levels with prison, core services – GP practices and outreach providers	Continued review and monitoring screening levels with prison, core services – GP practices and outreach providers	Maintain contact with outreach providers through regular contact updates and monitoring		**Work with the prison continues and shows steady improvement. Attending outreach providers meeting and review quarterly action plan. Held Chlamydia GP update evening with GPs and their practice staff incl feedback, refresher, lessons learned, way forward.**
Piloting pre-packed dispenser kits for pharmacies and GP practices to enable young people to self test easily	Continued reviewing and monitoring of all measures taken	Continued reviewing and monitoring of all measures taken		**Pre-packed dispenser kits have been rolled out to the 10 GP practices with the highest proportion of 16-24 yr olds. Considering newsletter for Christmas for core services.**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, new service contract now in place	**Green, Interventions can be measured**	**Amber, milestones are on track**	**Amber, new structure for the screening office is expected to result in meeting benefits**	**Amber, Quality of milestones is not assured until new screening contractor established**	**Amber, minor issues, plan is mostly reviewed regularly**	**Green, engagement with stakeholders is established**



Dental Access ▲	Lead Director – Miles Freeman KPI Contact: Alastair Foster	Trajectory (Nov) 109,509 Actual (Nov) 106,219)	End of year forecast: AMBER

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report
				The trajectory set with NHS London requires the target to be met in May 2011 whereas the actual confirmed deadline for meeting this target is March 2013. This means that although performance is steadily improving and we expect to meet the target by the deadline, we are substantially below trajectory, which is misleading. The forecast is to remain amber at the end of this year but to meet the target by March 2013. Our NHS London contact is looking into whether the trajectory can be altered.
Canberra Community Engagement group has been established for White City area. Dental Lead to attend this group and report on actions targeted at improving dental access in the area	Canberra Dental Lead will attend White City Community Engagement group and ensure that actions are being taken to improve access to dental care in the area.	Canberra Canberra's UDAs were reduced to 7500. With performance returned to trajectory the original allocation of 15000 UDAs will be returned	Canberra will be performing to plan.	**The 2008 Oral Health Needs Assessment identified unmet oral health need in the deprived parts of the borough and Canberra was set up to meet this need. However this has not yet converted into demand. 15000 UDAs were commissioned from the new service at Canberra, which suffered from IT problems at the outset and is currently performing below trajectory. 7500 UDAs have been removed from Canberra in 2010/11. The Dental Care lead expects that Canberra will steadily increase its UDAs and reach full potential in Q2 of 2011/12.**

Assessment of Progress against Improvement Plan

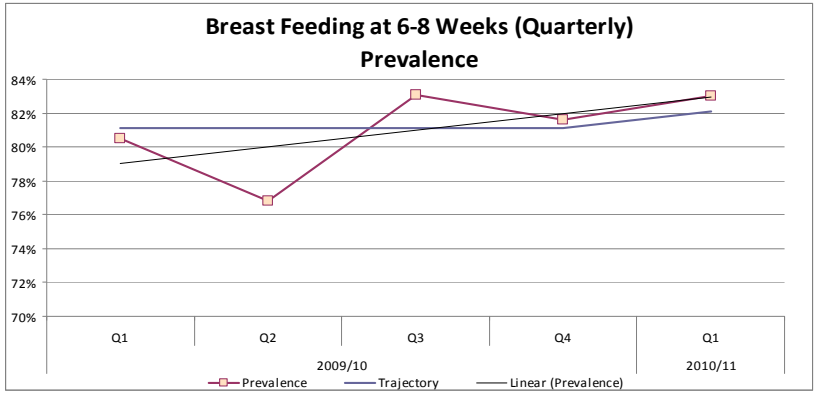
Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, No identified resource pressures	**Green, effectiveness of interventions is easily measured**	**Green, Milestones are on track**	**Amber, Target will be met by deadline but this is not reflected by trajectory**	**Amber, Quality of trajectory is under question**	**Green, The plan is reviewed monthly**	**Green, Stakeholders are engaged**

Breastfeeding ▲	Lead Director – Carole Bell Lead Manager – Julia Mason	Target : 82.1% Latest Position 83.4% (Q2)	End of year forecast GREEN

Milestones Q3 2010/11	Milestones Q4 2010/11	Milestones Q1 2011/12	Milestones Q2 2011/12	Progress Report M8 (to November 2010)
Children's Joint Strategic Needs Assessment will identify areas and populations with low breastfeeding rates.	Evaluation of impact of initiatives. Final data quality assurance exercise.	Plans for 2011/12 depend on the outcome of services specification across the cluster.		**Data for Q2 for H&F shows an increase to 83.4% for the quarter; CLCH have reported 100% for coverage, both of which are greatly improved results. The prediction for the target is green by the end of the year.**
Health champions engaged in breastfeeding initiatives. Proposal for Chelsea and Westminster become a UNICEF "Breastfeeding Friendly Environment".	Review effectiveness and provision of midwifery, health visiting, Children's Centre and voluntary sector breastfeeding support			**New health visitor is in place to provide breastfeeding support group in south of borough. Cluster model to make best use of resources. Draft Healthy Children's Centre Standards includes breastfeeding support and is currently being piloted**
New Family Nurse Partnership service aims to improve breastfeeding prevalence by 10% for participating teen mothers.	Review Family Nurse Partnership effectiveness in increasing breastfeeding prevalence			**The Joint Strategic Needs Assessment includes breastfeeding. The Breastfeeding lead manager will work with the GPs to inform commissioning. Data has been analysed and identified the areas with lowest breastfeeding prevalence and support is now being targeted to these areas.**
Medical Team will report on effectiveness of QOF+ incentivisation in December 2010	Review service specification across cluster for health visiting and child health including breastfeeding at end November			**Contract review meeting with CLCH took place at the end of November. Comparative analysis of children's service specifications related to provision of breastfeeding support is being undertaken across the cluster. Plans for next year are being agreed across the cluster.**

Assessment of Progress against Improvement Plan

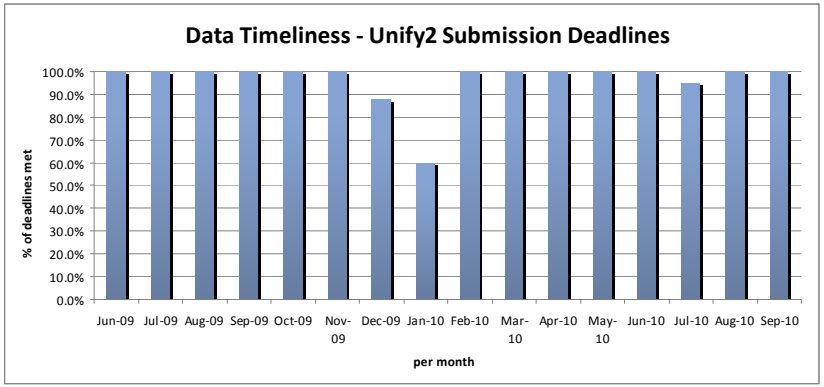
Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, no resource issues identified	**Green, effectiveness of inter-ventions will be measured**	**Green, milestones are on schedule**	**Green, no current issues**	**Green, milestones are robust**	**Green, regular reviews are scheduled**	**Green, stakeholders are engaged**



Data Quality	Lead Director – David McCoy		Target : 100% (all returns submitted on time)	
Milestones Q3 2010/11	**Milestones Q4 2010/11**	**Milestones Q1 2011/12**	**Milestones Q2 2011/12**	**Progress Report M8 (to November 2010)**
The December Quality, Performance and Finance Committee to review KPI data quality (Data confidence report Jun 10 – Dec 10). This report was due to be prepared in November	Data Quality will be absorbed by the BIU lead			**The BIU Lead has taken over the responsibilities with effect from the end of November when the Data Quality Manager left. The performance lead is meeting with the BIU lead to ensure that plans and systems are in place to provide assurance of data quality in future.**
Further refinements to DQ failsafe report to CET	Monthly submission and refinements of Failsafe report to CET	Monthly submission and refinements of Failsafe report to CET	Monthly submission and refinements of Failsafe report to CET	**Resourcing issues postponed refinements to the DQ failsafe report.**

Assessment of Progress against Improvement Plan

Resources	Effective-ness	Milestones	Benefits Realisation	Quality	Review	Stakeholder Engagement
Green, no identified resource issues	**Green, Interventions can be measured**	**Green, milestones are on schedule**	**Green, no current issues**	**Green, No quality issues identified**	**Green, reviews are in place**	**Green, No issues identified**



Section 3: **Criteria to determine Progress against improvement plan**							
Status	**Resources**	**Effectiveness**	**Milestones**	**Benefits Realisation (outcome)**	**Quality**	**Review**	**Stakeholder engagement**
Green	No identified resources pressures	Effect of interventions is easily measured/observed	On Schedule, projected milestone dates all OK.	No Current Issues. On track to achieve target and service improvement	No Current Quality Issues.	No current issues. Plan is reviewed regularly (frequency in line with target dependencies)	Provider/ commissioner stakeholders are fully engaged.
Amber	Minor identified pressures identified	Effect of some interventions is not easily measured/observed	In jeopardy of missing a milestone date – recovery plan in place.	Minor problems known or projected in meeting agreed benefits targets – recovery plan in place.	Minor problems with plan e.g. some milestones not defined or poor quality of intervention	Minor issues. Plan is mostly reviewed regularly (frequency in line with target dependencies)	Some provider/commissioner stakeholder engagement
Red	Significant pressure on resources	Effect of most interventions is not easily measured/observed	Has missed, or projected to miss key milestone. Note that this may be because of a dependency on another project.	Problems known or projected in meeting agreed benefits targets.	Significant problems with plan e.g. several milestones not defined and poor quality of interventions	Significant issues. Plan is rarely reviewed regularly (frequency in line with target dependencies)	Inadequate provider/ commissioner stakeholder engagement
	Normal mitigation and management are not working control resourcing	Unable to measure/observe effect of interventions	Normal mitigation and management are not working to control or correct the project schedule.	Normal mitigation and management are not working to meet agreed benefits targets.	Normal mitigation and management are not working to produce acceptable quality.	Plan is not reviewed regularly	No provider/ commissioner stakeholder engagement

2010/11 ANNUAL OPERATING PLAN DELIVERY REPORT - MONTH 08

Summary:

This report sets out progress against the delivery of programmes set out in the 2010/11 Annual Operating Plan, and cross-cutting enabling programmes, set out in the 2009-14 Strategic Plan and refined through CET. The programmes of work are collectively monitored by the Strategy and Planning Team, who work with programme managers, finance managers and the risk manager to monitor progress. The programmes of work are listed below:

Clinical Change Programmes:

- Maternity and Newborn
- Children and Young People
- Staying Healthy
- Mental Health
- Acute Care
- Planned Care
- Long Term Conditions
- End of Life Care
- Offender Health

Enabling Programmes:

- Continuity of Care (formerly Out of Hospital Support – programme in development)
- Informatics
- Transition (replaces Organisational Development, Integration, and Commercial Strategy)

This report for Month 08 (November) also contains more up-to-date information where available. The associated project budgets and identified savings for each programme are monitored through the central financial reporting process. Risks to successfully delivering the individual programmes have been captured in the organisation's risk register. Milestones from the Communications and Engagement programme relating to Expert Patients and Health Checks promotional activities have been inserted in the Staying Healthy programme.

Most activities are those set out in the Annual Operating Plan, additional information has been included where appropriate.

Board action required:
The Board is asked to:

- note the report and progress made to date on programmes;
- provide feedback on the headline reports

Responsible director: Tim Tebbs, Interim Borough Director	**Author:** Nick Day, Programme Manager

Date of paper: 7 January 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	The Annual Operating Plan sets out how we will deliver the 2010/11 elements of the Strategic Plan.

Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	None identified.
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	This plan was developed with commissioning leads and sponsoring directors.
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	Reducing health inequalities is one of our goals. It is one of our key outcomes that our plan seeks to address.
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	The Strategic Plan was subject to an equality impact assessment.

Achievements – key points to note for Month 08

Programme	Activity	Date Due	Progress	Comments
Maternity and Newborn	Community engagement for targeted ante-natal care.	Apr 10	Complete.	Timing needed to be linked to phone line go-live date.
	Maternity Matters Framework established to monitor joint investment with Westminster PCT	Jun 10	Complete	
	Imperial extend SLA with WLMHT to include peri-natal provision at Queen Charlotte's.	Oct-10	Complete	
	12-week assessments up to 88.2% (based on CQC calculation and 95.2% based on NHS London calculation)	-	-	Actual performance increased from 77% in Quarter 1 to 88.2% in Quarter 2. Target is 90%.
Children and Young People	6 month review of school nurse cluster team including cluster's heath needs analysis	Sep 10	In progress	School Health Service Review has commenced and should be complete Jan 2011.
	Develop specialist health visitor safeguarding project and evaluate the impact.	Jan 11	Complete	
Staying Healthy	NHS Health Checks implemented	Sep 10	Complete	Further update – 107 health checks were completed in first month of operation.
Mental Health	Number or people with mild or moderate mental illness moving off benefit each year	Sep 10	Target exceeded (30 by Q2)	By the end Quarter 2 2010/11, 86 people with mild or moderate mental illness had moved off benefit.
Planned Care	Improving Primary Care – Define minimum core standards, Implement balanced scorecard and segmentation, implement GP improvement plans and confirm Polyclinic Management approach for Charing Cross and WBR.	Sep 10	See comment	Local balanced scorecard refreshed for Q2, London-wide balanced scorecard may be delayed. Sector or cluster option under consideration as part of primary care commissioning design process.

Programme	Activity	Date Due	Progress	Comments
	Any Willing Provider contracting in place	Sep 10	In progress	Under review but may be used for commissioning enhanced long term condition management/ continuity of care in 2011/12.
	Meridian patient feedback mechanism implemented in all practices	Sep 10	Effectively complete	Web feedback available for all practices. Pilot being evaluated and positioning of kiosks optimised to increase use. Promotional posters and literature being developed.
Long Term Conditions	New services for diabetes and respiratory go live.	Oct 10	Complete	
Offender Health	Commence tender process (jointly with NHS K&C) for the Criminal Justice team to extend from courts in response to the Bradley report	Apr 10	Progress	Interim post in place funded by NHS H&F and K&C. NHS Westminster is now also involved and service specifications completed Nov 2010. The tendering process starts Jan 2011.
	Commence tender process (jointly with NHS K&C) for the Criminal Justice team to extend into police custody suites in response to the Bradley report	Apr 11	Progress	The current specification extends the DIP service to include screening for mental health and learning disability. This will be part of the tender if agreed by K&C.
Comms and Engagement	Resident satisfaction analysis. Baseline survey	Jun 10	See comment	National survey was stopped. LBHF local residents' survey being collated.
	4 new voluntary organisations to deliver EPP and 16 courses commissioned	Oct 10	Completed	

Strategic Risks

o The key risk that could prevent successful delivery of the Operating Plan is **financial**; this is due to the impact of the savings programme and the commitment

to delivering management cost savings which could lead to resource constraints. This will be mitigated by routine monitoring, escalating issues, and prioritisation.

- There is a risk that implications of the programme are not considered widely enough in programme and project planning i.e. **internal resource constraints in the context of staff reductions.** This is being mitigated by routine monitoring and escalating issues when necessary as well as prioritisation and developing cluster arrangements to provide cross-cover and support.
- There is a risk that, as the sector and clusters develop, **visibility could be lost at a local level.** Maintaining a borough based director should mitigate against this.
- **Governance:** lines of responsibility and accountability for delivery of various programmes could become blurred during the transition to GP consortia commissioning with a risk that outcomes are not realised fully and in a timely way.
- There is a risk that benefits from **the demand management programme** are not realised. This is being mitigated through monitoring in the Acute Performance report, and through the Long Term Conditions programme.

Board action required

- note the report and progress made to date on programmes;
- provide feedback on the headline reports

Next Key Milestones

Programme	Activity	Date Due	Comments
Maternity and Newborn	Map services providing support for women with peri-natal MH problems	Jan 11	
Children and Young People	Year One evaluation of the Immunisations Failsafe team	Jul 10	Moved to Nov 10 (one year of operation) but not completed due to management constraints. Immunisation performance has improved
	6 Month Review of School health cluster team model	Sep 10	To be completed end Jan 2011.
	Analysis of Boost service usage data, specifically around health inequalities	Jan 11	Started. Further work to evaluate the programme is planned with public health support.
Staying Healthy	Complete training of health workers (at 3 GP practices) and midwives to be able to identify and refer victims of domestic violence on to support services	Jan 11	
Mental Health	Commence IAPT evaluation	Sep 10	Evaluation is on hold pending the savings programme.

Programme	Activity	Date Due	Comments
Planned Care	Improving Primary Care - Sign off balanced scorecard.	Sep 10	London-wide scorecard may be delayed. Sector or cluster option under consideration.
	Any Willing Provider contracting in place	Sep 10	May be used to commission enhanced LTC management/ continuity of care in 2011/12
Long Term Conditions	MSK: Reaching agreed percentage reduction for diverting inappropriate referrals from secondary care to the new service	Mar 2011	
End of Life	Local needs analysis and review of potential service redesign to improve care and value for money	Jul 10	(As previous reports) Further work required to re-cast programme in view of savings and other changes in health context
	Increase capacity and resource for specialist palliative care posts to deliver non cancer agenda of end of life pathway	Jul/ Sep 10	
Offender Health	Commence tender process (with K&C) for the Criminal Justice team to extend from courts in response to the Bradley report	Apr 10	Interim post in place funded by NHS H&F and K&C. NHS Westminster is now also involved and service specifications will be complete by Nov 2010. The tendering process starts Jan 2011.

Programme Implementation

1. The table below provides a summary of the status of the actions, outcomes, finances and risk of each programme. Risks reflect the final submission of the Operating Plan. The outcome data for Quarter 2 has been provided where it is available.

2. Finances are monitored through the financial reporting processes and not through this report.

Programmes	Projects and Actions	Outcomes	Risk	Comments
Maternity and Newborn	G	G	G	12 week access target and associated risk has moved from red to amber.
Children and Young people	G	A	A	Immunisations targets and associated risk are currently amber, though have improved. Moderate risk around safeguarding assurance.
Staying Healthy	G	A	R	The savings programme may have significant impact on achieving the programme outcomes.
Mental Health	A	G	A	There are some high target-related risks.
Acute Care	G	G	R	We continue to monitor closely high risks around successful delivery of the Demand Management Programme.
Planned Care	A	A	A	Issues in the informatics programme could affect the timely delivery of the programme milestones and fail to fulfil GP expectations.
Long-term conditions	G	A	G	New services are now live. Outcome data not available until Jan 2011.
Continuity of Care (was *Out of Hospital Support*)	A	A	A	Programme detail being developed.
End of Life	A	A	A	Amber status requested by CET as EOL strategy not yet approved.
Offender Health	G	G	A	Risks remain moderately high.
Transition	G			
Informatics	A		A	Full programme of work to be confirmed.

BOARD ASSURANCE FRAMEWORK

Summary:

The Board Assurance Framework (BAF) sets out the key risks to achieving the Board's objectives, the controls in place to prevent those risks from materialising and the assurances that the Board receives that the controls are effective. It also includes the gaps in control and assurance and the actions to fill those gaps.

This is an update to the paper that was reviewed by the Audit and Risk Management Committee on 8th December.

Board action required:

The PCT Board is asked to accept the risks as stated and to agree that the actions to provide assurance are satisfactory.

Responsible director: Tim Tebbs	**Author:** Ben Westmancott

Date of paper: 11th January 2010

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	This document sets out the main risks to achieving the organisation's objectives
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	None identified
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	This has been developed with directors of the PCT.
Health Inequalities (How does this report support the reduction of health inequalities in H&F)	Not applicable
Single Equality Scheme (Has the report been equality impact assessed and quality assured)	Not applicable

NHS HAMMERSMITH AND FULHAM

Board Assurance Framework

1. INTRODUCTION

1.1 The Board Assurance Framework (BAF) sets out the key risks to achieving the Board's objectives, the controls in place to prevent those risks from materialising and the assurances that the Board receives that the controls are effective. It also includes the gaps in control and assurance and the actions to fill those gaps.

1.2 Since the previous report to the PCT Board, a review of the entries has taken place. This consisted of:

- Cross-referencing between the BAF entries and the risk register;
- A review by each director of their allocated entries, supported by the Risk Manager; and
- Review of the BAF by the members of CET.

1.3 The Board should also note that the Risk Manager has left the organisation. Business continuity plans are being enacted across the cluster to ensure that risk receives appropriate attention.

2. KEY CHANGES SINCE THE PREVIOUS VERSION

2.1 There are currently 18 risks on the BAF, one more than previous report to the Board. Of these 6 are high risks, rated 15 and above. The remaining 12 risks are scored moderate, rated 9 to 12. Since the previous report the risk rating for 1 risk has been reduced. Entry 4: GP services not meeting patients need and expectations has reduced from 16 to 12 as the controls have reduced the likelihood of the risk materialising. The new entry, number 18, was identified by the Audit and Risk Management Committee. It is the risk that the PCT is unable to close the 2010/11 accounts on time due to reductions in staffing numbers. A resource plan is being developed to control this.

2.2 Actions have been identified with directors to provide assurance that gaps in providing controls are being addressed.

3. NEXT STEPS

3.1 An internal audit of the assurance framework was carried out in November and the recommendations are being finalised. It is intended that advice and guidance from this audit will be used to continue with the NHS HF BAF, but more so to inform the production of a cluster-wide BAF that will need to be in place from 1 April 2011.

4. RECOMMENDATIONS

4.1 The PCT Board is asked to accept the risks as stated and to agree that the actions to provide assurance are satisfactory.

Board Assurance Framework - Reference Sheet

Vision	Goal No	Goal	BAF Reference	Risk Register Reference
NHS hammersmith and Fulham will improve the health of the local population	Goal 1	Enable and support health, independence and well-being	1	391
	Goal 2	Give people more control of their own health and healthcare	2,3	319, 398
	Goal 3	Improve patient experience by offering timely and convienant access to quality, cost effective care	4,5,6,7	48, 398, 464
	Goal 4	Proactively tackle health inequalities	8	393
	other	Enablers	9,10,11,12, 13,14, 15, 16, 17	All KPI Risks High risks, 34, 39,117, 159, 160, 163, 177, 183, 277, 315, 319, 345, 377, 378, 380, 382, 363, 397, 441, 445, 446, 456, 457, 461, 462, 465,

BOARD ASSURANCE FRAMEWORK 2010/11

Updated: November 2010 (with additional updates following amendments agreed at the Audit and Risk Management Committee)

BAF Ref	Risk Register ID	Principal Risks	Accountable Director	Impact	Likelihood	Risk Rating	Key Controls	Source of Assurance	Results of assurance	Gaps in Control / Assurance	External impact factors	Actions to provide assurances and controls	Date for Actions / Review
Goal 1 – Enable and support health, independence and well-being													
1	391	**That we cannot positively influence sufficiently people's lifestyle choices and other determinants to deal with the drivers of poor health**	**David McCoy**	**5**	**3**	**HIGH (15)**	• Public Health Directorate work plan • Community Engagement Team • Risk register • Integrated management agreement	• Performance Reporting • Integration with Local Borough • Stronger and better co-working with commissioners through JSNA	• Minutes from CET/QPFC/Board	•Lack of a coherent Information, Education, Communication Plan (IEC) • Transition Plan to cluster arrangements and GP Consortia	•High unemployment •De-regulation of commercial sector • Public sector budget cuts	•Develop a more coherent plan for IEC in conjunction with cluster leads •Strengthen public health across inner NWL cluster •Promote importance of health trainers and health champions to GPs (e.g. Through showcasing in the Annual Public Health Report)	April 2011
Goal 2 - Give people more control of their own health and healthcare													
2	319	**Risk of failing to find people with disease and patients not being place on relevant GP disease registers**	**Josip Car**	**4**	**2**	**MODERATE (8)**	•QOF+ programme (Health Checks) •iCAP (automatically generating disease registers) •Balanced scorecard looks at practice disease prevalence •Community Health checks from Pharmacies • QOF+ evaluation programme for ICHT.	•Performance reports to CET, QPFC and Board •Practice visits •QOF+ Steering Group meets on a monthly basis •Regular meetings between the medical directorate and primary care commissioning to discuss ways of improving GP performance •QOF+ mail box	• Performance against QOF+ assessments and feedback from clinicians currently used to inform revision of indicators and support/ training packages • Practice Handbook which helps to identify patients has been sent out to all Practices as a hardcopy and electronically •GPs able to access their performance indicators • Quarterly reporting on new cases identified through health checks	•Process to improve screening and lung cancer awareness •Regular BIU search that can be run to pick up cases as a result of health checks		•Plan to transmit iCAP information from GP's to PCT (currently GP only) •Screening taskforce group meeting monthly to monitor improvement • Lung cancer campaign to raise awareness of symptoms	January 2011 March 2011 January 2011
3	398	**People are not aware of the choices available to them to make appropriate decisions about their healthcare**	**David McCoy**	**3**	**4**	**MODERATE (12)**	• Benchmarking of services • Communications Department • NHS choices •New external website	• Communications Action Plan • Equalities, Patient and Public Engagement Strategy 2009-2012 • Engagement and health trainers.	• CET reporting	•IEC Strategy for health improvements • Low Choose and Book performance	• Responding to and implementing the Public Health White Paper •Enhanced role for LINks	•Developing local health watch •Choose and Book improvement • Annual Public Health Report chapter.	April 2011
Goal 3 - Improve patient experience by offering timely and convenient access to quality, cost effective care													

BOARD ASSURANCE FRAMEWORK 2010/11

BAF Ref	Risk Register ID	Principal Risks	Accountable Director	Impact	Likelihood	Risk Rating	Key Controls	Source of Assurance	Results of assurance	Gaps in Control / Assurance	External impact factors	Actions to provide assurances and controls	Date for Actions / Review
4	48	**GP services not meeting patients need and expectations**	**Miles Freeman**	**4**	**3**	**MODERATE (12)**	• Additional Practices in place to address needs • Performance management • Extended hours contract improving access • Health care assistant (HCA) training for non clinical staff • GP balanced score card data is now in the data warehouse enabling local report generation.	• Performance Management Group reports to Part 2 Board Meeting. • Balanced scorecard monitoring	• Priority setting based on areas identified in the balanced scorecard. • High QOF scores compared to other PCTs nationally.	• NWL developing Transforming Primary and Community Care programme.		•London balanced scorecard being developed • Work in progress with PBC Consortium to define a quality assurance process for implementation based on quality indicators for agreement by clinicians, patients and the Commissioner. •Continuity of Care work stream •Investigating Royal College of GPs accreditation to improve quality • Develop materials for the public about GP performance • Improve the quality and standardisation of data collection amongst GPs	January 2011 Ongoing April 2011
5	398	**Patient demand for healthcare exceeds expected contracted capacity and financial envelope**	**Miles Freeman**	**4**	**4**	**HIGH (16)**	• Acute Commissioning Vehicle • Governance structure • Sector strategy •Strategic Plan • Financial monitoring •Managing Director is the SRO of ACV	• ACV Business Group • Polysystems programme • Prioritisation Board •Demand Management monitoring	• Winter pressure management • Waiting list management •Rehabilitation beds reduced •Outpatient referrals increasing	•Performance management of acute contracts and use of contract levers •Chelsea and Westminster activity data requires improvement	Impact of new Government reforms	•Development of referral system by PBC. •Working with the ACV to manage contracts and use contractual levers to manage demand. •Continuing engagement with GPs regarding demand management schemes	January 2011
6	415, 417	**Transforming Community and Primary care programme is not successful in designing and delivering adequate services to shift patient care into primary & community settings**	**Miles Freeman**	**4**	**4**	**HIGH (16)**	• PEC oversight of service redesign • Financial and activity model outsourced to McKinsey via NWL sector • Financial monitoring & control	• PEC • Board seminars and Board •GP Forums •CET monitoring reports	• PEC minutes • Board seminars and Board reporting	•Transition Plan needed •Role of PBC		•Role of PBC to be agreed •Developing Transition plan •Out of Hospital work stream •Role out use of Map of Medicine and Encompass	Ongoing

BOARD ASSURANCE FRAMEWORK 2010/11

BAF Ref	Risk Register ID	Principal Risks	Accountable Director	Impact	Likelihood	Risk Rating	Key Controls	Source of Assurance	Results of assurance	Gaps in Control / Assurance	External impact factors	Actions to provide assurances and controls	Date for Actions / Review
7	464	**Inadequate healthcare provision for prisoners leading to poor health outcomes including avoidable death**	**James Reilly**	**3**	**4**	**MODERATE (12)**	• Quarterly Prison Partnership Board chaired by lead director and includes prison governor. • Prison Safety and Governance Board monitors quality of care delivered in the establishment to reduce risk and improve access to healthcare services.	• NHS H&F agreed a proposal from Central London Community Healthcare and Central and North West London Foundation Trust to integrate healthcare services in HMP Wormwood Scrubs. ` •CLCH recruited an Associate Director for Offender Health and Mental Health Services	• Minutes from Quarterly Prison Partnership Board • HR KPI monitoring for Prison	• Stronger governance structures and the need for a new set of commissioning/ provider relationships to be established		• Working with the Prison and healthcare partners to ensure the recommendations from the Prison Patient Ombudsman are implemented • Offender Health Commissioner is working with CLCH to deliver a robust contract that will manage the risks associated with the secure environment.	Ongoing
Goal 4 - Proactively tackle health inequalities													
8	393	**Not identifying and engaging the people with the biggest needs (inequalities)**	**David McCoy**	**4**	**3**	**MODERATE (12)**	• JSNA • Operational Research and secondary data from internal and regional surveys • Single Equality Scheme • Health checks in community pharmacies trial •Health trainers and champions •Expert Patient programme •Connected Care	• Equalities, Patient and Public Engagement Strategy • Outcome from the trail of health checks in community pharmacies	• Equalities, Patient and Public Engagement Action Plan • Equality Steering Group minutes.	•Continuation of effective community engagement team •Transition Plan • Patient level data	•Achieving the management cost target •Change in NHS	•Strengthening community engagement to be able to reach and empower people. • Health trainers and champions •Enhancing local intelligence capability through further development of BIU	All: April 2011
Enablers													

BOARD ASSURANCE FRAMEWORK 2010/11

BAF Ref	Risk Register ID	Principal Risks	Accountable Director	Impact	Likelihood	Risk Rating	Key Controls	Source of Assurance	Results of assurance	Gaps in Control / Assurance	External impact factors	Actions to provide assurances and controls	Date for Actions / Review
9	All KPI risks 277, 345, 446, 461, 462	**Not achieving improvements in quality of services by 2011**	**Josip Car**	**3**	**3**	**MODERATE (9)**	• Implementation of KPI Improvement Plan 2010/11 •Quality development visits by clinical leads to GPs • QOF+ programme • Annual Operating Plan 2010/11	• Improvement action plan • KPI reports • Performance meetings with key staff • Weekly Performance Reporting to CET • Monthly Board reporting • Reporting to Quality, Performance & Finance Committee (QPFC) • Collaboration between Performance Team and Accountable Director	• Minutes from CET/QPFC/Board • Risk analysis of each KPI • Year end forecast performance against KPI	• Achieving management cost target may impact of capacity and capability to deliver	CQC do not provide a periodic indication of the rating	•Ongoing collaboration between Performance Team and Accountable Director •Bi-weekly monitoring of milestones in Improvement Plan •Improvement Opportunities Group to be set up to oversee delivery of savings programme	Ongoing
10	117, 315, 319, 382, 441	**Failure to provide complete, accurate and timely information effectively to inform business decisions**	**David McCoy**	**4**	**3**	**MODERATE (12)**	• Collaboration; Academic/Research • BIU • JSNA	•Reports generated from BIU and JSNA • Progress made with information on patients with hospital admissions	•Strategic Plan informed by JSNA	• Further BIU development for full implementation • Sector capacity to deliver timely and accurate information	•Changes to health system and potential disruption of work plans	• Further development of the BIU • BIU linking hospital and GP data	April 2011
11	34, 39, 363, 397, 456, 457	**Lack of adequate finance prevents delivery of plans fails to achieve control total**	**Tim Tebbs**	**4**	**3**	**MODERATE (12)**	•Identification of savings plan •Medium Term Financial Plan •Strategic Plan •Operating Plan	•CSP programme reviews •Monthly CET reporting •Financial reporting to QPFC & PCT Board •External & Internal audit, annual review •Monitoring of savings plan by PMO and Finance	•Minutes from meetings •Satisfactory external audit •Positive opinion from Internal audit on adequacy and application of financial controls	•Savings plan not fully identified •reprioritisation of investment plan required •Overspend on Acute expenditure	•White Paper updates •NWL financial recovery of challenged Trusts •Management cost realisation	•Detailed project plans to report savings delivery reviewed on a monthly basis •Action plan to be developed for reducing acute expenditure • Actions to identify further £1m contingency to be refined follwing discussions at the Board Seminar on 16th December	Ongoing to Q4 January 2011

BOARD ASSURANCE FRAMEWORK 2010/11

BAF Ref	Risk Register ID	Principal Risks	Accountable Director	Impact	Likelihood	Risk Rating	Key Controls	Source of Assurance	Results of assurance	Gaps in Control / Assurance	External impact factors	Actions to provide assurances and controls	Date for Actions / Review
12	377, 378, 380, 445, 465	**Inability to retain or develop staff to have the required skills to deliver the change**	**Sarah Whiting/ Miles Freeman**	**4**	**4**	**HIGH (16)**	•NWL, NHSL, CSL support •Staff Engagement Group •Mentoring Programme • Additional focussed training and support commissioned by NHS Westminster.	•Reporting of staff numbers •Training programmes • Workshops and 1:1 sessions taking place from Oct 2010 to support staff during the period of change.	• HR performance scorecard and management reporting to Equality Steering Group. • Remuneration & Workforce Committee	•Identification of resources required from key programmes •Pace of change •Transition Plan •Completion of training programmes	•65% management cost reduction plan • White Paper	•Develop Transition Plan and develop plan for developing the inner NW London cluster. •Ongoing mandatory training programmes for all staff • Cluster organisation/consultation	December 2010/ January 2011
13	39, 177	**Risk that the externally controlled contracting regime does not allow sufficient control over quality and cost of services**	**Miles Freeman**	**3**	**3**	**MODERATE (9)**	•Clinical Governance Team • Allocated Commissioner for each commissioning programme •Contract management and commissioning process, through the Commissioning Team •Quality, Finance & Performance Committee •ACV	• Quality Assurance Framework (QAF) • Reporting of performance and cost	• Minutes from CET/QPFC/Board	•Overspend on Acute expenditure •Lack of specific action plan on acute expenditure reduction		• New arrangements of Cluster Director of Acute Commissioning and Performance should enabe greater control	December 2010/ January 2011 and ongoing
14	159, 160, 163, 378, 401	**Changes to NHS commissioning structures (development of the sector and cluster) reduces control over services with potential adverse impact on outcomes**	**Sarah Whiting**	**4**	**4**	**HIGH (16)**	• SLA Commissioning Partnership/Sector • Cluster Chief Executive in place. • Cluster directors in place	• JCPCT and Operations Group •Executive report to each Board meeting	•Minutes and reports from JCPCT to the Board - Board discussion on ways to strengthen the JCPCT • Board minutes	• Revised roles and functions of the sector • New SLA to cover changes needed • Less people to deliver • Cluster arrangements not yet in place.	NHS White Paper - Liberating the NHS agenda	•Develop Transition Plan for PCT clusters •Develop management of ACV	December 2010/January 2011
15	183	**Liberating the NHS - loss of focus on commissioning outcomes during the transition phase.**	**Sarah Whiting**	**4**	**4**	**HIGH (16)**	• GP engagement in the ongoing development and delivery of our plans • NWL sector leading on Transforming Primary and Community Care Programme	• Bi-monthly GP Forums • PEC involvement PBC Steering Group • JCPCT • NWL Clinical Working Groups	• Action Plan for increased GP engagement • Minutes and reports from JCPCT to the Board	•GP lead for each programme needs to be identified •NWL Transition Plan		•Integrating GP consortia representatives in to decision making processes •Work with the NWL sector to develop Transition Plan	Ongoing

BOARD ASSURANCE FRAMEWORK 2010/11

BAF Ref	Risk Register ID	Principal Risks	Accountable Director	Impact	Likelihood	Risk Rating	Key Controls	Source of Assurance	Results of assurance	Gaps in Control / Assurance	External impact factors	Actions to provide assurances and controls	Date for Actions / Review
16	39, 456,	**The PCT is unable to deliver the savings plan to support the sector financial strategy**	**Tim Tebbs**	**4**	**3**	**MOD (12)**	• Monthly reporting to CET • Bi-monthly Board reporting • Reporting to Quality, Performance & Finance Committee (QPFC)	• Savings Plan paper	• Minutes from CET/QPFC/Board • Risk analysis of individual financial aspects	•Savings action plan needs to be completed •Insufficient headroom to ensure savings target delivered in year	•New government impact •Capital budget allocation	•PMO to monitor savings plan delivery	End of March 2011
17	457	**The PCT is unable to achieve the management cost target for 2010/11**	**Tim Tebbs**	**4**	**3**	**HIGH (12)**	•Initial Plan in place to reduce posts from total establishment • NWL cluster PCT's set up • MARS	•Interim Director of Finance reports to Board meetings (bi-monthly)	•Interim contracts have not been renewed	•NWL Transition Plan		•Work with the NWL sector to develop Transition Plan to move towards cluster PCTs • Voluntary Redundancy Scheme	March 2011
18	tbc	**The PCT is unable to close the 2010/11 acounts on time due to reductions in staffing numbers.**	**Tim Tebbs**	**4**	**3**	**HIGH (12)**	• Close working with the auditors on requirements and timetable for closure • Audit Committee included in discussions	• Audit Committee minutes recording discussions.	• Consistent arrangements being agreed across the cluster	•Possibility of key staff leaving prior to accounts closure.	• changing commissioning regime.	• Development of resource plan	March 2011

NHS HAMMERSMITH AND FULHAM
CAPITAL AND ESTATES UPDATE – JANUARY 2011

Summary:

NHS Hammersmith and Fulham is committed to the implementation of an Estate Strategy which will provide modern, fit for purpose accommodation for the future delivery of health and social care services.

The attached paper updates the Board on the progress of a number of priority estates and capital projects.

Board action required:

The Board is asked to NOTE the content of the report.

Responsible director: Miles Freeman, Director of Commissioning	**Author:** Sue Hardy, Director of Estates

Date of paper: 5th January 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	The delivery of the Estate Strategy is critical to the PCT delivering its Commissioning Strategy Plan.
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	Where appropriate advice is obtained from the PCT's lawyers and the District Valuer.
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	The opportunity to develop new facilities for the integrated provision of health and social care services is a key objective of the PCT's Estate Strategy
Health Inequalities (how does this report support the reduction of health inequalities in H&F)	The implementation of the Estate Strategy ensures the provision of fit for purpose, compliant accommodation for the safe delivery of healthcare.
Single Equality Scheme (has the report been equality impact assessed and quality assured)	N/A

CAPITAL & ESTATES UPDATE REPORT – JANUARY 2011

1. INTRODUCTION

This paper provides the Board with an update on the current status of a number of estates projects.

2. LIFT PROJECTS

2.1 White City Collaborative Care Centre

The business case for White City development was submitted to the SHA for comments in November 2010. The SHA reviewed the document and returned it with their feedback and further queries. These queries have been allocated to various parties including staff at the PCT, Fundco, Frontline, WLHE and the PCT solicitors.

As part of the funding options for this project the PCT requested assurance from the SHA that the £5m contributed to the Sector in 2010/11 will be returned to the PCT as capital and that the PCT will be allowed to retain the receipts from property disposal to be used to fund any gap in capital allocation. This assurance was given.

The revised business case will be submitted to the SHA by the end of January 2011 and if no further queries are raised the PCT will receive "a letter of comfort" from Paul Bauman – Director of Finance NHS London as authority to proceed with the project.

Financial close is now expected to happen in June 2011, with the project completing mid 2013.

2.2 Bridge House Centre for Health

Practical completion and handover of the site to the PCT took place on the 26th November 2010 as programmed.

The commissioning and move plan for the practices and other services relocating to the facility have progressed well and the Sands End Practice will be operational from the site from the 10th January 2011 and Dr Das and Partners from the 17th January 2011.

3. PRIMARY CARE PREMISES DEVELOPMENTS

3.1 Shepherds Bush Health Facility

The PCT has prepared a strategic case for this proposed development to be consideration by the Board.

Negotiations between the PCT, District Valuer and developer regarding the cost of the development are underway and the outcome of these negotiations will form part of the final business case.

The development of the new health facility is dependent on Board approval, planning consent, District Valuer value for money opinion, the PCT agreeing the Heads of Terms and agreement to lease the premises and availability of capital funds in 2011/12.

3.2 Maystar

Practical Completion of this development was achieved on 17th December 2010, a week delayed due to inclement weather.

The North End Road practice relocated to the new facility on the 20th December 2010.

This project is now closed.

3.3 The Brook Green Medical Centre

Following amendments to the proposed development of this site due to planning restrictions a revised proposal was considered by the Capital and Estates Committee at its meeting held on the 5th November 2010.

The Committee gave in principle support to the development but stressed the need to develop a strong operational policy to ensure the maximised use of space and increased service delivery.

The Committee also discussed the potential delivery and funding route for the development which required further consideration and discussion with the practices involved.

Following a meeting with the practices to discuss the view of the Committee, a draft business case for the proposed development has been submitted to the PCT by the practice and will be considered at the Capital and Estates Committee meeting scheduled for the 18th January 2011.

3.4 Improvement Grants

The practices receiving improvement grants are responsible for completion of the works by the 31.03.11 and work is reportedly underway.

4. REVIEW OF THE ESTATE STRATEGY

The Board agreed to approve the strategy for consultation with General Practitioners, the Council and the public. It was agreed that the consultation process should ensure that there is clarity as to whether the Council and General Practitioners are willing to give their endorsement to the strategy and that the outcome of this should be reported to a future Board meeting.

As a number of projects identified as priorities in the previous estate strategy have now reached successful completion an invitation will be extended to Board members to visit a number of new sites early in the New Year.

5. PRIMARY CARE FACILITY, CHARING CROSS HOSPITAL

The second phase of work at Charing Cross is now complete and services have commenced.

No decision has been taken regarding phase 3, which will be dependant on the PCT's capital position.

6. PCT HEADQUARTERS

The successful relocation of PCT Headquarters from Hammersmith Broadway to the Town Hall extension took place at the end of November 2010.

7. CAPITAL PLAN 2010/11

The PCT total capital allocation for the year of £3.13m is now fully committed. Year-to-date spend is £2m with an additional £430k already committed. With 3 months left in the financial year budget-holders are now increasingly being monitored to ensure all funds are utilized and the capital control total met. The PCT does not foresee any risk to the outstanding 707k remaining to spend for the year.

8. LOCAL DEVELOPMENT FRAMEWORK (LDF)

As reported previously the PCT has formally responded to the consultation on the LDF.

9. RECOMMENDATION

The Board is asked to note the content of this report.

Sue Hardy
Director of Estates
January 2011

AUDIT & RISK COMMITTEE

Minutes of the meeting

Wednesday 8th December 2010, Hammersmith Town Hall Extension

Present

Peter Worthington (PW)	Non-Executive Director, Chair
Trish Longdon (TL)	Non-Executive Director
Liz Rantzen (ER)	Non-Executive Director

In attendance

Tim Tebbs (TT)	Interim Director of Finance
David McCoy (DMc), Items 6.1 & 6.2	Interim Director of Public Health
Golda Okpala (GO)	Deputy Director of Finance
Sarah Whiting (SW), Item 11.1	Inner NW London Cluster Chief Executive
Ben Westmancott (BW)	Associate Director, Strategy & Planning
Nick Atkinson (NA)	Internal Auditor, RSM Tenon
Jon Hayes (JH)	District Auditor, Audit Commission
Julian McGowan (JM)	Audit Manager, Audit Commission
Andy King (AK)	Local Counter Fraud Specialist
Maureen O'Sullivan (MO'S)	Deputy Board Secretary, Minutes
Kieran Seale (KS)	Company Secretary, Minutes

		ACTION
1	**Welcome and introductions**	
1.1	The Chair welcomed all present.	
2	**Apologies**	
2.1	Apologies were received from Jeff Zitron.	
3	**Declarations of interest**	
3.1	There were no declarations of interest.	
4	**Minutes of meetings**	
4.1	The minutes of the meeting of 17th September 2010 were approved.	
5	**Matters arising**	
5.1	Reviewing the follow-up actions from previous meetings, the Committee noted: (a) the provision of an IT service shared with NHS Kensington & Chelsea with effect from 6th December 2010. NHS Westminster are expected to join by the end of March 2011 (58/09). (b) that risks associated with business continuity in the process of transition would be covered within the internal audit plan (30/10). (c) the assurance from Trish Longdon that discrepancies noted between electronic and paper records of staff training had no impact on the safety of children.	

5.2	Reviewing the follow-up actions from the 2009/10 audits, the Committee: (a) requested that an up-to-date set of HR policies be sourced, for example, from NHS Westminster (10/25). (b) requested that all the follow-up actions relating to IT be grouped together. (c) noted that the PCT had been unable to produce a finalised and signed-off memorandum of accounts for 2009/10 within the deadline because the Council's accounts were only finalised in June 2010 (10/56).	
6	**Assurance and Corporate Governance**	
	Board Assurance Framework (BAF)	
6.1	(a) The issue of risks relating to the provision of, and satisfaction with, GP services were referred to the Quality, Performance & Finance Committee. Ben Westmancott agreed to provide a briefing on the measurement of performance, actions taken in response and the management of such risks during transition (**34/10).** (b) The Committee agreed to add the risk of a gap in control in relation to the need for a new set of relationships to be established for the remainder of the period during which the PCT was responsible for offender healthcare to the Board Assurance Framework (**35/10)**. (c) The Committee also agreed to add a risk relating to being able to close the 2010/11 accounts on time in the context of staff reductions (**36/10)**. (d) The Committee noted that risks in relation to the work of HR in the context of impending redundancies and the transition to cluster working would be discussed at the first meeting of the Integrated Management Team. (e) The Committee accepted the risks as stated and agreed that the planned assurance actions were satisfactory.	**BW** **BW** **BW**
	Risk Register	
6.2	(a) David McCoy introduced the Public Health directorate's risk register, noting the risks arising from lack of staff continuity and reduced morale. He drew the Committee's attention to current plans for the future role of public health. The Committee noted that public health risks had been discussed by CET on 30th November 2010 and within the directorate two to three weeks prior to that. (b) The Committee noted the risks as set out in the risk register and agreed to sign off the closure of risks as set out in the report.	
	Review and update of SFIs and SOs	
6.3	Kieran Seale informed the Committee that a single set of Standing Financial Instructions (SFI) and Standing Orders (SO) would be drafted for the three PCTs in the Inner NW London cluster. A paper on this would be going to the Board on 16th December, with a view to having them in place by 1st April 2011. The Committee agreed that, in the event of the Audit Committee's approval of the new SFIs and SOs being required, this could be obtained from the Chair and Non-Executive Directors outside the meeting.	
	Review of Audit Committee Terms of Reference	
6.4	The Committee noted that a single set of committees and terms of reference would be drawn up for the cluster. In the meantime, the Committee was content for the current terms of reference to remain in force.	
7	**Current year audits – 2010/11**	
	Internal audit progress report	

7.1	Nick Atkinson (RSM Tenon) gave an update on the internal audits that have been carried out since the last meeting. Financial Forecasting was rated Green, and thanks was given to the Finance team for their hard work in this area. Complaints was rated Amber/Green. The proposal to seek feedback from those making complaints was discussed and it was agreed that a form should be made available on the PCT website (rather than being sent to all complainants). The audit on Transforming Primary Care is underway. The focus for future internal audit work was discussed and it was agreed that Nick Atkinson will contact the new Cluster Director of Finance (who takes office on 13th December) regarding priorities. The report was noted (**37/10)**.	**NA**
	Safeguarding children audit	
7.2	This item was deferred to the March 2011 meeting.	
	Continuing care audit	
7.3	A full report will be available in February 2011.	
	External audit progress report	
7.4	Jon Hayes gave an update on the status of the Audit Commission. The Commission is due to be abolished but the timescales are unclear as legislation is needed. He then gave a presentation on the Payment by Results (PbR) Data Assurance Framework, expressing the hope that the data will be useful as a spur for further research. The report was noted.	
	Impact of formation of Inner North West London cluster on sign-off of 2010/11 accounts	
7.5	The implications of the creation of the Cluster were described to the Committee. It is proposed to move to a single set of Board committees from 1st April 2011, but to continue with individual Audit Committees until the accounts for 2010/11 are signed off. The Committee endorsed this approach but asked that the Director of Finance draw up a resource plan, to be signed off by the Chief Executive, to provide assurance that there are sufficient resources available to ensure the continuity of financial management after the change (**38/10)**.	**TT**
8	**Counter Fraud**	
	Counter fraud progress report	
8.1	Andy King reported that there have been no new fraud referrals and that two on-going matters have been concluded. The report was noted.	
	Strategic fraud risk assessment	
8.2	It was noted that the PCT has received a green rating in the assessment.	
	Qualitative assessment guidance 2010	
8.3	The guidance was noted.	
	Qualitative assessment 2010	
8.4	It was noted that the PCT is rated as Level 2, despite receiving green ratings in the assessment. Andy King agreed that he would investigate this issue. There are concerns arising from the transition to the new Cluster organisation. Nick Atkinson agreed to consider if there are lessons that can be learnt from elsewhere (**39/10)**.	**AK** **NA**
9	**Financial Control Report**	
	Quarterly governance return	
9.1	The return was noted.	

	Month 7 finance report	
9.2	Tim Tebbs reported that the PCT is still forecasting that it will achieve its financial targets. The report was noted.	
	Financial control report	
9.3	The proposal to write off a debt owed to an employee of £4,060.98 was approved. It was noted that the events took place some time ago, at a time when the HR function was being transferred from Central London Community Healthcare to the PCT. The Committee was however concerned about the length of time that had passed since the incident and asked that in future issues be reported up the line management chain as soon as they arise. The report was noted.	
	Update on sector financial position	
9.4	Noted.	
	Procurement report – waivers of SFIs and SOs	
9.5	No waivers had been issued. The report was noted.	
10	**Business from other PCT committees**	
10.1	The minutes of the Quality, Performance & Finance Committee meeting of 21st October 2010 were noted.	
10.2	The minutes of the North West London Sector Audit Committee Chairs' meeting of 22nd November 2010 were noted.	
11	**Any other business**	
11.1	<u>Implementing a common financial system</u> (a) The Committee discussed an outline business case for a new common financial system to support the Inner North West London cluster to be provided by NHS Shared Business Services (SBS). Comments on the proposal made by the internal and external auditors were considered. Sarah Whiting (Cluster Chief Executive) told the Committee that there is an urgent need to implement the system to address financial control weaknesses. (b) The Committee endorsed the business case on the basis that the proposal would provide suitable enhancement of control in the transition to cluster working and would offer cost savings in the longer term. (c) The Committee noted that protection for any future GP consortium was provided by a break clause after two years (provided that at least 30 days' notice is given). (d) The Committee recommended that the PCT's internal auditors be involved in the project team during the transition phase. (e) The Committee will recommend to the Board the adoption of the revised system.	
12	**Actions to be referred to the PCT Board**	
12.1	See item 11.1.	
13	**Date and time of next meeting**	
13.1	• Friday 11th March 2011, 9.30am (unless otherwise advised).	

QUALITY, PERFORMANCE & FINANCE COMMITTEE

Minutes of the meeting
Thursday 16th December 2010, 1 Hammersmith Broadway

Present

Liz Rantzen, Chair (ER)	Non-Executive Director
Trish Longdon (TL)	Non-Executive Director
Peter Worthington (PW), items 1-4, 9-11	Non-Executive Director
Miles Freeman (MF), items 1-11	Director of Commissioning
Tim Tebbs (TT), Items 1-3, 9-11	Interim Director of Finance

In attendance

Nick Day (ND)	Programme Manager
Golda Okpala (GO) items 1-11	Deputy Director of Finance
Julia Mason (JM), items 5-7	Maternity & Children's Commissioner/Interim CLCH Contract Manager
Shelley Shenker, items 12-13	Joint Head of Mental Health, Strategy & Performance (item 12 onwards)
Tim Spicer, items 6-17	GP Consortium Chair
Kieran Seale (KS)	Company Secretary (Minutes)

		ACTION
1.	**Apologies**	
1.1	Apologies were received from David McCoy, Ike Anya, James Reilly, Frances Donnelly, Ben Westmancott and Josip Car.	
2.	**Minutes of meetings**	
2.1	The minutes of the meeting of 21st October 2010 were approved.	
3.	**Matters Arising**	
3.1	See Matters Arising report. It was agreed that the Matters Arising report should be circulated in January to encourage those with actions to respond to them (**61/10**).	**KS**
4.	**Acute: Imperial NHS Trust/Chelsea & Westminster NHS Trust**	
4.1	The report on Acute performance was considered. It was agreed that the data was not presented in the most useful format and that using the Standard Monitoring Report format would be more helpful. It was agreed that further consideration should be given to this issue at the next meeting.	

5.	**Central London Community Healthcare (CLCH)**	
5.1	It was noted that a number of productivity measures are showing improvement, although there are still data and reporting issues and there is concern about CLCH's failure to deliver promised improvements. It was agreed that Liz Rantzen will raise the continuing concerns regarding CLCH's failure to deliver promised improvements at the PCT Board (**62/10**).	**LR**
5.2	The report was noted.	
6.	**Transforming Primary & Community Care**	
6.1	The development of a balanced scorecard was discussed. It was agreed that Tim Tebbs will co-ordinate the production of a note showing the direction in which monitoring will go, having regard to patient experience, safeguarding and incidents. A list of items that could be included in the scorecard will be drawn up, discussed with the GP consortium and brought to the February meeting of the Committee (**63/10**).	**TT**
6.2	The committee noted the report.	
7.	**Standard Monitoring Report**	
7.1	The format of the monitoring report was welcomed and it was agreed that consideration should be given to using it for other providers.	
8.	**GP Consortium**	
8.1	Tim Spicer gave an update on the work of the GP Consortium. It was noted that the Consortium Steering Group will now be a major driver of decisions in the PCT.	
9.	**Finance**	
9.1	Tim Tebbs gave an update of the financial position of the PCT. The proposed saving schemes have been reviewed and it has been necessary to abandon some of them as they were not expected to deliver as hoped. There has been some deterioration in areas such as Acute over-performance so that it has been necessary to release more of the contingency reserve, which is now all allocated. It has been possible, however, to reach agreement on a fixed level of payment to Imperial for the current financial year. Another area of concern is bed-watch pressure (offender health): three-way discussions are now scheduled with the Prison and Central London Community Healthcare to bring these under control.	
9.2	The issue of investment in controlling prescribing costs was discussed. It was agreed that investment in control of prescriber costs can both improve clinical quality and save money. **The Committee agreed to recommend to the Board that this should continue as a specific workstream, with additional resource allocated to it if necessary.**	
9.3	Overall Tim Tebbs expressed a reasonable degree of confidence that it will be possible to meet the PCT's financial targets.	
9.4	Trish Longdon asked whether cost savings have threatened the meeting of the Chlamydia screening target. Tim Tebbs agreed to investigate this and report back to the next meeting (**64/10**).	**TT**
9.5	The report was noted.	
10.	**Month 7 Annual Operating Plan Delivery Report**	
10.1	Progress with delivery of the PCT's operating plan was discussed.	

10.2	An update was requested from Carole Bell as to why deadlines for the Children & Young Persons part of the plan have been put back (**65/10**).	**ND**
10.3	The report was noted.	
11.	**Month 7 Performance Report**	
11.1	A performance review has recently been held with NHS London, who are happy with the progress being made.	
11.2	The progress that has been made in meeting the immunisation targets was acknowledged.	
11.3	The report was noted.	
12.	**West London Mental Health Trust**	
12.1	The desirability of involving the GP Consortium in mental health issues was discussed. Shelley Shenker will meet Tim Spicer and a colleague who specialises in this area, to discuss.	
12.2	Liz Rantzen expressed concern about the impact of cuts in the voluntary sector on services. The importance of monitoring this issue closely was agreed.	
12.3	The report was noted.	
13.	**Offender Health**	
13.1	Meetings are being held with Central London Community Healthcare to look at how costs can be controlled.	
13.2	It was agreed that Shelley Shenker should produce an update on the impact of the Offender White Paper on diversion schemes for the next meeting of the Committee (**66/10**).	**SS**
14.	**Commissioning Infection Prevention Committee Minutes**	
14.1	The Minutes of the meeting of 14th October were noted.	
15.	**Forward Plan**	
15.1	The next meeting of the Committee is likely to be the last before the integrated structure for the Cluster is put into place. It was therefore agreed to put the handover to the new Committee on the Agenda for that meeting.	
16.	**Any Other Business**	
16.1	Miles Freeman will circulate the latest Demand Management Update to members of the Committee (**67/10**).	**MF**
16.2	Kieran Seale will put the date of the next meeting in Tim Spicer's diary (**68/10**) and Tim was thanked for his contribution to this meeting.	**KS**
17.	**Date and time of next meetings** – the next meeting would be on Thursday 17th February 2011 (2pm to 5pm).	

NHS Hammersmith and Fulham

Equality Strategy Group (ESG)

Meeting Minutes

Thursday 9 December 2010, 10am - 12pm
Room 1, 6th floor, Hammersmith Town Hall Extension, King Street W6 9JU

Chair	Trish Longdon
Note-taker	Maureen O'Sullivan
Present	Samira Ben Omar – Head of Engagement Brian Colman – Head of Inclusion, NHS Westminster Carly Fry – Equality Manager, LB Hammersmith & Fulham Rosie Glazebrook – Non-Executive Director Malika Hamiddou – LINk Co-Chair Bev Lavall – Head of Human Resources Susan McGoldrick – GP Commissioning Steering Group Jonathan McInerny – Equality & Human Rights Manager Charles Oduka – Community Engagement Manager Jane Wilmot – Disability Forum Kay Wong – Diabetes User Group
Apologies	None received

3	**Minutes of the last meeting**	**Trish Longdon**
• The minutes of the last meeting, held on 9 September 2010, were approved.		
Actions	**Person responsible**	**Deadline**
• Work on internet (including translation of some pages into community languages) is ongoing	Tom Stevenson Jonathan McInerny	Post-meeting
• Savings programme – Samira Ben Omar reported that four consultation events had taken place on the effects of the savings programme, and Charles Oduka agreed to circulate a written report	Charles Oduka	Post-meeting
• A further consultation event would be needed in the New Year on Quality, Innovation, Productivity and Prevention (QIPP), as decisions on cuts would need to be made soon	LINk & Charles Oduka	Late January/early February 2011
• The group would like to support GPs and the new cluster to develop representative patient groups with a clear role	Cluster	Ongoing
• Bev Lavall updated the group on measures to support staff in the merger process, with local and sector-level Equality Impact Assessments to take	Bev Lavall	March 2011

place by the end of March 2011 • Jonathan McInerny reported that two-thirds of PCT staff had attended training on equality and diversity, and CET had had a separate training session – an audit would be conducted in February 2011 • The group discussed the possibility of providing equality and diversity training for future GP commissioners with a view to their carrying out managerial and statutory responsibilities to reduce health inequalities	Bev Lavall Cluster	Late February 2011 Ongoing

4	**Future of ESG in the light of the emergence of the Inner NW London Commissioning Cluster**	**Jonathan McInerny**
• The group discussed how best to document and share its legacy and provide support to the cluster and GP colleagues.		
Actions	**Person responsible**	**Deadline**
• A half-day workshop to be held at the beginning of March 2011 to celebrate the successes of the PCTs in engagement, equality and diversity, to share learning and to hand over that learning to those who would be leading and delivering this work in the future.	Jonathan McInerny	Post-meeting

5	**Equality Impact Assessment (EqIA) for 2010/11 savings programme and consultation on 2011/12 savings programme**	**Jonathan McInerny**
• Jonathan McInerny reported that, largely because of the in-year nature of the savings required, it had been difficult to carry out an EqIA of the 2010/11 savings programme. However, it was important that consultation and engagement on future savings took place, linked with consultation on QIPP. Cluster and sector EqIAs would also be important. The group endorsed the recommendations of the written report, but decided that the figures should not be shared externally because they were not reliable.		
Actions	**Person responsible**	**Deadline**
• Carry out consultation/engagement on QIPP	Charles Oduka	End February 2011
• Carry out EqIA on QIPP and savings initiative	Commissioning directors & Jonathan McInerny	End February 2011

6	**Reducing child oral health inequalities in Hammersmith and Fulham**	**Julia Mason**
• Julia Mason presented an overview, highlighting the needs of population groups experiencing or at risk of poor oral health. She acknowledged that insufficient information was available on the needs of disabled children. Children's oral health was poor in the borough, with – for example – dental extraction under anaesthetic the main cause of hospital		

admissions between 2007 and 2010. It was proving difficult to recruit dentists to the group of child-friendly dentists, although a registrar was carrying out outreach work with dentists and in special schools. Integration between general practice and dentistry was poor. The Council had formed a task group to investigate children's oral health. The ESG endorsed the recommendations of the written report.

Actions	Person responsible	Deadline
• Check the impact of planned £125,000 savings and whether the future of the *Brush for Life* programme was secure	Julia Mason	End February 2011
• Julia Mason and Susan McGoldrick to meet to discuss preparing and sourcing information to help GPs signpost dental services	Julia Mason/Susan McGoldrick	End February 2011

7	Diabetes Service User Group	Christine Mead Kay Wong

• This service redesign model had been very successful as an example of engagement and consultation, in addition to supporting service users productively. The ESG endorsed the recommendations in the report, congratulated everyone involved and agreed that the process should be written up so that it could be replicated in other areas in the future.

Actions	Person responsible	Deadline
• Request that the GP consortium steering group sign off the Diabetes Service User Group Patient Charter	Susan McGoldrick	Post-meeting

8	Date of next meeting	Trish Longdon

The next meeting would be half-day workshop at the beginning of March 2011, the exact date to be determined. Colleagues from Westminster and Kensington & Chelsea PCTs would be invited, together with GP representatives. The aims of the workshop were to celebrate the successes of the PCTs in engagement, equality and diversity, to share learning and hand over that learning to those who would be leading and delivering this work in future.

NHS North West London

NHS North West London
Joint Committee of the PCTs (JCPCT)

Minutes of the meeting held on 13th October 2010
in the Great Hall, Fulham Palace, London SW6 6EA

PRESENT

Peter Molyneux	JCPCT Chair/Chair, NHS Kensington & Chelsea
Marcia Saunders	Chair, NHS Brent
Andreas Lambrianou	Chair, NHS Hounslow
Phillip Young	Chair, NHS Ealing
Jeff Zitron	Chair, NHS Hammersmith & Fulham
Joe Hegarty	Chair, NHS Westminster
Martin Roberts	Chair, NHS Hillingdon
Chandresh Somani	Audit Chair, NHS Brent
Anne Rainsberry	Chief Executive, NHS NWL
Robert Creighton	Chief Executive, NHS Ealing
Patricia Wright	Chief Executive, NHS Kensington & Chelsea
Michael Scott	Chief Executive, NHS Westminster
Sarah Whiting	Managing Director, NHS Hammersmith & Fulham
Mark Easton	Chief Executive, NHS Brent and Harrow
Yi Mien Koh	Chief Executive, NHS Hillingdon
Nick Relph	Chief Executive, NHS Hounslow
David Slegg	Director of Finance, NHS NWL
Mark Spencer	Clinical Director, NHS NWL

IN ATTENDANCE

Nigel Coomber	Director of Performance & Contracting, NHS NWL
Daniel Elkeles	Director of Strategic Planning, NHS North West London
Adrian Pollitt	Corporate Governance Adviser, NHS London
Richard Segall Jones	Governance Lead, NHS North West London
Georganne Toomey	Head of CPO & Transition Lead, NHS North West London
Heather Lawrence	Chief Executive, Chelsea and Westminster Hospital NHS Foundation Trust (for item 6)
Yvonne Robertson	Lead Director of HIEC, Chelsea and Westminster Hospital NHS Foundation Trust (for item 6)

OBSERVING

Kim Rollinson	Leadership & Management Fellow (Clinical Directorate), NHS North West London
Rebecca Rawesh	Leadership & Management Fellow (Clinical Directorate), NHS North West London

APOLOGIES

Gillian Schiller	Chair, NHS Harrow
Dennis Abadi	CEC Chair, NHS Westminster

ITEM **DISCUSSION**

1. Welcome, introductions and apologies

Peter Molyneux welcomed the group and apologies were given.

2. Minutes of the meetings held on 15th September 2010

The minutes of the previous meeting were agreed as a correct record.

3. Chair's and Chief Executive's Reports

As all key matters were to be covered on the agenda, the Chair and Chief Executive did not give reports.

4. Finance stock-take

David Slegg advised the committee that the overall financial picture disguised some deficits attributable to SLA pressures and CIP slippage. He added that the Month 6 report would offer a good indication as to whether remedial action was working (where required) and also clarify the position on management cost reductions. NHS North West London was in discussion with NHS London about how the sector might use centrally held contingency funding to meet redundancy costs over the 2010/11 and 2011/12 period without being disincentivising those PCTs which had already set reserves aside for this purpose.

In response to questions, David Slegg reported that:

- he had confidence in those PCTs currently forecasting a year-end break even position and that he now had a more detailed understanding of what was needed to eliminate deficits in PCTs facing in-year cost pressures. He believed he would have only limited flexibility to assist in terms of access to NHS London contingency funding;
- it was difficult to explain why SLA over-performance was not reflected in provider surpluses although it was believed that income assumptions played a part. It was known that provider performance on CIPs was close to target;
- the sector Challenged Trust Board (CTB) was due to hold its inaugural meeting in October with its November meeting scheduled to address the position at North West London Hospitals NHS Trust. David Slegg agreed to circulate information on the CTB's activities to committee members. **DS**

Anne Rainsberry suggested that the Month 6 report, together with the mid-year reviews due to take place imminently, would offer a good steer on the action needed to ensure financial balance at year end. Jeff Zitron felt that a contingency plan, articulating the sector's proposed approach in the event of on-going financial difficulties, would offer the committee reassurance.

JCPCT was concerned that the financial position, and the measures necessary to achieve a healthy year end position, be clearly understood. It was agreed that the November JCPCT meeting would receive a thorough update on the Month 6 financial position, together with proposals for correcting any adverse performance identified.

5. Performance Report – Month 5

Nigel Coomber summarised his report adding that NHS London had asked NHS North West London to continue work with North West London Hospitals NHS Trust on their preparations for winter pressures. Anne Rainsberry stressed that it would be important to address this with the Trust now that its financial position had been clarified.

Sarah Whiting pointed out that legitimate repeat procedures needed to be borne in mind when assessing SLA volumes in future. Nick Relph reminded the committee that a new version of Choose and Book was about to be released and the sector needed to improve performance in this area.

6. North West London Health Innovation Education Cluster report

Heather Lawrence, Chair of the Operational Group of the North West London HIEC, presented a brief introductory report along with the HIEC's newly appointed Director, Yvonne Robertson. They explained that it was central to HIEC's mission to align workforce education, innovation and research with the North West London strategy and give added value via practical support

Key Performance Indicators were to be developed in year one and delivery against them was required to secure funding in year two. The two key areas for the HIEC were the use of technology and surviving cancer. The first area would seek to bring about a reduction in new to follow-up ratios while the second area would aim to diffuse good practice. It would also be vital for the HIEC that the introduction of innovation translated into professional education so that latest best practice could be spread.

In discussion, it was suggested that:

- the transfer of knowledge from professionals to carers be considered;
- monitoring be undertaken to ensure that the work of the HIEC fully reached minority ethnic people;
- the NWL JCPT would facilitate the appointment of key people from GP leadership and PCT(s) management to the partnership and operational boards of the HIEC, delegating this to discussion between Mark Spencer, Heather Lawrence and Marcia Saunders, who chairs the Partnership Board. **MSp**

7. Strategy update

i) Update on emerging commissioning strategy

Following Daniel Elkeles's presentation, discussion covered the following points:

- that the sector should be wary of using external help at a time when so many staff faced uncertainty. Anne Rainsberry responded that key sector staff would be very much involved but that the scale and urgency of the exercise entailed the need to procure temporary external assistance. This would, of course, be appropriately tendered.
- a key enabler would be to focus on GPs as providers of care in changing practice;
- there would be a need to build resilience into the strategy to enable it to survive beyond the demise of the PCTs.

ii) ICO Project update

It was agreed that there would need to be incentives for GPs if they were being required to take on more work. If successfully rolled out across the sector, however, the ICO benefits might deliver half of the savings required in the strategic period.

8. Delivering Management Costs and Managing Transition in North West London: update and implementation proposals

Adrian Pollitt was working on guidance and proposals to ensure appropriate governance arrangements for the merged PCT management teams and the ongoing JCPCT. He agreed to circulate an explanatory paper to committee members.

9. Other business

There was no other business.

10. Dates of future meetings

3rd November 2010, 9:30 to 11:00am (Board Room, 15 Marylebone Road).
1st December 2010, 1.00 to 2.30pm (Board Room, 15 Marylebone Road).

NHS North West London

NHS North West London
Joint Committee of the PCTs (JCPCT)

Minutes of the meeting held on 3rd November 2010
in the Board Room, 15 Marylebone Road, London NW1 5JD

PRESENT

Peter Molyneux	JCPCT Chair/Chair, NHS Kensington & Chelsea
Marcia Saunders	Chair, NHS Brent
Andreas Lambrianou	Chair, NHS Hounslow
Phillip Young	Chair, NHS Ealing
Jeff Zitron	Chair, NHS Hammersmith & Fulham (for item 4 onwards)
Joe Hegarty	Chair, NHS Westminster
Martin Roberts	Chair, NHS Hillingdon
Chandresh Somani	Audit Chair, NHS Brent
Ursula Gallagher	PEC Chair, NHS Ealing
Tony Snell	PEC Chair, NHS Hillingdon
Anne Rainsberry	Chief Executive, NHS NWL
David Slegg	Director of Finance, NHS NWL
Robert Creighton	Chief Executive, NHS Ealing
Yi Mien Koh	Chief Executive, NHS Hillingdon
Nick Relph	Chief Executive, NHS Hounslow

IN ATTENDANCE

Ian Adams	Head of Communications, NHS North West London
Nigel Coomber	Director of Performance & Contracting, NHS North West London
Kevin Croft	Director of Workforce Transformation, NHS North West London
Richard Segall Jones	Governance Lead, NHS North West London
Georganne Toomey	Head of CPO & Transition Lead, NHS North West London

APOLOGIES

Gillian Schiller	Chair, NHS Harrow
Mark Easton	Chief Executive, NHS Brent and Harrow
Michael Scott	Chief Executive, NHS Westminster
Sarah Whiting	Managing Director, NHS Hammersmith & Fulham
Patricia Wright	Chief Executive, NHS Kensington & Chelsea
Mark Spencer	Clinical Director, NHS North West London

ITEM	DISCUSSION	ACTION

1. Welcome, introductions and apologies

Peter Molyneux welcomed the group and apologies were given.

2. Minutes of the meetings held on 13th October 2010

The following amendments to the minutes were agreed.

Item 4: in the final paragraph, delete "It was agreed that the November meeting of JCPCT would focus on financial performance" and insert "JCPCT was concerned that the financial position, and the measures necessary to achieve a healthy year end position, be clearly understood. It was agreed that the November JCPCT meeting would receive a thorough update on the Month 6 financial position, together with proposals for correcting any adverse performance identified. "

Item 6: delete the first paragraph and insert "Heather Lawrence, Chair of the Operational Group of the North West London HIEC, presented a brief introductory report along with the HIEC's newly appointed Director, Yvonne Robertson. They explained that it was central to HIEC's mission to align workforce education, innovation and research with the North West London strategy and give added value via practical support." In the third paragraph, delete the final bullet point and insert "the NWL JCPT would facilitate the appointment of key people from GP leadership and PCT(s) management to the partnership and operational boards of the HIEC, delegating this to discussion between Mark Spencer, Heather Lawrence and Marcia Saunders, who chairs the Partnership Board."

Subject to these amendments, the minutes of the previous meeting were agreed as a correct record.

JCPCT agreed that, in future, it would like the minutes of its proceedings to include greater detail of its discussions. **RSJ**

The action arising from Item 8 of the previous meeting to circulate Adrian Pollitt's paper on governance remained outstanding. **RSJ**

3. Chair's and Chief Executive's Reports

Peter Molyneux waived his report but asked Anne Rainsberry to give a Sector update.

Strategy: the impact of medium-term savings targets on providers was now known and joint PCT/NHS Trust meetings were to take place within the clusters to address this. The recent meeting between the Sector Chair, Sector Chief Executive and Trust Chairs had included some useful discussion on provider landscape issues. The Sector had also had discussions on this subject with the DH lead.

Secretary of State visit: the Secretary of State was due to visit NHS London on 15th November and one presentation to him would cover the ICO project.

Communication with stakeholders: party group briefings on transition and strategy matters were being arranged by NHS North West London. It was agreed that local authority colleagues and OSC Chairs should be kept briefed and that existing local relationships with Chairs, Chief Executives and Communications Leads should be exploited. It was felt it would be helpful to brief stakeholders on the scale of, and timescale for, the savings needing to be achieved and on emerging thinking regarding GP consortia. Dates set for local briefings would be advised to JCPCT members. **IA**

Provider development: Anne Rainsberry confirmed that there was no current intention on the part of Monitor to change the criteria for granting Foundation Trust status.

4. Clinical update: improving the quality of general practice

Professor Gallagher gave a presentation. In discussion the following points were made:

- Feeling among local GPs was that, whilst future commissioning of non-GP primary care services should sit with the proposed National Commissioning Board, commissioning of GP primary care services should sit with GPs. This would require some form of purchaser-provider split but it was not realistic to expect all GP primary care to commissioned by a national body;
- Commissioning of maternity services may yet remain at local level;
- Clarity on future arrangements would emerge from the forthcoming Operating Framework and the Health Bill;
- The Sector's workstream on primary care and improving general practice needed to be developed and include the primary care elements of the QIPP Plan. This work would come under the auspices of Clinical Strategy Group to ensure broadest possible GP awareness and engagement;
- Work on improving general practice should not overlook the beneficial effects of good facilities and availability of practice nurses. In view of the likely shortage of development funding for the foreseeable future, incentives to bring about such improvements would need to be considered.

5. Finance

i) Finance Report for Month 6

David Slegg summarised his report and Jeff Zitron expressed concern that strategic plans might be jeopardised if clarity could not be gained on why PCT overspends were not matched by providers' surpluses. In response, David Slegg advised that this was a longstanding and NHS-wide phenomenon which would take an excessive amount of time to research. Robert Creighton added that, as more providers became Foundation Trusts, this information would become increasingly difficult to access. However, Anne Rainsberry suggested that the proposed new Economic Regulator for the NHS might have the powers to require the necessary information to clarify this issue.

Chandresh Somani believed there was a need to understand better the reasons for excess unplanned activity and how Trusts can assume income levels in excess of that in PCT plans. It was suggested that one reason for over-activity was simply that the capacity existed for it. It was also thought that financial pressures might have increased as a result of the introduction of HRG4 pricing.

Nick Relph and Andreas Lambrianou stressed that the Hounslow PCT position reflected historic debt rather than any in-year deficit. David Slegg agreed to discuss this point with them. **DS**

ii) Sector Challenged Trust Board Report

The report was noted.

6. Performance

Report on mid-year review meetings

After Nigel Coomber had presented his report, Martin Roberts commented that the NHS system carried a mismatch between providers' need to maximise income and payers need to control it. Tony Snell added that clearer evidence for all activity claimed for would be helpful. Anne Rainsberry stated that concerns about the basis of claims for extra activity were taken very seriously at the highest level and that the Sector would be focusing on and challenging provider over-performance. The quality schedule would allow analysis to enable commissioners to have meaningful conversations with their providers. Ursula Gallagher added that there was also a need to understand how to achieve clinical challenge, for instance, with regard to certain provider business development initiatives.

7. Transition

i) Transition update

The latest position was as per the recently published bulletin but Anne Rainsberry advised that she was happy to field questions outside the meeting at any time.

ii) GP Commissioning: Pathfinder pilots

Bids for pilot projects had been invited and development needs were to be considered; an update would be brought to the next meeting. **AR**

8. Governance

Board Assurance Framework

Speaking to the paper presented, Peter Molyneux stressed the need for the Sector to have both an aggregation of bottom-up risk and a Board Assurance Framework through which JCPCT could identify threats to the NHS North West London Strategy. It was commented that it was for the executive directors to generate such information and for the non-executives to challenge, and assure themselves regarding, proposed mitigation of risks.

The Audit Committee Chairs were asked to convene to consider the proposal in more detail, including the appropriate balance between executive and non-executive input, and report back to the December JCPCT meeting. **CS/ RSJ**

9. Other business

Interventions not normally funded: Nick Relph asked if the INNF report from Clinical Strategy Group could be brought back to JCPCT for sign off. This was agreed on the understanding that Chief Executives had seen and approved the report beforehand.

10. Dates of future meetings

1st December 2010, 1.00 to 2.30pm (Board Room, 15 Marylebone Road).
11th January 2011, 09:30-12:00 (venue to be advised).

USE OF SEAL

Summary: The PCT seal was used on the following occasion: • 10th November 2010 – Lease for 4th Floor of Town Hall Extension, King Street, Hammersmith.
Board action required: The Board is asked to ratify the use of the seal for the above purposes.

Responsible director: Sarah Whiting	**Author:** Kieran Seale

Date of paper: 10 January 2011

Strategic Fit (How does this help to deliver the Trust's key priorities: Commissioning Strategy Plan, KPIs, Board Assurance Framework etc)	n/a
Legal implications (Are there any legal implications which would impact on the Board's decision? Has legal advice been taken? What was the advice?)	The use of the seal on documentation demonstrates the Board's approval. Use of the seal therefore needs the authorisation or ratification of the Board.
Stakeholder Engagement (Will implementation impact on either the way in which services are provided or the range of services provided? If yes, have the relevant stakeholders been consulted?)	n/a
Health Inequalities (how does this report support the reduction of health inequalities in H&F)	n/a
Single Equality Scheme (has the report been equality impact assessed and quality assured)	n/a