TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 21 July 2009 at 6.30 p.m.

A G E N D A

VENUE
M73, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Members:	**Deputies (if any):**
Chair: Councillor Tim Archer **Vice-Chair:Councillor Ann Jackson**	
Councillor Lutfa Begum **Councillor Stephanie Eaton** **Councillor Alexander Heslop** **Councillor Abjol Miah** **Councillor Bill Turner**	Councillor Rajib Ahmed, (Designated Deputy representing Councillors Bill Turner, Lutfa Begum, Alex Heslop and Ann Jackson) Councillor Ahmed Hussain, (Designated Deputy representing Councillor Tim Archer) Councillor Waiseul Islam, (Designated Deputy representing Councillors Bill Turner, Lutfa Begum, Alex Heslop and Ann Jackson) Councillor Abdul Munim, (Designated Deputy representing Councillor Abjol Miah) Councillor M. Mamun Rashid, (Designated Deputy representing Councillor Abjol Miah) Councillor Rachael Saunders, (Designated Deputy representing Councillors Bill Turner, Lutfa Begum, Alex Heslop and Ann Jackson) Councillor Dulal Uddin, (Designated

	Deputy representing Councillor Abjol Miah)

[Note: The quorum for this body is 3 Members].

Co-opted Members:		
Ann Edmead	–	(Future Women Councillors Initiative)
Myra Garrett	–	(THINk Interim Steering Group Member)
Dr Amjad Rahi	–	(THINk Interim Steering Group Member)

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Amanda Thompson, Democratic Services, Tel: 020 7364 4651, E-mail: amanda.thompson@towerhamlets.gov.uk

LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 21 July 2009

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

		PAGE NUMBER	WARD(S) AFFECTED
3.	**UNRESTRICTED MINUTES** To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 16 June 2009.	3 - 10	
4.	**MATTERS ARISING FROM LAST MEETING** (10 minutes)	11 - 14	
5.	**HEALTH FOR NORTH EAST LONDON - REVIEW OF HEALTHCARE SERVICES** (15 minutes)		
6.	**HEALTH SCRUTINY WORK PROGRAMME** Discussion to consider items for inclusion in the work programme 2009/10. (30 minutes)		
7.	**REPORTS FOR CONSIDERATION**		
7.1	**East London NHS Foundation Trust Annual Plan 2009-2010** (15 minutes)	15 - 90	

7.2	**Equitable Access to Primary Medical Care Programme Procurement of a GP Led Health Centre at St Andrews**	**91 - 136**
	(15 minutes)	
7.3	**Unplanned/Urgent Dental Care Review - North East London**	**137 - 140**
	(15 minutes)	
8.	**END OF LIFE CARE ACTION PLAN**	**141 - 150**
	(10 minutes)	
9.	**ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT**	

DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

What constitutes a prejudicial interest? - Please refer to paragraph 6 of the adopted Code of Conduct.

Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 16 JUNE 2009

M72, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Ann Jackson
Councillor Abjol Miah

Councillor Dr. Emma Jones

Other Councillors Present:
Nil

Co-opted Members Present:
Nil

Guests Present:

Dianne Barham	–	THINk Director
Judith Bottriell	–	Associate Director Governance, Barts & The London Trust
Jane Canny	–	Barts & The London Trust
Vanessa Lodge	–	Tower Hamlets PCT
Leeanne McGee	–	Tower Hamlets Centre for Mental Health
John Wilkins	–	Tower Hamlets Centre for Mental Health

Officers Present:

Ashraf Ali	–	(Scrutiny Policy Officer)
Afazul Hoque	–	(Acting Scrutiny Policy Manager)
Michael Keating	–	(Service Head, Scrutiny & Equalities)
Helen Taylor	–	(Service Head, Commissioning & Strategy)
Alan Ingram	–	(Democratic Services)

1. ELECTION OF CHAIR FOR THE 2009/2010 MUNICIPAL YEAR

Mr A. Ingram, Democratic Services Officer, opened the meeting and indicated that Councillor Tim Archer had been appointed Chair of the Health Scrutiny Panel by the Overview and Scrutiny Committee on 9 June 2009. In Councillor Archer's absence, nominations were requested for a Chair for this meeting and it was **RESOLVED**

That Councillor Ann Jackson be appointed Chair of this meeting of the Health Scrutiny Panel.

Councillor Ann Jackson in the Chair

2. ELECTION OF VICE-CHAIR FOR THE 2009/2010 MUNICIPAL YEAR

RESOLVED

That Councillor Ann Jackson be elected Vice-Chair of the Health Scrutiny Panel for the Municipal Year 2009/2010.

3. APPOINTMENT OF CO-OPTED MEMBERS

Ms D. Barham, THINk, indicated that the organisation would be happy to have Dr Amjad Rahi and Ms Myra Garrett re-nominated as Co-opted Members, along with Ms Jean Taylor, if possible. Formal nominations would be proposed at the meeting of the Health Scrutiny Panel on 21 July 2009.

4. APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillors Tim Archer (for whom Councillor Dr Emma Jones deputised), Lutfa Begum, Stephanie Eaton, Alexander Heslop and Bill Turner.

Apologies were also submitted on behalf of Lynne Hunt, Assistant Chief Executive of the Eats London and City NHS Foundation Trust, whose role had changed and who would be represented by Mr John Wilkins for the next 6-9 months.

5. DECLARATIONS OF INTEREST

No declarations of interest were made.

6. UNRESTRICTED MINUTES

Referring to Item 4.1 – Tower Hamlets PCT Declaration to the Healthcare Commission 2008/09, (penultimate paragraph) the Chair made the point that it would be preferable for reports on patient issues and complaints to be provided by Barts & The London Trust and LBTH prior to the meeting of THINk.

Subject thereto, the minutes of the meeting held on 14 April 2009 were agreed as a correct record.

The Chair then indicated that the order of business on the agenda would be varied to receive item 9 – Health Scrutiny Panel 4 Year Work Programme, as

the next matter for discussion. For ease of reference, the agenda items are set out below in their original order.

7. REPORTS FOR CONSIDERATION

7.1 Health Scrutiny Panel Terms of Reference

The Panel received a report outlining its terms of reference, a schedule of meeting dates and details of membership for the Municipal Year 2009/2010. The Chair commented that further consideration might need to be given to the proposed meeting date of 23 March 2010.

The report was noted.

7.2 Annual Complaints Report 2008/2009 - BARTS and the LONDON NHS Trust

Ms J. Canny introduced the report that gave details of the central management of complaints by the Quality Development Department. She made the following points:

- A sharp increase in complaints last summer resulting from problems with implementing the new appointments system: such complaints had comprised some 44% of the total received. However, a range of issues had been addressed by the Patient Access Service and new complaints in this area had dropped significantly.
- A clinical restructure had also caused confusion resulting in complaints, along with staff leaving and moving locations.
- Transport issues were no longer in the top five causes of complaint and the top cause continued to be delays and cancellations of appointments.
- A fall in complaints performance overall had led to a decision to declare that core standard 14c (Standards for Better Health) had not been met and a plan was underway aimed at stabilising performance.
- Staff attitudes in complaints handling continued to be a source of concern and would be the subject of a further report to the Trust Board.

Ms J. Bottriell added that there was a performance target of dealing with 80% of complaints within a 25 day period and resources had been diverted towards maternity-related complaints, including staff attitudes, with particular regard to midwives. She pointed out that, if patients could achieve immediate action on, or resolution of their problems, they were less likely to proceed with a formal complaint.

In response to queries from Members, Ms Canny and Ms Bottriell commented that:

- With regard to the failure to properly address the appointment problems experienced by a Member's relative, changes had been made to enable compensation for out-of-pocket expenses. Amendments to appointments letters and the distribution system

meant that problems would be less likely. Patients who had experienced appointments problems had been contacted by phone or letter to ensure that they received essential treatment and were not medically disadvantaged.
- Posters and leaflets explaining the complaints process were provided in all clinical areas and information would be given by all staff.
- All GPs now knew how to take problems forward on behalf of patients or advise them on how to proceed.
- New regulations meant that it was no longer necessary to raise a formal complaint to have problems addressed and resolved.
- The Trust employed some 8,000 staff and training on attitudes and complaints handling was continuing. It was important that staff were taught or enabled to show empathy in order to deal properly with patients' needs and requests.

The Chair thanked Ms Canny and Ms Bottriell for their report.

7.3 Annual Complaints Report 2008/2009 - EAST LONDON NHS

Ms L. McGee, East London Mental Health Trust, introduced her report detailing the number of reports received and performance against required timescales. She added that:
- About one complaint a week was received in the Tower Hamlets part of the Trust and all patients received complaints information packs. Packs were also made available for carers.
- Of the 60 complaints received in the Tower Hamlets area, 16 were of staff attitude, 6 related to occupancy, arising from lack of bed spaces and several concerned untoward incidents involving staff.
- A strong advocacy service was available for patients who were unable to speak for themselves.
- Hygiene improvements were being made in the Mental Health Unit.
- Customer services and relevant training would comprise a big part of this year's annual plan.

In response to queries from Members, Ms McGee commented that:
- In order to reduce pressure on staff in dealing with psychiatric emergencies, a protocol had been developed that gave responsibility for such issues to the duty senior nurse and the on-call duty manager from LBTH to decide together on procedures to be used and admissions.
- Efforts were made to educate patients in the Mental Health Unit against smoking but this was permitted at certain times in the courtyard.
- Patient records systems had been improved. It was now possible to access critical information on patients 24/7 and this could be accessed London-wide, wherever a patient presented. Computers were also available on wards to enable patients to communicate with people in the outside world.

The Chair thanked Ms McGee for her presentation.

7.4 Tower Hamlets Primary Care Trust

Ms V. Lodge, Tower Hamlets Primary Care Trust, presented her report setting out details of complaints received by the Trust both as a service provider and commissioner; a summary of the new complaints regulations and their impact; the requirement that the providers of services to the PCT also had robust complaints procedures in place.

She added that there had been 92 complaints over the last year and results for reaching the targeted response time of 25 days had been poor but this would improve over the next year. This would be helped as the Chief Executive would sign in all complaints and sign them out when completed.

The new regulations removed the 25-day requirement in favour of negotiations with patients but the PCT had decided to retain the standard in order to ensure proper control.

In response to queries from Members, Ms Lodge commented that:

- Complaints could be resolved earlier than the 25 day standard and she agreed that future reports should give percentage details of complaints thus resolved.
- She indicated that she would look into possible improvements on sharing information between the PCT/LBTH through the Datex database and how this might best be used for patients' benefit.
- Consideration would also be given to using information gained from complaints as part of the work on the patient experience category and there would also be local patient surveys and focus groups in that connection.

Mr Keating and the Chair referred to the need for the Health Scrutiny Panel to have access to a single report to combine information from all of the Health Service organisations within the Borough as a single source document. This could enable further analysis of problems underlying complaints and address issues, including equalities information, in a co-ordinated manner. Ms Lodge confirmed that she would contact the other health services providers accordingly.

8. THINK UPDATE

Ms D. Barham gave a comprehensive presentation outlining the role of THINk and how the organisation tried to take a lay-person's view of health services commissioning in a fully independent way. THINk was always seeking ways to engage local people, not simply in a consultative manner, and worked with existing patient panels and forums to avoid duplication of effort.

The aim was also to undertake 10 enter and view programmes around various health services providers, which would be decided after discussions when a full membership had been achieved. The membership was currently 280 individuals, who were being asked to decide on main issues on which to focus attention.

THINk had already provided Third Party Commentary on a number of issues involving health services commissioners and had been successful in conveying patients' concerns.

In response to queries from Members, Ms Barham further commented that:

- Any resident of user of health services in Tower Hamlets could be a member of THINk.
- Their programme included training for young people on how to contact their peers to combat drug use and identify reasons why drugs were such a major issue in the Borough.
- Work was also being undertaken with PRAXIS on identifying problems experienced by Eastern European, Chinese and Vietnamese communities, Somali older women, etc. This was undertaken by an active campaign to engage people through such means as texting and phoning.
- THINk was looking at ways of interacting with the Health Scrutiny Panel to match up with the next Four Year Programme and would seek its input and support before health care commissioners were approached.
- THINk was aware of work being carried out by the Council's Disability Panel and there had been reflection on how to share information at one access point to avoid duplication. They had asked the PCT to map out all patient panels/user groups/local authority groups accordingly.
- Efforts were also being made to focus on how residents and service users may be enabled to feed into the commissioning process.

The Chair indicated that there had been previous recommendations from the Panel to the PCT and Royal London Trust identifying the need for staff training on attitude and empathy. However, this had remained a common theme for complaints as contained in all of the reports considered earlier. This could be a big issue for THINk to take on and it was also necessary to consider how to collate the information requested from the organisations.

Mr Keating commented that discussion was needed over the coming year on how the Health Scrutiny Panel could use information provided by THINk and how the organisations could best complement each other.

9. HEALTH SCRUTINY PANEL 4 YEAR WORK PROGRAMME

Mr M. Keating, Service Head Scrutiny and Equalities, introduced a presentation "Taking Stock" on the progress of the Four Year Work Programme, which was in the final year. He made the point that the Health Scrutiny Panel was not simply a process for the Council but affected and involved all its partner organisations and was crucial to achieving One Tower Hamlets.

Mr Keating then spoke regarding the key themes that had been addressed over the Four Year Programme, namely, health inequalities; health promotion and prevention; integration and partnership; access to services. He detailed the work carried out to date in delivering the programme and set out

challenges for future years, adding that the Borough also had to take account of London-wide requirements and the Mayor's Health Inequalities Strategy.

In addition, the Communities in Control White paper had the potential to lead to the building of more partnerships and Mr Keating felt that his team might be able to co-ordinate further support innovatively to wider partners and residents. It was necessary to build on and nurture the current themes to be able to move forward.

The Chair indicated that there were no equalities breakdowns in the reports from NHS bodies on the agenda and felt that the council might be able to provide assistance to them in this respect, in helping with further analysis and clarification of issues. Mr Keating commented that the Borough had achieved a Level 5 score on the Equalities Standards for local government and had a diversified network that brought people together quarterly over its area: this might be a suitable forum for consideration of the matter.

10. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

10.1 Health for North East London

The Chair referred to a letter from Alwen Williams, Chief Executive, NHS Tower Hamlets, requesting comments on proposals for improving local health services. Eight Councils in North East London were being asked for views on how best to review commissioning of health services. This was proposed on the basis of establishing either two joint committees to report back separately or all of the Boroughs to form a single committee to report back to the JCPCT. (The letter was circulated to those present at the meeting.)

The Chair commented that it was necessary to consider how the community would wish the matter to go forward, however, it might be that it would be preferable to establish an Inner North East London committee and Outer North east London committee so as potentially to get more people around the table. Mr A. Hoque, Acting Scrutiny Policy Manager, stated that this was the preferred view in other areas.

Discussion ensued on how to ensure that Members could be properly engaged in this process and it was agreed that a report would be provided for the Overview and Scrutiny Committee later in the year. The Chair asked that, in the meantime, Members pass on any comments to the appropriate Officers.

The meeting ended at 8.45 p.m.

Chair, Councillor Tim Archer
Health Scrutiny Panel

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Matters Arising to Tower Hamlets Health Scrutiny Panel 21st July 2009	Agenda Item number

NHS Tower Hamlets

Directorate of Corporate Quality and Development

Presentation of Complaints Data

At the HSP meeting on 16th June 2009 a number of reports were presented to Councillors relating to complaints data held by the three local trusts.

Presenting last NHS Tower Hamlets were asked a number of questions relating to the potential, desire and/or usefulness of compiling amalgamated data for the sector. Further to this query the responsible Head of Service wishes to pose a number of questions (for response) to the Tower Hamlets Health Scrutiny Panel prior to beginning dialogue with our NHS peers operating within the borough.

We would ask the panel to be mindful that the task of combining and analysing such data has the potential to be both a complex and resourceful undertaking which presents its own risks including losing some ability to capture specific concerns regarding a service. We therefore invite comments upon the following areas;

- Whether the HSP would wish to view all complaints received by an organisation irrespective of where the user was a resident
- Where able demonstrate the ethnic groups of those making the complaint (please note this is not always possible)
- For the PCT group complaints by location (eg GP practices) or by LAP area.
- Group by age band (where information exists)

Upon response NHS Tower Hamlets will then begin discussion on this matter with colleagues from BLT and ELFT to ensure that the data systems capture the required information to allow manipulation before reporting back on options to the HSP.

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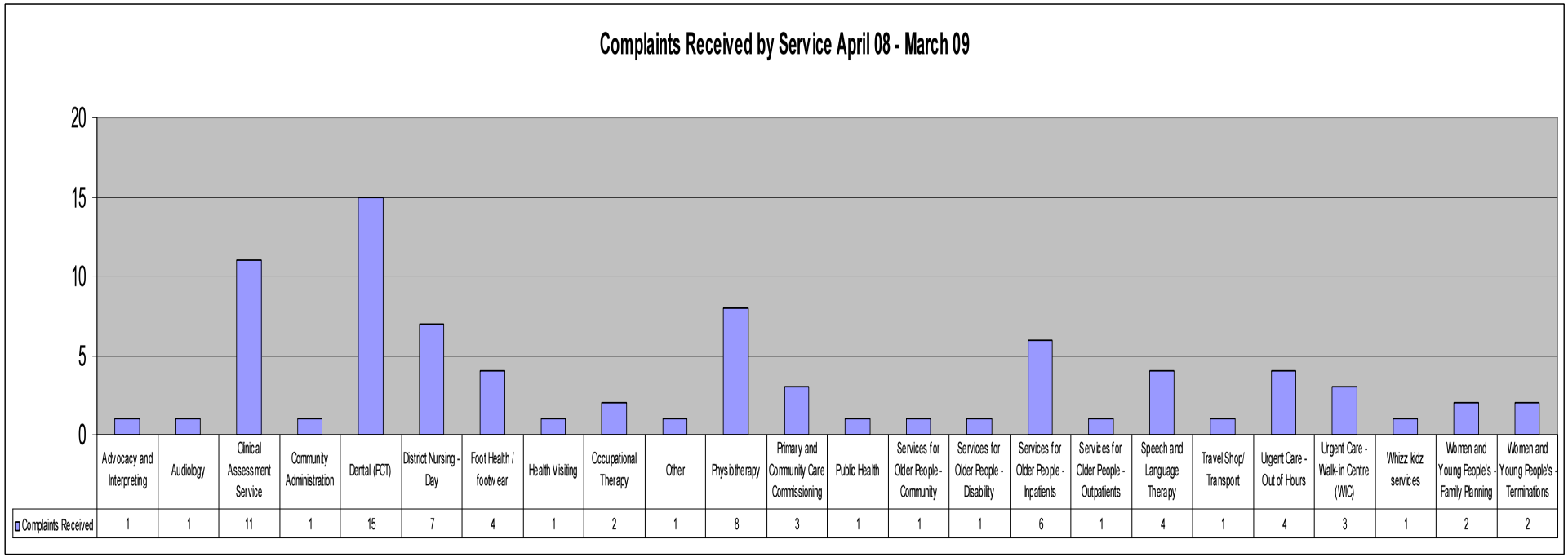
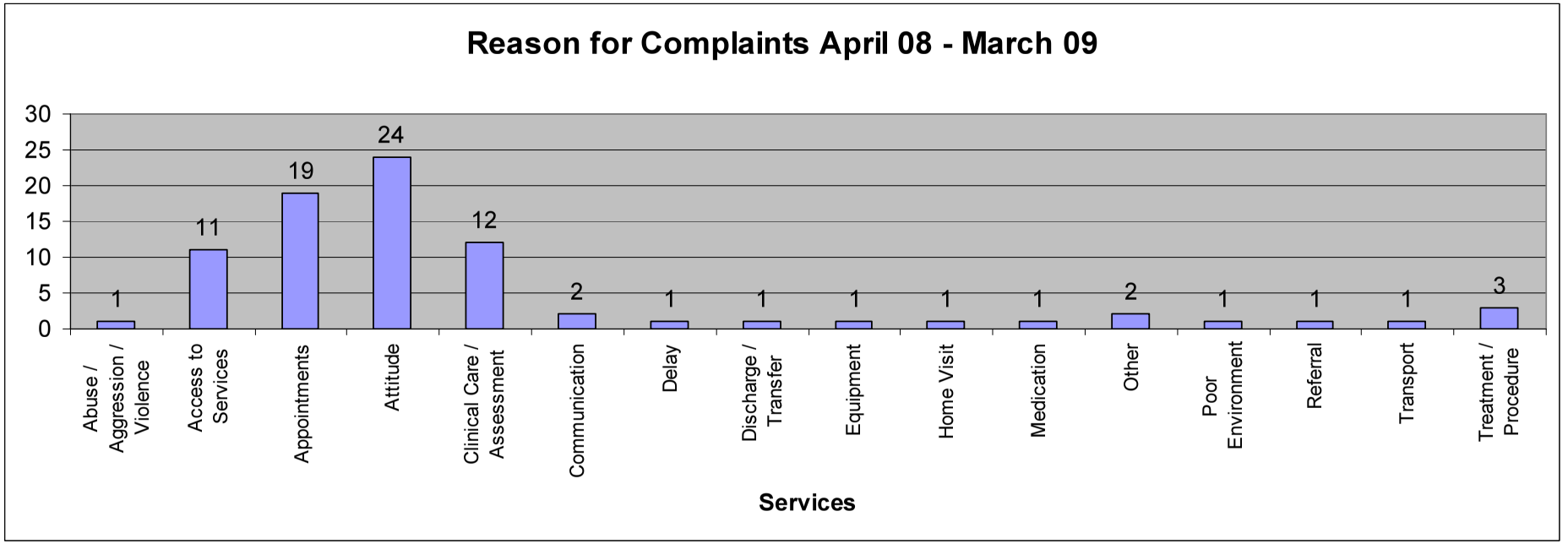
Complaints report 08/09

This report provides some further detail to the paper presented to the Health Scrutiny Panel on 16th June 09. See full report for further detail.




Reason for Complaints April 08 - March 09
30
25
20
15
10
5
0
1
11
19
24
12
2
1
1
1
1
1
2
1
1
1
3
Abuse / Aggression / Violence
Access to Services
Appointments
Attitude
Clinical Care / Assessment
Communication
Delay
Discharge / Transfer
Equipment
Home Visit
Medication
Other
Poor Environment
Referral
Transport
Treatment / Procedure
Services

East London NHS
NHS Foundation Trust

ANNUAL PLAN
2009 – 2010

CONTENTS

1 PAST YEAR'S PERFORMANCE

1.1 Chief Executive's summary of the year

Background and introduction

The Trust provides a wide range of community and inpatient services for children, young people, adults of working age and older adults who live in the City of London, Hackney, Newham and Tower Hamlets. It also provides Forensic services to these boroughs as well as North East London Boroughs including: Barking and Dagenham, Havering, Redbridge and Waltham Forest. The Trust provides other specialist mental health services to North London, Hertfordshire and Essex. The specialist Chronic Fatigue Syndrome/ME adult outpatient service also serves North London and the South of England.

The East London areas served by the Trust are the most culturally diverse and deprived areas in England and therefore provide significant challenges for the provision of mental health services. The Trust's local services are provided to a population of 710,000 in East London and the Trust's forensic services are provided to a population of 1.5 million in North East London.

The Trust operates from 47 community and inpatient sites and has four main inpatient sites, employs approximately 2,830 staff (as at 31st March 2009) and has 642 general and specialist inpatient beds.

The Trust's vision is: ***To provide high quality mental health care to our local communities. We aim to do this in partnership with service users, their carers and families, and statutory and voluntary organisations***.

This vision has guided our direction of travel during our first full year as an NHS Foundation Trust and underpins our key priorities for 2009/10. We regularly discuss our key annual plan priorities with our Members Council and the wider membership.

Highlights of the year

The last year has been the Trust's first full year as a Foundation Trust. I am extremely proud of the way staff have embraced the new opportunities brought by Foundation Trust status. We have made good progress on improving the quality and range of services that we provide to our service users and have made significant improvements in the quality of our community premises. We have achieved our financial targets and plans and have made excellent progress towards our challenging target of a 6% vacancy rate, with the Trust wide figure currently standing at 7.6% which is the lowest vacancy level across London Mental Health Trusts. This is an important marker of progress in our drive to employ a high quality and stable workforce.

This overall progress was reflected in our ratings from the Healthcare Commission where we received an Excellent rating for the quality of our services and an Excellent rating for use of resources. This was an improvement on the previous year's position of Excellent for services and Good for use of resources.

We're also delighted that all four acute inpatient wards in Newham that were externally assessed as part of the Royal College of Psychiatrists' standards for Acute Inpatient Mental Health Services [AIMS] were rated as 'excellent'.

One of the important highlights of 2008/09 was the launch of *Florid,* a user led and run website which was supported by the Trust and launched in January 2009. The website provides a comprehensive directory of statutory and voluntary services in East London in addition to other resources for service users, parents and carers which include a moderated blog/chat room where information and ideas can be exchanged. Professionals are invited to join the blog as guest speakers. This exciting and innovative development has been led by the Trust's public participation programme and also provides paid employment and training opportunities for service users.

During the past year I have been particularly pleased with the very positive contribution made by of our Members Council, with its 45 highly committed Council Members. I am also pleased that we have continued to expand our membership and have achieved our target goal of having 8000 Members by the end of March 2009. Our membership is also broadly representative of the highly diverse populations we serve.

Over the past six months, we have also been working closely with our Members Council, the wider membership and our service user groups on the development of the 2009/10 Annual Plan and our priorities for the year ahead.

Our Annual General Meeting held on 11 September 2008 was well attended and this is an indication of the continued interest from our local communities and the support of our membership. There was also an Annual Members meeting, part of which was led by council members and used as an opportunity to engage Members in the process of setting of defining the main priorities for the 2009/10 Annual Plan.

Over the past year, we have been working closely with our PCT and Local Authority partners to develop new services and enhance our existing services within the strategy frameworks of the local healthcare community.

We also made significant changes to the way our Human Resources [HR] function was arranged and this has resulted in further HR management and recruitment support being deployed within our five Directorate Management Teams.

We have had a busy year in terms of services, developing 42 new or enhanced services such as a new Alcohol Service in City & Hackney, a new Dual Diagnosis Service in Tower Hamlets and a new Perinatal service in Newham, and a new low secure development in our Forensic service. The Trust has also started work on the development of the following service strategies: young people's, older adult and non-verbal therapies. However, we need to make more progress on these areas in 2009/10. We also managed to achieve or partially achieve 68 of the 72 key targets in 2008/09 with the four remaining being delayed due to internal or external factors.

In keeping with our vision statement, we have this year entered into a number of new strategic partnerships with voluntary sector organisations. This strategy has led to a successful joint bid with Look Ahead for a new Crisis House and Rehabilitation Home in Tower Hamlets.

In addition to the above, infection control and standards of cleanliness in inpatient areas across the Trust have been subject to continued improvement and audit within our healthcare governance processes. The Trust had an unannounced visit by the Healthcare Commission in January 2009 with respect to the Hygiene Code. The Trust was assessed compliant against its three main duties under the hygiene code, and to date, this places the Trust as one of the top performing Trusts in the country.

The Trust Board, our members and service users are in complete agreement over the need to measurably improve the quality of our services. This strong sense of common purpose has resulted in this issue remaining at the top of our priorities for 2009/10.

For further information on the Trust's performance against the 2008/09 Annual Plan priorities and Monitor, Healthcare Commission and other targets, refer to section 1.2.

1.2 Performance Overview

1.2.1 Summary

In 2008/09, we have continued to make good progress in meeting the key national and local targets within the annual health check framework. The Healthcare Commission will report on our 2008/09 ratings in October 2009.

Continued progress has been made around addressing increased demand for inpatient services. Fluctuating demand for inpatient beds has, on occasions, been very difficult to manage for local services but through effective Trust-wide bed management, we have been able to accommodate all admissions within local inpatient services, without recourse to inappropriate and expensive out of area placements. The latest information would indicate that the overall occupancy levels have decreased during 2008/09 to meet our 95% occupancy target but we will still need to manage this situation very closely in 2009/10.

Progress on Delivering the 2008/09 Annual Plan Priorities

During the year, we have made significant achievements in the following seven priority areas to:

- **Improve the quality of adult inpatient care services**
    - Royal College of Psychiatrist's Accreditation for Acute Inpatient Mental Health Services [AIMS] rated all four of the four wards assessed as Excellent - the highest rating. The remaining eight wards will be rated in 2009.
    - Improvements on the five key areas of our inpatient improvement plan, in response to the Healthcare Commission's acute inpatient review.
    - Good progress on compliance with the Department of Health Medium Secure Benchmarking standards, i.e.: 164 standards are green, 30 are amber and five are red. An action plan is in place to improve the red and amber areas.
- **Improvement in the quality of community care services**
    - Significant progress in implementation of the community services review action plan.
    - Regular audits and monitoring of the implementation of key community standards.
    - An extensive review of community services for adults of working age was undertaken. The implementation phase started in May 2009 and the new model for services will strengthen clinical leadership and will improve response times and outcomes for service users and carers.
- **Ensure that we have a high quality workforce that is locally representative**
    - Significant progress in reducing vacancy levels from 20% in 2007/08 to the current level of 7.6%. This figure continues on a positive trend having been at 10.1% in January 2009.

- Retention of a highly skilled and motivated workforce has also been supported by the implementation of new workforce strategies for nurses and administrative staff, which have introduced significant new career development opportunities for these important staff groups.
- Successful implementation of a new system of appraisal and personal development plans [PDPs] with all staff now having objectives linked to Trust priorities. This has increased from 18% at the beginning of the year to 92% at the end of March 2009.

- **Improve premises for both service users and staff to provide modern and fit for purpose environments**
  - Significant progress was made in upgrading and securing new fit for purpose community and inpatient premises. Developments have included the opening of a new forensic low secure inpatient ward and five new or refurbished community premises across the Trust.
  - Good progress has been made on the development of the Outline Business Case [OBC] for the re-provision of the services currently provided at the City & Hackney Centre for Mental Health.
- **Improve older adult services**
  - Good progress on the development of a Trust-wide Older Adult Service Strategy with the aim of improving community and inpatient services and making the best use of available resources. This strategy is being developed into draft borough level implementation plans for discussion with our PCTs.
  - Preparation for the Royal College of Psychiatrist's AIMS assessment of the six older adult wards across the Trust
- **Implementation of Homicide and other serious untoward incident recommendations**
  - Developed and implemented action plans arising from agreed Homicide and SUI inquiries including those of the independent panel which were received in 2008.
  - Improved management of SUIs and significantly reduced number of outstanding SUIs.
  - Implemented the recommendations of the external review into the Trust's SUI policy and procedures.
- **Development and implementation of outcome measures and standards**
  - Significant progress in the introduction of a range of community and inpatient key performance indicators and standards, and outcome measures across the full range of our services during the past year, e.g. the AIMS accreditation process for inpatient care as already described. In addition, the Trust introduced outcome measures developed by the CAMHS Outcome Research Consortium [CORC] for children and young people, Health of The Nation Outcome Scales [HONOS] for adolescent, adult, older adult and forensic services and the Treatment Outcome Profile [TOP] for specialist addiction services.
  - Introduction of a clinical dataset and dashboard for use by the Clinical Directors.

- Introduction of a new set of service user defined inpatient standards which are audited by service users and reported to the Trust Board on a quarterly basis.
- Outcome measures have been chosen for psychological therapies and relate to the four domains of Health and Wellbeing; Choice and Access; Social Inclusion and Service User Experience. Further work remains to be done in agreeing specific measures and data collection will begin in 2009/10.

1.2.2 Performance against national and Healthcare Commission targets

The national targets are either included within the Annual Health Check assessment or the PCT Local Delivery Plan detailed below.

a) Annual Health Check Declaration 2007/08

Annual Health Check Results – Quality of Services

In 2007/08 the Healthcare Commission assessed the Trust's quality of services as 'Excellent'. This assessment consists of three components:

a) The Trust 'fully met' compliance with the **core standards**;

b) The Trust 'fully met' compliance with **existing national targets** which measure crisis resolution team implementation; and

c) The Trust received a performance score of 'Excellent' in meeting **new national targets** to improve the health of the population.

This covers areas such as experience of patients, increasing the proportion of users successfully sustaining or completing drug treatment programmes, suicide prevention, infection control and community mental health team integration.

Annual Health Check Results – Use of Resources

The Trust was awarded an Excellent rating for use of resources. This is an improvement from the 2006/07 Good rating.

b) 2008 National Service User Survey

The Trust's scores in 2008 in relation to overall care were similar to scores awarded to other Trusts with Mental Health Services. Since 2007 the Trust has improved results on recent contact rates with health professionals and psychiatrists and scored better than average in this area. The Trust also scored higher than average in providing information on Mental Health problems to service users and supporting family and carers. The results show that the Trust has managed to maintain and build on the excellent progress that was made in 2007. The issues for action/improvement areas highlighted by the 2008 Survey were:

- Improvement in quality of community care services
- Improve customer care across the organisation
- Increase service user participation and involvement in evaluation of services
- Continue to develop culturally competent services
- Better information including to families and carers (including information on medication

- CPA – care plans and reviews
- Employment
- Out of hours support – including an out of hours phone number.

The Trust is committed to improving service user experience through responding to feedback and addressing identified areas for improvement. The above areas have been built in to the 2009/10 Annual Plan priorities and these will be monitored on a quarterly basis by the Trust's Service Delivery Board to ensure the action plan is implemented.

The 2009 National Service User Survey will cover inpatients only, however, the Trust has separately commissioned a new community survey to continue to monitor and improve results in this area.

c) 2007 Quality of Working Lives Staff Survey

In relation to the Healthcare Commission's results for 2007 the results of the Staff Survey were disappointing and could in part, be a reflection of the high levels of organisational change which were required at the time as the Trust achieved financial recovery and service improvement. Irrespective of this, the Trust will work hard on improving the areas where we need to make significant improvements. On comparing this Trust's performance with other mental health Trusts in England, the following areas are those in which the Trust did not perform as well as other Trusts:

- % of staff appraised in last 12 months
- % of staff having received health and safety training in the last 12 months
- % of staff suffering work-related stress in last 12 months

Whilst the report was disappointing, the report overall presents a mixed picture which includes some progress. This includes the response rate which has improved from last year although we are still in the lowest 20% of mental health trusts. In response to the report, the Trust has been implementing an action plan to address the identified areas for improvement.

The 2008 staff survey results have recently been received by the Trust and this survey shows improvement in most areas. A more detailed report will be reviewed by the Trust board.

d) National and PCT Vital Signs Targets

This section summarises the Trust's current performance on key national performance measures. Definitions for some indicators are still to be confirmed, but the overall picture is positive with the Trust complying with all the national targets.

Table 1: National Indicators

	NATIONAL INDICATORS		
Indicator	**Target** (Trust wide)	**2007/8**	**2008/9**
National Targets Applicable to Mental Health Trusts for 2008/9			
Annual number of MRSA bloodstream infections reported	0 Cases	N/A	0 cases
Reduction in C. Diff	0 Cases	N/A	0 cases
Enhanced CPA inpatient discharges followed up within 7 days (face to face and telephone)	95%	99.4%	99.5%

	NATIONAL INDICATORS		
Indicator	**Target** (Trust wide)	**2007/8**	**2008/9**
Patients occupying beds with delayed transfer of care *	7.5%	N/A	3.8%
Admissions made via Crisis Resolution Teams	90%	N/A	98.3%
Number of Crisis Resolution Teams	7.1	7.3	7.3
Integration of Older Peoples Community Mental Health Teams	100%	100.0%	100%
Completeness of Ethnicity Coding – Inpatient in MHMDS **	95%	97.1%	98.5%
Completeness of Mental Health Minimum data set (Benchmarked - 90% local target) **	90%	90.4%	95.5%
CPA Patients with recorded Care Coordinator ***	Nationally benchmarked	Target not applicable this year	81%
Child and Adolescent Mental Health Services - patients aged 16 or 17, on adult wards (bed days, year to date)	Notified to Mental Health Act Commission	0	45
Membership	8,000	7,098	8,036

* Figure is a provisional local calculation based on the recently published National definition which uses Quarter 1 data only.
** Quarter 3 MHMDS data. Quarter 4 data is not available until July 2009
*** Provisional based on Quarter 1 local data only. Final figures are calculated externally as part of annual assessment and achievement thresholds are not yet known.

As demonstrated in Table 1 above, all key national targets, as set by the Healthcare Commission and Monitor, have been achieved or exceeded, in particular:

- Delayed transfers of Care have reduced steadily during the year – with just 15 (2.5%) delayed patients at year end (35 in April 2008). Bed days lost represented 4.2% of occupied bed days.
- Enhanced/New CPA discharges from inpatient services were rigorously followed up within seven days – a rate of 99.5% was achieved against the target of 95%
- Data quality and capture of ethnic codes for service users – as measured by the national Mental Health Minimum Data Set – continue to show improvement with performance exceeding targets.
- Trust Membership recruitment targets were also met.

Table 2: Trust Targets 2008/09

Trust Performance Targets 2008/09	Target for 2008/09	Performance in 2008/09	Comment
Adult Inpatient Readmission rate	8.3%	5.6%	**Achieved** - Local target set as expected to contribute to Annual Assessment under "Patterns of Care and Outcomes" theme
Older Adult Inpatient Readmission rate	3.2%	2.5%	

Trust Performance Targets 2008/09	Target for 2008/09	Performance in 2008/09	Comment
Adult Services Bed Occupancy Rate – for year to date	95%	95%	**Achieved**
Number of people waiting more than 4 hours in A&E before admission, transfer or discharge	98%	98%	**Achieved**
Response to Complaints within 25 days	75%	80%	**Achieved**
Enhanced CPA inpatient discharges followed up within 7 days (by face to face contact)	80%	94%	**Achieved**
Information Governance - compliance with national standards	85%	87%	**Achieved**
Data Quality – NHS Number completion for current Inpatients	95%	95%	**Achieved**
Data Quality – NHS Number completion for Community	95%	97%	**Achieved**
Data Quality – Primary Diagnosis Code completion for Inpatients	95%	97%	**Achieved**

Table 2 above shows performance against a range of local Trust targets set for 2008/9. Main highlights are:

- 95% target for overall adult services bed occupancy rates achieved
- Complaints response time targets were met
- Achievement of key Information Governance compliance and data quality targets.
- Local targets met on follow-up of Enhanced/New CPA discharges by face to face contacts.

Table 3: PCT and Trust Partnership Targets

Partner Performance Indicator	Target for 2008/09	Performance in 2008/09	Comment
Commissioning a comprehensive Child and Adolescent Mental Health Service. Coverage and compliance assessed by four measures that are graded at level 1-4	Level 4 for each indicator	All four measures achieved Level 4, full compliance	**Achieved**
Commissioning Crisis Resolution/Home Treatment services – episodes	2,280	2,346	**Achieved**
Commissioning Early Intervention in Psychosis Services: - • Caseload • New referrals for first episode psychosis	 509 176	 569 243	 **Achieved** **Achieved**
Drug Misusers retained in Treatment for 12 weeks	85%-86%	96%	**Achieved**
Drug Misusers in treatment	678	710	**Achieved Trust-wide** (slightly below target in City and Hackney and Tower Hamlets)

Table 3 demonstrates that all of key national partnership targets for 2008/9 were met.

e) Performance against PCT Contracts

Table 4: Annual Plan 2008/09 Activity Summary

ANNUAL PLAN 2008/09 ACTIVITY SUMMARY	2008/9	
SERVICE SUMMARY	**Target**	**Actual**
Children and Adolescent Mental Health Services		
Community Contacts and Outpatient attenders	29,800	30,887
Inpatient - Beds (snapshot as at 31st March)	15	15
Inpatient - Occupied Bed days	4,654	4,852
Adult Services (Excl Forensic PD and Med Secure)		
Community Contacts and Outpatient attenders	290,490	303,500
Inpatient - Beds (snapshot as at 31st March)	288	302
Inpatient - Occupied Bed days	99,070	100,900
Adult Services - Forensic Med Secure and Personality Disorder		
Community Contacts and Outpatient attenders	4,755	4,830
Inpatient - Beds (snapshot as at 31st March Excl Tarriro House and Baxter Rd)	167	180
Inpatient - Occupied Bed days	61,046	67,228
Older Adult Services		
Community Contacts and Outpatient attenders	42,603	42,754
Inpatient - Beds (snapshot as at 31st March)	152	145
Inpatient - Occupied Bed days	49,933	44,923
Total CAMHS/Adult/Older Adult		
Community Contacts and Outpatient attenders	367,648	381,971
Inpatient - Beds (snapshot as at 31st March)	622	642
Inpatient - Occupied Bed days	214,703	217,903
Addictions Services		
Number of Drug misusers in treatment	798	810
Percentage of drug users retained in treatment for 12 weeks or more	85-86%	95%

f) Commentary on significant 2008/09 variances from target

Inpatient Activity

Total bed numbers at the close of 2008/9 were 642, some 20 higher than originally planned (622). The changes in inpatient capacity were due to:

- Retention or creation of 14 Adult inpatient beds to meet increased demands, seven via conversion of smoking rooms and seven new female beds in Hackney (Gardner Ward)
- The opening of 13 new Forensic Low Secure beds (Colin Franklin Ward)
- The above is offset by a net reduction in Older Adult Services beds.

Community Activity

For 2008/9 the number of recorded community contacts with service users is just under 382,000, some 4% above the original target. This is mainly due to better capture of activity in Adult Services on the Trust's central RiO IT system.

The RiO system has bedded in well since it was installed as a Patient Administration System in July 2007 and then extended to Community Services for Adult, Older Adult and Forensic services in January 2008. During 2008/9 considerable work was undertaken to roll the system out to further teams and individual practitioners. The system is sufficiently established to provide the basis for full clinical deployment - the design stages of which are planned to start in Quarter 4 2009/10.

1.2.3 Foundation Trust 3-year contracts

The Trust has 3-year legally binding contracts with each of the three East London PCTs for local mental health services and one contract with the seven North East London PCTs for Forensic services and the CAMHS Tier 4 inpatient unit. These contracts commenced on November 1st 2007, on a 3-year rolling contract basis from April 2007. In relation to these contracts, the Trust has complied with all of its key contractual requirements for 2008/09.

1.2.4 Monitor's Quarterly Monitoring Arrangements

Throughout the year, Monitor has assessed the Trust as being: Financial risk rating 3; Governance risk ratings: Green; and, Mandatory services risk rating: Green.

1.2.5 External Review of Serious Untoward Incident [SUI] Policy

An external review of the Trust's SUI policy and procedures was undertaken in 2008 and the Inquiry's report and recommendations were presented to the Trust Board and sent in 2008. In response to this review the Trust has further strengthened its SUI procedures, management of SUIs reviews within agreed timescales and learning from these incidents. The final action plan was also reviewed at a Trust Board development event in March 2009.

1.3 Summary of Financial Performance

1.3.1 Overview

The Trust achieved an operating surplus below plan, resulting in an overall risk rating of 3 (compared with a plan of 4). This was due primarily to decisions to spend some of the Trust's cash on one off initiatives to speed up its service strategies; this included investment in recruitment, restructuring and pre-recruitment and set up costs for new services. The net surplus shortfall (compared with plan) was significantly lower than the operating surplus shortfall (compared with plan) due to significant sums received from interest received from investment of in year cash. Liquidity was high throughout the year with £47.2m held as at 31st March 2009.

The draft accounts were submitted on 23 April 2009. A number of changes have been agreed with the external auditors subsequently, including the revaluation of fixed assets as a result of the downturn in the property market. These changes have been incorporated in the tables below. The figures for 2008/09 are pre-audit. No significant changes are expected following final audit sign-off.

1.3.2 Income and Expenditure – EBITDA and Net Surpluses 2008/9

These, compared with plan were:

Table 5: EBITDA and Risk Rating

	Achieved		Plan	
	£m	%	£m	%
EBITDA	**8.2**	**4.4**	**12.1**	**6.6**
Net Surplus	**2.7**	**2.6**	**5.5**	**2.9**

Table 6: Income and spend, and the composition of the surpluses

INCOME	**2008/9 plan £m**	**2008/9 actual £m**
Mandatory		
Block Contracts	165.5	166.3
Non Contract	2.7	3.6
Non Mandatory		
Other Income		
Research	0.8	0.9
Education and Training	5.6	5.6
Other Income	7.1	8.3
TOTAL INCOME (excl. interest)	**181.7**	**184.7**
SPEND		
Pay	125.7	125.9
Non Pay	45.6	50.6
TOTAL SPEND	**171.3**	**176.5**
EBITDA	**10.4**	**8.2**
Impairments	-	(2.1)
Depreciation	(2.7)	(2.2)
PDC Dividend	(3.7)	(3.8)
Interest Receivable	1.5	2.6
NET SURPLUS	**5.5**	**2.7**

1.3.6 Performance Compared With Plan

The reduction in EBITDA surplus, compared with plan, is due to one off investment in initiatives to speed up implementation of key service initiatives, as outlined above. These initiatives were funded from surplus cash.

The decrease in the net surplus, compared with plan, is due to the above factors offset partially by increased interest receivable (above plan) from in-year cash management and the impact of the impairment as a result of the revaluation exercise to reflect the downturn in property prices.

High levels of liquidity were maintained through working capital control, and despite a capital programme of £15m. Cash balance at the end of the year of £47.2m

Capital spend was £15m compared with plan of £10.9m. Increased spend was primarily due to purchase of a new site to increase capacity for new surplus generating initiatives and bring forward some of 2009/10 schemes.

1.3.7 Use of Accumulated Surpluses

The accumulated liquidity will fund service initiatives within the service plan. This will include financing of £20m for the 3-year capital programme, funding (where required) of set up costs for new developments, restructuring, and double running costs where new services replace existing services.

1.3.8 Performance Against Foundation Trust Metrics

Table 7: Overall Rating

	£m	%	Rating
Plan Achievement (%)	n/a	78.7	3
EBITDA margin	8.2	4.4	2
Asset Return (%)	n/a	6.5	5
Net Surplus	2.7	2.6	4
Liquidity (days)	n/a	99.9	5
OVERALL RATING			**3**

1.3.9 Conclusion

The Trust used its cash reserves to speed up its service strategy by investing in one off revenue initiatives and capital, recognising that this would reduce its overall risk rating. This was funded by continued high levels of liquidity, and was a sensible use of such liquidity. Adequate surpluses were generated despite this investment.

1.4 Other major issues

There were the following changes to the Members Council in 2009/10:

- Professor Watts resigned from his post as City University's Members Council representative on 27th May 2008.
- Patrick Ryan replaced Joseph De Lappe as the Tower Hamlets public member, from 1st July 2008.
- Jeremy Burden, a nominated member from Tower Hamlets PCT, resigned from his post as of 22nd January 2009.
- Patricia Justice (Tower Hamlets) died in February. Her position is yet to be filled.
- Jennifer Edie resigned from her post as City University's Members Council representative on 8th March 2009.

The Trust did not vary mandatory service provision or dispose of assets contrary to the terms of authorisation. The Trust acquired a property in Hackney and since this will be critical to the delivery of its services, this asset will be protected, in line with Monitor's requirements.

The Audit Commission continued to be the Trust's external auditors in 2008/09.

2. FUTURE BUSINESS PLANS

2.1 Overall Vision

The Trust's vision is: ***To provide high quality mental health care to our local communities. We will do this in partnership with services users, their carers and families and statutory and voluntary organisations***. The Trust's core values are at the heart of our vision for the future development of our services. These will underpin everything we do and include:

- Putting the service user and carer at the centre of everything we do
- Ensure wider choice and promote independence
- Provide safe, effective and value for money services
- Ensure equality and value diversity
- Recognise the contribution of our staff and provide a capable workforce
- Promote social inclusion and recovery.

2.1.1 Strategic objectives

To deliver this vision, we will build on the strong clinical and managerial expertise of our staff, our excellent track record of managing our finances and further strengthen service user and carer participation. We will also continue to build relationships with existing partners and develop new partners to make best use of our joint resources. We also aim to develop and expand in areas where we have a strong and established track record of delivering high quality and responsive services.

The Trust's strategic objectives for the next 1-3 years are detailed below:

- Ensure the meaningful participation of service users, their carers and families in the shaping, delivery and evaluation of their care and the future direction of our services
- Improve the quality of our community and inpatient services
- Develop a highly skilled, motivated and culturally capable workforce
- Maximise learning opportunities for all staff, provide high quality teaching and training, and remain a centre of excellence for research
- Make the best use of our resources, increase surpluses, improve performance and develop the quality of information and IT systems
- Develop existing and new partnerships to promote social inclusion for all our service users
- Seek new business opportunities consistent with our vision.

2.1.2 Formation and Development Process

The 2009/10 Annual Plan is consistent with the Trust's vision and second year of the 5-year service development strategy, included within the Trust's IBP. The IBP was widely consulted on internally with senior clinicians and managers and externally with a range of stakeholders. The 2009/10 Annual Plan also builds on the quality and service improvements achieved in 2008/09 and is consistent with London and the East London

PCTs' overall strategies and commissioning plans. The Trust is also working closely with the PCTs to develop its older adult strategy. In 2009/10, two of the PCTs have also invested additional funding for the development of new and existing services in line with their commissioning intentions and strategies. For further information refer to the service development plans (section 2.2.4).

To develop the 2009/10 Annual Plan, the Trust Board of Directors has held several events challenging the priorities and investment strategy within the plan as well as reviewing the original Year 2 IBP proposals and the additional service proposals and investments from East London PCTs. The Trust Board held seminars in March and May 2009 to discuss priorities and also formally reviewed the draft and final copies of the Annual Plan at its public meetings prior to submission to Monitor.

During the latter part of 2009, the Chief Executive held seminars with senior clinicians and managers within each of the five Directorates and these were supplemented by the Directorate meetings with Executive Team members and the Clinical Directors, Borough/Service Directors and Performance Managers. This process has challenged assumptions within the plan and agreed delivery dates for service developments.

The Trust's Service Delivery Board has reviewed and had input into the development of the Annual Plan. In addition, the Medical Director has reviewed elements of the plan with the Trust's Clinical Directors group.

Regular updates have been posted on the staff intranet and in *Trusttalk* (Trust-wide staff magazine) and within the 2-way briefing communication (a monthly notification to all staff and used by team leaders to facilitate team and 1-1 communication). In addition, service users have reviewed and/or given feedback on the plan in a variety of settings, including through the Trust-wide Working Together Group.

The 2009/10 Annual Plan has been reviewed by the Members Council at several meetings and development events from September 2008 – March 2009 and they have made a significant contribution to the final content and priorities contained within it. The Members Council were also given an opportunity to give feedback in April 2009 on a draft of the full plan.

The Members Council were in support of the majority of service initiatives outlined in the service development plan but also suggested further areas for improvement, review and/or development. The wider membership also made suggestions at an evening event in March 2009 which was attended by over 80 members and Members Council members. The key suggestions have informed the development of the 2009/10 Annual Plan and the service initiatives proposed.

2.2 Strategic overview

2.2.1 National and Local Challenges

The Trust's 5-year service plan is detailed in the Integrated Business Plan and as part the development of the 2nd year of the plan; the Trust Board had undertaken an analysis of the political, economic, social and technical context for the next 1-3 years. A summary is attached (refer to Appendix 1).

This analysis has been updated to take into account the changing operating and future economic environment and the key factors impacting on the 2009/10 Annual Plan. These factors and their mitigation actions are detailed overleaf.

Impact of the Economic Situation and Department of Health [DH] Central Allocations, National Pay Awards, NHS London and Local Health Economy Financial Position

The Trust is anticipating significant changes to its operating and economic environment over the short and medium terms, as the difficulties facing the national economy feed through into public sector funding and the local health care economy.

The Trust still remains subject to potential reductions in DH central allocations, e.g. DSPD allocations, and also indirectly as any reductions in PCT allocations will adversely effect the commissioning and contract environment. Pay awards above levels assumed in the financial plan now appear less likely.

In 2009/10, NHS London's financial position has been significantly affected by the changes in: i) the baseline allocation formula which has caused East London PCTs to be over target and therefore they will need to reduce expenditure over the next 3 years to be within target; ii) financial implications of the overall Acute Hospital HRG4 tariff and, iii) the need to bring expenditure back into balance across London through top-slicing PCTs to transfer investment to areas of overspending This has had an adverse financial impact on the East London PCTs and has significantly reduced their ability to increase their investment in mental health for 2009/10; however, City & Hackney and Tower Hamlets PCTs are still able to make some investment in mental health but for future years growth is unlikely.

The Trust remains committed to working in partnership and the proposals on polyclinics and shared premises provides potential opportunities for the Trust to rationalise its estate through being more integrated with primary care and sharing premises.

Overall, the Trust is anticipating a challenging environment ahead in the short and medium terms and will respond by placing a high priority on organisational sustainability and the generation of surpluses. The Trust will also seek to take advantage of any future opportunities arising from significant service change, driven by efficiency and service improvement and further develop 3rd sector partnerships.

Payment by results

In preparation for payment by results in 2010/11, the Trust is participating in the London Mental Health Trust pilot on service line reporting and is also implementing trading accounts and service line reporting.

18 Week Referral to Treatment

18 week referral to treatment is likely to affect Mental Health Trusts by the end of March 2010. This will primarily affect psychological therapies and the Trust will be a London pilot to amend the current national guidance for mental health trusts. In preparation for this the Trust is developing robust systems to monitor wait times, reduce did not attends [DNAs] and is developing Trust-wide access and 18 week referral to treatment policies.

World Class Commissioning, Contracts and Patient-led NHS and Service User Choice

In East London, the development of world class commissioning and of commissioning capabilities within local PCTs continues and is likely to impact on the local health economy through more sophisticated commissioning and increased tendering of services. In addition, plurality, contestability and diversity of providers has begun to affect the Trust's preferred provider status locally as predicted in last year's annual plan. This has resulted in some

competition from other NHS Trusts, the 3rd sector, independent sector as well as Practice Based Commissioning [PBC] and primary care provider arrangements.

The Trust's market assessment and discussions with local PCTs indicates that this will continue although risks are likely to be accompanied by opportunities to access new markets.

The Trust's mitigation plan to address this potential competition over the next 1-3 years will be to continue to develop closer working relationships with the 3rd sector and, where appropriate, develop joint or linked service provision. The Trust has already started to achieve good progress with this approach during 2008/09, with joint bids leading to the acquisition of new business in competitive tendering processes.

The Trust intends to work more closely with the 13 Practice Based Commissioning Consortia [PBCs] covering East London.

Although the levels of choice currently offered for people with physical healthcare problems are not currently proposed for mental health service users, the impact of commissioning a Patient-led NHS, will provide more choice of community services through a range of providers. The choice agenda is also being pursued through the development of personal budgets within social care and this is likely to increase competition.

The Trust positively embraces this move to greater choice and control for service users which sits very comfortably with the stated core values of the organisation. The Trust will continue to develop closer partnership working with service users to ensure improved satisfaction and responsiveness. The Trust has also recently implemented the use of voluntary Advance Directives for service users as part of this new agenda.

Population and Demand Changes

The significant population increases in Newham and Tower Hamlets over the next 5 years have, until recently, only had a minimal impact on the Trust's services. However, there are signs that the increase in population may be beginning to affect demand for Trust services. The Trust will be closely monitoring this situation during 2009/10 and will work closely with its partner East London PCTs.

The links between socio-economic factors and mental health problems in the general population are well documented. The current national economic picture and rising unemployment may well translate into increased demand for the Trust's services over the medium term.

In mitigation, the Trust is monitoring new demand on all of its services and is working with the East London PCTs to scope the impact of this on 2009/10 contract volumes and targets.

Market context and competition

The market context and competition is not anticipated to change markedly during 2009/10 although, as already described, the wider economic context may yield both threats and opportunities as public sector financing becomes affected.

The key elements of the current market context and competition are as follows:

- The Trust continues to be the main provider of specialist and secondary mental health and substance misuse services in the City of London, Hackney, Newham and Tower Hamlets. It is also the main provider of forensic services to North East London.
- East London will remain the key market therefore the Trust will be working closely with local Primary Care Trusts [PCTs] and Local Authorities [LAs] to ensure that we deliver high quality and responsive services and retain and grow our current market share. This will involve exploiting partnership arrangements and Joint Ventures to ensure that we provide excellent services through collaboration with others, e.g. primary care and the 3rd Sector.
- The Trust has developed expertise and a track record of providing high quality services and therefore is ideally placed to market our services to East London, North East London sector and to new markets.
- We already compare favourably with most London Mental Health Trusts and the key Private, Independent and 3rd Sector providers on quality and price. The Trust will continue to improve upon this position and become even more competitive through implementation of service improvement plans and measures to improve the quality of our services, efficiency and effectiveness.

The Trust has secured its market share during 2008/09 having attracted additional investment from East London and North East London PCTs for its local and forensic services.

In relation to this competitive environment, the Trust has reviewed the Principles and Rules on Cooperation and Competition and is currently compliant with this guidance and will ensure that it remains compliant during 2009/10.

Quality Account reporting

The Trust's quality and improvement plan has built upon the achievements made in 2008/09, as outlined in the 2008/09 Annual Report. The Trust has also complied with the Quality Account reporting requirements, issued in April 2009. For further information on the Trust's quality agenda refer to section 2.2.2.

The Trust has submitted the 2008/09 Annual Health Check Declaration in Quarter 1 of 2009/10 and has declared compliance with core standards. In addition, the Trust has recently registered with the Care Quality Commission with a registration classification of unconditional.

2.2.2 Quality

The Trust has set out ten priorities (refer to section 2.2.4) of which six focus on quality improvement and two support this improvement. The rationale for these quality improvement targets is set out below along with proposed means for measuring them during the year. Performance against targets will be reported to the Board quarterly through the performance report.

Improving Quality (Clinical Effectiveness and Patient Experience) and Safety

Priority One: *Older adult services*

The Trust had not carried out a major review of older adult services since its inception in 2000. The services provided in each borough are mainly bed-based, and varied considerably

across the boroughs. In 2008 the government identified dementia services as a priority and the Department of Health started to develop a national strategy. The Trust Board therefore agreed to develop a strategy, in conjunction with local Primary Care Trusts, in order to improve the quality of services provided for older people.

The Trust does not currently have an Older Adults survey but will establish one during the year; this will enable measuring improvement in Older Adult Services.

Priority Two: ***Inpatient services***

The quality of the Trust's adult inpatient services is of major importance to service users and their carers. In 2007 the Healthcare Commission carried out a review of the Trust's acute inpatient mental health services, assessing whether admissions were appropriate, purposeful, therapeutic and safe. The review identified a range of issues where the care provided was not consistent across the Trust. The Trust Board therefore agreed to focus on this area and receives regular audits on performance.

The Trust aims to achieve at least 95% compliance on all five standards as shown in Table 8.

Table 8: Healthcare Commission Inpatient Standards

Standard:	Performance as at June 2007	Performance as at March 2009	Target Performance 2009/10
1. All service users on admission receive a physical health check and the outcome recorded	54%	87%	95%
2. All services will hold a multi-disciplinary team meeting within 7 days of admission to discuss the care of the service user and this will be recorded	56%	82%	95%
3. The community care coordinator for service users known to the service will attend and provide input into the first multi-disciplinary team meeting and their attendance will be recorded	N/A*	62%	95%
4. Within the first 7 days of admission, formal 1:1 sessions to discuss the nursing care plan with nursing staff must be recorded at least once per day and thereafter weekly	2%	37%	95%
5. Service users' views on their inpatient care plans will be recorded as part of the 1:1 Sessions and following the first reviews.	42%	62%	95%

* The Standard agreed within the Trust was different from that used by the Healthcare Commission and so a comparison could not take place.

Priority Three: ***Adult Community services***

The Trust receives feedback on the quality of its adult community services through the National Patient Survey. The survey has identified that there are several areas for improvement regarding the quality of community services, including the use of the Care Programme Approach.

In view of this the Trust will focus on the following areas:

- At least 95% of assessments undertaken and care plans to be in place within 28 days.
- At least 95% compliance with CPA requirements.
- Introduction of service user community surveys.

These areas will be monitored during 2009/10 and quarterly reports will be submitted to the Trust Board.

Priority Four: ***Physical Healthcare***

This priority has been identified by our members and Members' Council. The Trust was aware that from the Health Care Commission review of our inpatient services in 2007 we were not carrying out physical healthcare checks regularly upon admission. The Trust has recognised the importance of a holistic approach to mental and physical healthcare.

Table 9: Physical Healthcare Standard

Standard:	Performance as at June 2007	Performance as at March 2009	Target Performance 2009/10
1. All service users on admission receive a physical health check and the outcome recorded	54%	87%	95%

Further measures will be agreed once the Trust-wide Physical Healthcare and local inpatient implementation plans are in place.

Priority Five: ***Carers services***

This priority has been identified by our members and members' council. Through our surveys and performance reporting we are aware that service across the Trust has not been consistent.

The Trust will develop a Carers Plan and will aim to increase the numbers of carers having an assessment by 30%. Baseline figures will be confirmed in Quarter 1. The Trust does not currently undertake formal carers' surveys but will establish a survey this year. Feedback from this survey will help the Trust to improve its services to carers.

Priority Six: ***Learning from Incidents, SUIs, Homicides and Serious Case Reviews [SCRs]***

Providing safe services is of great importance to the Trust as is the need to learn lessons from incidents in order to reduce the possibility of recurrence.

The Trust aims to keep the number of SUI reports with outstanding recommendations to a minimum. SUI reports on outstanding action plans will be submitted quarterly to the SUI subcommittee and areas of concern will be escalated to the Trust Board.

The results of the 2008/09 staff survey have highlighted to the Trust that there are relatively high incidents of violent and aggressive behaviour in inpatient services.

The Trust aims to have 90% of frontline inpatient staff trained in prevention and management of violence and aggression.

The 2009/10 Commissioning for Quality and Innovation [CQUIN] payments will be made to the Trust by the East London PCTs on production of data sets, as outlined in the contract KPI schedule. In relation to the specialist commissioner's contract, these payments will be included within their monthly payments, once an improvement plan has been agreed.

2.2.3 Key actions

2.2.3.1 Service Strategy

Within the framework of the 5-year service strategy, the 2009/10 Annual Plan aims to ensure continuous and sustained service improvement in all areas and will develop more community based services that promote independence, choice and recovery. It will also create clear community and inpatient pathways and will result in further modernisation of our inpatient services which will include expansion of forensic capacity.

We will work with statutory and non-statutory partners to address social inclusion and health inequalities, improve health and well-being. We will also develop more responsive services to primary care and work alongside GPs to deliver improved care pathways between primary care and secondary mental health services.

The service developments over the next 3 years, based on the need to respond to national and local challenges (see section 2.2.1), will focus on:

- Improving services and support to GPs and Primary Health Care Teams
- Developing high quality community services which promote independence and recovery as well as more choice for service users
- Increasing access for service users to employment, education & training opportunities, physical healthcare services and ensure that we provide culturally appropriate services
- Improve our inpatient services so that service users can access the best type of service at the right time
- Expanding the capacity of our forensic services to provide further business opportunities
- Provide modern and fit for purpose environments and buildings for both service users and staff
- Ensure that there are good information systems so that clinicians and service users can access the right information at the right time.

During our first full year of Foundation Trust status we made good progress in addressing the above areas and this has provided an excellent foundation for taking forward the 2009/10 Annual Plan, and the second year of the IBP. Over the next two years, the Trust will continue to be competitive in terms of quality and cost, and will:

- Deliver our 5-year service improvement and development plan, with a full review at the end of year 3
- Improve the quality of the Trust's services, through implementation of its Annual Health Check action plans to maintain Excellent ratings for Quality of Services and Use of Resources in 2009/10

- Continue to sustain robust Trust-wide financial management and increase surpluses so that performance against financial ratios is returned to a risk rating of 4
- Meet national, PCT and Trust Mental Health Key Performance Indicators and Targets, including the 18-week target for psychological therapies
- Continue our good progress towards becoming the Mental Health Provider of Choice and the Mental Health Employer of Choice for East London.

2.2.3.2 Competition and marketing proposals

As outlined earlier in the market context and competition section (2.2.1), the Trust intends to build on the 2008/09 service initiatives and has developed business case proposals to expand its forensic capacity and into new markets such as the secure inpatient services for people with learning disability and expansion of the existing Mother and Baby to a wider population. These new services will come on stream during 2009/10 and will secure additional market share for the Trust.

The Trust also intends to continue with its current marketing approach to:

- Maintain and, where possible, grow our existing market share within East London
- Expand our existing services and develop new ones within North East London
- Expand into new markets, where these are consistent with our vision and strategic objectives.

To achieve further expansion and improvement to its existing facilities, the Trust has purchased a property in Hackney for healthcare purposes.

2.2.3.3 Relationships with stakeholders and commissioning

The Trust's 5-year IBP is now in its second year having previously been agreed by the local East London PCTs and Local Authorities, and in respect to Forensic services with the seven North East London PCTs. The Trust's 2009/10 Annual Plan is consistent with the local East London PCTs' Commissioning Strategy Plans and their 2009/10 Operating Plans.

The Trust has strengthened its relationships with the East London PCT and Local Authority partners and is also continuing to develop closer relationships with the 13 Practice Based Consortium [PBCs] covering East London.

As part of the original process to develop the IBP the Trust held joint meetings with some of the PBC Borough forums to review the 5-year service strategy. The Trust has recently undertaken a survey of selected GPs in Tower Hamlets and Newham to identify how the Trust can improve its services to primary care. During 2009/10, further work will be undertaken with GPs and PBCs to ensure that the Trust is providing the range and quality of service provision that primary care require and want to commission. This will be complemented by the work of the new Consultant Psychiatrists in Primary Care in City & Hackney and Tower Hamlets.

The Trust is also working closely with the Local Authority Health Overview and Scrutiny Committees and intends to develop closer liaison and joint working with the LINKs [Local Involvement Networks] during 2009/10.

The new London PCT collaborative commissioning arrangements for 2009/10 will mean that Tower Hamlets PCT will be the lead commissioner for the three East London PCTs and the existing North East London arrangements will either continue for specialist commissioning arrangements or they will become London-wide.

In line with NHS London guidance to PCTs and in order to move to the new Mental Health Contract, the East London PCTs (local contracts) and the North East London PCTs (forensic and CAMHS inpatient contract) gave the Trust 2 years notice of termination on the existing four contracts from 1st April 2009. In the meantime, the Trust and East London PCTs have agreed to amend the schedules to the existing 3 year East London PCT contracts to be more in line with the new National Mental Health contract. These revised schedules include a Services Quality and Safety Improvement Plan which is consistent with the Trust's quality accounts and improvement agenda outlined in section 2.2.1 and 2.2.2.

The Trust has also been working closely with commissioning partners and stakeholders to develop new services and enhance our existing services, in line with the four borough Children and Young Peoples', Adult and Older Adult strategies and plans. The 2009/10 Annual Plan builds on the achievements of 2008/09 and therefore remains consistent with and addresses the national and local service needs.

2.2.3.4 Engagement with Council Members and Membership

During 2008/09, the Trust's Chairman has continued to offer 1-1 meetings with all existing and new members and maintains a close working relationship with the membership team. There have also been five formal meetings of the Council and one development event. The Council members have also participated in a comprehensive induction programme which has involved visits to numerous services across the Trust. These meetings and events have all been very well attended. Considerable work has been undertaken with the Members Council and Membership, as described in section 1, on the development of the 2009/10 Annual Plan.

Membership recruitment continues and regular Foundation Trust Newsletters and invitations to mental health related seminars are sent to the membership. The membership has also been consulted on how the Trust can effectively communicate and engage them in the development of the Trust.

2.2.4 Service development plans and priorities for the next 3 years, with a particular focus on the 2009/10 Annual Plan

2.2.4.1 Priorities

As part of the development of the 5-year IBP, the Trust completed a SWOT analysis [Strengths, Weaknesses, Opportunities and Threats]. This SWOT analysis has been updated (see Appendix 2) and the 2009/10 Service Development Plan priorities aim to address the Trust's strategic objectives and the key weaknesses and threats identified.

The overall focus of the 2009/10 Annual Plan will be to build on the quality and service improvements made in 2008/09 and improve the service user experience and the services we provide for service users and their carers and families. The 2009/10 plan will do this through ***Improving Quality and Safety*** and ensure ***Sustainability*** so that the Trust is financially robust enough to meet the economic challenges over the next 3 years***.*** Within these broad areas, there will be 10 priority areas and these will be supported by the

existing enabling strategies and plans. The key quality priorities will also be used to inform the development of the 2009/10 Quality Report.

To ensure that these key priorities and target areas are delivered, the Board of Directors will regularly review and monitor delivery. The delivery of these priorities will also be the key 2009/10 personal objectives for the Executive Team, Corporate and DMT staff. The key priorities and targets for the 2009/10 Annual Plan are detailed below:

Improving Quality (Clinical Effectiveness and Patient Experience) and Safety

Priority One: ***Older adult services***

- Delivery of the Older Adult Strategy implementation plans

  Success Measures: *Strategy approved* by Trust Board in December 2009 subject to PCT involvement and approval*

  **Agreed in principle, subject to consultation with the PCTs, LAs, the public and other relevant bodies*

  Delivery of implementation plans, as per timescales

Priority Two: ***Inpatient services***

- Delivery of improvement plans, in line with the Care Quality Commission's quality measures and standards

  Target: *Full compliance against all standards*

  Success Measures: *At least 95% compliance*

  Quarterly improvement against service user-led inpatient standards and service user survey results

- Continued development of and implementation of AIMS for adults and older adults and the Quality Network for CAMHS

  Target: *Excellent rating (AIMS)*

  Achievement of standards rated not fully met by 2009 QNIC peer review

  Success Measure: *Accreditation rating achieved for all wards (AIMS)*

  Full implementation of action plan arising from the 2009 QNIC peer review

- Development of gender specific inpatient services

  Success Measures: *Plan in place by end of October 2009*

  Full Compliance with Department of Health's Safety, Dignity and Privacy guidance (mixed sex accommodation standards) by end of August 2009

Quarterly service user inpatient feedback on key areas of the guidance

- Introduction of service user older adult surveys

  Success Measures: *Surveys in place by end of October 2009*

  Assessment of baseline performance and improvement plans/targets in place by January 2010, and progress monitored quarterly thereafter

Priority Three: ***Adult Community services***

- Improvements in clinical leadership, responsiveness and timeliness of assessment and brief treatment interventions, through delivery of the community review's implementation plans.

  Targets: *Initial assessments completed by senior staff and initial care plan in place within 28 days*

  Full implementation of the new community services' structures in all three Boroughs by December 2009

  Success Measures: *At least 95% of assessments and care plan in place within 28 days*

- Improve the implementation and quality of adult CPA

  Targets: *Full compliance on all CPA elements of care planning*

  Undertake six monthly reviews/audits to monitor compliance and identify any areas for further development

  Success Measure: *At least 95% compliance with CPA requirements*

- Introduction of service user community surveys

  Target: *Surveys in place by end of July 2009*

  Success Measure: *Assessment of baseline performance and improvement plans/targets in place by November 2009, and improvements to be agreed and monitored quarterly thereafter*

Priority Four: ***Physical Healthcare***

- Improve in-patient physical healthcare for service users and access to primary care services, through delivery of the Trust-wide and local inpatient implementation plans

  Targets: *Plan in place by end of June 2009 and review by December 2009*

  Success Measure: *Achievement of all key improvement areas, as outlined in the plan by end of March 2010*

Priority Five: ***Carers services***

- Improve carers services, engagement and support, and improve the number of carer's assessments offered, through the development and implementation of a Trust-wide plan

Targets: *Plan in place by end of June 2009*

All carers offered information and an assessment, with support as detailed within the assessment plan

1 'Psychosis Seminar' learning event to have been undertaken by the end of March 2010, with service users, carers and staff.

Success Measures: *30% increase in the number of carers having had an assessment by end of March 2010, together with the appropriate service provision*

Introduction of carer surveys/feedback arrangements by end of July 2009, assessment of baseline performance and improvement plans/targets in place by November 2009, and progress monitored quarterly thereafter

Priority Six: ***Learning from Incidents, SUIs, Homicides and Serious Case Reviews [SCRs]***

- Improved management of SUIs, SCRs and action planning

Target: *100% completion of reviews within agreed deadlines*

- Regular reviews and audit to ensure that learning is embedded within clinical practice

Success Measure: *Quarterly reviews (starting in July 2009) and seminars on learning from SUIs and SCRs*

Six monthly report to the Trust Board on themes and lessons learnt from SUIs.

- Ensure that levels of violence and aggression amongst patients and staff are minimised

Target: *Monitor levels, review incidents and introduce measures such as training and support, review of activities, and reflective practice to reduce the number and severity of incidents*

Success Measure: *Reduction in frequency and severity of violence and aggression for both patients and staff.*

90% of frontline inpatient staff trained in prevention and management of violence and aggression.

Evidence of an improvement in safety on the wards, as perceived by staff and patients, demonstrated by survey results.

Sustainability

Priority Seven: *Driving up Surpluses*

- Delivery of new service developments on time and to budget, e.g. Mother and Baby, Specialist Inpatient Secure Service for People with Learning Disability and Low Secure Developments
- Major progress on strategy to enhance forensic bed capacity
- Service strategy reviews
- Invest to Save initiatives
- Extension of market testing

Target: *As per project timescales*

Priority Eight: *Improved budget management*

- Budget accountability
- Improved cost reporting
- Implementation of trading accounts and service line reporting

Target: *As per project timescales*

The above priorities would be supported by the following:

Priority Nine: Training, Education and Development Programme

- Increased uptake of statutory and mandatory training, in line with the Trust's policy and agreed key training sessions

Target: *All staff to have undertaken key training sessions by the end of March 2010*

Success Measure: *95% of staff to have undertaken key training*

- Delivery of and increased uptake of the targeted customer care training

Target: *All eligible front-line staff to have been trained by end of March 2010*

Success Measure: *95% of staff trained*

- Development and delivery of the Organisational Development and Leadership Programme for the Trust Board, Directorate Management Teams and inpatient and community teams.

Success Measures: *Review of existing 'Coaching for Capable Teams' development programme to be completed by end of May 2009*

Development programme in place for Community Mental Health Teams by the end of July 2009

Clinical and Management Leadership programme in place by December 2009

Priority Ten: Modern and fit for purpose premises

- Delivery of the 2009/10 capital investment programme for community venues/sites and ensure that existing premises are maintained to a high standard

  Success Measures: *Acquire 3 new community and fit for purpose premises for Tower Hamlets (2 CMHT and 1 CAMHS) and 1 new community base for City & Hackney by October 2009, subject to affordability*

  Implementation of the back-log maintenance programme, in line with the 2009/10 plan

- Development of the business case for the re-provision of the City & Hackney Centre for Mental Health inpatient service

  Target: *Strategic Outline Business Case to be completed by end of June 2009, subject to planning negotiations*

In addition to the above, the work started in 2008/09 on the development of the Trust's Young People's Service Strategy and Non Verbal Therapies Strategy will continue.

2.2.4.2 Enabling Strategies and Plans

To support the delivery of the above priorities, the integrated organisational development programme, focussing on capability and effectiveness at all organisational levels will continue to be implemented and developed over the next year.

In addition, the following enabling strategies or plans will also continue to be implemented:

i) ***Public Participation Strategy and Trust-wide and Local Implementation Plans***, to consult on and agree the new people participation strategy and the reward and recognition policy, making links to the Trust's membership, as well as the volunteering strategy. To improve the meaningful engagement of service users and their carers in the shaping, delivery and evaluation of the Trust's services.

ii) ***Performance management,*** to further develop the existing quarterly and monthly performance review meetings with the Directorate Management Team and the Corporate Directorates/Department leads on delivery of the annual plan priorities; and, develop performance dashboards to monitor standards and outcomes, as outlined in the key priority areas.

iii) ***Risk management,*** to further embed risk management, SUI and SCR monitoring and learning at every level of the organisation, in particular, Directorate and Clinical Team levels.

iv) ***Service Line Reporting***, to participate in the London-wide pilot for mental health services through Child and Adolescent Mental Health Services [CAMHS] and Forensic service pilots. In addition, to develop internal work to refine service- and Directorate-level pricing models and activity based contract performance information in preparation for Payments by Results.

v) ***Social Inclusion and Equalities,*** to implement the Single Equalities Scheme following consultation and the equality and diversity training programme to support it. To implement the domestic abuse work programme and develop a robust Safeguarding Vulnerable Adults strategy and structure. To further develop and focus the work of the employment coaches and put in place a clear strategy with target for getting people into work.

vi) ***Information, Management and Technology***, in particular, clinical deployment pilots of RIO in community and specialist settings, ensuring that all relevant clinical activity is properly captured on RIO and to agreed standards, establishment of an information/data warehouse and exploiting new technologies to improve efficiency and productivity, e.g. piloting digital dictation to facilitate flexible working.

vii) ***Workforce***, in particular, maintain the agreed vacancy levels, further develop the new HR structure and a new competency framework and implement the training, education and leadership programme following the review undertaken in 2008/09.

viii) ***Review of corporate structures and functions***, to ensure that these structures are fit for purpose, cost effective and are able to deliver the Trust and DMTs' objectives and priorities.

ix) ***Local Safeguarding Children Boards,*** to implement, monitor and continue to develop safeguarding children strategies and recommendations throughout the Trust, taking into account all children in contact with service users or children who are service users themselves.

x) ***Local Safeguarding Adults policies and partnership arrangements,*** *to ensure compliance with current guidance and good practice; and to publish an Adult Domestic Abuse Strategy and develop an action plan.*

2.2.4.3 Specific Service Developments

The 2009/10 service development plan involves the establishment of ten new services and enhancement of five services. This includes the recruitment of 94 new staff (15 doctors, 35.5 nurses, 9 psychologists, 11.5 therapists, 15 administration staff, 2.5 clinical managers, 2.5 social workers, 2 support workers, 1 gateway worker).

The 2009/10 service developments include:

a) 2nd year of the 5 year IBP developments and 2009/10 developments to increase surpluses, i.e.:

- Further reconfiguration of older adult inpatient services in City & Hackney
- Reprovision of the rehabilitation and recovery inpatient service in City & Hackney
- Specialist secure inpatient service for people with learning disability
- Expansion of the Mother and Baby Unit, and
- Increasing forensic low secure capacity – subject to business case approval

b) 2009/10 PCT funded developments, i.e.:

- Expansion of the CAMHS Parental Mental Health Service
- New Child and Adolescent Mental Health service to under 25s
- Expansion of the Paediatric Liaison Service

- Additional staffing for Home Treatment Team for Adults in City & Hackney
- New Psychiatric Liaison Service for Adults in City & Hackney
- Enhanced Psychological Service for Older People in City & Hackney
- New Specialist Intermediate Care Service for Older People in City & Hackney
- New Early Detection Service in Tower Hamlets
- New Non-Verbal Therapies Service for Adults in Tower Hamlets
- Partnership Project for Rehabilitation Home in Tower Hamlets
- Partnership Project for Crisis House in Tower Hamlets
- Additional staffing for Home Treatment Team for Adults in Tower Hamlets

2.2.4.4 Impact on mandatory services and volume changes

The only material changes to the mandatory services being proposed in 2009/10 are related to the additional activity for service developments detailed in section in section 2.2.4.3. The activity plans for the next three years are summarised below in Table 10.

Table 10: Activity Plans: 2009/10 – 2011/12

ANNUAL PLAN 2009/10 ACTIVITY SUMMARY	ACTIVITY PLANS		
SERVICE SUMMARY	**2009/10**	**2010/11**	**2011/12**
Children and Adolescent Mental Health Services			
Community Contacts and Outpatient attenders	29,800	29,800	29,800
Inpatient - Beds (snapshot as at 31st March)	15	15	15
Inpatient - Occupied Bed days	4,654	4,654	4,654
Adult Services (Excl Forensic PD and Med Secure)			
Community Contacts and Outpatient attenders	309,606	314,158	314,265
Inpatient - Beds (snapshot as at 31st March)	308	296	296
Inpatient - Occupied Bed days	102,844	102,456	102,456
Adult Services - Forensic Med Secure and Personality Disorder			
Community Contacts and Outpatient attenders	4,989	4,880	4,760
Inpatient - Beds (snapshot as at 31st March Excl Tarriro House and Baxter Rd)	194	194	194
Inpatient - Occupied Bed days	69,439	70,190	70,190
Older Adult Services			
Community Contacts and Outpatient attenders	52,292	58,158	58,158
Inpatient - Beds (snapshot as at 31st March)	145	115	115
Inpatient - Occupied Bed days	50,279	39,876	39,876
Total CAMHS/Adult/Older Adult			
Community Contacts and Outpatient attenders	396,687	406,996	406,983
Inpatient - Beds (snapshot as at 31st March)	662	620	620
Inpatient - Occupied Bed days	227,215	217,175	217,175

ANNUAL PLAN 2009/10 ACTIVITY SUMMARY	ACTIVITY PLANS		
SERVICE SUMMARY	**2009/10**	**2010/11**	**2011/12**
Addictions Services			
Drug misusers in treatment	888	908	928
Percentage of drug users retained in treatment for 12 weeks or more	85%	85%	85%

Commentary on Activity Plans 2009/10-2011/12

Inpatient Activity

The Trust plans show a net reduction of inpatient capacity over the next three years. Total bed numbers at the close of 2009/10 are planned to be 662, potentially falling to 620 by the end of 2011/12. The net change arises from growth of Mother and Baby and Forensic Learning Disability capacity that is offset by a potential reduction in Older Adult and Adult rehabilitation beds. The Older Adult reprovision is subject to further agreement with the East London PCTs.

Table 11 - Bed Change Proposals	**Beds**	**Timetable**
Actual 31/3/2009	**642**	
Expansion of Mother and Baby Unit (4 to 10 beds)	6	Assumed from 1/1/2010
New Forensic Learning Disabilities Service	14	Assumed from 1/6/2009
Potential developments at 31/3/2010	**662**	
Community unit to replace Rehabilitation Ward	-12	Assumed from 1/10/2009
Community unit to replace Older Adult Wards	-30	Assumed from 1/4/2010
Potential at 31/3/2011 and 31/3/2012	**620**	

Community Activity

By 2011/12 the number of recorded community contacts with patients in CAMHS, Adult and Older Adult services will grow by approximately 25,000 to just under 407,000 contacts per annum (about 6.5% above the 2008/9 out-turn of around 382,000). The main areas of expansion are:

- Adult Services – Personality Disorder and Dual Diagnosis services in Tower Hamlets (c 7,000)
- Older Adult Services – Dementia Teams and Intermediate Care Services for City and Hackney and Newham (c 18,000)

Mandatory Goods and Services

A Mandatory Services Schedule is attached (Schedule 2, section 7.1). This table summarises the main service currencies and activity volumes agreed and contracted with the Trust's main East London Commissioners.

For the Trust's three local PCTs, a new and standardised range of Commissioning Key Performance Indicators (KPIs) have been agreed and will form the basis of performance reporting during 2009/10.

2.2.4.5 Compliance with Schedule 4

The Trust's private income cap is zero. The Trust will achieve compliance with this cap.

2.2.5 Summary of key service developments

The new service developments have been informed by the Trust's SWOT analysis and the workforce, estates and information, management and technology implications of the developments are detailed in Table 12 overleaf. The activity and financial (capital and revenue) implications of these new developments are included within the activity and financial plans (refer to sections 2.2.4.4 and 2.3.1 respectively). For further information on the delivery dates and lead director responsibility refer to the 2009/10 Implementation Plan in Appendix 3.

Table 12: 2009/10 Service Developments: Summary of Workforce, Estates and Information Management and Technology implications

Service Development	Workforce	Estates	IM&T
2nd Year IBP service developments and developments to increase surpluses			
City and Hackney Rehabilitation and Recovery Service	This will involve redeployment of staff or be subject to another provider so there will be no additional staffing requirements.	▪ Subject to the service model and provider	▪ Subject to the service model and provider
Expansion of Trust-wide Mother & Baby Unit based at the City and Hackney Centre for Mental Health	▪ 7 WTE new staff are required ▪ Reconfiguration of existing staff will also be required. ▪ All new staff in post by January 2010.	▪ Refurbishment of existing ward at City & Hackney Centre for Mental Health site ▪ Service will be fully operational in February 2010 and funded through the capital programme.	▪ Full IM&T kit-out and networking required and is included within capital plan.
Specialist Secure Inpatient Service for People with Learning Disability based at the John Howard Centre	▪ 38 WTE new staff required. ▪ All staff in post by May 2009.	▪ Refurbishment of existing ward at John Howard Centre site ▪ Service will be fully operational in June 2009 and there is no capital implication.	▪ Full IM&T kit-out and networking required. ▪ IM&T infrastructure to be funded through existing IM&T strategy.
PCT Funded Developments			
City & Hackney CAMHS			
Expansion of the CAMHS Parental Mental Health Service	▪ 3.5 WTE new staff required	▪ Service will be based within existing community team site ▪ Service will be fully operational in July 2009 and there is no capital implication.	▪ Full IM&T kit-out and networking required and is included within capital plan.
New Child and Adolescent Mental Health service to under 25s	▪ 2.5 WTE new staff required	▪ Service will be based within existing community team site ▪ Service will be fully operational in July 2009 and there is no capital implication.	Full IM&T kit-out and networking required and is included within capital plan.

Service Development	Workforce	Estates	IM&T
City & Hackney Adults and Older Adults			
Expansion of the Paediatric Liaison Service	▪ 1 WTE new staff member required	▪ Service will based within the existing team at Homerton Row and at Homerton University Hospital Foundation Trust ▪ Service will be fully operational in July 2009 and there is no capital implication.	▪ Full IM&T kit-out and networking required and is included within capital plan.
Additional staffing for Home Treatment Team for Adults in City & Hackney	▪ 5 WTE new staff required ▪ All staff in post by July 2009	▪ Service will based within the existing team at Homerton Row and at Homerton University Hospital Foundation Trust ▪ Service will be fully operational in September 2009 and there is no capital implication.	▪ Additional capacity, e.g. computers, hardware and networking required. ▪ IM&T infrastructure to be in place by June 2009, funded through existing IM&T strategy.
New Psychiatric Liaison Service for Adults in City & Hackney	▪ 9 new staff required ▪ A Care Pathways Project Manager (non-recurring) will also be appointed and in post by August 2009. ▪ All other staff in post by Sept 2009.	▪ Service will based at Homerton University Hospital ▪ Refurbishment of office space should be completed by September 2009 and will be funded through the capital programme. ▪ Service will be fully operational in December 2009.	▪ Additional capacity, e.g. computers, hardware and networking required. ▪ IM&T infrastructure to be in place by September 2009, funded through existing IM&T strategy.
Enhanced Psychological Service for Older People in City & Hackney	▪ 2.2 WTE new staff required. ▪ All staff in post by Oct 2009.	▪ Service will based within the existing team at Primrose Resource Centre and Homerton University Hospital ▪ Refurbishment of office space will be completed by September 2009 ▪ Service will be fully operational in December 2009 and funded through the capital programme.	▪ Additional capacity, e.g. computers, hardware and networking required. ▪ IM&T infrastructure to be in place by September 2009, funded through existing IM&T strategy.

Service Development	Workforce	Estates	IM&T
City & Hackney Adults and Older Adults continued			
New Specialist Intermediate Care Service for Older People in City & Hackney	▪ 7 WTE new staff required. ▪ All staff in post by Oct 2009.	▪ Service will be based within the existing older adults team at Primrose Resource Centre and the older adult inpatient ward at Homerton University Hospital ▪ Service will be fully operational in December 2009 and funded through the capital programme.	▪ Additional capacity, e.g. computers, hardware and networking required. ▪ IM&T infrastructure to be in place by September 2009, funded through existing IM&T strategy.
Tower Hamlets Adults			
New Early Detection Service in Tower Hamlets	▪ 4.9 WTE new staff required. ▪ All staff in post by August 2009.	▪ Staff will be based at the existing EIS building but see patients in a range of community settings ▪ Service will be fully operational in September 2009 and there is no capital implication.	▪ Additional capacity, e.g. computers, hardware and networking required. ▪ IM&T infrastructure to be in place by August 2009, funded through existing IM&T strategy.
New Non-Verbal Therapies Service for Adults in Tower Hamlets	▪ 5 WTE new staff are required. ▪ All staff in post by July 2009.	▪ Staff will be based at location or service to be confirmed ▪ Service will be fully operational in September 2009 and there is no capital implication.	▪ Additional capacity, e.g. computers, hardware and networking required. ▪ IM&T infrastructure to be in place by September 2009, funded through existing IM&T strategy.
Rehabilitation Service for Tower Hamlets	▪ 2.8 WTE new staff are required.	▪ Subject to further review.	▪ Subject to further review
Crisis House Service for Tower Hamlets	▪ 1 WTE new staff member required.	▪ Subject to further review.	▪ Subject to further review

Service Development	Workforce	Estates	IM&T
Tower Hamlets Adults continued			
Additional staffing for Home Treatment Team for Adults in Tower Hamlets	▪ 5 WTE new staff required. ▪ All staff in post by October 2009.	▪ Service will based within the existing team at Mile End Hospital ▪ Service will be fully operational in October 2009 and funded through the capital programme.	▪ Additional capacity, e.g. computers, hardware and networking, will be purchased ▪ IM&T infrastructure to be in place by June 2009, funded through existing IM&T strategy.

2.3 Summary of Financial Forecasts

2.3.1 Overview

The three year financial forecasts complement the five year service plan agreed with our PCTs. Detailed budgets have been agreed with Directors for 2009/10, supported by more indicative figures for the following two years. The figures in this section are summaries, with details included in the Annual Plan financial template submission.

Developments in 2009/10 will be recurrently funded by a combination of confirmed new PCT investment (£5.6m, being a net increase of £3.3m for new Low Secure and Learning Disability units, and £2.3m from local PCT investment in core services) and internal savings (£0.5m) in line with the five year service plan. A capital programme of £13.4m (part of a 3 year capital programme of £20.1m) will support this service agenda, including creating capacity for delivery of new services. Cash forecasts indicate high liquidity throughout the year, carried forward into the following 2 years.

2.3.2 Income and Expenditure

Table 13: Summary figures including the impact on the EBITDA and net surplus margins

		3-Year Plan		
		2009/10	**2010/11**	**2011/12**
INCOME		**£m**	**£m**	**£m**
Mandatory		**181.2**	**189.8**	**205.4**
Contracts/Agreements		179.1	187.7	203.2
Non Contract		2.1	2.1	2.2
Other Income				
Research		0.4	0.5	0.4
Education / Training		5.7	5.8	5.8
Other		3.5	3.6	3.7
TOTAL INCOME		**190.7**	**199.7**	**215.3**
SPEND				
Pay		(131.7)	(131.2)	(135.8)
Non Pay		(47.4)	(51.1)	(60.7)
TOTAL SPEND		**(179.1)**	**(182.3)**	**(196.5)**

		3-Year Plan		
		2009/10	**2010/11**	**2011/12**
EBITDA		**11.6**	**17.4**	**18.8**
Depreciation		(3.6)	(3.6)	(3.6)
PDC Dividend		(4.3)	(3.4)	(3.4)
Interest Expense		(1.9)	(1.9)	(1.9)
Interest Receivable		0.5	0.9	1.1
NET SURPLUS		**2.3**	**9.4**	**11.0**

2009/10

Income of £161.1m has been formally signed off with commissioners; income of £19.9m has been agreed in principle (for jointly commissioned services between Local Authorities and PCTs, and for central services with the Department of Health). Non contract income is £3.7m, an increase of £0.9m compared with previous budgets but in line with amounts achieved in the last two years. Contracts to be agreed to support income assumptions are Learning Disability (£1.7m) and the balance of targeted new Low Secure income (£0.5m).

Spend has been signed off by relevant Directors and includes full establishment budgeting and internal reprioritisation of £5m to fund validated cost pressures. A recurring provision has been made for inflation pressures in line with national guidance contained within the National Operating Framework, and for costs of the second year of the three year national pay agreement and associated incremental drift, and within the 1.7% national generic uplift.

2.3.3 The impact of IFRS

Until 2008/9 the financial statements were prepared under the Generally Accepted Accounting Practice (GAAP). From 2009/10 International Financial Reporting Standards (IFRS) are being adopted across central government and the public sector in the UK as required by HM Treasury. NHS foundation trusts are therefore required, for the first time, to prepare their three year plan under IFRS.

The main impact for us is that some of our leases are now classified as Finance leases under IFRS; these plus the PFI scheme will now appear on the balance sheet. The comparative information to show the impact of implementing IFRS on the key risk rating ratios is summarised in the table below:

Table 14: Impact of IFRS

GAAP	**IFRS**	**Underlying performance (weighting 25%)**				
2	3	5	4	3	2	1
4.9%	6.1%	11%	9%	5%	1%	<1%
GAAP	**IFRS**	**Return on assets (weighting 20%)**				
5	4	5	4	3	2	1
7.3%	5.3%	6%	5%	3%	-2%	< -2%
GAAP	**IFRS**	**IS surplus margin (weighting 20%)**				
3	3	5	4	3	2	1
1.7%	1.2%	3%	2%	1%	-2%	< -2%

3	**3**	**Overall Risk Rating**

The “underlying performance” indicator has improved from 4.9% to 6.1%, primarily because of the treatment of the PFI unitary charge; an element which would have been charged as operating expenditure, is now treated non-operating expenditure as an interest expense.

“Return on assets” indicator has deteriorated from 7.3% to 5.3%, mainly because the additional depreciation charge as a result of an increase in the asset base. The additional depreciation charge reduces the net surplus which consequently reduces the return on assets.

2010/11 and 2011/12

Income is assumed to increase annually at assumed generic increases of 1.7% for 2010/11 and 1.2% thereafter. The principle of increase in income for carry forward services at the generic uplift is agreed within the signed contracts with PCTs. No assumption has been made for further development income (which, if received, will be offset by spend, thus being neutral for net income/expenditure purposes) or for reductions in PCT or national income. Income from new initiatives has not been factored in.

Pay Spend reflects the third year of the three year pay agreement plus incremental drift.

Non pay spend reflects assumed inflation of 1.5%, to be allocated against specific non pay pressures.

Annual cost savings will need to increase from past years to reflect the reduced growth available to the NHS, with plans being set to generate minimum savings (and/or surpluses from new initiatives) and achieve the a risk rating

2.3.4 Savings Plans

Table 15: 3-Year Savings Plans

	2009/10	2010/11	2011/12
	£m	£m	£m
Administration / Community Services Review	1.1		
Establishment Review Exercise	1.7		
Spend to save initiative	0.3		
Ward Closure Savings	0.9		
Elderly Services Reconfiguration	0.2		
CMHT Rationalisation £108k, Homerton Overhead Reduction £100k, Repatriation of Private Sector Placements £123k	0.3		
Combination of new business / Invest to save schemes / VFM reviews / Cost containment and good housekeeping measures		6.2	8.9
TOTAL	**4.5**	**6.2**	**8.9**

Savings plans will top up PCT investment to fund service developments and changes in service provision (as agreed with the PCTs within the 5 year plan), and to finance national generic inflation shortfalls. The total savings includes the effect of the assumed reduction in NHS resource availability and the need for increased amounts of annual savings.

2.3.5 Performance Against Foundation Trust Metrics (Ratings-R) and Key Assumptions

Performance against the metrics show considerable margin in all, with the exception of the underlying margin as outlined in the table overleaf.

Table 16: Overall Rating

	Plan	Actual		3-Year Plan					
	2008/9	2008/9		2009/10		2010/11		2011/12	
	R	R		R	%	R	%	R	%
Plan Achievement	5	3		3	78.6	3	78.6	3	78.6
EBITDA margin	3	2		3	6.1	3	8.7	3	8.7
Asset Return	5	5		4	5.3	5	9.5	5	9.9
Net Surplus	5	4		3	1.2	5	4.7	5	5.1
Liquidity (days)	5	5		4	59.6	5	73.8	5	91
OVERALL RATING	**4**	**3**		**3**		**4**		**4**	

2.3.6 Conclusions

The three year financial plan maintains the Trust's financial base whilst supporting the service plan. The overall risk rating has reduced from 4 to a plan for 3, partly due to the use of the continued high level of liquidity to fund revenue spend to finance restructuring consistent with the Trust's strategy and to maintain the Trust's competitive position in selected areas. Main risks are the need to fulfil key initiatives required to fund the assumed increase in efficiency savings.

2.4 Capital Investment and Disposal Strategy

Table 17: 2008/09 and 3-Year Plan

	Plan	Actual		3-Year Plan		
	2008/9	2008/9		2009/10	2010/11	2011/12
	£m	£m		£m	£m	£m
Maintenance	**1.2**	**1.7**		**1.6**	**1.6**	**1.6**
Asset Replacement						
Non Maintenance	**9.7**	**13.3**		**11.8**	**3.3**	**0.2**
Community Facilities	5.6	3.6		0.1		
In-patient Facilities	0.8	5.2		9.5	3.0	0
Increased Capacity	3.3	4.5		2.2	0.3	0.2
TOTAL	**10.9**	**15.0**		**13.4**	**4.9**	**1.8**

The planned capital investment complements the service plans, concentrating on enhancing the capital infrastructure through the Asset Replacement Programme, replacing community facilities not fit for purpose, preparing replacement in-patient facilities, rationalising other premises into new build and increasing capacity for new income attracting services.

For further information on the 3-year Capital Development Plan refer to Appendix 4.

2.5 Financing and working capital strategy

Table 18: Working Capital

	Plan	Actual		3-Year Plan		
	2008/9	2008/9		2009/10	2010/11	2011/12
	£m	£m		£m	£m	£m
EBITDA	**12.1**	**8.2**		**11.6**	**17.4**	**18.8**
Working Capital:	**(21.9)**	**(11.5)**		**(4.5)**		
Debtors / Creditors Movement		(5.6)		(4.5)		
Cash in Advance	(19.3)	(5.9)				
Cash Inflow From Operating Activities	**(9.8)**	**(3.3)**		**7.1**	**17.4**	**18.8**
Capital Spend	**(10.9)**	**(13.6)**		**(13.4)**	**(4.9)**	**(1.8)**

	Plan	Actual		3-Year Plan		
	2008/9	2008/9		2009/10	2010/11	2011/12
	£m	£m		£m	£m	£m
Capital Receipt		**6.0**				
Exceptional Spend	**(1.6)**	**(0.3)**				
Cash Inflow < Financing	**(22.3)**	**(11.2)**		**(6.3)**	**12.5**	**17.0**
Dividends Paid	(3.8)	(3.8)		**(4.3)**	**(3.4)**	**(3.4)**
Net PDC Receipts		0.9				
Interest Received	**1.5**	2.6		**0.6**	**0.9**	**1.1**
Int/Capital element on Balance Sheet				**(2.4)**	**(2.3)**	**(2.3)**
Cash Inflow > Financing	**(24.6)**	**(11.5)**		**(12.4)**	**7.7**	**12.4**
Opening Balance	**58.7**	58.7		**47.2**	**34.8**	**42.5**
Closing Balance	**34.1**	**47.2**		**34.8**	**42.5**	**54.9**

The liquidity strategy is based on continued effective working capital control and supported by continuing surpluses, less capital spend. The Trust will be reviewing the advantages of accessing the NHS Bank for capital spend, which, if attracted, will further support the cash figure. Targeted creditor days are 30 with targeted NHS debtor days of 9 and 30 (non NHS); the latter will require support from local authority commissioners who currently pay quarterly in arrears.

The Working Capital Facility of £13m will not be required but will be available up to its current expiry in September 2009. The need for this will be reviewed at this time.

2.6 Summary of key assumptions

The summary of key financial and other assumptions are detailed below.

Financial:

- No income claw back by PCTs or by the Department of Health.
- Full achievement of signed off contract income where appropriate.
- Operating spend including achievement of savings' plans, and management of cost pressures to budget levels.
- Adequate inflation provision including that required to meet the 3 year pay award agreements, and incremental drift.
- Achievement of savings plans including savings / surpluses from key initiatives planned in 2009/10 for implementation in 2010/11 onwards.
- Continued working capital control.

Other:

- Successful implementation of the Organisational Development and Leadership programme to ensure that the Trust is able to retain highly skilled staff and develop their skills to equip them to deliver high quality services.
- The capability, capacity and effectiveness of the organisation will be improved through the integrated organisational development plan and the enabling strategies and plans.
- Improved Quality and Safety through successful implementation of service development plans, Quality Accounts and the 10 Key Priorities and targets.
- Stakeholder partnerships will continue to be developed and strengthened, including with Practice Based Commissioning Consortium.
- Securing new business and exploiting market opportunities, in line with the Trust's vision and strategic objectives.

3. RISK ANALYSIS

3.1 Introduction

The Trust Board has identified no major risks, but four medium risks, i.e.: i) increased demand for inpatient services, ii) public confidence resulting from SUIs and adverse public reaction to the restructuring of older adult services, iii) income for new low secure developments and iv) in-year financial pressures. Further information on the medium and other risks is detailed below.

3.2 Governance Risk

3.2.1 Legality of Constitution

The Trust has made no changes to its Constitution since Authorisation on 1st November 2007.

3.2.2 Growing a Representative Membership

At the time of Foundation Trust approval, the Trust had an overall membership of almost 7,500 – 4,919 public members and 2,510 staff members. As at 1st April 2009 we have a total membership of 10,563 comprising, 8,036 public and 2,527 staff members. This represents an increase of over 40% with the largest percentage increase being within the public group.

3.2.3 Board Roles, Structures and Capacity

The Trust Board and Executive Team development programme, externally facilitated (by an experienced management consultant who is currently working with a number of Mental Health and Acute Foundation Trusts), will continue in 2009/10. This will be supported by the implementation of the next phase of the Trust's organisational development programme to develop and strengthen clinical and management leadership and capability within the five Directorate Management Teams including community and inpatient teams.

During 2008/09, the Human Resources Directorate restructuring was completed. This will now ensure that the organisation has the skills and capacity to lead on the delivery of the workforce and key annual plan priorities. In addition, the Chief Executive/Deputy Chief Executive have started reviewing the other major corporate directorates and functions such as Finance, IM&T, Estates, Facilities and Capital Development. This review is to ensure that they are fit for purpose and capable of delivering the Annual Plan priorities; and, are structured to support the five DMTs to deliver their local objectives and priorities. A further review of the corporate structures will be undertaken in 2009/10 with the aim of ensuring value for money.

The Trust is also working with Concordat to share information with regulators, audit and review bodies and Strategic Health Authorities to support improvement. The London Strategic Health Authority risk summits were held on December 10th 2008 and January 6th 2009 where there was a systematic review of concerns for all trusts in the region. Through these discussions, there was a collective agreement that there are currently no areas of concern pertaining to the Trust.

The Board maintains its register of interests, and can confirm that there are no material conflicts of interest in the Board. The Board is also satisfied that all Directors are appropriately qualified to discharge their functions effectively including setting strategy, monitoring and managing performance.

The management structure in place is appropriate to deliver the annual plan objectives in the next 3 years, in particular, in 2009/10.

3.2.4 Service Performance (targets and national core standards)

The Trust has maintained the risk and performance management process identified in its 5 year IBP and further developed in 2008/09.

In March 2009 internal audit following a review concluded that there exists "Substantial Assurance that the Trust has a generally sound system of internal control designed and operating in a way that that gives a reasonable likelihood that the system's objectives will be met," concluding that "there is an effective system in place to enable the Trust Board to sign off the Declaration of Compliance with the Core Standards in April 2009."

The Trust achieved ratings of "excellent" for quality of services and "excellent" for use of resources in the Annual Health Check results published in October 2008. The Trust was fully compliant with the core standards, existing national targets and new national targets.

In January 2009, the Trust received an unannounced visit from the Healthcare Commission to monitor compliance with the Hygiene Code. The Trust was assessed compliant against its three main duties under the hygiene code, the highest possible rating. This will be kept under review by the Trust to ensure that compliance is maintained during 2009/10.

The Trust was also compliant with or achieved all of the key national and PCT contract targets in 2008/09 and has set in place monitoring arrangements to ensure that all 2009/10 service targets will be achieved.

The Board is satisfied that there are plans in place to ensure the Trust meets the national standards in 2009/10.

3.2.5 Clinical Quality

Clinical quality is maintained internally by scrutiny of various quality indicator data. The five Service Directorates are accountable for service quality through the performance management and healthcare governance process.

The Board considers as medium risk increased demand for adult inpatient services, resulting in high occupancy levels and therefore potential failure to deliver high quality inpatient care.

3.2.6 Effective Risk and Performance Management

As in previous years, the Trust obtained a rating of Substantial Assurance by internal audit following a review of the Board Assurance Framework. The review focuses on the adequacy and the appropriateness of risk management control and review processes to support the Statement of Internal Control (SIC) during 2008/09.

In March 2008 internal audit evaluated the Trust's progress in preparing compliance with the Standards for Better Health. It concluded that there was Substantial Assurance to enable the Trust Board to sign off the declaration of compliance for the period 1st April 2008-31st March 2009.

During April - December 2008 internal audit reviewed whether the Trust has appropriate systems in place to make robust agreements / contracts which are sustainable and are suitably linked to the objectives of the Trust and the health needs of the population. The audit also assessed the effectiveness of the operation of the internal controls surrounding the Trust's legally binding contracts with purchasers and its ability to meet the health needs of its patients. The auditors gave Substantial Assurance for this area.

An external review of the Trust's SUI policy and procedures was undertaken in 2008 and the inquiry's report and recommendations were presented to the Trust Board in September 2008. The Trust has further strengthened its SUI procedures, management of SUIs reviews and learning from these incidents.

The Inquiry Panel's recommendations were fully implemented in 2008/09 and the management and monitoring of SUIs has also been further strengthened. The Board reviewed the action plan at its Board Seminar in March 2009. In view of this, the Board does not consider this to be a significant risk for 2009/10.

The Trust achieved level 2 of The NHSLA Risk Management Standards for Mental Health & Learning Disability NHS Trusts, the assessments of which took place in November 2008 and February 2009.

The Board considers as medium risk the loss of public confidence in the Trust because of major serious untoward incidents.

The Board continues to receive a quarterly Performance Report from the Director of Performance and Business Department which describes performance in key areas, including the Annual Plan priorities. This will be developed in 2009/10 to address the key 10 priority areas. In addition, monthly meetings are held with the five Service Directorate Leads to review performance against key objectives and priorities.

The monthly KPI scorecard is reviewed monthly with the Director of Performance and Business Development and all Service Directorate and Care Group Performance Leads, prior to submission and further review by the monthly Service Delivery Board. The latter group is chaired by the Chief Executive and includes the Executive Team, Corporate Directors, Clinical Directors and Borough/Service Directors.

3.2.7 Cooperation with NHS Bodies and Local Authorities

The strategic approach of the Trust is to work together with key partners and stakeholders to achieve its objectives.

The Trust is working to further develop its relationships with the local PCTs which commission the bulk of the services provided by the Trust as well as the Local Authorities which serve our local populations. In Newham and City and Hackney we are in the process of negotiating new Section 75s. In Tower Hamlets, local authority employees are seconded to East London NHS Foundation Trust and the secondment agreement is being updated.

In 2009/10 we will be working more closely with 13 Practice Based Commissioning Consortia covering East London in order to improve services and support to GPs and Primary Health Care Teams and provide care that is more responsive to local needs. In City & Hackney and Newham this work will be informed and supported by the Trust's Consultant Psychiatrists in Primary Care.

The Trust is committed to and participates in the local Drug Action and Alcohol Teams which oversee the provision of Drug and Alcohol services in our catchment area.

We also contribute to the local strategy and planning groups which shape the provision of Child and Adolescent Mental Health Services and those services which provide care for older people with mental health problems. Finally, the Trust is developing strong relationships with the police by a number of means including senior representation of Multi Agency Public Protection Panels.

3.3 Mandatory Service Risks

3.3.1 Mandatory Services

During 2008/09 the Trust purchased a property in Hackney and since this will be critical to the delivery of its services, this asset will be protected, as required by Monitor. There have been no other changes to protected assets.

The Trust Board has changed its 2009/10 Mandatory Services Schedule 2 (section 7.1) to reflect new services or additional activity arising from reconfiguration of services or additional PCT investments.

The Board has assessed the possible adverse public reaction to the reconfiguration and closure of older adult inpatient beds as a medium risk.

3.3.2 Significant Risks

No significant risks have been identified in relation to the Trust's ability to comply with the terms of its Authorisation with regard to the provision of mandatory services.

3.4 Financial Risk Assessment

The Board, and the FBIC, has assessed the financial risks. There are two medium financial risks, i.e. i) income for new low secure developments and ii) in-year financial pressures. Income is largely secure. Spend budgets include £5m of internal reprioritisation funds to offset clinically validated pressures evident in previous years and predicted for 2009/10; consequently spend budgets are robust. However, there is little contingency, emphasising the need for improved cost control and cost reporting.

The Board has agreed key priorities to progress in 2009/10, each of which will generate significant surpluses or savings, and which will contribute to increasing the operating surplus up to the Board target of 7% from 2010/11.

Table 19: Financial Risk

Risk	Likelihood	Impact	Score	Mitigating Actions
Pay Drift	1	4	**4**	A provision has been established for incremental drift. Protocol reconfirmed that re-grading costs to be offset by skill mix changes.
National Pay Awards	1	4	**4**	A provision has been established to fund the agreed national pay award.
In Year Financial Pressures	2	4	**8**	Budgets at full establishment against unique post numbers. Main cost pressure areas funded through the 2009/10 budget setting round. Improved cost reporting
Reduced Income	1	4	**4**	Signed contracts. Non-contract income £3.4m out of budgeted income of £192m. Balance of Low Secure (£0.5m) and Learning Disability (£1.7m) to be signed off.
Savings' Shortfall	1	4	**4**	Savings signed off against start dates. Vacancy and community review savings of £2.2m budgeted.
Reduced Liquidity	1	2	**2**	Commissioning payment terms agreed.
Income for new low secure developments	2	4	**8**	Reduced operating costs Marketing strategy to be put in place by June 2009. External capacity/staffing to be employed as required.

3.5 Risk of any other non-compliance with Terms of Authorisation

In November 2008 internal audit reviewed whether the Trust had put in place controls to ensure that the Foundation Trust complies with their Constitution and statutory duty as required by Monitor and set out in the Compliance Framework. The auditors gave Substantial Assurance for this area.

The Board is not aware of any other risk to compliance with the Terms of Authorisation. The Board has reviewed all the issues identified as risks within the Annual Plan submission and has concluded that while there are challenges facing the Trust, none of them are of sufficient severity or likelihood to result in non-compliance with the Trust's Terms of Authorisation.

3.6 Presentation of Key Risks

The Trust has used the risk assessment criteria and methodology detailed in 3.6.2 to determine its key risks and has identified four medium level risks. These risks and those detailed within this risk section have been included within the Trust's risk register which is regularly reviewed by the Assurance Committee.

3.6.1 Summary of Key Risks

Table 20: Key Medium Risks

Risk Area	Description	Impact 1-4	Likelihood 1-4	Main rating (impact x likelihood)	Implication	Mitigating Actions
Increased demand on adult inpatient services	High occupancy levels resulting in failure to deliver high quality inpatient care.	3	3	**9 (Medium Risk)**	i) Failure to deliver therapeutic inpatient environments. ii) Service user and carer dissatisfaction. iii) Potential increase in violence and aggression. iv) Low staff morale.	• Regular bed management monitoring and review and utilise bed managers and discharge coordinators more effectively. • Ensure effective A&E and Crisis Resolution/Home Treatment Team coordination and review of all admissions to avoid unnecessary admissions. • Utilise emergency capacity at times of high demand. • Further develop alternatives to inpatient services through the Recovery and Rehabilitation Teams. • Implement action plans to address areas of dissatisfaction identified through inpatient service user surveys. • Review incidents of violence and aggression and introduce/deploy strategies to reduce these incidents. • Staff focus groups to address low staff morale and provide additional staffing/clinical support as required.
Public Confidence.	1) Loss of public confidence in the Trust because of major serious untoward incidents and credibility with partners and commissioners. 2) Adverse public reaction to the	4	2	**8 (Medium risk)**	1a) Increased litigation. 1b) Risk to income because of exercise of service user choice and commissioners place contracts elsewhere.	• Continue to improve quality of services, strengthening CPA and risk management arrangements. • Strengthen SUI policy and procedures following implementation of an external review and the management and monitoring of SUIs. • Strengthen learning across the Trust following all SUIs and change and monitor practice in accordance with agreed action plans. • Strengthen clinical leadership. • Implement the key priorities of the workforce strategy, in particular, implementation of more robust appraisal and supervision arrangements.

Risk Area	Description	Impact 1-4	Likelihood 1-4	Main rating (impact x likelihood)	Implication	Mitigating Actions
	restructuring of older adult services.				2) Risk to delivery of the Annual Plan/5 year service strategy, in particular, the older adult community service developments.	• Work closely with service users, carers and relatives on the plans for older adult inpatient bed reductions. • Ensure Trust's Older Adult Strategy is developed in full consultation and agreement with local stakeholders, including carers. • Work jointly with PCTs, LAs and Health Scrutiny Committees to link the Trust's service developments with their wider strategies. • Involve the Members Council in the annual planning process and to work with local stakeholders and explain the rationale for these initiatives.
Income for new low secure developments	Failure to secure sufficient income and meet surplus targets.	2	4	**8 (Medium risk)**	a) Failure to achieve financial targets.	• Reduced operating costs • Marketing strategy to be put in place by June 2009. • External capacity/staffing to be employed as required.
In Year Financial Pressures	Unbudgeted in year financial pressures	2	4	**8 (Medium risk)**	a) Failure to achieve financial targets.	• Budgets at full establishment against unique post numbers. • Main cost pressure areas funded through the 2009/10 budget setting round. • Improved cost reporting.

3.6.2 Risk Assessment Criteria and Methodology

Table 21: Risk Methodology

Impact	1 **Minor**	2 **Moderate**	3 **Significant**	4 **Critical**
	The Trust will face some issues but which will not lower its ability to deliver quality services.	The Trust will face some difficulties, which may have a small impact on its ability to deliver quality services, and/or some elements of its long term strategy may have to be revised.	The Trust will face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and/or its long term strategy.	The Trust will face serious difficulties and will be unable to deliver services on a daily basis. Its long-term strategy will be in jeopardy.
Likelihood	1 **Unlikely**	2 **Possible**	3 **Probable**	4 **Almost certain**
	Unlikely to occur Probability is 1-25%	Reasonable chance of occurring Probability is 25-50%	Likely to occur Probability is 50-75%	More likely to occur than not Probability is 75-100%

4. DECLARATIONS AND SELF-CERTIFICATION

Board Statements

As part of the FT Compliance Framework, the Trust is expected to declare and self-certify that it is compliant with all aspects of Monitor's regulatory regime. The Trust's Board of Directors considers that it is fully compliant on all areas detailed below but additional assurance and related commentary is available in Section 3: Risk Analysis of this plan.

Clinical quality

The board of directors is required to confirm the following:

☒ The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients; and

☒ The board will self certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

Service performance

The board of directors is required to confirm the following:

☒ The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards, and a commitment to comply with all known targets going forwards.

Risk management

The board of directors is required to confirm the following:

☒ Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;

☒ All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;

☒ The necessary planning, performance management and risk management processes are in place to deliver the annual plan;

☒ A Statement of Internal Control ("SIC") is in place, and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk);

☒ The trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit; and.

☒ All key risks to compliance with their Authorisation have been identified and addressed.

Compliance with the Terms of Authorisation

The board of directors is required to confirm the following:

☒ The board will ensure that the NHS foundation trust remains at all times compliant with their Authorisation and relevant legislation;

☒ The board has considered all likely future risks to compliance with their Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and

☒ The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with their Authorisation.

Board roles, structure and capacity

The board of directors is required to confirm the following:

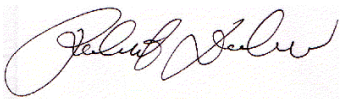
☒ The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;

☒ The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;

☒ The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills;

☒ The management team have the capability and experience necessary to deliver the annual plan; and

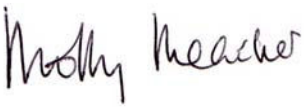
☒ The management structure in place is adequate to deliver the annual plan objectives for the next three years.

Signature 

Printed Name Dr Robert Dolan

Date 28th May 2009

In capacity as Chief Executive & Accounting Officer

Signature 

Printed Name Baroness Molly Meacher

Date 28th May 2009

In capacity as Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the governors.

5. Membership

5.1 Membership Report

The Trust has a total membership of 10,802, i.e.: 8,036 public members and 2,766 staff members, as at 31 March 2009.

5.1.1 Membership Size and Movements

Tables 22-24 below show:

- changes to our membership in the past 12 months;
- planned membership growth in 2009/10; and
- the demographic composition of our membership.

Table 22: Public Constituent Membership Changes

Public Constituency	2008/09	2009/10 (estimated)	Percentage Increase
At Year Start (April 1)	7,088	8,036	13%
New members in year	1575	1764	12%
Members leaving in year	637	800	26%
At year end (March 31)	8036	9000	12%

Table 23: Staff Constituent Membership Changes

Staff Constituency	Members	2009/10 (estimated)	Percentage Increase
At Year Start (April 1)	2568	2766	7.7%
New members in year	554	587	6%
Members leaving in year	356	387	8.7%
At year end (March 31)	2766	2966	7.2%

Table 24: Patient Constituent Membership Changes

Patient Constituency*	Members	2009/10 (estimated)	Percentage Increase
At Year Start (April 1)	N/A	N/A	N/A
New members in year	N/A	N/A	N/A
Members leaving in year	N/A	N/A	N/A
At year end (March 31)	N/A	N/A	N/A

*ELNFT does not have patient constituent members. Service users can be members but are counted in the public membership and are not required to disclose whether they are service users or not

Table 25: Public Membership Analysis by Age

Public Constituency by Age	Number of Members	Eligible Population [1]	% of Membership (Category known) [2]	% Target of Population
0-16	112	161822	1.56	23.42
17-21	609	50938	8.50	7.37
22-29	1281	115637	17.89	16.73
30-39	1635	138933	22.83	20.10
40-49	1467	93156	20.48	13.48
50-59	974	56288	13.60	8.15
60-74	807	48917	11.27	7.08
75+	277	25368	3.87	3.67
Total (Age Known)	**7162**	**-**	**-**	**-**
Unknown	874	N/A	-	-
Total	**8036**	**691059**	**100**	**100**

Table 26: Public Membership Analysis by Ethnic Grouping

Public Constituency by Ethnicity	Number of Members	Eligible Population	% of Membership (Category known)	% Target of Population
White	2964	343896	45.90	49.76
Mixed	368	23270	5.70	3.37
Asian or Asian British	1636	179728	25.34	26.01
Black or Black British	1278	122787	19.79	17.77
Other	211	21378	3.27	3.09
Total (Ethnicity Stated)	**6457**	**-**	**-**	**-**
Ethnicity Not Stated	1579	N/A	-	N/A
Total	**8036**	**691059**	**100**	**100**

[1] Eligible population figures in all tables do not include the Other London Boroughs Constituency.
[2] Percentage of Membership' figures in all tables are based on percentage of members where data has been provided, e.g. where age, ethnicity, or gender was stated.

Table 27: Public Membership Analysis by Socio-economic Grouping (ACORN category profile) [1]

Public Constituency by Socio-economic grouping (ACORN Category Profile)	Number of Members	Eligible Population	% of Membership (Category Known)	% Target of Population
1. Wealthy Achievers	8	10	0.17	0
2. Urban Prosperity	2745	273037	35.82	39.51
3. Comfortably Off	152	9513	1.98	1.38
4. Moderate Means	1009	105355	13.17	15.25
5. Hard Pressed	3750	303144	48.93	43.87
Total (Category Known)	**7664**	**N/A**	**N/A**	**N/A**
Unknown	372	N/A	N/A	N/A
Total	**8036**	**691059**	**100**	**100**

Table 28: Public Membership Analysis by Socio-economic Grouping (NRS category profile)[2]

Public Constituency by Socio-economic grouping (NRS Category Profile)	Number of Members	Eligible Population	% of Membership (Category Known)	% Target of Population
Middle Class	4119	220218	51.26	51.32
Skilled Working Class	1082	55236	13.47	12.87
Working Class	1808	93433	22.50	21.77
Dependent on State	1026	60211	12.77	14.03
Total (Category Known)	**8035**	**N/A**	**N/A**	**-**
Unknown	1	N/A	N/A	-
Total	**8036**	**429098**	**100**	**100**

[1] The membership commentary is based on the ACORN category profiling information in Table 27 as ACORN uses total population figures whereas NRS socio-economic data is only available for employed individuals aged between 16 and 64.

[2] The eligible population figures in Table 28 are based on the full 2001 census data available for the Trust's catchment area because NRS socio-economic data is only available for employed individuals aged between 16 and 64.

Table 29: Public Membership Analysis by Gender

Public Constituency by Gender	Number of Members	Eligible Population	% of Membership (Category known)	% Target of Population
Female	4619	342051	57.92	49.50
Male	3356	349008	42.08	50.50
Total (Gender Stated)	**7975**	**-**	**-**	**-**
Gender Not Stated	61	N/A	N/A	N/A
Total	**8036**	**691059**	**100**	**100**

5.2 Membership Commentary

The Trust's membership constituencies and their representation on the Members' Council are as follows:

- Public Members – City of London (1 representative), Hackney (7 representatives), Newham (7 representatives), Tower Hamlets (7 representatives), and Other London Boroughs (1 representative). Anyone aged 12 years and above and living within the constituent areas of the Trust is invited to become a member of the Trust. Based on feedback from the public consultation the Trust opted not to have a separate patient and carer constituency.

- Staff Members – Single staff constituency (7 representatives). All staff on permanent contracts or on fixed-term contracts that run for 12 months or longer are automatically members unless they opt out of membership. Staff who are seconded from partner agencies and bank staff in post or on contracts longer than 12 months were invited to opt in as staff members.

The Trust's focus for 2008/09 was setting up systems to support the increased involvement of members in the life of the Trust and to support the work and development of the Members Council in its first full year of operation. As shown above, the Trust has now built a solid membership base and in 2008/09 its major achievements were:

- Further development of the Membership Office as a drop-in facility/welcoming space for members and council members
- Smooth running of Members Council meetings and events
- Delivering ongoing support for individual council members and a development programme for the Members Council
- Organisation of membership events, including a Trust-wide Carers Event, the Trust's Annual Members Meeting, Annual General Meeting and a number of membership events associated with the development of the Trust's Annual plan for 2009/10.
- Developing communication methods for members/council members (i.e. council member forum on the website, revamping of Membership Newsletter)
- Development of a membership information pack that is provided to all new and existing members (and includes an personalised membership card)

- Carrying out the Trust's first (annual) membership survey
- Development of a Volunteering Strategy (currently out for consultation before being submitted to the Board) and recruitment of a Volunteer Coordinator
- Providing work experience placements for members
- Working in partnership with other Trust staff, council members and stakeholders in relation to the above achievements

Priorities for 2009/10 focus on:

- Developing more effective recruitment methods, via implementation and use of a new membership database that supports targeted recruitment, and a stakeholder database.
- Working to clarify and develop the role of members and council members, and to promote the role of council members within the local community.
- Delivery of an increased range of membership events and other involvement opportunities for members
- Implementation of the Trust's Volunteering Strategy
- Development of a mental health promotion strategy in line with the national "Time to Change" campaign
- Running of elections to the Members Council.

5.2.1 Representative Membership

Representation within the membership has been monitored monthly and recruitment efforts have been targeted to address any under-representations. In 2009/10 a new membership database will be implemented which will allow the membership team to directly target under represented groups for relevant events. Analysis of the current membership shows that it is largely representative of the local population (by location, age, gender, and ethnicity). Ongoing action is being taken to address areas where the membership is unrepresentative.

5.2.2 Membership Engagement

The successful delivery of the Trust's Membership Strategy involves developing an active membership, which provides an opportunity for members to become engaged in the work of the Trust, and use and develop their skills and experience, should they wish to do so. Information on member interests gathered from members shows that the Trust has recruited a potentially active public membership and is helping to inform the Trust's plans for member engagement.

Membership engagement is a main focus of the Trust's work plan for 2009/10. The Trust has sent out a regular newsletter to members over the past year. Following the success of involving members in the annual plan drafting process in 2008/09 the Trust has held four events (three borough specific events and one Trust wide event) to consult public members on the 2009/10 annual plan. Member input from this event was compiled and fed back to the board and then integrated into the draft annual plan.

The membership database will be used to engage current members in events of specific interest through targeted mail shots. The Trust has also appointed a volunteering coordinator to proactively engage members in the Trust's work. Feedback from members

shows that over 40% of current members are interested in volunteering opportunities with the Trust. Opportunities are advertised via the newsletter which is distributed to all members, in Quarter One of 2009/10 there are 5 volunteering schemes open to members.

The membership office is in consultation with Trust HR and the seven staff membership representatives to address engagement of the staff membership in 2009/10. The new staff induction process will include a presentation on membership.

5.2.3 Elections

The Trust completed the election process in June 2007. The next election is due to take place towards the end of summer 2009. There were no elections in 2008/09.

5.2.4 Resourcing the Membership

The Membership of the Trust is supported by a Membership Manager and Membership Officer. The Trust also plans to spend approximately £7 per member per year on ensuring effective and meaningful engagement. This is in addition to the £7 per member budgeted for new member recruitment.

5.2.5 Evaluating success

The success of the Trust's Membership Strategy will be monitored by the following key performance indicators:

- Size of public membership
- Representative membership
- Active involvement of members
- Active involvement of council members
- Feedback from members/council members
- Membership Office performance.

Performance against these indicators will be monitored on a monthly basis by the Trust Board Secretary and Membership Manager and reports will be submitted quarterly to the Public Participation Committee meeting and the Trust Board for review. A report detailing analysis against the targets will be prepared at the end of the year in order to inform the annual revision of the strategy.

6. FINANCIAL PROJECTIONS

The financial projections have been included within section 2. The detailed financial information is included within the financial template/workbook submitted to Monitor.

7. SUPPORTING SCHEDULES

7.1 Schedule 2: Mandatory Goods and Services 2009/10

Sub care group		Learning disability	Adult mental illness	Child and adolescent psychiatry	Forensic psychiatry	Psycho-therapy	Old age psychiatry	Perinatal Services	Personality Disorder	Specialist Addictions	Psychotrauma	Chronic Fatigue Service	Improving Access to Talking Therapy (IAPT)	Dual Diagnosis	Talking Therapies	Primary Care Liaison	Check Total
Sub care group	Currency	700	710	711	712	713	715										
Inpatient	Bed Days	4,104	81,572	5,010	748	0	27,046	1,655	6,935	0	0	0	0	0	0	0	127,070
PICU	Bed Days	0	11,718	31	2,555	0	0	0	0	0	0	0	0	0	0	0	14,304
Rehabilitation - Inpatient	Bed Days	0	7,584	0	0	0	0	0	0	0	0	0	0	0	0	0	7,584
Continuing Care	Bed Days	0	0	0	9,490	0	24,273	0	0	0	0	0	0	0	0	0	33,763
Low Secure	Bed Days	0	3,815	0	1,734	0	0	0	0	0	0	0	0	0	0	0	5,549
Community Forensic	Male community forensic rehabilitation facility places	0	0	0	16	0	0	0	0	0	0	0	0	0	0	0	16
Medium Secure	Bed Days	0	0	0	46,355	0	0	0	0	0	0	0	0	0	0	0	46,355
Other	Crisis House bed-days	0	2,146	0	0	0	0	0	0	0	0	0	0	0	0	0	2,146
Other	Crisis House Patients	0	95	0	0	0	0	0	0	0	0	0	0	0	0	0	95
Community Forensic	Male specialist forensic personality disorder hostel places	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	8
Community Forensic	Community Contact	0	0	0	4,830	0	0	0	0	0	0	0	0	0	0	0	4,830
Community	Supported Housing Placements/Beds/Patients	0	81	0	0	0	0	0	0	0	0	0	0	0	0	0	81
Community	Service Users with Self Directed Support	0	50	0	0	0	0	0	0	0	0	0	0	0	0	0	50
Community	Carers offered an assessment	0	200	0	0	0	0	0	0	0	0	0	0	0	0	0	200
Community	Carers receiving an assessment	0	190	0	0	0	0	0	0	0	0	0	0	0	0	0	190
Outpatient	Follow up	0	13,880	0	38	0	370	420	0	0	450	494	0	0	0	0	15,652

Sub care group		Learning disability	Adult mental illness	Child and adolescent psychiatry	Forensic psychiatry	Psycho-therapy	Old age psychiatry	Perinatal Services	Personality Disorder	Specialist Addictions	Psychotrauma	Chronic Fatigue Service	Improving Access to Talking Therapy (IAPT)	Dual Diagnosis	Talking Therapies	Primary Care Liaison	Check Total
Sub care group	Currency	700	710	711	712	713	715										
	Apts/Attendances																
Outpatient	First Appointments	0	102	0	0	0	58	120	0	0	50	225	0	0	0	0	555
Outpatient	Referrals	0	0	0	0	0	0	700	0	0	165	0	0	0	0	0	865
Outpatient	Clozapine Clinic Caseload	0	456	0	0	0	0	0	0	0	0	0	0	0	0	0	456
Outpatient	Clozapine Clinic Contacts	0	2,050	0	0	0	0	0	0	0	0	0	0	0	0	0	2,050
Day Care	Referrals	0	519	0	0	0	0	0	0	0	0	0	0	0	0	0	519
Day Care	Caseload	0	449	0	0	0	0	0	0	0	0	0	0	0	0	0	449
Day Care	Day Treatment Attendances	0	9,933	0	0	0	0	0	0	0	0	0	0	0	0	0	9,933
Day Care	Discharges	0	517	0	0	0	0	0	0	0	0	0	0	0	0	0	517
CMHT	Caseload	0	3,715	0	0	0	248	0	0	0	0	0	0	0	0	0	3,963
CMHT	Community Contact	0	74,608	0	0	0	0	0	0	0	0	0	0	0	0	0	74,608
Community	Referrals	0	121	0	0	0	0	0	100	0	0	0	0	100	474	260	1,055
Community	Caseload	0	0	0	0	0	420	0	135	718	0	0	0	0	0	0	1,273
Community	Contacts	0	0	0	0	0	5,030	0	14,383	0	0	0	5,000	0	37,758	0	62,171
Community	Assessments	0	0	0	0	0	0	0	0	0	0	0	0	0	460	0	460
Community	Crisis Intervention Contacts	0	1,500	0	0	0	0	0	0	0	0	0	0	0	0	0	1,500
Community	Consultations and training (Refugee and Asylum Seeker Team/Primary Care Liaison)	0	681	0	0	0	0	0	0	0	0	0	0	0	0	402	1,083
Community	Discharges	0	1	0	0	0	120	0	0	0	0	0	0	0	0	103	224
Assertive Outreach Team	Caseload	0	479	0	0	0	0	0	0	0	0	0	0	0	0	0	479
Assertive Outreach Team	Community Contact	0	27,216	0	0	0	0	0	0	0	0	0	0	0	0	0	27,216

Sub care group		Learning disability	Adult mental illness	Child and adolescent psychiatry	Forensic psychiatry	Psycho-therapy	Old age psychiatry	Perinatal Services	Personality Disorder	Specialist Addictions	Psychotrauma	Chronic Fatigue Service	Improving Access to Talking Therapy (IAPT)	Dual Diagnosis	Talking Therapies	Primary Care Liaison	Check Total
Sub care group	Currency	700	710	711	712	713	715										
Crisis resolution team	Patients Receiving Service	0	2,432	0	0	0	0	0	0	0	0	0	0	0	0	0	2,432
Crisis resolution team	Community Contact	0	21,052	0	0	0	0	0	0	0	0	0	0	0	0	0	21,052
Early Intervention team	Caseload	0	509	0	0	0	0	0	0	0	0	0	0	0	0	0	509
Early Intervention team	Community Contact (Including CAMHS)	0	13,777	0	0	0	0	0	0	0	0	0	0	0	0	0	13,777
Early Intervention team	New cases	0	176	0	0	0	0	0	0	0	0	0	0	0	0	0	176
Early Intervention team	Supported Housing bed days	0	4,746	0	0	0	0	0	0	0	0	0	0	0	0	0	4,746
Rehabilitation - Community	Caseload	0	482	0	0	0	0	0	0	0	0	0	0	0	0	0	482
Rehabilitation - Community	Community Contact	0	20,450	0	0	0	0	0	0	0	0	0	0	0	0	0	20,450
Intermediate Care Services	Caseload	0	0	0	0	0	1,021	0	0	0	0	0	0	0	0	0	1,021
Intermediate Care Services	Referrals	0	0	0	0	0	20	0	0	0	0	0	0	0	0	0	20
Tier 3	Referrals	0	0	3,511	0	0	0	0	0	0	0	0	0	0	0	0	3,511
Tier 3	Caseload	0	0	2,118	0	0	0	0	0	0	0	0	0	0	0	0	2,118
Tier 3	Community Contact	0	0	28,400	0	0	0	0	0	0	0	0	0	0	0	0	28,400
-		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total		**4,104**	**307,302**	**39,070**	**65,766**	**0**	**58,606**	**2,895**	**21,561**	**718**	**665**	**719**	**5,000**	**100**	**38,692**	**765**	**545,963**

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7.2 Schedule 3: Mandatory Education and Training Services 2009/10:

NHS Foundation Trust: East London NHS Foundation Trust
MARS ID: EASTLONDON
NHS ID: RWK

Commissioning body	Educational body	Contract Length	Expiry date of contract	Student group	Type of training	Number of Students	Contract Value
		(Years)					(£' 000s)
NHS London and London Deanery	Not applicable	1 Year	31st March 2009	Junior Doctors	Salary support for training grade doctors	72	2355
NHS London	Not applicable	1 Year	31st March 2009	Post Graduate Centre	Study Leave and support for training facilities	Not applicable	139
NHS London	Not applicable	1 Year	31st March 2009	Undergraduate Doctors	SIFT	43	2194
NHS London	Not applicable	1 Year	31st March 2009	Specialty School	Medical	Not Applicable	76
NHS London	Various	1 Year	31st March 2009	Allied Health Professionals	Non Medical Training	22.58	277
NHS London	City University	1 Year	31st March 2009	Nursing	Non Medical Training	10.42	198
NHS London	Various	1 Year	31st March 2009	Practice Facilitators	Salary Support	Not Applicable	74
NHS London	City University	1 Year	31st March 2009	Nursing and Allied Health Professionals	CPD Allocation		237
NHS London	Various	1 Year	31st March 2009	Various	NVQ Allocation		70
Total							**5620**

APPENDICES

Appendix 1:

Summary PEST Analysis

Political	**Economic**
• World Class Commissioning, Contracts and Patient-led NHS and Service User Choice • Improved access to Psychological Treatments – Operating Plan • Healthcare for London, a framework for action • Local Authority elected members and Health Scrutiny • Children's Trust arrangements • Cultural and political diversity of East London, Delivering Race Equality [DRE] and Race Relations Amendment (Act) [RRA(A)] • New Mental Health FT contract from 2009/10.	• Impact of the wider economic situation and DH Central Allocations, National Pay Awards, NHS London and Local Health Economy Financial Position • Practice Based Commissioning • Payment by Results from 2010/11 • NHS and Private Sector competition • Olympics 2012 and Thames Gateway Regeneration • Workforce issues, including vacancies and recruitment hotspots • New demand, e.g. new cases, overseas patients, refugees, including substance misuse problems. • 18 week referral to treatment.
Social	**Technological**
• Social inclusion, including impact on secondary care • Population growth, e.g. young people, older adults, immigration • Deprivation across East London including high levels of physical morbidity • Litigation • Housing • Substance Misuse and Addiction. • Rising Unemployment.	• Information, Communication and Technology [ICT] • New technologies, NICE guidance, Cognitive Behavioural Therapy • Assistive technology • Pharmacology.

Appendix 2:

Summary SWOT Analysis

Key Strengths	Key Weaknesses
• Our staff and their expertise – leaders in a wide range of clinical areas and delivery of education and training • Financial performance including accumulated revenue surpluses and cash deposits • Working with and responding to the needs of diverse communities • Service user participation in planning and delivery of services • Partnership working including academic institutions • Service improvement and performance, including specialist services • Overall Leadership of Trust Board • Assurance and risk management arrangements • Centre of excellence for research and development. • Well-established, dedicated Safeguarding Children team.	• Information infrastructure • Some parts of the Trust estate • Locality Services in some areas of the Trust • Clinical leadership and middle management capacity • Health outcomes monitoring.

Opportunities	Threats
• Use of accumulated revenue and cash surpluses to support financing of service re- configuration • Provision of specialist and gender and culturally sensitive services, e.g. forensic, women only services, psychological therapies • Service growth and opportunities over the next 2 - 3 years in relation to primary care, substance misuse, forensic learning disability, prisons serving North East London and psychological therapies • Potential capital funding for improvement of inpatient and community premises • Regeneration and development of the social inclusion agenda being led by PCTs and Local Authorities. • Population Growth and Demand.	• National and London Financial Position, National Pay Awards and Research and Development Funding Taper • Competition through plurality and diversity of providers • Practice Based Commissioning • Revised Mental Health Act & Capacity Act • Recruitment and Retention • Poor housing and social infrastructure • Adverse publicity due to publication of Homicide Inquiry Reports and Serious Incidents, and reaction to the closure of inpatient beds. • 18 week referral to treatment • Population Growth and Demand. • Socio-economic consequences of recession such as rising unemployment.

Appendix 3

5-YEAR INTEGRATED BUSINESS PLAN: 2ND YEAR

2009/10 IMPLEMENTATION PLAN

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
IMPROVING QUALITY (Clinical Effectiveness and Patient Experience) AND SAFETY				
1	Older adult services	Delivery of the Older Adult Strategy implementation plans *Strategy to be approved by Trust Board* *Delivery of implementation plans*	December 2009 subject to PCT involvement and approval As per project timescales	Director of Operations and Borough Directors
2	Inpatient services	Delivery of improvement plans, in line with the Care Quality Commission's quality measures and standards *95% compliance against all standards* *Quarterly improvement against service user led inpatient standards and service user survey results*	Quarterly progress reports	Director of Operations and Borough Directors
		Continued development of and implementation of AIMS for adults and older adults *Accreditation rating achieved for all wards*	Quarterly progress reports	Medical Director
		Development of gender specific inpatient services *Plan to be approved by Trust Board* *Full compliance with Department of Health's Safety, Dignity and Privacy guidance (mixed sex accommodation standards)*	October 2009 August 2009	Deputy Chief Executive and Director of Social Inclusion
		Introduction of service user older adult surveys *Surveys to be introduced* *Assessment of baseline performance and improvement plans/targets and progress monitored quarterly thereafter*	October 2009 January 2010 and quarterly reports	

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
3	Adult community services	Improvements in clinical leadership, responsiveness and timeliness of assessment and brief treatment interventions through delivery of the community review's implementation plans. *95% of initial assessments completed by senior staff within 28 days* *Full implementation of the new community services' structures in all three Boroughs.*	Quarterly progress reports December 2009	Director of Operations and Borough Directors
		Improve the implementation and quality of CPA *95% compliance rate on all CPA elements of care planning* *Undertake six monthly reviews/audits to monitor compliance and identify any areas for further development*	Quarterly progress reports Six monthly review/audit	Medical Director
		Introduction of service user community surveys *Surveys in place* *Assessment of baseline performance and improvement plans/targets and improvements to be agreed and monitored quarterly thereafter*	July 2009 November 2009 and quarterly reports	Deputy Chief Executive and Director for Social Inclusion
4	Physical Healthcare	Improve physical healthcare for service users and access to primary care services through delivery of the Trust-wide and local inpatient implementation plans. *Plan in place* *Review of plan* *Achievement of all key improvement areas as outlined in the plan*	June 2009 December 2009 March 2010	Deputy Chief Executive and Head of Nursing

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
5	Carers services	Improve carers services, engagement and support, and improve the number of carer's assessments offered through the development and implementation of a Trust-wide plan. *Plan in place* *30% increase in the number of carers having had an assessment* *Introduction of carer surveys/feedback arrangements* *Assessment of baseline performance and improvement plans/targets in place, and progress monitored quarterly*	June 2009 March 2010 July 2009 November 2009 and quarterly reports	Deputy Chief Executive and Director for Social Inclusion
6	Learning from incidents, SUIs, Homicides and SCRs	Improved management of SUIs and SCRs and action planning *100% completion of reviews within agreed deadlines*	Quarterly progress reports	Deputy Chief Executive
		Regular reviews and audit to ensure that learning is embedded within clinical practice. *Quarterly reviews and seminars on learning from SUIs and SCRs* *Six monthly report to the Trust Board on themes and lessons learned from SUIs*	Starting July 2009 6 monthly	
		Ensure that levels of violence and aggression amongst patients and staff are minimised *Monitor levels, review incidents and introduce measures such as training and support, review of activities, and reflective practice to reduce the number and severity of incidents* *Reduction in frequency and severity of violence and aggression for both patients and staff.* *90% of frontline inpatient staff trained in prevention and management of violence and aggression.* *Evidence of an improvement in safety on the wards, as perceived by staff and patients, demonstrated by survey results.*	Quarterly progress reports	

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
SUSTAINABILITY				
7	Driving up Surpluses	Delivery of new service developments on time and to budget, e.g. Mother and Baby, Specialist Inpatient Secure Service for People with Learning Disability and Low Secure Developments *Major progress on strategy to enhance forensic bed capacity* *Service strategy reviews* *Invest to Save initiatives* *Extension of market testing*	Quarterly progress reports	Director of Finance and Director of Performance and Business Development
8	Improved budget management	Budget accountability *Improved cost reporting* *Implementation of trading accounts and service line reporting*	Quarterly progress reports	Director of Finance
THE ABOVE PRIORITIES WOULD BE SUPPORTED BY THE FOLLOWING				
9	Training, Education and Development Programme	Increased uptake of statutory and mandatory training, in line with the Trust's policy and agreed key training sessions. *All staff to have undertaken key training sessions*	March 2010	Deputy Chief Executive and Director of Human Resources
		Delivery of and increased uptake of the targeted customer care training. *All eligible front-line staff to have been trained.*	March 2010	
		Development and delivery of the Organisational Development and Leadership Programme for the Trust Board, Directorate Management Teams and inpatient and community teams. *Review of existing 'Coaching for Capable Teams' development programme* *Development programme in place for Community Mental Health Teams* *Clinical and Management Leadership programme in place.*	May 2009 July 2009 December 2009	

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
10	Modern and fit for purpose premises	Delivery of the 2009/10 community capital investment programme for community venues/sites and ensure that existing premises are maintained to a high standard *Acquire 3 new community premises for Tower Hamlets (2 CMHT and 1 CAMHS) and 1 new community base for City & Hackney* *Implementation of the backlog maintenance programme*	October 2009, subject to affordability Quarterly reports	Director of Estates, Facilities and Capital Development
		Development of the business case for the re-provision of the City & Hackney Centre for Mental Health inpatient service *Strategic Outline Business Case to be completed*	June 2009, subject to planning negotiations	Projects Director
TRUSTWIDE DEVELOPMENTS				
1	Young People Service Strategy	Strategy to be considered by Service Delivery Board prior to submission to Member's Council.	July 2009	Medical Director and Clinical Directors
2	Non Verbal Therapies Strategy	Strategy to be considered by Service Delivery Board. *Implementation of Trust-wide and borough plans.*	June 2009 March 2010	Medical Director, Director of Therapies and Director of Research
3	City and Hackney Rehabilitation and Recovery Service	Reprovide inpatient rehabilitation services at City and Hackney centre for mental health as per IBP. *New reprovided service fully operational.*	October review	Director of Performance and Business Development and City and Hackney Borough Director
4	Expansion of Trust-wide Mother & Baby Unit based at the City and Hackney Centre for Mental Health	Service fully operational	March 2010	Director of Performance and Business Development and City and Hackney Borough Director

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
5	Specialist Secure Inpatient Service for People with Learning Disability based at the John Howard Centre	Service fully operational	June 2009	Director of Performance and Business Development and Forensic Service Director
CITY AND HACKNEY CAMHS SERVICE DEVELOPMENTS				
1	Expansion of the CAMHS Parental Mental Health Service	Service fully operational	July 2009	Director of Operations and Specialist Services Director
2	New Child and Adolescent Mental Health service to under 25s	Service fully operational	July 2009	Director of Operations and Specialist Services Director
3	Expansion of the Paediatric Liaison Service	Service fully operational	July 2009 subject to PCT involvement and approval	Director of Operations and Specialist Services Director
CITY AND HACKNEY ADULTS AND OLDER ADULT SERVICE DEVELOPMENTS				
1	Expansion of the Paediatric Liaison Service	Service fully operational	July 2009 subject to PCT involvement and approval	Director of Operations and City and Hackney Borough Director
2	Additional staffing for Home Treatment Team for Adults in City & Hackney	New staff in post	September 2009 subject to PCT involvement and approval	Director of Operations and City and Hackney Borough Director

Area		Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
3	Psychiatric Liaison Service for Adults in City & Hackney	Service fully operational	December 2009 subject to PCT involvement and approval	Director of Operations and City and Hackney Borough Director
4	Enhanced Psychological Service for Older People in City & Hackney	Service fully operational	December 2009 subject to PCT involvement and approval	Director of Operations and City and Hackney Borough Director
5	New Specialist Intermediate Care Service for Older People in City & Hackney	Service fully operational	December 2009 subject to PCT involvement and approval	Director of Operations and City and Hackney Borough Director
TOWER HAMLETS ADULTS SERVICE DEVELOPMENTS				
1	Tower Hamlets Early Detection Service	Service fully operational	September 2009	Director of Operations and Tower Hamlets Borough Director
2	Non-Verbal Therapies Service for Adults in Tower Hamlets	Service fully operational	September 2009	Director of Operations and Tower Hamlets Borough Director
3	Rehabilitation Service for Tower Hamlets	New staff in post	September 2009	Director of Operations and Tower Hamlets Borough Director

	Area	Action/Target	Delivery/Review Date	Executive & Corporate Director Leads
TOWER HAMLETS ADULTS SERVICE DEVELOPMENTS				
4	Crisis House Service for Tower Hamlets	New staff in post	September 2009	Director of Operations and Tower Hamlets Borough Director
5	Additional staffing for Home Treatment Team for Adults in Tower Hamlets	New staff in post	September 2009	Director of Operations and Tower Hamlets Borough Director

Appendix 4

Capital Plan 2009 - 2012

3 Year Capital Plan	2009/10	2010/11	2011/12
City & Hackney Locality			
Homerton Moves	300	0	0
Mother & Baby	1,293	23	0
Homerton East Wing Reprovision OBC/FBC	230	230	230
Shepherdess Walk - Dilapidation	100	0	0
City & Hackney Total	**1,923**	**253**	**230**
Forensics			
Wolfson House	9,263	3,087	0
Learning Disabilities - Interim unit	269	0	0
Moorgate Seclusion Room	150	0	0
Forensics Total	**9,682**	**3,087**	**0**
Tower Hamlets			
Pharmacy Mile End	250	0	0
Tower Hamlets Total	**250**	**0**	**0**
Trust-wide			
Asset property management	850	1,000	1,000
Staff Capitalisation	500	500	500
Connecting for Health	100	100	100
Nurse Rostering System	100	0	0
Trust-wide Total	**1,550**	**1,600**	**1,600**
Grand Total	**13,405**	**4,940**	**1,830**

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Tower Hamlets NHS
Primary Care Trust

Equitable Access to Primary Medical Care Programme
Procurement of a GP Led Health Centre at St Andrews
Briefing to LBTH Health Scrutiny Committee,

1.0 Purpose of document

To present to members of the Health Scrutiny Committee, a briefing of the commissioning process for a GP Led Health Centre at the old St Andrew's Hospital site. This development has been identified to deliver the PCTs obligation under the Department of Health (DH) Equitable Access to Primary Medical Care (EAPMC) procurement programme and also supports the PCT and Partnership planned health and social care development programme outlined in Improving Health and Wellbeing. The initiative outlines the process for commissioning of a new GP Led Health Centre and a new development at St Andrew's as the hub of services in LAP 6.

2.0 Overview - National and Local Context to EAPMC

The Equitable Access initiative is outlined in the NHS Operating Framework, the National Planning and Priorities Guidance and is consistent with statements made by the Health Minister Lord Darzi in the NHS Next Stage Review.

In 2007, as part of action from the Next Stage Review, DH wrote to PCTs outlining the requirements needed to underpin the development of new Health Centres and GP practices in the EAPMC programme. At this time front runner PCTs were identified and given a deadline of December 2008 for their services to commence, most of these initial PCTs were identified as being in under-doctored areas and/or outside London. The programme is now being rolled out to all PCTs and Tower Hamlets has been given a target for one "Health Centre" to be procured by Autumn Q3 2009/10 and open during 2010.

The aims of the EAPMC programme have particular focus on achieving closer integration with other health / community services and social care, with extensive opening hours and access to walk-in services for registered and un-registered patient services. The principles map closely to the local Tower Hamlets partnership model of health and well-being centres and in particular those health centres identified as locality hubs.

3.0 Programme Principles, Core Criteria and Success Criteria

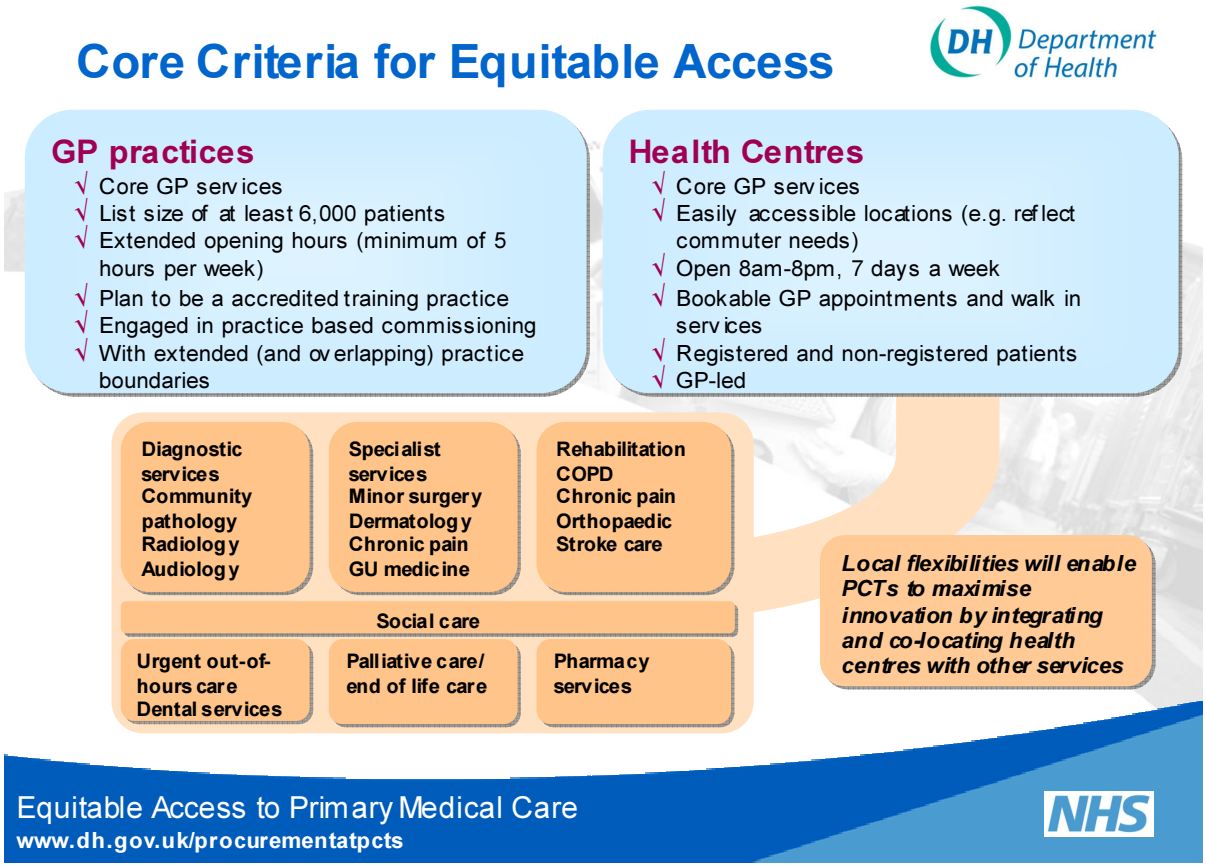
The outline requirements of the programme are detailed in table one below.

The principles for the EAPMC programme include:

- A core requirement of the programme is that services are for new capacity i.e. "green field" sites and therefore **must not** include expansion or replacement or transfer of existing general practices, health centres or lists.

- Investment must be for additional clinical capacity (i.e. extra GPs, nurses and support staff).
- These are procurements for new and innovative services, but not necessarily for new buildings or facilities

Table one



- Every GP led health centre (GPLHC) will have at its core the provision of GP services.
- Anyone, registered or unregistered will be able to use these services, to get bookable GP appointments and walk-in services 8am to 8pm, 7 days a week.
- Under the programme the GPLHC will be managed and operated by an APMS Provider offering an appropriate clinical care and services
- There must be evidence that services are located in areas that maximise convenient access.
- For Tower Hamlets, the GPLHC is expected to open in Q1 2010 in a new facility, although it is intended to enter into a contractual arrangement for GP services by the end of October 2009. Dates for pharmacy and dental contracts are to be confirmed once the timelines around the building programme become firmer.

There are also a number of key success criteria e.g. “evidence that the new services will have a specific focus on promoting health and preventing ill-health, for instance through introduction of smoking reduction services, sexual health, alcohol and substance misuse services, diet, exercise and weight management, supporting back to work services”.

4.0 Local strategic objectives and choice of site

This initiative is closely linked to Tower Hamlets PCT's strategic objectives which relate to- Urgent Care, Community Pharmacy, Dental, Commissioning Strategic Priorities and operating frameworks. The Tower Hamlets Partnership Strategy Improving Health and Wellbeing identified a number of developments including the creation of new health centre in each locality.

The specific objectives of the Integrated Centre include improving access to primary care through providing an extended hours GP practice offering core and enhanced services with the expectation that some specialist services will be provided to meet local priorities and needs as part of an integrated and multidisciplinary approach, with potential to grow the list size to 15,000 patients.

In choosing a site to propose to deliver the EAPMC programme requirements a number of factors have been considered: -

- Fit with current local strategy (e.g. IHWB, Urgent Care Strategy, Community Pharmacy Strategy + Pharmacy Procurement Process, Dental Strategy)
- Programme requirements out-lined above
- Capital programme plans
- Timescales for delivery of build
- Anticipated locality growth in population
- Fit with polyclinics requirements as a federated polyclinic with other practice sites in LAP 6

The St Andrew's development is proposed as the preferred choice for delivery of the EAPMC programme requirements for the following reasons: -

- There is good fit between the EAPMC project requirements and the proposed services as outlined for St Andrew's (see below) in the IHWB Strategic Programme Business Case
- Significant consultation has already taken place on these proposals which have been well received by patients and the public and they are part of a clear partnership commitment between health and social care.
- The population in the area is due to rise by 15K by 2020 and many of the plans for development for the NE Locality are on the east of the Borough, an area where significant new services will be required to meet demand. The St Andrew's site is at the eastern edge of the borough close to significant proposed housing and business development and Olympic fringe
- The programme build is the only one planned in IHWB that is close to the timescales required by DH for EAPMC.

DH national timelines for this procurement require service commencement by March 2009. This deadline has been extended to Autumn 2009 for PCTs in London but NHS London are clear no further extension is available. The PCT is required to sign the APMS contract by Autumn 2009 for service commencement early in 2010. St Andrew's

new premises will not be available for occupation until est.Q3 2010/11 therefore an interim accommodation solution will be required at service commencement to move to St Andrew's once the build there is complete.

The current service plans for the St Andrew's development include: -

Dentistry, General Practice, Community Pharmacy, Social Services (Adult care, housing/benefits advice, back to work), District Nursing, Health Visiting, School Nursing, primary care psychology, low level diagnostics (near patient testing, ultrasound), community mental health, long term condition management (respiratory disease, diabetes, neurological disease), community services sessions (e.g. foot health, SALT, physiotherapy etc), bookable space for care outside hospital shift

The planned schedule of accommodation of the development has been drawn up with flexibility built in to the designs. This will enable the services delivered to flex to meet the requirement of the EAPMC programme.

5.0 Finance

Cost modelling is one of the earliest stages of the project plan, DH letter (Gateway ref 9194 21st December 2007) states; "funding for Health Centres will be included in PCTs overall allocations, given that the scale of investment in these new services is best determined locally taking into account the range of services that should be included".

6.0 Considerations for the Committee

The commissioning team would be very grateful to receive the comments of the committee on any aspect of the process and in particular in relation to the services to be offered. The PCT would be happy to provide regular updates throughout the process if requested.

7.0 Recommendations

The committee is asked to note the proposals for the commissioning of new general practice services for the St Andrews area of LAP 6.

8.0 Next Steps

The programme proposals have recently been presented to the PCT Executive, Board and Competition, Choice and Contestability panel of the PCT. The advertisement was placed in May and the formal tender will be issued in late July or August. Timelines for other procurements (dental and pharmacy) will depend on the St Andrew's Building timelines.

Charlotte Fry
Associate Director

Primary & Community Care Commissioning Directorate

Tower Hamlets NHS
Primary Care Trust

Provision of New Health Centre (St Andrew's Development) in Tower Hamlets PCT

Memorandum of Information (MOI)

Table of Contents

1 PURPOSE, STRUCTURE AND NEXT STEPS FOR BIDDERS

1.1 Purpose of this document

This Memorandum of Information (**MOI**) provides potential bidders an overview of the Tower Hamlets Primary Care Trust (PCT) Procurement of a new Health Centre to be based ultimately at the St Andrews site, and provides details of the:

- Procurement process and its objectives
- Procurement commercial framework
- Sets out the process to be used for selecting providers for a new Health Centre planned by Tower Hamlets PCT, at a new development at the St Andrew's site.
- Sets out the criteria for selection and the decision-making process to be followed.
- Includes guidance on the Pre Qualification Questionnaire (PQQ) pre-selection process and subsequent formal application.
- Procurement governance and administration requirements
- The document does not describe the range and quality of services to be provided.
- The service required (see Annex A)

The MOI should is to provide potential Bidders with sufficient information on the Tower Hamlets PCT Procurement to enable them:

- To make an informed decision about whether they wish to participate; and
- To submit an Expression of Interest **(EOI)** see Annex B.

1.2 Organisation of this document

This MOI is organised into the following sections:

Section 1: Purpose, Structure and Next Steps for Bidders

Detailing the purpose and organisation of the MOI and the next steps for potential Bidders.

Section 2: Introduction and Overview

Detailing the background and objectives to the Tower Hamlets PCT Procurement, the scope of services to be procured, the bidder pool and the factors critical to the success of the Tower Hamlets Primary Care Trust Procurement.

Section 3: Commissioning PCT

Details of the Commissioning PCT.

Section 4: Procurement Process Overview

Detailing the steps involved in the Tower Hamlets PCT Procurement.

Section 5: **Commercial Framework**

Detailing the key commercial terms and other legal and contractual arrangements for the Tower Hamlets PCT Procurement.

Section 6: **Governance and Administration**

Detailing key governance and administration requirements of the Tower Hamlets PCT Procurement.

Section 7: **Glossary of Terms and Abbreviations**

Providing a glossary of the terms used in the MOI.

Annexes: **Annex A**

Detailing specific summary information for the PCT Scheme.

Annex B

Template to be used by potential Bidders for submitting an EOI.

1.3 Next Steps for Bidders

Interested parties wishing to participate in the Tower Hamlets PCT Procurement **must** submit an EOI, in the standard format detailed in Annex B, by email to shaju.jose@thpct.nhs.uk

EOIs should arrive before 5pm on 5th June 2009

Tower Hamlets PCT will not consider any potential Bidder who does not meet the deadline.

2 INTRODUCTION AND OVERVIEW

2.1 Background and Context to Equitable Access to Primary Medical Care

The NHS Next Stage Review Interim Report (October 2007) carried out by Lord Darzi (the Report), reported that, despite sustained investment and improvement in the NHS over the past ten years, access to primary medical care services and the quality of those services, continues to vary significantly across the country. Many of the poorest communities experience the worst health outcomes and major inequalities exist within England in life expectancy, infant mortality and cancer mortality. Further, the gap in life expectancy between the most deprived and least deprived areas has widened, despite improvements in life expectancy in the most deprived areas.

The Report identifies improving access to primary care as a key priority if we are to deliver more personalised care that meets the needs of individuals and communities, especially those in more disadvantaged or deprived areas. This builds on the work that the Strategic Health Authorities are already doing with PCTs to improve access, responsiveness and choice in primary medical care in response to the GP patient survey (Your Doctor, Your Experience, Your Say) results in 2007.

Equitable Access to Primary Medical Care (EAPMC) will play a significant role in achieving more personalised care set out by Lord Darzi. It is essential that there is recognition that the EAPMC programme will address specific issues highlighted in the Report. The focus of the EAPMC programme will be on achieving the visions of a fair and personalised NHS (whilst upholding the values of safe and effective primary care services).

Ministers have announced that the Government will be providing new investment of £250m to support PCTs in establishing:

- at least 100 new General Practices in the 25% of PCTs with the poorest provision (based on the fewest primary care clinicians, lowest patient satisfaction with access and the poorest health outcomes), both to increase capacity and offer an innovative range of services

- at least one new GP-led health centre in each PCT in easily accessible locations, providing a flexible range of bookable appointments, walk-in services and other services for either non-registered or registered patients, based on the guiding principle of ensuring that the local public can access GP services any time from 8am to 8pm, seven days a week

The Report states that these changes could not be achieved by the NHS alone but stressed that PCTs would have a key role to play in working alongside other agencies (including local authorities and Local Strategic Partnerships), communities, industry, the voluntary and private sectors.

The programme is now being rolled out to all PCTs and Tower Hamlets has been given a target for one “Health Centre” to be procured by Autumn Q3 2009/10 and open during 2010. Tower Hamlets PCT will lead and manage the St Andrew’s procurement, with guidance from NHS London and assistance and support from the Department of Health.

The aims of the EAPMC programme have particular focus on achieving closer integration with other health / community services and social care, with extensive opening hours and access to walk-in and registered services. Many of the principles map closely to the local Tower Hamlets partnership model of health and well-being centres and in particular those health centres identified as locality hubs.

2.2 Objectives of the PCT Procurement

The key objectives of the Tower Hamlets PCT Procurement are:

- To provide new services that fit in with the current local strategy including Tower Hamlets Partnership Strategy Improving Health and Wellbeing (IHWB) Strategy, Urgent Care Strategy, Community Pharmacy Strategy and, the Dental Strategy
- To provide patients with greater access to NHS primary medical care services through additional capacity;
- To improve the quality of primary medical care available to patients; and
- To deliver high quality affordable and value for money (VfM) NHS primary medical care services.

2.3 Scope of Services

The scope of primary medical care services for the Tower Hamlets PCT Procurement has been developed by Tower Hamlets PCT in conjunction with the Strategic Health Authority (**SHA**) and based on the needs of the local community.

The primary medical care service specification required for Tower Hamlets procurement are detailed in Annex A of this MOI.

2.4 Bidder Pool

Tower Hamlets PCT wishes to receive responses to the Pre-Qualification Questionnaire (**PQQ**) from suitably qualified and experienced healthcare providers (including general practitioners, social enterprise / third sector organisations and other providers) with the necessary capacity and capability (or a demonstrable ability to provide the necessary capacity and capability) to provide the range of primary medical care services as set out in Annex A, in a safe and effective manner and to meet the requirements of paragraph 2.5 below. Potential Bidder's may bid in partnership with other organisations such that the Clinical Services Supplier may be different to the potential Bidder.

2.5 Critical Success Factors (CSFs)

Tower Hamlets PCT requires the Provider to meet the following CSFs throughout the life of the Contract:

- **Quality** – Patient-centred primary medical care services, delivered in a safe and effective manner and delivered via a multidisciplinary workforce with extended skills, responsibilities and training.
- **Access** – The primary medical care procured must be provided in locations and facilities that meet local patient access preferences.
- **Value for Money and Affordability** – The primary medical care services procured must be affordable for Tower Hamlets PCT and provide value for money.
- **Integration** – Providers will be expected to integrate with, and positively contribute to, the local healthcare community.
- **Satisfaction -** Patients, staff, referring clinicians & other health professionals must be satisfied with the quality and delivery of the Services.
- **Innovation** The Services must introduce and catalyse affordable innovations in clinical practice that improve the quality and responsiveness of patient care and encompass a health and social care approach.

2.6 Local context and Location

Tower Hamlets Partnership Strategy 'Improving Health and Wellbeing' (web link: http://www.towerhamlets.nhs.uk/EasysiteWeb/getresource.axd?AssetID=3732&type=full&servicetype=Attachment) identified a number of developments including the creation of new health and wellbeing centres in each locality. In choosing a site from which to deliver the EAPMC programme requirements a number of factors have been considered: -

- Fit with current local strategy (e.g. IHWB, Urgent Care Strategy, Community Pharmacy Strategy, Dental Strategy)
- Programme requirements out-lined above
- Capital programme plans
- Timescales for delivery of build
- Anticipated locality growth in population
- Fit with requirements of the Healthcare for London strategy

The St Andrew's development proposed is the preferred choice for delivery of the EAPMC programme requirements for the following reasons: -

- There is good fit between the EAPMC project requirements and the proposed services as outlined for St Andrew's
- Significant consultation has already taken place on these proposals which have been well received by patients and the public and they are part of a clear partnership commitment between health and social care.
- The population in the area is due to rise by 15K by 2020 and many of the plans for development for the NE Locality are on the east of the Borough, an area where significant new services will be required to meet demand. The St Andrew's site is at the eastern edge of the borough close to significant proposed housing and business development

The planned schedule of accommodation of the development has been drawn up with flexibility built in to the designs. This will enable the services delivered to flex to meet the requirement of the EAPMC programme.

In considering the health needs of the community the following factors are relevant to Tower Hamlets and the locality within which St. Andrew's is located - LAP 6 (Mile End East and Bromley by Bow together make up LAP 6 and St Andrew's is situated within Bromley-by-Bow)

Detailed information on Bromley-by-Bow and LAP 6 can be obtained at the following websites: -

http://publichealth.thpct.nhs.uk/index.aspx?pid=171

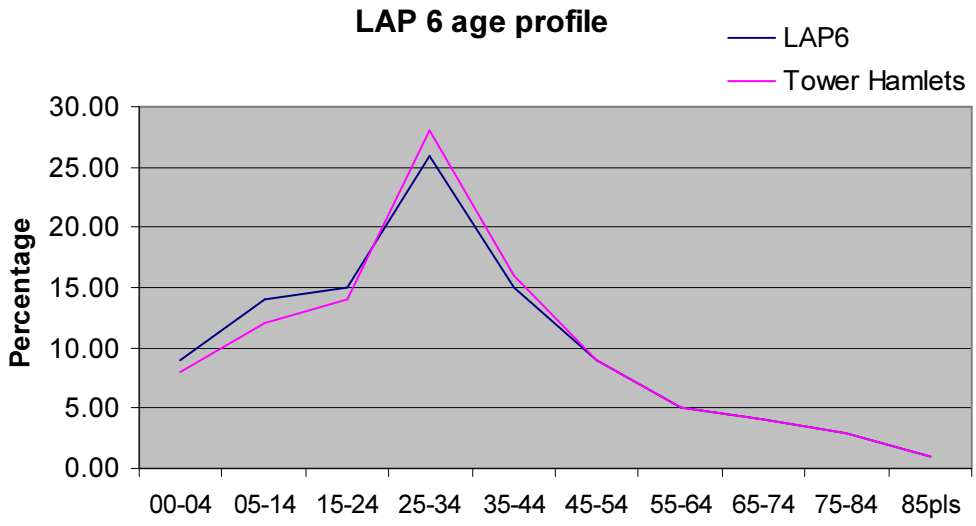
http://www.onetowerhamlets.net/

http://thisborough.towerhamlets.gov.uk/

Relevant local health factors relating to areas within LAP 6:-

- High level of circulatory disease mortality;
- High cancer mortality rates;
- Breast screening currently 50% of national targets;
- Cervical screening currently 90% national targets;
- Mental health
    - Admissions are 80-90% greater than expected across England; and
    - Amongst highest prevalence of child/adolescent mental disorder in the Borough;
- Lifestyles Issues;
    - High rates of obesity;
    - Low rates of binge drinking; and
    - Low consumption of fruit and vegetables.
    - High levels of smoking;
- High levels of crime in the southern area;
- Large areas of education, skills and training deprivation;
- High levels of overcrowding;

LAP 6 - Population Profile

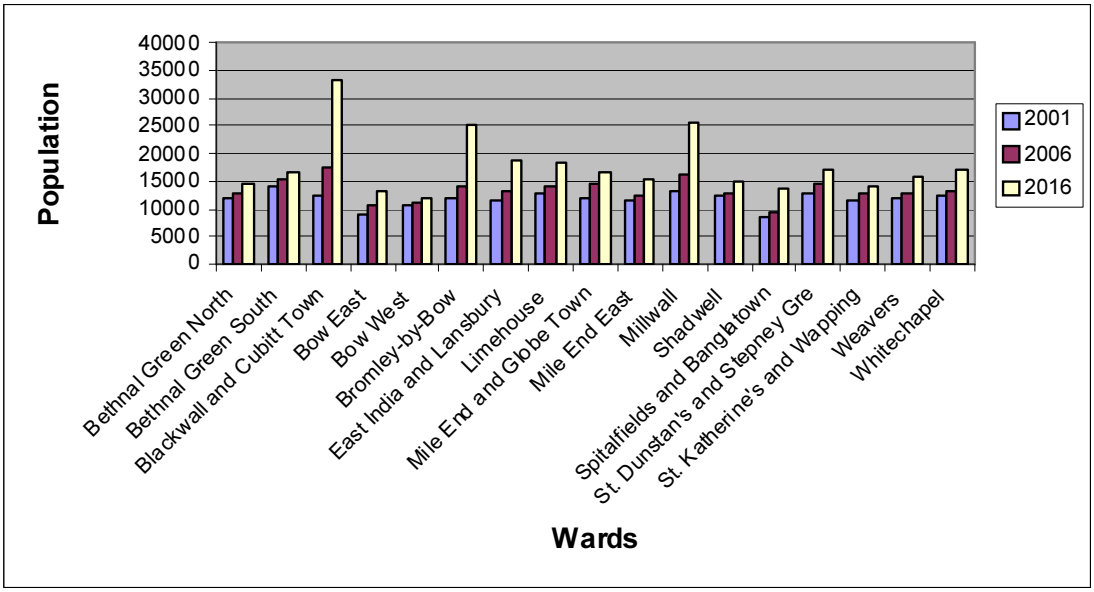


Age demographics

LAP 6 has a younger population than the Tower Hamlets average. The largest age group is between

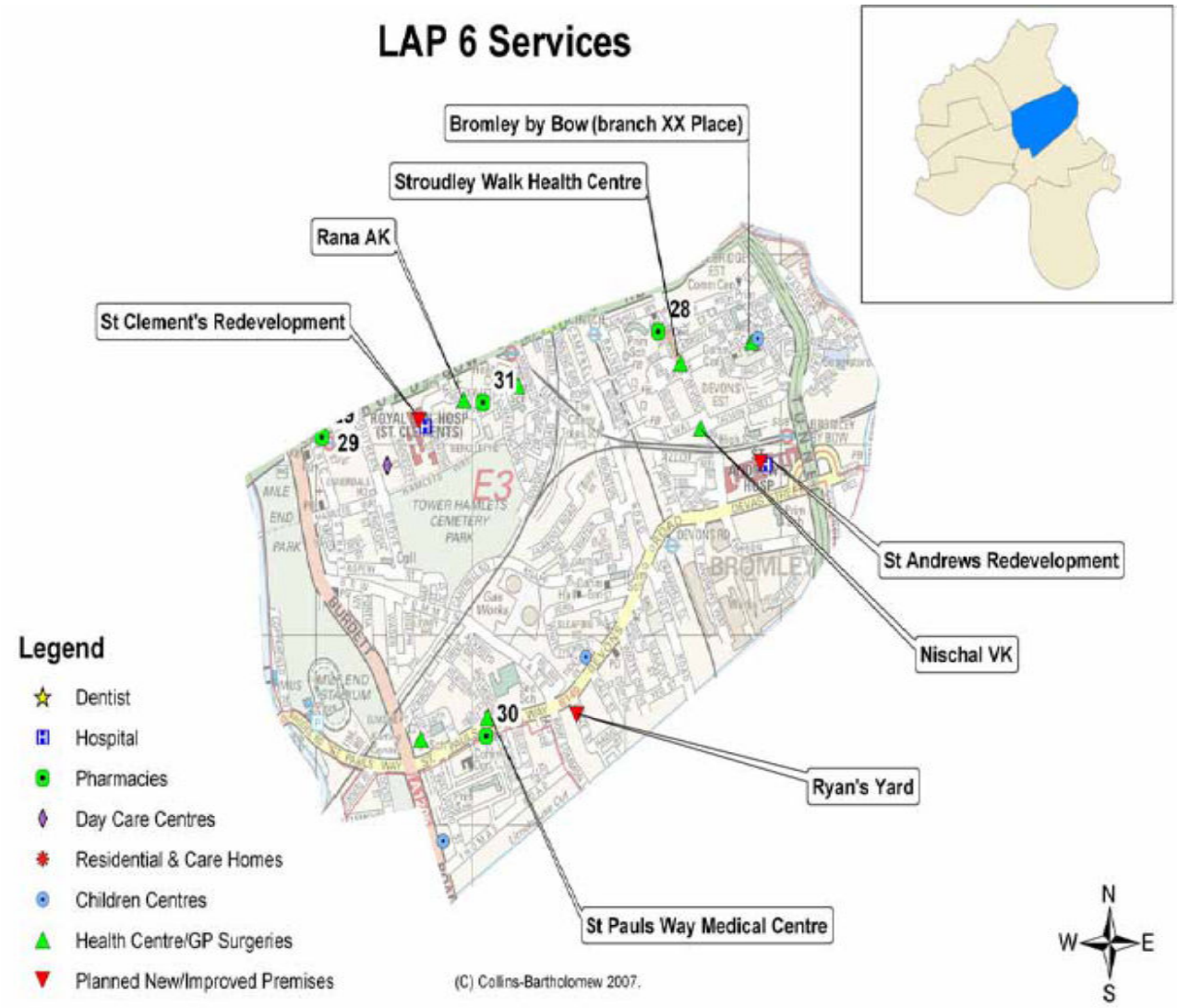
25 to 34 and 88% of residents are under 55 years of age.

Population projections for electoral wards in Tower Hamlets



Source GLA Oct 2005

A map of the wards in Tower Hamlets PCT is set out below:


LAP 6 Services
Bromley by Bow (branch XX Place)
Stroudley Walk Health Centre
Rana AK
St Clement's Redevelopment
28
31
29
30
St Andrews Redevelopment
Nischal VK
Ryan's Yard
St Pauls Way Medical Centre
Legend
Dentist
Hospital
Pharmacies
Day Care Centres
Residential & Care Homes
Children Centres
Health Centre/GP Surgeries
Planned New/Improved Premises
(C) Collins-Bartholomew 2007.
N
W
E
S

3 COMMISSIONING PCT

3.1 Commissioning PCT

The commissioning PCT for this procurement is:

SHA	Commissioning PCT
NHS London	Tower Hamlets Primary Care Trust

Table 1: Commissioning PCT

Tower Hamlets PCT sub-divides into the seventeen wards and 8 Local Area networks (LAPS), as detailed below:

The PCT boundaries are coterminous with those of the London Borough of Tower Hamlets. It has higher than average healthcare needs and inequalities, with a population that is becoming more diverse with increasing numbers of new entrants from other parts of the UK as well as abroad. There are a total of 34 practices within the PCT boundary with a total registered population of 236,458 patients.

Census projections suggest that a growth in the Borough's population, with a particular increase in the proportion of non-white minorities. The main growth in population in the last decade has been in children and in the very old. The projected population growth over the next ten years across the Borough is 50%. Details of the current age profile across the Borough are given below.

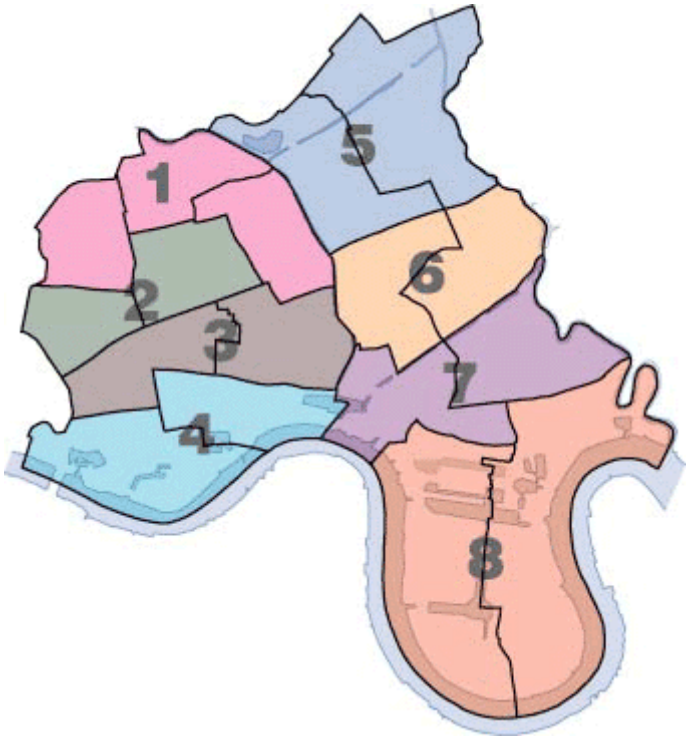


Figure 1: Commissioning PCT location

The aim of Tower Hamlets PCT is to improve the health of local people living in Tower Hamlets in east London. We want to reduce inequalities in health and modernise services for local people. We achieve these through assessing the health needs of our communities, commissioning services from hospital trusts and other local organisations, and by providing a range of services ourselves. We are supporting general practice, bringing more GPs and practice staff to Tower Hamlets, developing the range of services available from practices and health centres, and improving premises near to where people live.

Working in partnership with local people

One of our priorities is to work with the local authority and other community organisations to integrate health and social care. We have made progress with some integrated teams already and more work is underway to make sure local people receive convenient, co-ordinated and good quality services. The London Borough of Tower Hamlets, PCT and other public and community sector partners come together as part of the Tower Hamlets Partnership to work closely with local people over a range of health and social care issues. Active consultation on Health and Wellbeing plans continues on the partnership website at http://www.onetowerhamlets.net/.

3.2 Our aims are to:

- reduce inequalities in health
- improve the experience of those who use our services
- increase choice
- promote independence
- target resources effectively

3.3 Our key objectives are to:

- achieve a measurable improvement in the overall quality and effectiveness of services,
- develop primary care,
- develop our workforce,
- commission secondary (hospital) services that are more responsive to the needs of local people,
- implement National Service Frameworks which have been introduced for a number of services.
- achieve recurring financial balance
- achieve effective, economic and efficient use of available resources,

3.4 Our values - we will work in a way that:

- values the patient's personal experience of health and healthcare,
- values and celebrates the diversity of its workforce and the population it serves,
- takes a "whole systems" approach to healthcare provision,
- empowers patients and staff to develop and improve the health of individuals and the population as a whole

3.5 PCT Scheme

Bids will be sought for the following PCT Scheme(s):

One GP Led Health Centre for the provision of primary medical care and related services

4 PROCUREMENT PROCESS – OVERVIEW

The procurement application process will be a four stage ITT process and will essentially include:

- Initial expressions of interest will be invited by advertisement. These will be required to complete a standard PQQ, all sections of which **must** be completed. All PQQ's received will be reviewed by a Panel to create a short-list, of no more than 5 applicants.

- Short listed bidders, who will then be invited to submit a formal application to provide services against a full specification, for each practice. The formal applications will be required to a standard format. A question and answer event will be organised early in the process during which bidder will be offered clarification on any issues relating to the bid and proposed contract. A written Q&A process will also be available.

- All formal applications will be reviewed by a selection panel, convened for each practice; potential preferred or reserve bidders may be invited to an interview to allow clarifications to be asked and/or raised. The panel will then select a preferred and possibly a reserve provider.

- The preferred provider will then be invited to finalise and sign an APMS contract.

The number, quality and nature of applications, as well as the type of contract will determine the precise timescales, but the indicative timetable is set out in table 3 below.

4.1 Procurement Timeline

The Tower Hamlets PCT Procurement timeline is summarised in paragraph 4.1 and further detailed in paragraphs 4.2 to 4.9 below.

The timeline for the Tower Hamlets PCT Procurement is set out in Table 2 below. It should be noted that the dates are expected dates at the time of issuing this MOI and may be subject to change.

Stage	Date
Advert published and Expressions of Interest invited	W/C 18th May
Send out Information Packs/PQQ	8th June
Closing date for receipt of completed PQQ	29th June 5pm
Panel short-listing of applicants and issue invitations for formal applications and information packs to preferred bidders	First week July
Meetings with Bidders	19th August
Submission of tenders	18th September
Selection of preferred providers	w/c 12th Oct
Contract finalisation	October'09
Final agreement with one preferred provider once the PCT is satisfied that the provider can meet all requirements of the bid	November'09
Commence provision of service	Jan / Feb 2010

Table 2: Tower Hamlets PCT Procurement Timeline

Further details on the timeline for the ITT stage will be provided in the Tower Hamlets PCT Scheme ITT.

4.2 Advert, Memorandum of Interest & Expression of Interest

Advertisement

The PCT is keen to encourage applications from any organisation legally entitled to provide services under a Medical Services contract. National and local adverts have been published describing, in general terms, the primary medical care services being procured by Tower Hamlets PCT. Adverts have been placed at national and local level to encourage responses from as wide a range of organisations as possible. Potential Bidders must register their interest by submitting an EOI in accordance with the requirements of paragraph 1.3.

Applicants are at liberty to form consortia and partnerships with other service providers. All proposed service providers should be identified in the PQQ application

Memorandum of Information

This MOI provides details of the Tower Hamlets PCT Procurement.

This MOI should provide potential Bidders with sufficient information on the Tower Hamlets PCT Procurement process and the Tower Hamlets PCT Scheme to enable them to make an informed decision about whether they wish to register their interest in the Tower Hamlets Procurement.

A copy of the Memorandum of Information will be available to download from the Primary Care Trust web site: http://www.towerhamlets.nhs.uk/tenders/ by **5.00 pm on 20th May 2009.**

Interest must be registered by submitting an EOI in accordance with the requirements of paragraph 1.3

Expression of Interest

Expressions of Interest in response to the advert are to be made electronically in the format provided in Annex B by email to shaju.jose@thpct.nhs.uk

The PQQ and any subsequent formal applications must be submitted in writing and via electronic document, by the due date. Applicants are responsible for ensuring documentation reaches the named person at the PCT by the specified date. The PCT will not automatically confirm the receipt of applications.

EOIs should arrive before 5pm on 5th June 2009.

Tower Hamlets PCT will not consider any potential Bidder who does not meet the deadline.

4.3 Pre-Qualification Questionnaire (PQQ)

The initial Expression of Interest will followed up by an invitation to complete a standard Pre-Qualification Questionnaire (PQQ) that will request the following information:

- Name and details of the individuals and/or organisation(s) applying and contact information.
- Legal and Regulatory experience and qualification.
- Evidence of sound financial stability, capacity and credibility
- An outline overview of how the applicant/s would provide the service including the range of services and the proposed model of care and clinical experience.
- Details of the organisation's general capacity and capability
- Innovative proposals
- Signed Non Disclosure Agreement

The PQQ provides detailed information on the PQQ process, guidance on how to complete the PQQ and a series of questions for potential Bidders to answer.

The PQQ will be issued, by email, week commencing 8th June 2009 to all potential Bidders who submitted an EOI by the deadline. All potential Bidders wishing to bid for the Tower Hamlets PCT Scheme must respond to the PQQ before the deadline stated in the PQQ. Tower Hamlets PCT reserves the right not to consider any PQQ submission received after that deadline.

A clarification question and answer process will operate during the PQQ stage and will be explained in the PQQ documentation.

The PQQ is designed to evaluate the capacity, capability and eligibility of potential Bidders to provide the primary medical care services which are the subject of the Tower Hamlets PCT Procurement.

The PQQ evaluation will include a short-listing process and potential Bidders will be told whether or not they have been short-listed.

Further details of the PQQ process and evaluation will be set out in the PQQ.

4.4 Invitation to Tender

Bidders short-listed will be invited to complete a Formal Application which will include the completion of a standard detailed pro-forma (not included in this document), linked to the proposed Service Agreement (Contract), that will address all of the requirements set out in the specification and will include a requirement for the following information:

- Name of the individuals and/or organisation(s) applying
- Type of organisation (e.g. company, NHS body, etc)
- Contact information including a lead contact
- A formal statement of intent to provide
- Confirmation of willingness to work on a preferred provider basis to negotiate the contract
- Detailed statements on how the applicant intends to provide the service, as defined in the specification and required by the pro-forma
- Any services or requirements of the initial specification that cannot be met by the provider or, are additional to those advertised
- Statement of any services that the provider intends to sub-contract
- Contract price over duration period of contract, against a standard financial proforma
- Details of any sub-contractors or partners

- A clear demonstration and commitment to achieve the QoF and additional Performance monitoring criteria
- Details of any potential conflicts of interest
- Concurrence with the contractual terms in the contract

The PCT will evaluate applications according to the Selection Process broadly outlined in Section 4.6 below. Through this process the PCT will identify a preferred provider and offer that provider the opportunity to enter into a contract. Other providers may be identified as reserve bidders

The detailed requirements of the Tower Hamlets PCT Scheme ITT, the information required from Bidders and the timescales for submission of bids will be included in the relevant ITT.

Further details of the ITT process and evaluation will be set out in the Tower Hamlets PCT Scheme ITT.

4.5 The Selection Process

Short-listing - A specially constituted selection panel, will meet to assess the PQQ submitted. The intention will be to "screen out" any clearly unsuitable/unviable applications and rank suitable applicants. The decision will be made on the basis of the following criteria:

Criterion	Standard
Information	1) Submission of all required information
Experience, capability and capacity to bid and operate service	1) Demonstrates significant experience in providing the primary care services required 2) The application includes a clear exposition of sub-contractual/partnership or consortium arrangements 3) The bidder demonstrates that they have sufficient resource and support to complete the bidding process
Response to out-lined service and infrastructure needs	1) The application demonstrates how the service described will be delivered 2) The level of innovation proposed 3) Demonstrates efficient and effective use of the facilities and infrastructure provided 4) Their approach will provide sufficient, quality and motivated staff
Financial Risk	1) Demonstrate a sound financial position. 2) Provides the information requested.
Conflict of Interest	1) The application clearly sets out any conflicts of interest for individuals working for or on behalf of the provider

The composition of the selection panel will be drawn from the PCT management team assisted by clinical and other advisors and will be responsible to a Steering Committee established by the PCT Board for this purpose.

The scoring system and associated weighting applied will be defined within a separate 'PQQ Evaluation Plan' document.

All applicants will be notified whether or not their application has been short-listed. Successful applicants will be invited to submit a formal application against a detailed specification and Service Agreement (Contract).

Unsuccessful applicants can request feedback on their application but have no right of appeal against the decision.

4.6 Development of ITT response

Successful applicants from the PQQ stage will be invited to submit a formal application against a detailed specification and Service Agreement (Contract), for each practice (if appropriate). During this stage a mid-tender meeting will be arranged with bidders to clarify detail ITT specifications and requirements using standardized fixed agenda

4.7 Detailed evaluation of formal applicants

A selection panel for this purpose will be drawn from key clinical and technical experts and advisers constituted by the PCT and include a non executive director. The Panel has the responsibility for the evaluation and will ensure that:

- evaluation is fairly carried out
- evaluation includes relevant input from clinicians and other professionals experienced in all aspects of the service being commissioned
- a record is made of the evaluation including any scoring system used for the purpose

Evaluation criteria and Selection will be detailed in a Evaluation Plan Document (not included), but will generally be made against the following criteria.

Criterion	*4.7.1.1 Standard*
A: Technical capability	1) The application demonstrates significant experience in providing the primary care services required 2) The application includes a comprehensive analysis of clinical and organisational risks 3) The application includes a clear explanation of sub-contractual/partnership or consortium arrangements 4) The application demonstrates how service requirements, standards and targets will be achieved 5) The application demonstrates that the provider understands the requirements of clinical governance and describes how this will be handled 6) The application demonstrates both an understanding of, and an approach to, the particular health and population challenges in the local area 7) The application includes clear strategies on the retention of key clinical staff to maintain continuity of service.
B: Capacity	1) The application clearly describes how the provider will meet all of the service requirements set out in the detailed specification/Contract, including the recruitment and retention of staff 2) The application clearly describes the way in which the provider will generate sufficient capacity to provide the service 3) The application demonstrates clear understanding of the need for workforce development in sustaining a service 4) The application demonstrates an understanding of local needs and issues and, a flexible approach to the dynamic changing environment.
C: Financial and	1) The application clearly describes how the provider organisation is financed and how this may impact on the service delivery 2) The application includes an understanding of financial risks and how these will be managed

economic standing	3) The application clearly sets out any conflicts of interest for individuals working for or on behalf of the provider
D Value for money	1) Realistic and affordable pricing and quotes for the total service 2) Comparative analysis – lowest cost over contract period 3) Financial risk 4) Clear and realistic financial model

Scoring system – the following scoring system will be used by the Panel for the detailed evaluation:

ASSESSMENT	SCORE
Deficient - Seriously deficient answer to the question or a nil response.	0
Limited - Limited information provided or an answer that largely fails to address the question or that is flawed in certain respects.	1
Acceptable - An acceptable answer in terms of the level of detail, accuracy and relevance.	2
Comprehensive - A comprehensive answer to the question in terms of detail and relevance.	3
Superior - As “comprehensive” but to a significantly better degree.	4

The panel will recommend the highest scored applicants, subject to achieving a minimum scores within defined sections against a weighted scoring system, to be financially assessed. The panel will then recommend which bidder to enter into preferred provider negotiations. Further details of this process will be provided in the specification documents. A reserve bidder may also be identified.

In the event that no application achieves the conditions set out above the Panel will make a recommendation to the Steering Committee as to whether the process can proceed. This will decide whether the failure to meet the standard will materially affect the ability of the applicant to provide the service and/or provide value for money.

Presentations/Interviews with Preferred Bidders

Bidders may be asked, during the evaluation process, to meet with the Selection Panel to give a short presentation on their proposals and address any clarifications or issues identified during the evaluation.

Decision

The panel will make a recommendation to the Steering Committee for selection of the preferred and reserve providers for the health centre.

The final decision on the preferred and reserve provider will be formally agreed and minuted by the Steering Committee and passed to the Board for final approval.

The PCT will ensure that all relevant internal and external stakeholders are notified of the outcome of the process.

Finalisation of Service Contract (if required)

Nominated officers and legal representatives of the PCT may wish to work with the preferred provider to agree changes to the contract.

Where agreement is not possible the PCT reserves the right to terminate discussions with the preferred provider and enter into discussions with the reserve bidder.

4.8 Contract Award

The final version of the service contract will be approved and agreed by the Steering Committee. The contract will be signed by an appropriate PCT representative with authority delegated for that purpose and the successful bidder following approval by the PCT board.

4.9 Service Commencement

Following contract award and in accordance with the Provider's mobilisation plan, each PCT and Provider will work together towards service commencement at the contractually agreed date.

The target date for commencement of the contract is has yet to be agreed, but is anticipated to be Early 2010.

5 COMMERCIAL FRAMEWORK

Potential Bidders' attention is drawn to the following commercial information:

5.1 Contract

The contract to be entered into by the PCTs and the selected Provider(s) for the Tower Hamlets PCT Procurement will be based on the Alternative Provider Medical Services (**APMS**) contract and will comply with the mandatory requirements of the APMS Directions 2008 (the **Directions**). Within this framework, the APMS contract has been adapted as necessary to reflect the requirements of the Tower Hamlets PCT Scheme (the **Contract**).

Each Contract will be separate to and independent of any existing contract currently in place between a Provider and Tower Hamlets PCT.

5.2 Contract Duration

The Contract will be for a term of ten years with the possibility of extending the term beyond the initial contracted duration by mutual agreement with the Provider.

5.3 Clinical

Tower Hamlets PCT is looking for providers with the necessary capacity and capability (or a demonstrable ability to provide the necessary capacity and capability) to deliver high quality, patient-centred and VfM primary medical care services, delivered in a safe and effective manner and through a learning environment which includes the training of doctors and other healthcare professionals.

5.4 Workforce

Policies and Strategies

Bidders will be required to provide evidence that all proposed workforce policies, strategies, processes and practices comply with all relevant employment legislation applicable in the UK and in addition comply with the provisions outlined in:

- Safer Recruitment – A Guide for NHS Employers (May 2005);
- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) (the Code of Practice); and
- Standards for Better Health (April 2006).

At PQQ Stage, potential Bidders will be required to provide executive summary information on the following, with full copies of policies and other documentation being required at ITT stage:

- Recruitment, Health & Safety and other relevant policies including those on environmental protection;
- Procedures for ensuring compliance that all clinical staff, including doctors, nurses and allied health professionals, are registered with the relevant UK professional and regulatory bodies;
- Policy for ensuring clinical staff meet the CPD requirements of their professional and regulatory bodies; and
- Staff handbook setting out terms and conditions of employment for staff.

Further details of the staff resourcing and workforce policy requirements will be included in the Tower Hamlets Scheme ITT.

Pensions

Potential Bidders should assume that their staff would not be able to participate in NHS pension and injury benefit arrangements. The only exception to this is if the Provider is an organisation that meets eligibility conditions for PMS or GMS contracting and staff meet eligibility conditions for the NHS Pension Scheme.

Staff Transfers (TUPE)

The Tower Hamlets PCT Procurement focuses on access and capacity issues in under-provided areas through procuring additional primary care medical services. In providing better access and additional capacity, it is expected that Bidders will identify in their bids the need to employ additional staff to deliver the primary medical care services. However, some patient transfers from existing providers to new providers may occur and where this involves significant patient numbers representing a material proportion of an undertaking, there may be staff transfers under TUPE.

Where TUPE applies, the Code of Practice on Workforce Matters in Public Sector Service Contracts Guidance (Cabinet Office, March 2005)[1] will apply. This means that staff transferring under TUPE should receive access to a pension scheme that is certified as "broadly comparable" with the NHS Pension Scheme by the Government Actuary's Department (**GAD**).

5.5 Training

The Provider(s) must, if required by Tower Hamlets PCT, be prepared to provide and / or accommodate, training teaching and education for doctors including Foundation Programme and Specialist Training in General Practice and the training, teaching and education for other healthcare professionals. The Provider(s) will be required to comply with the requirements of the Postgraduate Medical Education and Training Board, Postgraduate Medical Deaneries, Royal College of General Practitioners, higher education training providers and the Healthcare Commission (if applicable), and any other relevant training bodies, for the supervision of clinical training.

Providers will be expected (if required by Tower Hamlets PCT) to commit to obtaining accreditation for training status.

5.6 Premises, Facilities Management & Equipment

Premises

The PCT will provide a temporary building solution from which to initiate the service, prior to a move to the St Andrew's site on completion. On moving to the St Andrew's site the Provider will be required to enter into a lease arrangement for the use of that property. Further details on such proposals and / or requirements for the Tower Hamlets PCT Scheme will be set out in the Tower Hamlets PCT Scheme ITT.

[1] Code of Practice on Workforce Matters in Public Sector Service Contracts Guidance

The Provider will be expected to fund rent, rates, utility and insurance costs for the premises. However, Tower Hamlets PCT will reimburse the Provider for rent and rates costs, separately to payments for primary medical care services. The exact mechanics of the payment mechanism will be detailed in the Tower Hamlets PCT Scheme ITT.

Facilities Management Services

Providers will be expected to fund FM Services costs except where FM Services at a PCT mandated property are provided as part of a separate, wider arrangement. Under these circumstances, Tower Hamlets PCT may require the Provider to utilise existing FM Services. Tower Hamlets PCT will reimburse Providers for FM Services separately to payments for primary medical care services. Further details on FM services requirements and the exact mechanics of the payment mechanism will be detailed in the Tower Hamlets PCT Scheme ITT.

Equipment

Providers will be responsible for the provision and cost of equipment, unless there are compelling reasons in respect of the Tower Hamlets PCT Scheme why this would not be the optimal equipment solution.

Details on equipment requirements for the Tower Hamlets Scheme will be set out in the Tower Hamlets Scheme ITT.

5.7 Information Management & technology (IM&T)

Provision of IM&T hardware and software will be on a similar basis to that of General Practices under the New General Medical Services (**nGMS**) contract. The majority of the provision of software, hardware and telecommunications networks and the support for such networks will be funded by Tower Hamlets PCT. Providers will need to manage the selection and deployment of IM&T solutions in conjunction with the PCT.

Providers will be required to use software applications from the GP Systems of Choice Programme (**GPSoC**). These application services will be provided in accordance with the standard terms and conditions for all providers who receive application services from GPSoC and will be funded through Connecting for Health (**CfH**) and the PCT. Under the funding agreements for GPSoC there may be certain additional systems (e.g. finance systems and business applications) that the Provider will be required to provide and manage itself.

In supporting the provision of IM&T, at a minimum Providers will be expected to meet the requirements of the nGMS Contract Directed Enhanced Services for *Choice and Booking* and for *Information Management & Technology*. Providers will also be required to put appropriate information management and governance systems and processes in place to safeguard patient information. This will need to be supported by appropriate training of staff.

Further information on IM&T support under nGMS contracts and the GPSoC programme can be found at the following web-links:

- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133866;
- http://www.connectingforhealth.nhs.uk/delivery/serviceimplementation/engagement/gps/systems_of_choice/gpspec.pdf.

Further details on IM&T requirements for the Tower Hamlets PCT Scheme will be set out in the Tower Hamlets PCT Scheme ITT.

5.8 Payment Mechanism

Payment to a Provider for the Tower Hamlets PCT Scheme will generally be linked to volume of activity and/or patient list sizes. However, there will be a six month income guarantee following opening.

Further details on the payment mechanism for the Tower Hamlets PCT Scheme will be set out in the Tower Hamlets PCT Scheme ITT.

5.9 Financial Standing

Financial standing requirements for the Tower Hamlets PCT Procurement will be limited at the PQQ stage to confirmation of identity, solvency and proposed business structure, with no other financial requirements. At the ITT stage, Bidders will be required to put forward detailed proposals as to how the Tower Hamlets PCT Scheme funding requirement would be met.

5.10 Performance Security

It is expected that no performance security will be required from Providers for the Tower Hamlets PCT Procurement. However, if the Tower Hamlets PCT Scheme requires substantive infrastructure spending and expects high activity volumes, some performance security may need to be considered for the Tower Hamlets PCT Scheme. If required, details will be set out in the Tower Hamlets PCT Scheme ITT.

5.11 Insurance

A comprehensive schedule of insurances that the Provider(s) will be required to obtain for the Tower Hamlets PCT Scheme will be set out in the Tower Hamlets PCT Scheme ITT. This will typically include public liability, corporate medical malpractice and certain property cover. These required insurances are in addition to the Medical Defence Union indemnity insurance carried by GPs themselves and the Medical Protection Society indemnity insurance carried by nurse practitioners.

The insurance requirements will also require Providers to ensure that:

- PCTs' interests are fully protected;
- Members of the public utilising the primary medical care services are fully protected to the extent that they have a valid claim against the Provider and / or PCT; and
- The Provider maintains insurance which meets at least the minimum statutory requirements.

Providers will be required to indemnify the PCT against any claims that may be made against the PCT arising from the provision of the primary medical care services by the Provider. Tower Hamlets PCT will expect the Provider(s) to offer evidence that they have sourced appropriate (and sufficient) insurance or other arrangements. For the avoidance of doubt, this will include provisions for clinical negligence insurance covering all staff and operational risk in the facilities from which the Provider's primary medical care services are to be provided.

6 GOVERNANCE AND ADMINISTRATION

6.1 Requirements

Procurement Costs

Each Relevant Organisation will be responsible for its own costs incurred throughout each stage of the Tower Hamlets PCT Procurement process. Neither Tower Hamlets PCT, the SHA or DH will be responsible for any costs incurred by any Relevant Organisation or any other person through this process.

Consultation

PCTs will lead on all local stakeholder engagement issues. The PCT Consultation process has engaged with the local community and key Stakeholders in developing the new Premises site. Details of the Service Model and process for allocating the contracts have and are in the process of being passed to the key stakeholders.

The PCT has already engaged with the key Stakeholders during the planning for the new Centre. The approach to further communication and consultation is summarised in the table below;-

Stakeholder	**Communication Mechanism**	**When**
PCT Board	Paper and presentation	Prior to advert
Senior Management Team	Paper	Prior to advert
PBC Committee & PEC	Paper	Prior to advert
OOH Provider	Via Letter	Prior to advert
LB TH Scrutiny Committee	Briefing paper and presentation if requested	Pre-tender
Heads of Service	Via letter	Prior to advert
Other local providers	Via letter	Prior to advert
Local Medical Committee	Paper and discussion	Prior to advert
Local Dentistry Committee	Briefing paper	Prior to advert
Local area partnership	Formal presentation	Prior to formal tender
Local faith leaders	Briefing paper	Prior to formal tender
LPC (local pharmaceutical committee)	Briefing paper	Prior to advert
Public consultation regarding Improving Health and Wellbeing	PCT and local area partnership websites	ongoing

The purpose of the further communication and consultation will be to ensure that the PCT is commissioning in line with patients needs, and that key stakeholders understand how it will affect them, the process and, its transparency.

All consultation outcomes will be received and considered prior to finalising the Tower Hamlets PCT Scheme and will be included in the Tower Hamlets PCT Scheme ITT.

The Public Contract Regulations 2006

The primary medical care services to which this MOI relates fall within Part B of Schedule 3 to the Public Contracts Regulations 2006 **("the Regulations")** and Annex II B to Council Directive 2004/18/EC. Neither the inclusion of a Bidder selection stage nor the use of the term "Pre-Qualification Questionnaire" nor any other indication shall be taken to mean that Tower Hamlets PCT intends to hold itself bound by any of the Regulations, save those applicable to Part B services.

Conflicts of interest

In order to ensure a fair and competitive procurement process, Tower Hamlets requires that all actual or potential conflicts of interest that a potential Bidder may have are identified and resolved to the satisfaction of Tower Hamlets PCT.

All those involved in the procurement processes will be expected to declare any conflicts in interest at each stage of the process. Any potential conflicts will be discussed/addressed by the Steering Committee to decide if it is likely to have a material impact on the process, and if so what action to take.

Potential Bidders should notify Tower Hamlets PCT of any actual or potential conflicts of interest in their response to the PQQ. If the potential Bidder becomes aware of an actual or potential conflict of interest following submission of the PQQ it should immediately notify Tower Hamlets PCT. Such notifications should provide details of the actual or potential conflict of interest.

If, following consultation with the potential Bidder or Bidder, such actual or potential conflict(s) are not resolved to the satisfaction of Tower Hamlets PCT, then Tower Hamlets PCT reserves the right to exclude at any time any potential Bidder or Bidder from the Tower Hamlets PCT Procurement process should any actual or potential conflict(s) of interest be found by Tower Hamlets PCT to confer an unfair competitive advantage on one or more potential Bidder(s), or otherwise to undermine a fair and competitive procurement process.

Non-collusion and Canvassing

Each potential Bidder and Bidder must neither disclose to, nor discuss with any other potential Bidder, or Bidder (whether directly or indirectly), any aspect of any response to any Tower Hamlets PCT Procurement documents (including the PQQ and ITT).

Each potential Bidder and Bidder must not canvass or solicit or offer any gift or consideration whatsoever as an inducement or reward to any officer or employee of, or person acting as an adviser to, either the NHS or the DH in connection with the selection of Bidders or the Provider in relation to the Tower Hamlets PCT Procurement.

Freedom of Information

Tower Hamlets PCT is committed to open government and meeting its legal responsibilities under the Freedom of Information Act (**FOIA**). Accordingly, any information created by or submitted to Tower Hamlets PCT (including, but not limited to, the information contained in the MOI, PQQ or Scheme ITT and the submissions, bids and clarification answers received from potential Bidders and Bidders) may need to be disclosed by Tower Hamlets PCT in response to a request for information.

Applications will be regarded as in the public domain and may be made available to the public and stakeholder organisations as part of the process.

In making a submission or bid or corresponding with the PCT at any stage of the Tower Hamlets PCT Procurement, each potential Bidder, Bidder and each Relevant Organisation acknowledges and accepts that Tower Hamlets PCT may be obliged under the FOIA to disclose any information provided to it:

- Without consulting the potential Bidder or Bidder; or
- Following consultation with the potential Bidder or Bidder and having taken its views into account.

Potential Bidders and Bidders must clearly identify any information supplied in response to the Tower Hamlets PCT Scheme PQQ or the ITT that they consider to be confidential or commercially sensitive and attach a brief statement of the reasons why such information should be so treated and for what period.

Where it is considered that disclosing information in response to a FOIA request could cause a risk to the procurement process or prejudice the commercial interests of any potential Bidder or Bidder, Tower Hamlets PCT may wish to withhold such information under the relevant FOIA exemption. Any information, within the terms of the FoI Act, regarded by the applicant as confidential or any information they don't want to be shared, should be included in an appendix and clearly labelled **'Commercial in Confidence'**

However, potential Bidders should be aware that Tower Hamlets PCT is responsible for determining at its absolute discretion whether the information requested falls within an exemption to disclosure, or whether it must be disclosed.

Potential Bidders should therefore note that the receipt by Tower Hamlets PCT of any information marked "confidential" or equivalent does not mean that Tower Hamlets PCT accepts any duty of confidence by virtue of that marking, and that Tower Hamlets PCT has the final decision regarding the disclosure of any such information in response to a request for information.

Information to Applicants

The service specification and contract includes all relevant information about the service to be commissioned. This will be provided to the short listed bidders. The PCT reserves the right to modify the specification at any point up to the agreement of a contract. Wherever possible modifications will only be made in consultation with the preferred providers.

Other information may be available to short listed bidders on request, on a standard proforma. Any specific requests for information may be obtained from the named contact as shown in Section 5 below. Any such additional information will be shared with all short-listed applicants.

Contacts

Procurement Project Co-ordinator - Shaju Jose
shaju.jose@thpct.nhs.uk

Disclaimer

The information contained in this MOI is presented in good faith and does not purport to be comprehensive or to have been independently verified.

Neither the Tower Hamlets PCT, the DH, nor any of their advisers accept any responsibility or liability in relation to its accuracy or completeness or any other information which has been, or which is subsequently, made available to any potential Bidder, Bidder, Provider, Bidder Member, Clinical Services Supplier, financiers or any of their advisers, orally or in writing or in whatever media.

Interested parties and their advisers must therefore take their own steps to verify the accuracy of any information that they consider relevant. They must not, and are not entitled to, rely on any statement or representation made by Tower Hamlets PCT, the DH or any of their advisers.

This MOI is intended only as a preliminary background explanation of Tower Hamlets PCT's activities and plans and is not intended to form the basis of any decision on the terms upon which Tower Hamlets PCT will enter into any contractual relationship.

Tower Hamlets PCT reserves the right to change the basis of, or the procedures (including the timetable) relating to, the Tower Hamlets PCT Procurement process, to reject any, or all, of the PQQ submissions and Tower Hamlets PCT Scheme ITT bids, not to invite a potential Bidder to proceed further, not to furnish a potential Bidder with additional information nor otherwise to negotiate with a potential Bidder in respect of the Tower Hamlets PCT Procurement.

Tower Hamlets PCT shall not be obliged to appoint any of the Bidders and reserves the right not to proceed with the Tower Hamlets PCT Procurement, or any part thereof, at any time.

Nothing in this MOI is, nor shall be relied upon as, a promise or representation as to any decision by Tower Hamlets PCT in relation to this Tower Hamlets PCT Procurement. No person has been authorised by Tower Hamlets PCT or its advisers or consultants to give any information or make any representation not contained in this MOI and, if given or made, any such information or representation shall not be relied upon as having been so authorised.

Nothing in this MOI or any other pre-contractual documentation shall constitute the basis of an express or implied contract that may be concluded in relation to the Tower Hamlets PCT Procurement, nor shall such documentation/information be used in construing any such contract. Each Bidder must rely on the terms and conditions contained in any contract when, and if, finally executed, subject to such limitations and restrictions that may be specified in such contract. No such contract will contain any representation or warranty in respect of the MOI or other pre-contract documentation.

In this section, references to this MOI include all information contained in it and any other information (whether written, oral or in machine-readable form) or opinions made available by or on behalf of Tower Hamlets PCT, DH or any of their advisers or consultants in connection with this MOI or any other pre-contract documentation.

7 GLOSSARY OF TERMS AND ABBREVIATIONS

Term	*Description*
APMS	Alternative Provider Medical Services
Bidder	A single operating organisation/person that has been short-listed through the PQQ evaluation process and been invited to participate in the ITT stage and is bidding for one or more PCT Schemes
Bidder Guarantor	An organisation providing a guarantee, indemnity or other undertaking in respect of a Bidder's or a Bidder Member's obligations
Bidder Member	A shareholder or member or proposed shareholder or member in, or controlling entity of, the Bidder and / or that shareholder's or member's or proposed shareholder's or member's ultimate holding company or controlling entity
CfH	Connecting for Health
CPD	Continuing Professional Development
Clinical Services Supplier	All suppliers providing clinical services which are the subject of the Contract including, but not limited to, primary medical care services
Contract	A form of APMS contract, as detailed further in paragraph 5.1, to be entered into between the relevant commissioning PCT and Recommended Bidder for the provision of primary medical care services
DH	Department of Health
EOI	Expression of Interest
FM Services	Facilities management services including "Hard FM" (including services relating to security, fire, utility management, utility breakdown, pest control, landscape maintenance) and "Soft FM" (including services relating to cleaning, laundry, health and safety, portering, waste management, clinical waste management, infection control, linen, gowns and bedding)
FOIA / Freedom of Information Act	The Freedom of Information Act 2000 and any subordinate legislation made under that Act from time to time, together with any guidance and / or codes of practice issued by the Information Commissioner, the Department of Constitutional Affairs, the Office of Government Commerce and the NHS in relation to such legislation or relevant codes of practice to which the DH and Tower Hamlets PCT is subject
GMS	General Medical Services contract
GP	General Practitioner
GSPoC	GP Systems of Choice Programme
IM&T	Information Management and Technology
ITT	Invitation to Tender
MOI	This Memorandum of Information setting out the details of each PCT Scheme and the requirements of the Tower Hamlets PCT Procurement
nGMS	(n/N)ew General Medical Services Contract
NHS	National Health Service
PCT	That Primary Care Trust participating in the Tower Hamlets PCT Procurement
PCT Scheme	The primary medical care services to be procured by a PCT, as detailed (by PCT Scheme) in paragraph 3.5 and set out in Annex A
Tower Hamlets PCT **Scheme ITT**	An ITT that is specific to those primary medical care services set out in one or more PCT Schemes that a PCT wishes to procure and is sent to potential Bidders who have been short-listed following the PQQ stage

Term	*Description*
PMS	Personal Medical Services contract
potential Bidder	A single operating organisation or person that is participating in the Tower Hamlets PCT Procurement, but that has not at the relevant time been invited to respond to an ITT
PQQ	Pre-Qualification Questionnaire
Provider	The successful Bidder who has entered into a Contract with a PCT to provide the primary medical care services specified in the relevant PCT Scheme
Relevant Organisation	An organisation(s) or person connected with a response to a PQQ and / or connected with a bid submission including (without limitation): (i) the potential Bidder; (ii) the Bidder; (iii) the Provider; (iv) each Bidder Member; (v) each Bidder Guarantor; and (vi) each Clinical Services Supplier
Spearhead	A PCT is classified as "Spearhead" if it is one of a group of 62 PCTs based upon 70 Local Authority areas that are in the bottom fifth nationally for three or more of the following five indicators: (i) Male life expectancy at birth; (ii) Female life expectancy at birth; (iii) Cancer mortality rate in under 75s; (iv) Cardio Vascular Disease mortality rate in under 75s; (v) Index of Multiple Deprivation 2004 (Local Authority Summary.
SHA	Strategic Health Authority
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI/2006/246)
Under-doctored	A PCT is classified as "under-doctored" if its number of whole time equivalent GPs (excluding GP Retainers, GP Registrars and locums) per 100,000 weighted population is less than the national average. The average number of GPs per 100k weighted population at March 2005 was 57.89 GPs.
VfM	Value for Money which is the optimum combination of whole-life cost and quality (fitness for purpose) to meet the overall service requirement

Annex A – Tower Hamlets PCT – St Andrews Health and Wellbeing Centre Scheme Details

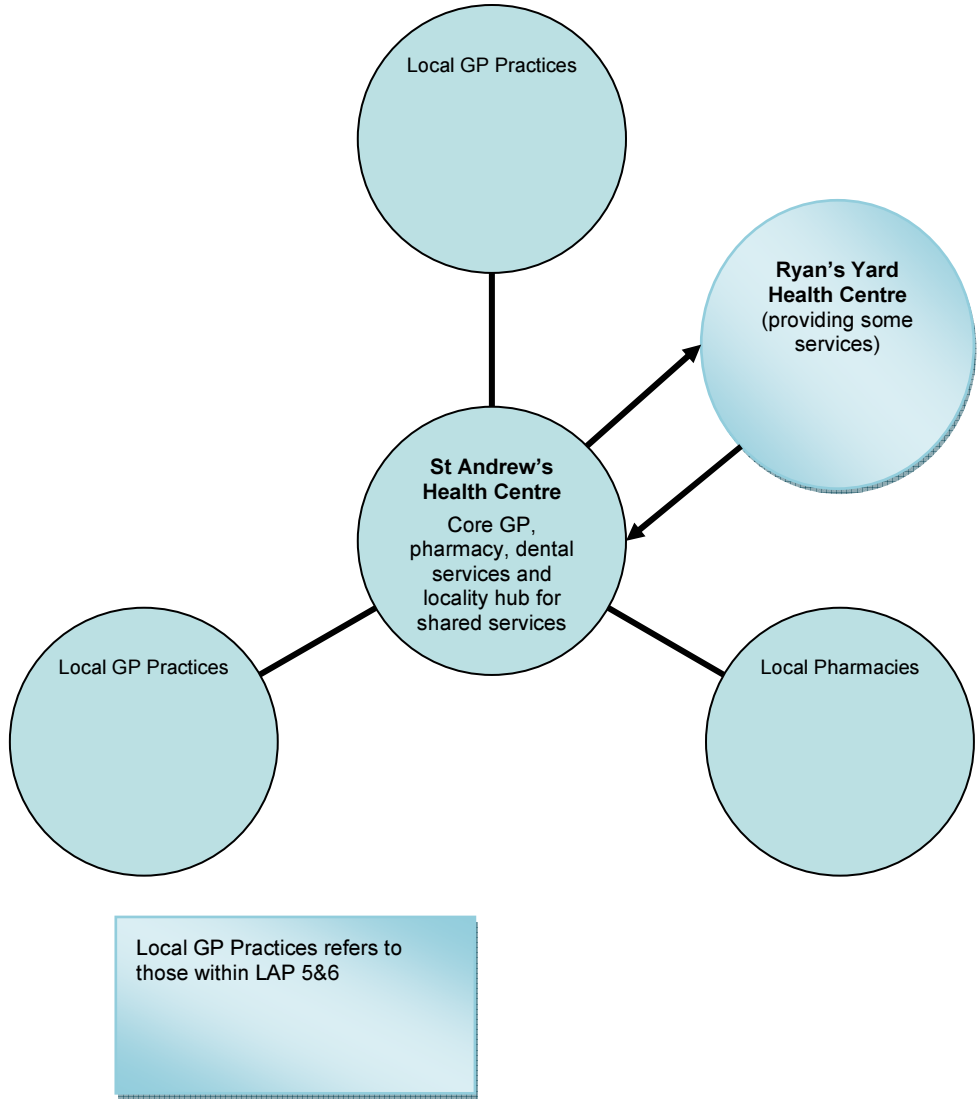
1 Introduction

1.1 This Annex to the Memorandum of Information outlines the service requirements of the GP Led Health Centre in Tower Hamlets PCT as part of the Equitable Access to Primary Medical Care Services procurement programme.

1.2 This Annex sets out a summary service specification and performance standards Tower Hamlets Primary Care Trust will require service providers to deliver and information about the demographics of Tower Hamlets to help inform potential providers about the healthcare needs of the relevant populations.

1.3 Service model – The hub and spoke integrated service delivery model is shown below:

Figure A.1



This initiative proposes the development and opening of a new extended hours GP Led Health Centre, providing core and enhanced primary care services, at a new development at St Andrew's. It will also act as the hub of a federated model of services designed to meet the requirements of the Healthcare for London programme. It is

currently planned to open the service at interim premises in early in 2010 and transfer to St Andrew's site when building works are complete and will be operated by a Provider under an APMS contract. These services will be provided to both registered and unregistered patients.

The Centre's key purpose and priority will be for the provision of Primary Care Services to members of the public visiting the walk-in-centre or attending the GP practice by appointment. The specific objectives of the Integrated Centre are to:

- Improve access to primary care through providing an extended hours GP practice offering core and enhanced services with the expectation that some specialist services will also be provided to deal with local priorities and needs as part of an integrated and multidisciplinary approach, with list size growth potential to grow to 15,000 patients.
- Provide a platform for the development of extended service with the potential to add diagnostics and outpatient (PBC) services.
- Integrate with the on-site pharmacy services
- Establish and operate a diagnostic service providing near patient testing and ultrasound for local registered and walk-in patients.

It is intended that the scope of services offered by the centre will meet the standard criteria for a GP Lead Health Centres with an agreed range of standard national and enhanced GP services.

Under these proposals the Centre will managed and operated by an APMS Provider offering an appropriate clinical and management model to deliver care specified in the most effective way, with an appropriate skill mix.

Under the proposed service model, registered patients arriving for planned consultations and care or, registered or unregistered patients arriving for urgent/unplanned care will be met and greeted by an appropriate single reception team. Whilst planned consultations will be dealt with in a standard manner urgent / unplanned visits will be seen by an available healthcare professional which could be a GP, healthcare assistant or nurse or, be referred to a pharmacist.

The new centre is expected to be provided initially from a temporary facility, identified and established nearby by the provider, and to move to the new St Andrew's site on completion of its construction, currently anticipated in August'10.The PCT are looking to enter into a contractual arrangement by the end of November 2009. New services are expected to be introduced in a phased manner, reflecting the projected growth in demand and PCT funding. Bidders will be expected to reflect this in their bids.

Bidders will also be expected to manage the day to day running of the centre, supporting other on-site services and sharing facilities.

2 General Requirements

2.1 We would expect the Health Centre to provide an innovative approach to primary care by using healthcare professionals that focus on planned and, urgent / unplanned care, in a flexible manner, and focus on health promotion as well as illness management.

2.2 The Centre should be welcoming, especially to those with the highest health needs, including the elderly and parents of young children, and fit in well with the local community and have active links with local authority Services, children's centres and schools.

2.3 Patients arriving for planned or unplanned care would be met and greeted by appropriately trained receptionists.

2.4 The Centre aims will be to provide a health as well as an illness service, where every interaction with a patient becomes an opportunity to improve their long term health and self care skills. We also want to make the illness service as high-quality as possible. To do this, we want providers to focus on appropriate consultations and on getting clinician-patient contacts right.

2.5 Providers will be expected to provide core and extended General Practice services as part of an integrated and multidisciplinary approach using appropriate clinical staff. These services are expected to be available to registered and non-registered patients. In addition to these services it is intended that the Centre will operate a telephone advice service offering advice to patients, which may require an urgent or unscheduled appointment. Patients using the walk-in or telephone service will be triaged to an appropriate professional, who may be a GP, nurse, health care assistant or pharmacist.

2.6 It is intended that this Centre will form a platform for the development of an extended range of locality services, with the potential to add a number of services in support of local practices including diagnostics, outpatient and PBC services, as illustrated in the enclosure, working with the new Health Centre proposed for Ryan's Yard and existing pratices. Whilst these will/may be subject to future separate contract action, bidders will be expected to bid for appropriate services under future procurements.

2.7 Providers will be expected to set high standards of Corporate Governance with clear processes, policies and practices that govern the way the organisation is managed and its relationships with its key stakeholders.

3 Services

3.1 **Integration of Operations** - The centre will be expected to offer an integrated service to both registered and unregistered patients.

3.2 **Extended GP Services** - In general, the providers operating the service will be expected to offer the following scope and standards of services from their premises:-

- GP Services, with a walk-in service, to registered and non-registered patients, as detailed in the new GMS contract including:-
    - Essential Services
    - Additional Services;
    - Cervical screening services
    - Contraceptive services;
    - Vaccinations and immunisations;
    - Childhood vaccinations and immunisations;
    - Child health surveillance services;

- Maternity medical services;

- A phased introduction of the following range of Enhanced services (to be confirmed):

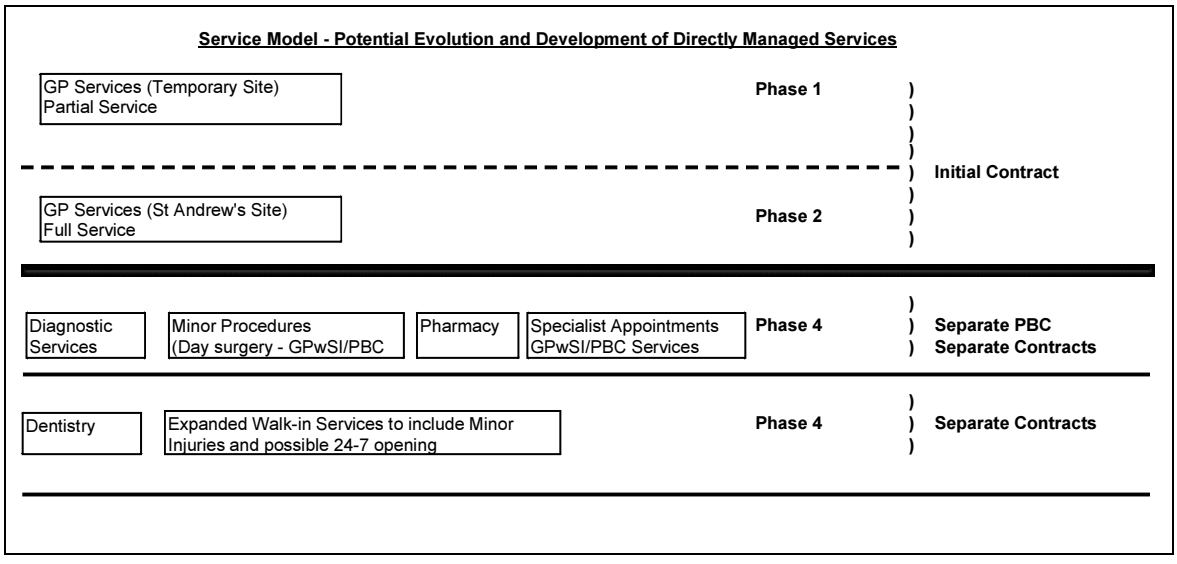
Possible Enhanced Service	NES/DES/LES No.
Substance Misuse	LES 1
Patient Centred Diabetes	LES 2
Surgical After Care	LES 3
BCG	LES 4
Patient Profiling	LES 5
COPD	LES 6
Diabetes Insulin Dependency	LES 7
Depression	LES 8
High Risk CVD	LES 9
Heart Failure	LES 10
Sexual Health	LES 11
Anti Coagulation	LES 12
Pathology	LES 13
Palliative Care	LES 15
Learning Disabilities	LES 16
Practice Based Commissioning	LES 17
Hep B	LES 19
Stop Smoking	LES 21
Chlamydia and Gonorrhoea Screening	LES 22
Choice and Booking	LES 23
Access	LES 24
Extended Hours	LES 25
HPV	LES 26
Alcohol	LES 27
MMR catch up	LES 28
Vulnerable Older People	LES 29
Minor Surgery	DES 2
Influenza and Pneumococcal Imm	DES 3
Childhood Immunisations	DES 4
Violent Patients	DES 5
IM&T	DES 7
Osteoporosis	DES 8
IUCD	NES 1

- Facilitate specialist consultations by Health Visitors and District Nurses
- Visits to local nursing home patients.
- Minimise waiting time for booked appointments, maximum 48 hours for a GP, and 24 hours for a practitioner.

- Offer efficient telephone appointment access and advice. The provider will be expected to provide telephone advice for its registered patients. Callers will either be satisfactorily answered on the phone (or called back), asked to come in for an emergency appointment (within 4 hours), a routine same-day appointment, offered a home visit or referred on to a pharmacist or A&E, as appropriate.
- A “walk-in” open access/first contact system, offering urgent same day walk-in assessment linked to unplanned and/or urgent care. This service is to be similar to the ‘Telephone Service’ above but directed to patients that walk in.
- Offer ‘choose and book’ access to the diagnostic centres, secondary care and specialist services.
- The Centre will be expected to work with other local practices to commission services, normally offered within secondary care (hospital) as part of the Practice Based Commissioning initiative. This will require the new Providers to be actively engaged in the commissioning of services at the practice or locality level.
- Offer an average consultation time of at least 10 minutes with GP and 15 minutes with a nurse.
- Maintain a maximum waiting time of 30 minutes for all patients.
- The establishment of ‘Expert Patient’ and self-care initiatives.
- Develop close links with the pharmacy provider.
- Providers will be expected to work with local schools to improve student education and health awareness.
- Use of new and flexible ways of working to achieve high utilisation of consulting and treatment spaces.
- Work with the local community to initiate and develop a more holistic approach to health improvement through initiatives such as addressing health inequalities, CVD, Smoking Cessation and Exercise.

4 Phased Introduction of Additional Services

It is intended that this Centre will form the Hub for the development of an extended locality network of services, with the potential to add a number of services in support of local practices including diagnostics, outpatient and PBC services, expanded Walk-in Services, as illustrated in Figure A.1. It is expected that some of these services will be delivered from the new Health Centre planned for Ryan’s Yard (which will house the St. Paul’s Way Practice). Whilst these will/may be subject to future separate contract action, bidders will be expected to bid for appropriate services under future procurements. The planned introduction of services to be broadly in-line with the timescales illustrated below.



Bidders will be expected to make proposals for additional services they might wish to offer and their basis for cost recovery, specified either in terms of a % of the published national 'Payment By Results (PBR) charges, or some other clearly defined basis.

5 Opening Hours

5.1 Opening hours are detailed in the table below. During opening hours a minimum of a GP and, a Nurse Practitioner will be available and appointments to be available continually during opening hours.

Opening Times		
	Weekdays	Weekends
GP Practice	8 am – 8 pm	8 am – 8 pm

6 Patient numbers and attendance rates

6.1 The practice will be set targets for patient list growth as detailed below, consistent with the local population under provision and, growth expectations. The practice will be expected to grow over 10 years to a list sizes of around 15000 patients.

	Contract Year									
Service during Core Hours	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
GP Practice Service: target size of Contractor's List of Registered Patients at year end (000)	2	4	4	8	10	11	12	13	14	15
GP Practice Service: average size of the Contractor's List of Registered Patients over 12 months (000)	1	3	5	7	9	10.5	11.5	12.5	13.5	14.5
Estimate of unregistered patients using service per day	40	60	60	60	60	60	60	60	60	60

6.2 Bidders should use the assumptions above for projected patient demand in their reference bid, the figures represent the minimum to be achieved and are reflective of the PCT's funding assumptions, and the PCT will reserve the right to cap these services if they exceed these levels. These assumptions should be used to develop the skill mix and staff numbers required for the tender response.

6.3 Bidders are expected to identify how they would endeavour to publicise the centres facilities to the local community to ensure that the planned patient list sizes and walk-in service through-puts are achieved.

7 Transitional Arrangements

7.1 It is anticipated that as the service develops, it would not be a cost effective use of staff and facilities to provide full range of services from day one. Therefore the following service assumptions should be used for the purpose of the reference bid:-

- Enhanced and additional service introduction to be phased and based on the criteria identified in the 'Enhanced Services' table.

8 Operating Principles

8.1 The provider will need to have policies practices for the management of patient interaction within the integrated Centre for planned (by appointment to GP and other services) and unplanned (Walk-in) patients for both registered and unregistered patients. These policies must include; interaction with the reception team, internal and external referrals and, the management of patient records (including consent and patient confidentiality). They must also include appropriate systems for transferring information to local GPs regarding patients seen at the Centre.

9 Out of Hours Services

9.1 The Provider will be expected to use the PCT's out of hours provider, outside of the opening hours above.

10 Translation and Advocacy Services

10.1 Providers will be expected to offer appropriate advocacy and translation services to patients, during opening hours.

11 Staffing and Recruitment

11.1 Providers would be expected to recruit locally, but without impact on other local services. Staff will be expected to be registered by their appropriate bodies and meet local and national career development and competency targets for the services offered.

12 Performance Monitoring and, Review

12.1 The PCT will expect to agree with the providers a range of performance criteria over and above those used for existing GMS and PMS practices against which the Practices will be regularly reviewed, to reflect the broader targets for the service and, the specific needs of the area.

12.2 Within this context, the practices will also be expected to achieve a 950 points QoF score, after its first year of operation.

13 Clinical governance, Standards and Inspection

13.1 Providers will be expected to have in place an effective System of Clinical Governance and should nominate a person who will have responsibility for ensuring its monitoring, operation and, interface with the PCT.

14 Training and Learning Practice Environment

14.1 The PCT will require the provider to provide a training environment to maintain and develop the professional competence of all staff.

14.2 The PCT will require the provide to prepare for and seek registration for creating a training practice within three years of contract start date.

15 Equality of Access

15.1 As part of this process the PCT will undertake an Equality impact assessment.

16 Premises

16.1 The PCT will identify a temporary building solution from which to initiate the service, prior to a move to the St Andrew's site on completion.

16.2 On moving to the St Andrew's site the Provider will be required to enter into a lease arrangement for the use of that property. Further details on such proposals and / or requirements for the Tower Hamlets PCT Scheme will be set out in the Tower Hamlets PCT Scheme ITT.

16.3 The Provider will be expected to fund rent, rates, utility and insurance costs for the premises solution. However, Tower Hamlets PCT will reimburse the Provider for rent and rates costs, separately to payments for primary medical care services. The exact mechanics of the payment mechanism will be detailed in the Tower Hamlets PCT Scheme ITT.

17 Service Commencement

17.1 Service commencement is expected to be early 2010

18 IM&T

18.1 Tower Hamlets PCT is able to provide the following IM&T Services to the Provider, including deployment, hardware, software, N3 connection and maintenance/ongoing costs. This is the preferred solution of Tower Hamlets PCT but Providers are able to select any solution under the GPSoC agreement. In either case the Provider will be required to manage the selection of IM&T provider and the installation and deployment of the system:

Annex B – Format for Submitting an Expression of Interest

Potential Bidders wishing to participate in the Tower Hamlets PCT Procurement must submit an EOI using the template below:

To: shaju.jose@thpct.nhs.uk

From:

Subject: **[INSERT PCT NAME] procurement Expression of Interest**

Contact Name:	[Name]
Organisation name:	[Organisation Name]
Organisation Type:	[Please choose one of the options below]

GPs	1	Social Enterprise	2
Independent Sector	3	NHS Organisation	4
Voluntary Sector	4	Other (please specify)	6

Organisation Address	[Organisation Address 1] [Organisation Address 2] [Organisation Address 3] [Organisation Address 4] [Postcode]
Contact Telephone Number	[Tel]
Contact email address:	[Email Address]
Organisation Website address:	[Website Address (if applicable)]

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Report to the Health Scrutiny Panel

Unplanned/Urgent Dental Care Review – North East London

Introduction

This paper has been put forward to the Tower Hamlets Health Scrutiny Panel to provide elected members with an update of the activity of the Emergency Dental Services Review, now named the Unplanned/Urgent Dental Care Review.

Within the initial stages of the project, it became clear a strategic approach was required and an unplanned/urgent dental care strategy should be developed across the North East Sector. This activity will ensure the provision of Out of Hours urgent care dental services is based on the needs of the communities in North East London and commissioned in a planned manner. This change in direction was reported verbally to elected members at the Health Scrutiny Meeting held on the 27th January, 2009.

Current Emergency Dental Services

PCTs have been required to commission Out of Hours dental services from April 1st 2006. The services, covering North East London boroughs, consist of a single telephone triage service and two walk in services at the Royal London Hospital and in Hornchurch. The PCTs within North East London all make equal contributions towards the funding of the telephone triage service.

The current Emergency Dental Service (EDS) arrangements include both telephone triage and face-to-face consultation. The service is accessed by a single Out of Hours (OOH) telephone number for the whole of the NE Sector. The calls are triaged by a dentist based in the walk in Centre at the Royal London Hospital. The patient may be offered anything from advice to referral on to a face-to-face consultation at either the Royal London Hospital or Hornchurch. In addition, to accessing the service through triage, there are walk in services provided both at the Royal London Hospital and at the Hornchurch EDS.

Review of North East London Unplanned Dental Care

The aim of the review is to ensure that patients who have unplanned dental care needs will be seen at the right time and in the most appropriate place and the objectives of the review are:

i. To ensure that all patients with a true urgent need have access to a clinical contact at an appropriate time.

ii. To enable consistent prioritisation of urgency for treatment, i.e. to give priority to patients where a delay in time could have significant impact on the outcome of subsequent treatment;

iii. To ensure those patients who need referral are referred to the appropriate service to meet their needs.

iv. To ensure urgent dental services provided within the North East Sector are high quality and provide best value of the funding allocation.

v To ensure that the Urgent Dental Service works within a 'whole system' approach to providing urgent dental care in the sector by ensuring effective interfaces and consistent protocols between primary care dental services and all urgent dental care services within the sector.

vi Improve access to urgent dental care services within the Sector.

vii To foster innovation and continuous improvement in all aspects of delivery of urgent care dental services

In order to achieve the aim and objectives a project has been set up with several work streams. An Unplanned Dental Care Steering Group is overseeing the activity and a Senior Project Board is

incorporating a strategic view and ensuring decision making is timely within the seven PCT areas within the North East Sector.

Involvement in Development of the Strategy

The initial review of the EDS Royal London and the Out of Hours Telephone Triage service raised concerns about the patient experience and highlighted the inconsistencies for patients accessing the service. The Unplanned/Urgent Dental Care review has built upon the findings of the original review, incorporating feedback from users of the EDS provided at the Royal London and the Hornchurch site, staff working within the EDS and Triage, a meeting held with the Tower Hamlets Local Involvement Network, the Homeless Centre in Brick Lane E1 and feedback from consultations regarding dentistry where the views are relevant to this activity.

The service is highly thought of by many patients and the staff providing and working within the service are committed to the delivery of good quality urgent dental care, however the following issues have been identified in addition to the access issues reported to elected members on the 27th January:

- **Opening times**: The Out of Hours Telephone Triage starts to accept calls at 6.30 p.m. These calls are initially taken by a Call Handler who logs the patient's details and passes the calls to the Triage Dentist. Dependant on the amount of calls required that evening the patient could find they are waiting one/two hours for a return call and within that period slots have been taken at the EDS, both in the Royal London and Hornchurch.

  The EDS Royal London and Hornchurch start providing clinical care at 7.00 p.m. The majority of General Dental Practices close their clinics earlier and therefore there is a gap for a patient trying to access urgent dental care. The majority of patients are accessing both the triage and EDS earlier in the evening.

- **Unmet Need –** Throughout this exercise it is clear there are numbers of patients accessing GPs, Walk-In Centres, A&E, Ambulance Services and the EDS Walk-In services throughout the day to receive treatment for dental health care. Whilst numbers are not kept on a consistent basis by these organisations the figures show a number of patients are not clear on how to access urgent dental care across the sector.

- **Lack of co-ordination between services:** The Emergency Dental Services within the Royal London and the Dental Institute are both based within the Royal London Hospital. Whilst both operate at different times many patients confuse the two services and try to access their appointments/urgent dental care within the wrong service. Both services refer patients they cannot see to the other and therefore patients may, on occasion, find they are unable to access either. There is also a lack of understanding amongst NHS Stakeholders of the roles and responsibilities of both services and therefore patients are often referred to these services when they should be accessing their local Dental Practitioner.

- **Confusion because of name of service**: The services at the Royal London and Hornchurch are presently called Emergency Dental Services (EDS) and this is causing confusion amongst patients and other urgent care services. Those in emergency need should be attending the Emergency Services and those in urgent dental care need should be accessing appointments at their local dentists or the EDS. Patients have also said that because it is called Emergency Dental Services they think it will be open 24 hours and that it will be free.

- **Referral pathways:** The majority of GP Practices, Walk-In Centres and General Dental Practices are all referring patients to the Emergency Dental Services based at the Royal London throughout the day and evening and as a result patients are not being referred locally to General Dental Practices where they can receive ongoing treatment. Whilst some patients are being given the triage telephone number the majority of patients are advised to attend the Walk-In service however have been given incorrect information about opening times and costs.

- **Perception of dental capacity across the sector**: Commissioners and dentists are advising that there is capacity within the majority of the sector for patients with dental need to receive NHS dental care however this conflicts with the patient perception that there is not enough NHS dental provision.

In some areas the capacity has been commissioned however some patients are advising that when they access dentists that provide NHS care they are being advised there are no NHS slots available however they can have a private slot. Whilst it is the role of the Commissioner to ensure the services are monitored this type of miscommunication can cause patients to develop a level of mistrust in dentists. Commissioners wish to improve the mechanisms for capturing this information and ensure patients are able to put forward their concerns when these issues occur however some patients are reticent to complain as they perceive it will affect their care in the future.

- **Lack of Information**: Many of the organisations contacted within this review have advised that the information they have regarding dental care services within the North East is not up to date. As a result patients are often being redirected and on many occasions, often more than once, before they manage to receive dental health care. There is concern that some patients may give up on trying to access services and therefore attend the emergency dental services when they have a problem that is causing pain that cannot be ignored.

These views will shape the proposals for future delivery of unplanned urgent care services across the North East Sector of London.

In Hours Pilot

Whilst the review is not complete Commissioners recognised the need to develop extra urgent dental care capacity to alleviate some of the pressure on the services. An In Hours pilot was taken forward by NHS City & Hackney where next day appointments were commissioned, within GDPs, specifically for patients that had tried to access the Out of Hours service the previous evening and not been successful in gaining an appointment. This pilot proved successful, providing choice for patients and extra capacity and therefore is now being rolled out across the sector. Tower Hamlets has provided the service with specific appointments within William Place General Dental Practice.

Next Steps

The Senior Project Board is meeting on the 15th July to discuss the draft proposals and how any consultation will be taken forward. When the final changes to the services has been agreed a Service Specification will be developed and the services put to tender. It is envisaged that the new services will be in operation by April 2010.

Vivienne Cencora
Associate Director
NHS Tower Hamlets

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NHS Tower Hamlets' Response to Health Scrutiny Panel Review on End of Life Care

Please note that we have presumed that social care and the council are the same entity for the purposes of interpreting the recommendations.

Recommendation		Response/Comments	Responsibility	Date
R1	That the Care-Plus project be commissioned by NHS Tower Hamlets and London Borough of Tower Hamlets for a minimum of a further two years. The scope for disseminating learning from the project locally should be explored within the commissioning of the project.	The care plus project has been funded by the Kings Fund as a pilot and funding ends in September 2009. NHS Tower Hamlets recognises the importance of the project for carers. At the beginning of March 2009, NHS Tower Hamlets requested a business case, from Care-plus, to allow for consideration to be given to funding the project from September and for the next year (including details of social care funding requests) and this was received in June 09. NHS Tower Hamlets anticipates bidding in 10/11 commissioning intentions for funding to continue this service as part of our adult health and well being programme. This funding request will be processed within defined commissioning and prioritisation processes for NHS Tower Hamlets and LBTH. Should the proposal prove to be unsuccessful, or require a tendering process, action will be taken by the Delivering Choice Programme (DCP) programme to review the action plan and consider future commissioning rounds as appropriate.	Health and social care	Interim funding (bridging from September 09 to April 10) may be agreed jointly by September 2009 between health and social care with consideration given for continued funding in 10/11 (not guaranteed funding)

Recommendation		Response/Comments	Responsibility	Date
R2	That the needs and rights of carers, partners, single sex partners and friends be recognised within the context of end of life care. In particular the tools used to facilitate discussion with families at end of life be extended to cover these groups.	Within the Healthcare setting there are three main tools recommended to use in end of life care – Gold Standards Framework (GSF), Liverpool care pathway (LCP) and preferred priorities for care (PPoC). NHS Tower Hamlets supports the use of these tools and currently has a large proportion of GP practices using the Gold Standards Framework which means they maintain a register of patients with end of life care needs and this includes recording of their primary carer which would cover the relationships within LGBT relationships. The LCP is used in the hospital and community as a care plan in the dying phase and the needs and wishes of the family/carer are recorded and this would not differentiate between the relationships in LGBT partnerships and other relationships. NHS Tower Hamlets is currently giving active consideration to implementation of the PPoC which also records the relationships the patient has and takes into account their views and wishes. NHS Tower Hamlets considers that it already applies the principles and aspirations set out by the panel in this recommendation in relation to end of life care. We welcome the panel's support of our current working practices.	Social care (in health this is already covered in the tools used)	

Recommendation		Response/Comments	Responsibility	Date
R3	That the Council and NHS Trusts work in partnership with St Joseph's Hospice to extend hospice care in the community and train health and social care and care home staff on managing end of life care discussions.	We would welcome a further definition of the committee's interpretation of the phrase 'hospice care' to provide clarity about what is being proposed here. As a provider of End of Life Care we work within a complex and layered area that provides care to patients in a variety of settings. Care provided in or by a hospice is just one form of palliative care Much palliative care sits in a generalist remit and as such, GPs and community health services may provide this service with specialist input from the hospice on complex cases. As a commissioner of end of life care we aim to support an develop the provision of a model of care which all services adhere and which meets the needs of our varied communities, rather than focussing only on 'hospice care' which is predominantly specialist care. NHS Tower Hamlets has, however, commissioned local hospice services to extend their care into non cancer illness within the community during 2008-10 Moreover through developing our approach to commissioning we have identified a need to train generalist staff in care homes, community nursing, community hospital and social care services in providing care and understanding end of life care needs and	Health, social and voluntary sector	During 2009/10

Recommendation	Response/Comments	Responsibility	Date
	communication skills and this could be provided by through the hospice. NHS Tower Hamlets has commissioned in 08/09 and 0910 a course run by St Josephs Hospice on 'initiating difficult discussions' for staff which has been attended by health and voluntary sector staff as well as some social care staff. We are also working on developing health care assistant training within the PCT and the hospice provides a palliative care course for Community Nurses through City University. NHS Tower Hamlets is jointly funding a palliative care course for the voluntary sector (age concern). We would b supportive of discussion with partners to develop a strategy for end of life care training which could provide clear responsibility training and include identified funding for provision to health, social care, care home staff and voluntary sector staff.		
R4 That the NHS Trusts in Tower Hamlets and London Borough of Tower Hamlets prioritise co-ordination across health and social care during discharge from hospital and as a part of this work that the major Hospitals	We feel that this should cover the planning of care as well as the discharge of patients. This area is clearly covered in the Delivering Choice Programme work (DCP) carried out by NHS Tower Hamlets. We would anticipate the current partnership agreement for DCP will continue to support proactive engagement from social care in this work	Health and social care	Work stream groups to be developed and proposal for service improvement by October 2009. for implementation soon as possible/when funding available

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	in Tower Hamlets explore options to prioritise the transport needs of those at end of life.	stream and indeed, the whole programme. Transport is also covered with the DCP report as a work stream.		
R5	That the Council provide signposting and advice services on how to make wills and put in place Advance Directives and that these should be linked to information provided by the Births, Deaths and Marriages Registry services in the Borough.	NHS Tower Hamlet's believes that signposting provides a valuable contribution to improving information flows and this is already covered using the GSF and PPoC in the community by health services. However, there is a need to ensure that all health, social and voluntary care staff are engaged in anticipatory care for patients and ensuring that advanced care plans are agreed and the outcomes communicated to all professionals involved with the patient and their carers. NHS Tower Hamlets has produced a local bereavement booklet that provides useful and relevant local information and can be given out prior to a death. We would welcome any steps taken by all partners involved in end of life care, for example, the register of births, deaths and marriages, to proactively communicate information relating to services so as to alleviate any family suffering and allow for preparation for a death.	Health and social care	
R6	That health and social care services develop a common definition of end of life care	As referred to in our recent consultation, there are already clear definitions of end of life care and the primary healthcare teams	Health and social care	

	Recommendation	Response/Comments	Responsibility	Date
	to be understood by all staff working with older people in particular. The definition should agree the trigger for health and social care services to consider the end of life care needs of the individual.	use the prognostic indicator guidance as part of Gold Standard Framework to identify patients for the palliative care register. We feel that it would be counterproductive to produce another definition and that the greatest potential for service enhancements and joint working lies in the scope to work more closely with social care staff on their understanding of existing definitions as well as health and social care working along side each other and sharing information about patients/clients		
R7	That a joint health and social care post be created to lead on the integration of health and social care services for end of life. The remit of the role would include creating a joint protocol for information share across health and social care including for the Older People's Panel and for co-ordinating care at the key points where health and social care interact.	NHS Tower Hamlets and the Council are currently working together in a number of ways in order to consider how best to develop enhanced integration between health and social care. End of Life Care is just one of many areas that this work may cover. The development of such a role as proposed by the panel is not included within either organisation's budgets as set out and agreed for 09/10. Priorities for future year's allocations will be influenced by the work already referred to and prioritised in line with already well understood processes. We will also consider other options for meeting the need of the patients and services e.g. promoting joint working and identifying leads within health and social care who can work together rather than develop an integrated	Health and social care (Delivering Choice Programme)	Delivering Choice Programme - Work stream group to be developed and proposal for service improvement by October 2009. for implementation soon as possible/when funding available

Recommendation	Response/Comments	Responsibility	Date
	post which may be less effective for both organisations. The success of the delivering choice programme would be supported by the identification of a social care lead who could represent all of social care on the board and delegate working groups to appropriate members. NHS tower Hamlet's recognises the potential for developing a joint strategy on information sharing and communication and as such this is identified within the DCP report as a need across all sectors as well as the. need for a coordination role. However, the DCP working group may not decide on the older people's panel for the coordination role as end of life care affects all age groups and there may be a need for a less didactic approach to the issues of coordinating care		
R8 That the NHS Trusts and the Council review their provision of rapid death certification services to take account of local community needs including that of faith and explore the options for an inter-borough service to ensure 24 hour coverage.	NHS Tower Hamlets has already began work on this issue and is in the process of setting up a work group to look at death certification and related issues for the community and hospital. Member of social care will be invited to join the steering group which is being scoped at this time. While we cannot guarantee that the outcomes of the group work will be as recommend in this report	Health and social care	Not set

	Recommendation	Response/Comments	Responsibility	Date
	The service that is developed as a result of this will need to include a community engagement plan to publicise and improve access to the service.	these will be taken into consideration as a whole, whilst acting within the current legal constraints about certifying deaths. We therefore welcome this recommendation and believe discussions should include social care and voluntary sector groups and not be restricted to just the PCT and council.		
R9	That the Council consider piloting a programme of community based discussions on end of life care.	Whilst NHS Tower Hamlets welcomes the potential to enhance community dialogue and understanding through this approach, we believe it should be done with sensitivity and must include follow up and provision of training for staff involved and dealing with the requests that might come from the discussions. NHS Tower Hamlets have previously participated in jointly hosted public discussions and welcomed this approach.	Social care (link to health for support and advise)	
R10	That on the basis of a common definition of end of life care being agreed by the Council and NHS Trusts, individuals should be assigned a single point of contact for co-ordinating all subsequent care.	Coordination of care is one of the DCP work streams. The end recommendations of this work may not be for a single point of contact but this is certainly something that will be considered alongside who would be best placed to fill this role throughout the patient journey. Engagement from social care in the work stream will be essential to its success. We would anticipate using existing definitions	Health and social care	Delivering Choice Programme - Work stream group to be developed and proposal for service improvement by October 2009. for implementation soon as possible/when funding available

Recommendation	Response/Comments	Responsibility	Date
	of end of life care but can clarify them for this purpose		
R11 That a strategic approach to commissioning care homes be developed taking into account the need to deliver high quality and efficient services but also in a way that ensures there are sufficient resources and flexibility for care home staff to take up training to meet the end of life care needs of residents.	NHS Tower Hamlets welcomes this recommendation. There is also a need for the care homes to accept their role in training and supporting their staff but a strategic approach should lay out the core standards of training and care that we expect from the homes for residents of Tower Hamlets. The PCT currently has a locally enhanced service for GP's covering care homes which includes that the GP must be actively using GSF. The responsibility for equipping the care homes is, we feel, the responsibility of the home but if you expect them to provide end of life care, this should be explicit within the contracts held with the homes. We recommend that each home meets a set requirement of core skills for basic end of life care provision alongside health and social care and that competency is measured. We can see merit in considering all care homes registering for the national GSF programme for care homes to allow them recognition of their work	Health and social care	

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