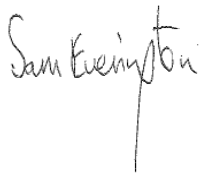
TOWER HAMLETS COMMISSIONING STRATEGIC PLAN 2012/13 – 2014/15

FOREWORD

NHS Tower Hamlets Clinical Commissioning Group (CCG) has led the strategy planning process for 2012/13. The CCG followed a robust process which initially included reviewing the local needs via the Joint Strategic Needs Assessment (JSNA) and then reviewing the existing commissioning strategy plans to offer assurance of future commissioning viability. Through-out this process the CCG, working in partnership with Commissioning Support Services, has derived a set of prioritised initiatives that are strategically relevant, achievable and owned by key stakeholders to allow us to address the key healthcare priorities across the health care system.

The focus of the CCG will be to centre on commissioning the best quality care, driving better clinical outcomes for our patients and improved performance of our providers. The CCG will take an integrated approach to all commissioning related to the 'Improving Health and Well-being strategy'. This will add value to the commissioning process and ensure the strategy is well embedded into partnership working between the CCG and other stakeholders such as the London Borough of Tower Hamlets (LBTH), Barts and London NHS Trust (BLT), East London Foundation Trust (ELFT), Patient and Public Involvement Groups, Public Health, Health and Wellbeing Board and other key Providers.

This is both an exciting yet challenging year ahead but with the support of the Clinical Commissioning Services and the commitment of NHS TH CCG we are confident we can continue to commission quality services to meet the needs of the local population.



Sam Everington
Chair Tower Hamlets Clinical Commissioning Group

INTRODUCTION

The NHS Tower Hamlets Commissioning Strategic Plan (CSP) describes how we will continue to improve the health outcomes of our local population, improve the quality of health services over the next 3 years, and do so while delivering a balanced budget. There are four main cornerstones to our CSP:

- The health needs of the local population: Public Health have refreshed our Joint Strategic Needs Assessment (JSNA) highlighting the most pressing health needs of the borough. This year we have looked at identifying these needs across the life course of our residents.
- The long term aspirations for the borough set out in our key strategies such as the Tower Hamlets Community Plan and the Improving Health and Well-being Strategy 2006-2016. These strategies are supported by our Primary Care Investment Plan and our Integrated Care Plan
- Reviewing the current programme of investment to ensure it remains appropriate and effective, and identifies new areas for investment and service redesign
- A continuous review of the quality of our services to ensure that, as well as delivering best value for money, they are delivering better health outcomes and a better experience for our patients.

The health needs of our population are well-known and well documented. We continue to face the challenge of reducing health inequalities and addressing deprivation.

This year we have seen changes in our provider landscape. The integration of the NHS Tower Hamlets Community Health Services (CHS) with Barts and the London NSH Trust (BLT), the new Royal London Hospital, and the emergence of Clinical Commissioning Groups, all give us tremendous opportunities to further develop integrated care. We have also continued to develop our primary care estate. In June this year we opened the new Dunbridge Street Health Centre in partnership with the London Borough of Tower Hamlets

In the coming year, the prospect of a merger between our three sector acute trusts: BLT, Newham University Hospital Trust, and Whipps Cross University Hospital Trust also present us with real opportunities to work with

Our new Health and Well-being Board (HWB) is bringing together health services, local authority and the local community together in meaningful dialogue to support more effective commissioning, chaired by the Mayor of Tower Hamlets, Lutfur Rahman. To support this, an integrated public seminar was jointly coordinated between the CCG and LBTH. Professor Sir Michael Marmot presented an analysis of how the learning from the government's review of health inequalities can be applied to Tower Hamlets.

We have made very real progress in improving the health of our children through a highly successful immunisation and vaccination programme which has seen us move from being among the bottom 25% of boroughs to top of London in coverage. Our care packages continue to provide support to people with long-term conditions keeping them from having unnecessary hospital admissions, engaged in the community and experiencing improved health.

Over the coming three years we will continue to embed our plans for integrated care across primary, secondary and social care through an alignment of our resources, by working more closely with providers and the local authority to jointly address health inequalities and supporting the Mayor's Pledges, such as increasing housing stock, thus tackling health inequalities in a joined up way. We already have clear evidence that our present initiatives are delivering improved service quality and a better patient experience. We are confident that these initiatives, for example the Primary Care Investment Programme and GP streaming in of A&E, will continue to deliver as planned.

As well as our programme of service redesign we will also be on making efficiency savings from the current contracts we hold with acute, community, mental health and other contracts. We will look to make efficiency savings on all contracts proportionately. We will be reviewing contracts that are coming to the end of their terms to determine ways to more effectively deliver services through combining contracts where this is possible, examining the current provider landscape to ensure we are procuring the best available services.

We know that our population is continuing to grow and age, that their health needs continue to be challenging, and that there are rising costs associated with health care, such as treatment and medication costs. We have examined how those costs will continue to rise against a "do nothing" scenario. Our projections are that if we do nothing but continue on with all our services and contracts as they are, in three years time we will be facing a £30 million shortfall to cover our local health costs. Therefore this year we are planning to ensure that this does not happen.

The CSP is not just about the financial investments. It is about how we will deliver better health outcomes for our patients making sure that they are getting the most-effective interventions, delivered in the right setting by the most appropriately skilled professionals. We have built local networks and localities configured to deliver quality care in line with our plans.

We will be looking to review the local pathways for the care of the elderly, and continuing to improve our planned care pathways. We will be expanding the cover of the Community Virtual Ward across the whole borough which provides support to the vulnerable in our communities to avoid unnecessary admissions to hospital. We will also be actively engaged in ELC wide programmes with cancer and maternity services

This CSP has been in development since July 2011. All 4 Locality Commissioning meetings were asked to identify areas for improvement, new investment or efficiency savings. This has been collated and reviewed by the Clinical Commissioning Group Board, who, with the support of the NHS Tower Hamlets Commissioning Support Services has been developing the identified initiatives. We are now

in a further consultation period, where we are checking that all GP Clinical Commissioners are in broad agreement with the borough approach.

VISION

'Reducing the inequalities and poverty that we see all around us, strengthening cohesion and making sure our communities live well together' *Tower Hamlets Community Plan, One Tower Hamlets Vision*

Our vision for the borough is to improve the quality of life for everyone who grows up, lives and works in Tower Hamlets. Our ambitions to reduce poverty and inequality, bring local communities closer together, have public sector organisations showing strong local leadership and have our residents taking personal responsibility to improve their own lives are all brought together under the banner of "One Tower Hamlets".

Our vision is set out in the Tower Hamlets 2020 Community Plan, an ambitious strategy for an aspirational borough, written following extensive consultation and conversations with local people who told us what mattered most to them as residents of Tower Hamlets. It has four key ambitions:

- A Great Place to Live – providing decent and affordable housing
- A Prosperous Community – access to learning, helping local people to get work and local businesses to thrive
- A Safe and Supportive Community – including preventing and reducing crime and supporting vulnerable residents
- A Health Community – making easier for everyone to get the support and treatment they need to live more healthily

We have a strong track record of partnership working in the borough which we will continue to build on as is described in the documents that represent how we will achieve our vision. We will look at three key documents in the following sections

The Tower Hamlets Community Plan

The Community Plan outlines how we will continue to reduce inequality and poverty, particularly among the most disadvantaged in our borough, to ensure that everyone has the opportunity to achieve their full potential. It has been refined to ensure that the borough is best placed to address its key issues and maximise opportunities. It also captures the core objectives of the borough's new directly elected Mayor, as follows:

- Housing: Tackling issues relating to housing and overcrowding
- Education: Continuing to improve on exam results and improving the environments in which our young people
- Jobs: Getting local people into work, especially those who are skilled and semi skilled workers.

BY 2015:

Our services will be the best in the country and will be recognised by the people of Tower Hamlets as being so.

High quality services will be provided to a dramatically regenerated borough, with a population half as big again as it is now. They will offer equal access and choice to every single person in the borough, reflecting the diversity of the population, and will be overwhelmingly staffed by local people whose profile the community serves.

Nobody will have the experience of being asked for the same information twice by different health and social care professionals: information will be controlled by the service user not the professional, and subject to the control which be instantly available to everyone who needs to see it wherever and whenever the need arises.

Care will be experienced as if it were provided by one organisation in a completely coordinated and seamless way, irrespective of the actual organisational arrangements in place.

The great majority of care will be provided in the communities in which people live, to in hospital and not in institutional settings. It will, however, be supported by the highest quality secondary care services, with maximum ease of access,. It will be largely delivered in, or close to, people's homes using modern technology to reduce travelling and to ensure prompt response.

Health, social care, voluntary sector and service user groups will work alongside each other in high quality primary and community care facilities, offering one point of localised access to the full range of services
individual, supported

The care and treatment of the individual will be controlled by that by the best professional staff. Services will be embedded in their local communities, drawing on all the resources of those communities, and with a clear accountability to those communities. Individuals will feel informed and enable to take decisions on their care, whether that be care by themselves or others. Individuals will feel they really have a choice.

Appropriate care and support will enable more children to reach their potential, supporting schools in increasing achievement to ensure our young people have the skills needed to access employment.

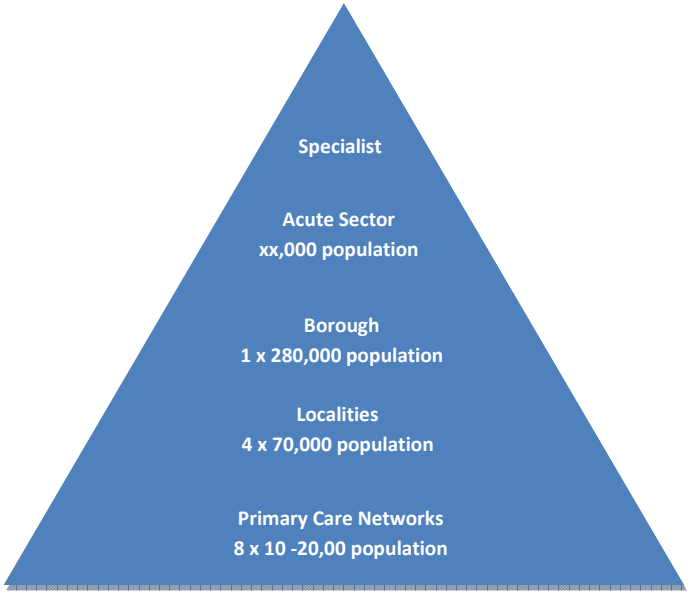
Source: Tower Hamlets Vision for Health

- Community safety: Continue to build on the way the police and council deal with concerns of crime and anti-social behaviour through greater resourcing
- Cleanliness: Ensuring our streets, parks and open spaces are clean and tidy so that people can take pride in the area where they live.

This vision has been the basis of our previous Commissioning Strategic Plans and this year will be no exception. We will continue make our visions a reality. With a continued emphasis and focus on how we can deliver more seamless and integrated care.

Improving Health and Well- being Strategy

Together the London Borough of Tower Hamlets and NHS Tower Hamlets have taken an integrated approach to commissioning over a number of years and have our joint Improving Health and Well-being Strategy (IHWB) which is our borough wide plan to create a truly integrated system built around Local Area Partnership based networks of services.



Our IHWB has five strategic aims:

- Reducing inequalities in health
- Improving the experience of those who use our services
- Developing excellent integrated and localised services
- Promoting independence, choice and control by service users
- Investing resources effectively

All our strategic documents are dynamic and evolving, and this year we will refresh both strategies to ensure that we continue to meet the ever-changing needs of our local population. Our IHWB review will have

a particular focus on strengthening further integration by including acute care, mental health care and community health service providers. The newly formed Clinical Commissioning Group (CCG) will continue to support this overarching integration strategy as they take over responsibility for the commissioning of services in Tower Hamlets in shadow form from April 2012 before full authorisation in 2013/14.

This year we will strengthen the way we work with clinicians to redesign care pathways and consolidate our clinical engagement with clinicians from primary care, acute care, mental health and social care services. Continuing our effective clinical relationships will continue to deliver real health improvements to our local communities by delivering the right care, at the right time and place, and by the right mix of skilled staff.

The Tower Hamlets Commissioning Strategic Plan will outline the initiatives we are planning in 2012/13 to continue to realise our "One Tower Hamlets" vision over the coming three years.

CURRENT PROVIDER LANDSCAPE

Acute Providers

Barts and the London Trust (BLT)

BLT is the main provider of acute and specialist services for local people. The Trust is currently based over 3 sites: The Royal London, St Bartholomew's, and The London Chest, and is at the end of a large and complex redevelopment. The Royal London will be Britain's biggest new hospital, the historic buildings of St. Bartholomew's will be refurbished and, along with a major new building, will create a Cancer and Cardiac Centre of Excellence. We are working actively with other commissioners across north east London to ensure that the new BLT will deliver the twenty-first century hospital care that we wish to commission.

Other Acute providers

- Moorfields Eye Hospital Foundation Trust
- Homerton University Hospital Foundation Trust
- Newham University Hospital Trust

Primary Care

We continue to invest in major capital development programme to deliver local services in an integrated way across networks and localities in line with our IHWB strategy and linked with Local Area Partnerships.

General Practice

We commission 36 general practices within Tower Hamlets to provide GMS/PMS services for local people, all of which now offer extended hours opening.

Community Pharmacy

There are 45 pharmacies locally. Tower Hamlets Pharmacies dispense around 220,000 prescription items per month and provide all other essential services in the national Community Pharmacy contract framework including the repeat dispensing service.

Dental Practices

We currently commission NHS dental services from 30 general dental practices within Tower Hamlets. Contractual performance is managed through mid-year and end of year review meetings with each dental contractor.

In line with the Oral Health Strategy, we are currently mid-way through a two-year programme of major investment into dental services which includes the commissioning of a new dental practice that will provide oral health promotion and prevention as well as treatment services.

Optometry

We currently commission 22 contractors operating from fixed premises and 19 contractors providing domiciliary services, under the General Ophthalmic Services contract.

Community Health Services

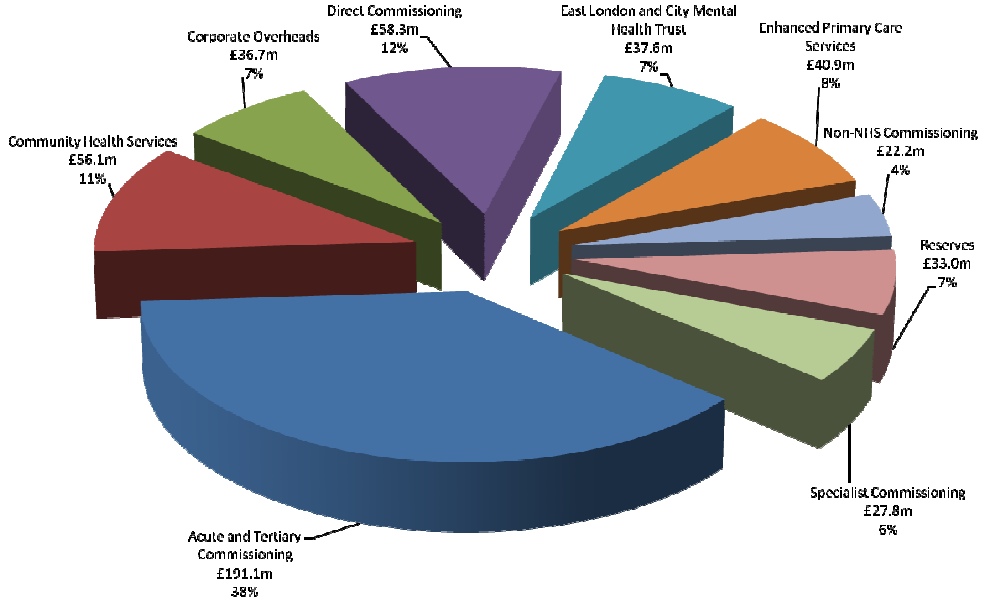
In 2011 Tower Hamlets Community Health Service integrated with Barts and the London. Community health services commissioned included Adult Community Nursing Services, Therapies services, children and young people's services among others

Mental Health

East London Foundation Trust is the main provider of inpatient and specialist mental health community services, the latter in conjunction with Tower Hamlets Council.

Financial

In 2009/10 NHS Tower Hamlets spent 43% of its budget – equivalent to £225 million – on acute secondary care for example, £75 million on commissioned services from the PCT's provider services, £77 million on primary care services excluding prescribing, and £58 million on secondary care mental health services. This graph shows the budget allocation for 2011/12



Graph 1: Financial Allocation for 2011/12

CASE FOR CHANGE

Tower Hamlets continues to face significant health challenges. Our residents experience more health inequalities than most other parts of England, have lower life expectancies and experience higher than average deprivation. Our population is on an upward growth trajectory, with an estimated population of 267,000 by 2015, an increase of 25,000 from the 2010 population figures. It is characterised by a more diverse, young and mobile population than elsewhere.

This section outlines the case for change, and focuses on three key, inter-related areas:

Health Challenges

Each year our Joint Strategic Needs Assessment (JSNA) pulls together all the information which is available on the needs of our local population and analyses this to highlight the major health challenges we face. This year our JSNA utilised the framework outlined in the national review of health inequalities "*Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010*" led by Professor Sir Michael Marmot. This framework takes a broad approach to health which encompasses the broader determinants of health, looking at the interaction of people with their environment over the course of their lives from birth through to old age. We have used this as our framework for understanding health and care issues across the lifespan (Figure 1).

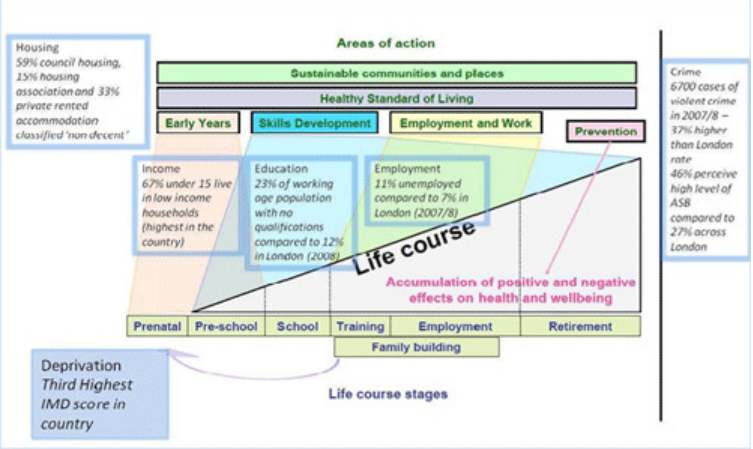


Figure 1: Tower Hamlets compared to the Lifecourse model used in the Marmot Review

Quality Challenges

We aspire to constantly drive up the quality of our health and care services to make sure when people access health and care services they are getting the most effective evidence-driven interventions, delivered by the most appropriately qualified staff, in the most appropriate setting. Understanding the patient experience of our services is a critical element of developing quality services, as is continually monitoring the quality of service delivered by our providers.

Financial Challenges

All of this ambition costs money, and like all other National Health Service organisations, NHS Tower Hamlets must use its financial allocation smartly to make sure it is getting the best value for money both now and on into the future.

We have adopted programme budgeting to help us manage the overall balance of our investment programmes. The Department of Health Programme Budgeting initiative seeks to assess the pattern of need that can be affected by health and social care interventions (allocative efficiency) which results in maximum impact (technical efficiency) The investment portfolios of Primary Care Trusts (PCTs) can then be benchmarked against national, regional and comparator areas. The findings for Tower Hamlets in 2008/09 and 2009/10 are set out below in summarised form in which relative spend is set against relative outcomes.

Whilst programme budgeting data can only raise high level questions about the relative prioritisation of investment, it does highlight that as would be expected from an understanding of need in Tower Hamlets, there is generally higher spend in those programmes identified in the JSNA as areas of higher need than elsewhere (Figure 2)

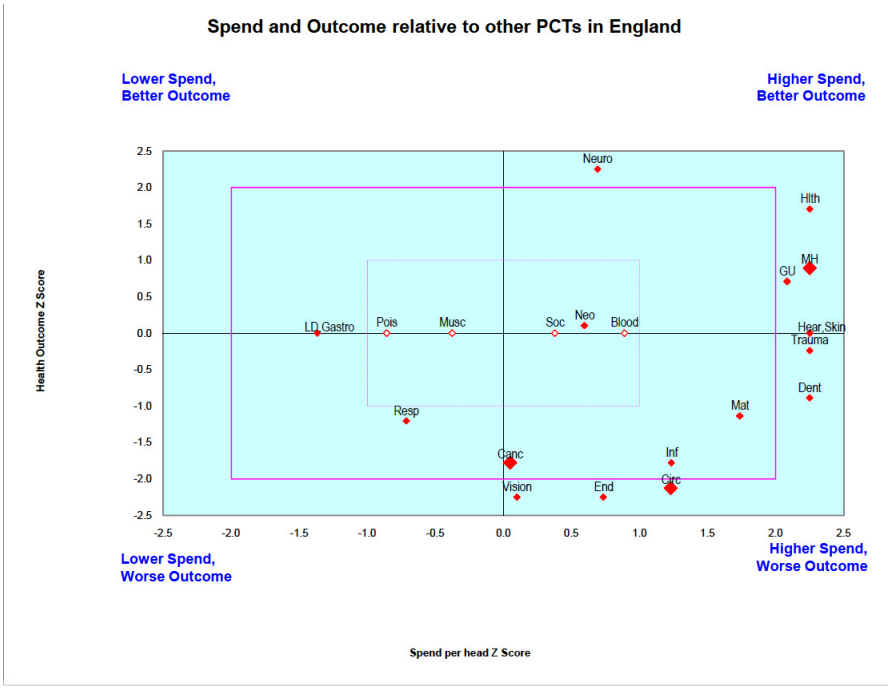
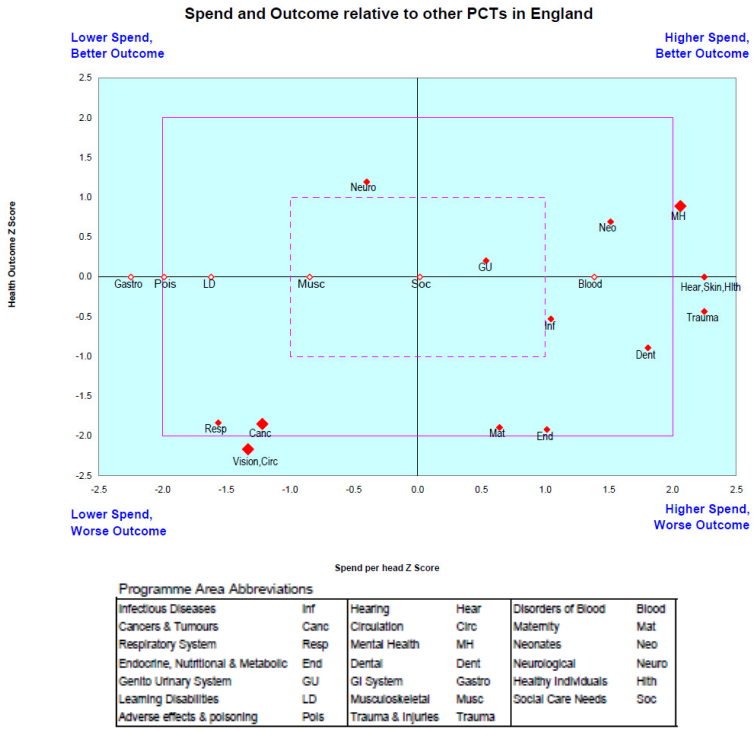


Figure 2: Programme Budgeting: Tower Hamlets 09/10 benchmarked against England PCTs (DH)

This is a significant shift from 08/09 programme budgeting data (Figure 2) in which cancer, circulatory disease and respiratory disease were at the extreme end of the bottom left quadrant (lower spend, worse outcomes).



Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Figure 3 Programme Budgeting: Tower Hamlets 08/09 benchmarked against England PCTs (DH)

The shifts in 2009/10 reflect the investment that was placed in cancer services and vascular disease (care packages). The 2009/10 data indicates potentially lower relative investment in respiratory disease. However, it would be expected that this would be reflected by 2010/11 data through investment in the Chronic Obstructive Pulmonary Disease (COPD) care package, which is part of our overall strategy addressing Long Term Conditions (LTC). Systematic review of programme budgeting data and marginal analysis (the impact of changes in the balance of the overall investment) is set out in the DH guidance on Annual Population Review and it is recommended that this methodology is considered for clinical commissioning groups to inform future prioritisation of commissioning options.

The following sections will examine each of these challenges in greater detail.

HEALTH CHALLENGES: LIVING IN TOWER HAMLETS

Our approach

This year our approach draws heavily on the framework for addressing health inequalities set out in the Marmot review ('*Fair Society, Healthy Lives, 2010*) published in 2010. This highlighted how a person's health depends on the 'accumulation of positive and negative effects on health and wellbeing' through the lifecourse and set out the evidence for action from before birth and throughout the life course. It particularly emphasises the importance of early years as well as the profound link between a person's health and the 'wider determinants of health' such as income, education, poverty, quality of housing, community cohesion and quality of local services

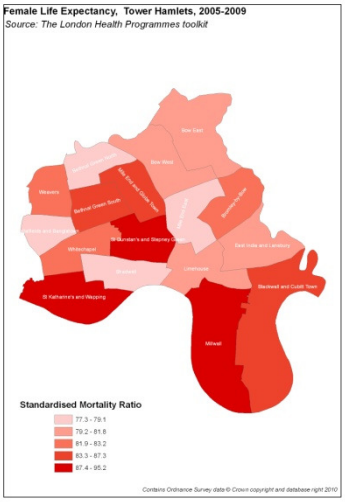
The recommendations of the Marmot report set out the evidence based policy goals to address health inequalities as follows:

- Give every child the best possible start in life
- Enable all to maximise capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure health standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen role and impact of ill-health protection

The Marmot review highlights the importance of thinking along the life course when addressing health improvement and health inequalities. The benefit of this is that it encourages thinking around the broad range of factors that impact on health at different stages of life and promotes an integrated strategic approach across the partnership. In this way, it makes clear that improving health and wellbeing in Tower Hamlets requires the concerted actions of a wide range of partners across the PCT, council, voluntary sector and business. The following sections drill down on the headlines set out above and sets out headlines, determinants, evidence and local strategies at each stage of the lifecourse.

Health headlines

Life expectancy in Tower Hamlets is lower than the rest of country but continues to improve. Male life expectancy is 75.3 years compared to 77 years nationally. Female life expectancy 80.4 years compared to 81.1 years nationally. However, the life expectancy gap between least and most deprived deprivation is 11.2 years in males and 6.5 in females. Geographically, ward life expectancy varies by 8 years in males and 6 years in females. The clearest difference is between the two most affluent wards and the variation is less marked between the other 15 wards.



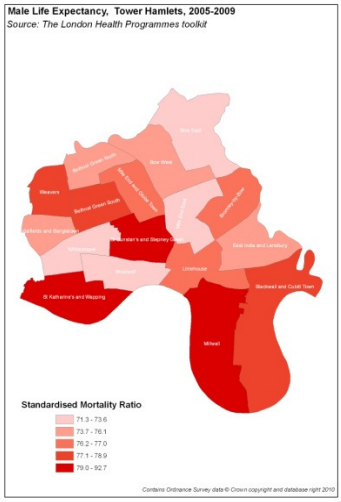


Figure 4: Male and Female Life expectancy (by Ward)

Emergency admission rates are strongly linked to the deprivation and Tower Hamlets has amongst the highest emergency admission and lowest elective rates in London. We are already addressing this through a range of planned care strategies, including how we manage Long Term Conditions, and our Care of the Elderly pathways

There are a number of demographic and socioeconomic factors that affect health and social care need in Tower Hamlets. These are population growth (expected to increase by 25,000 in 5 years from 242,000 in 2010), a relatively young population, a high degree of people moving in, out and within the borough, ethnic diversity (51% non-white and 34% Bangladeshi) and high socioeconomic deprivation (33% families live on an income less than £20k compared to 22% in London) and higher than average levels of unemployment (12% are unemployed compared to 9% in London). 16 of 17 Tower Hamlets wards are in the 20% most deprived in the country (12 are in lowest 5%).

There are a number of characteristics of Tower Hamlets as a place that affects health and social care need and that drive both inequalities between Tower Hamlets and elsewhere and those within Tower Hamlets. Over half (54%) of the population live in social housing compared to just over a third (37%) in London, levels of overcrowding are higher than the London average, green space is limited (1.1 hectares green space per 100 people compared to 2.4 nationally), there is a high density of fast food outlets (42 per secondary school – the 2nd highest in London), 46% residents perceive high levels of antisocial behaviour (compared to 27% in London) and the rate of people killed or seriously injured on the roads is significantly higher than the London average. The level of housing growth in parts of the borough also has impacts on the environment, housing conditions and the demographic mix of the population.

Mapping the 'gap' & identifying target areas

In order to identify target areas for action, the health 'gap' must be understood. This can be achieved through modelling local mortality and morbidity data (including disease registers) and

auditing performance. For example, analysis of primary and secondary causes of deaths; auditing management of chronic disease to identify poor performance; using chronic disease registers to estimate the potential of primary prevention interventions. This systematic approach allows us to effectively plan interventions.

When initiatives and patient pathways are designed or re-designed and services reconfigured, plans should take into account accessibility to patients (responding to needs identified through appropriate public and patient engagement), effectiveness and cost-effectiveness. Trajectories of disease and health may be plotted against national bench marks to estimate the likely impact of proposed interventions and to prioritise action.

High impact interventions

Early years: risk assessment and risk management at pre-, ante- and post-natal appointments of health behaviours (e.g. smoking, alcohol and diet); prevention of Sudden Infant Death Syndrome, uptake of childhood immunisations and; support for breastfeeding

Public health behaviour change initiatives to reduce the social gradient at all ages may include very brief advice incorporated in to all disease pathways; clear referral pathways for high-risk groups who wish to quit smoking; an annual offer of support to stop smoking for all patients on disease registers and; implementing targeted programmes to increase earlier clinical presentation and take up of screening programmes.

Chronic disease registers should be used to ensure systematic, person centred care for management and/or secondary prevention of key diseases, such as COPD, diabetes and CVD to achieve equitable outcomes.

Annual medication reviews and support to patients with complex health needs from deprived backgrounds will secure better management of priority diseases. Examples of outcomes achieved through integrated working with the local authority include collaborative activities to identify a list of vulnerable elderly/disabled individuals with complex caseloads that may require additional support and form a register, for example, for the annual flu vaccination campaign.

Strategy

The Tower Hamlets Community Plan (including the Improving Health and Wellbeing Strategy) has been the key strategy that addresses the recommendations of the Marmot review. The One Tower Hamlets vision that provides the foundation for this is to ‘reduce the inequalities and poverty that we see all around us, strengthening cohesion and making sure our communities live well together’. Our vision outlines the importance of these strategies and through further integration and localisation we will deliver real improvements to the residents of Tower Hamlets.

Of particular relevance to localised approaches to addressing health inequalities in the borough are the localisation agenda, the Local Development Framework, the housing strategy, the establishment of Local Area Partnership level GP networks and Community Health Services localisation.

From a health care perspective, the principles of the National Support Team for Inequalities (which visited Tower Hamlets in 2006) have been consistently applied to interventions to improve health and social care outcomes and have strongly informed the priority we have placed on maternity services, interventions to address behavioural risk factors, developing person centred care packages in primary care and driving further integration of care.

	Maternity Plan	Children and Young Peoples Plan	Improving Health and Well-Being Strategy	Healthy Improvement Strategy for Maternity Services	Improving Health and Well-being Strategy	Child Death Overview Panel	Immunisation Action Plan	Healthy Weights, Healty Lives	Community Plan	Tobacco Control	Primary Care Investment Programme	Substance Misuse	Sexual Health	Transforming Adult Social Care	Mental Health Whole	Carers' Strate	Pro
Being born	✓	✓		✓	✓	✓		✓	✓	✓							
Growing Up - Early Years		✓		✓	✓		✓	✓	✓	✓							
Growing Up - Children & Young People		✓			✓			✓	✓	✓		✓	✓		✓		
Being an adult			✓		✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	
Growing old			✓		✓				✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 1: Key Strategies aligned to life course in Tower Hamlets

From a place perspective, the Local Development Framework is a major vehicle for shaping Tower Hamlets into a place that builds health and well-being into everyday life. It is critical that health and wellbeing impacts are factored into significant developments in the borough. In terms of developing services, there is also a substantial opportunity to further drive more integrated and innovative working at the locality level between the NHS and local authority as both move towards more locality and sub-locality planning arrangement. The Community Virtual Ward will be a significant driver of this approach for more complex patients.

Tower Hamlets: JSNA Findings

The following table shows the key health headline findings from this year's JSNA. It is reported against each of the key life course stages.

Being born in Tower Hamlets	• Infant mortality not significantly different to London (4.4 per 1000 live births < 1 year) • Higher percentage of low birth weight babies to London (9% compared to 7.5%)
Growing up in Tower Hamlets – Early Years	• By the age of 5 only 46% of Tower Hamlets infants have achieved a good level of cognitive development compared to 56% nationally • 13.3% are obese - 7th highest in the country • 39% have experience of tooth decay compared to 31% nationally - declining
Growing up in Tower Hamlets – Children and Young People	• 25.7% 10-11 year olds are obese (3rd highest in the country) - plateaued • 8th highest incidence of sexually transmitted infections in the country • 2nd highest rate of injuries (deliberate and unintentional) to children and young people • 17% reduction teenage pregnancy since 1998 (now average for London) • 1 in 10 children are estimated to have a mental health disorder
Being an adult in Tower Hamlets	• Amongst the highest premature death rates from the major killers in London • 3rd highest CVD • Highest Cancer mortality • 5th highest COPD • 12,000 adults with diabetes and increasing (17,000 by 2020) • Amongst highest rates of HIV, TB and sexually transmitted infections • 5th highest admission rates for mental health reasons in London • Levels of long term illness/disability 34% higher than national average (2001 census)
Growing old in Tower Hamlets	• 56% of 65-84 year olds report long term limiting illness compared to 48% nationally • 80% of over 65s have at least one chronic condition of which 35% have at least 3 co-morbid conditions • Evidence of under-diagnosis of dementia • 2nd highest stroke mortality in London • Falls admissions lower than London average high in some wards • Most people do not die in their place of choice (over 60% in hospital)

Table 2: Health Headlines across the life course

Determinants of health across the life course

Being born in Tower Hamlets

The evidence base highlights the importance of the prenatal period for future health. However, this could mask particularly poor outcomes in certain population segments. In Tower Hamlets there is

encouraging evidence of progress e.g. early access, improvements in patient experience and birth outcomes are relatively good

Being born in Tower Hamlets	• High deprivation linked to low birth weight • 45% of births to Bangladeshi mothers • 3.3% smoke in pregnancy but 16% white mothers • Substance misuse, problem drinking, poor diet , poor mental health general issues • 17% reduction teenage pregnancy since 1998 (now average for London) • Average early access to maternity services (improving but only 65%), patient experience issue

Growing Up in Tower Hamlets – Early Years

Educational attainment is a major determinant of health. We have good early education, access to childcare and support to family which are the evidence based interventions that give infants the best start in life. The improvement in educational outcomes in Tower Hamlets is a fantastic achievement in the context of the levels of child poverty in the Borough

Growing up in Tower Hamlets – Early Years	• 55% children in Tower Hamlets classified as living in poverty • 80% mothers initiate breast feeding at birth and 68% are still breast feeding at 6-8 weeks (compared with 72% and 45% England) • Immunisation uptake in under 5s is amongst the highest in the country (94% have second dose MMR) • 40% of under 16s are estimated to have Vitamin D deficiency

Growing Up in Tower Hamlets – Children and Young People

It is good news that the rise in childhood obesity in levelling out but it still remains 1 in 4.
There have been improvements in the extent to which schools have promoted health within schools but there remains significant scope for further improvement

Growing up in Tower Hamlets – Children and Young People	• 55% children in Tower Hamlets classified as living in poverty • 52% pupils entitled to free school meals (highest in country) • Improvement at key stages 1, 2 and 4 to above national average • 49% pupils (yrs 1-13) participate in at least 3hrs high quality PE/Sport in week (69% nationally) • 1 in 5 children under 15 have tried a cigarette 3 in 10 an alcoholic drink by age 15

Being an adult in Tower Hamlets

Sustaining people's income, housing and employment through the economic downturn is a critical health intervention. It remains our intention to further embed healthy lifestyles into frontline services and target at risk groups . There is emerging but early evidence that the care package approach to long-term conditions (LTC) is impacting on primary care outcomes and secondary care admissions and it will be important to continue to monitor impact as new care packages are implemented.

Cancer remains an issue of particular concern as mortality rates are high and survival rates low. For this reason, the ongoing work to increase screening uptake, early awareness of symptom and early diagnosis must continue to be a top priority. Each of the local acute trusts in East London and the City (BLT, Homerton and NUHT) is part of the Integrated Cancer System, known as London Cancer, being set up across North Central and North East London. This will bring together clinical expertise to drive up quality, effectiveness and consistency of acute services for people with cancer.

Being an adult in Tower Hamlets	• 27% smokers compared to levels of 21% nationally • 43% drinkers (50%) have hazardous or harmful patterns (21% nationally)) • 68% do not do recommended levels physical activity (in line with the national average • 88% do consume recommended 5 a day (compared with 70% nationally) • Highest rate of problem drug users (23/1000 Compared with 12/1000 in London)

Growing Old in Tower Hamlets

Older people in Tower Hamlets are a smaller proportion of the population but the evidence suggests their health is generally worse than elsewhere. This highlights the particular importance of focussing on prevention in this group and ensuring that services across health and social are as integrated as possible.

The Community Virtual Ward is an important driver to embedding integrated approaches in more complex patients. It is recommended that the health needs of older people and the extent to which these needs are being met is an area for focussed review across the partnership

Growing old in Tower Hamlets	• Higher proportion living alone • 80% of TH residents aged 65+ do not meet recommended physical activity levels • At least 20% have significant hearing loss • 60-75% on District Nursing caseloads have incontinence problems

Conclusions

The health and wellbeing needs of people in Tower Hamlets persist but the resources across the health and local authority to address these needs is now even more challenging. Ever-increasing costs of health and social care need to be managed in a climate where we are experiencing a

reduction in allocated resources in health and a significant reduction in social care funding from LBTH.

The Marmot review is unequivocal in stating the critical importance and need to prioritise early years. Despite some encouraging outcomes, there is strong evidence Tower Hamlets infants have outcomes at age 5 that are linked to poorer health and wellbeing outcomes in later life.

Overall, it is encouraging that life expectancy continues to increase. However, inequalities persist both within Tower Hamlets and compared to elsewhere. As has always been the case, these inequalities will only reduce if there is accelerated progress in improving health in those at greatest risk of poor health outcomes. In view of the critical role of the Improving Health and Well-Being Strategy and this Commissioning Strategic Plan to deliver long term improvements in the health and wellbeing of people in Tower Hamlets it is essential to continually evaluate its impact on health and wellbeing and threats to delivery. This is particularly important in the context of the current economic climate and welfare reforms that are highly likely to impact on the physical and mental health and the well-being of all residents who live and work in Tower Hamlets.

It is therefore the responsibility of all organisations to prioritise and use our resources as effectively and efficiently as possible. We need to ensure the cost effectiveness of our services and to maximise the impact of resources on improving health and reducing health inequalities.

QUALITY CHALLENGES

Our approach across the cluster

The development of the NHS ELC Cluster in April 2011 brought together the quality functions of each of the PCTs into one team – the Quality and Clinical Governance Directorate. This directorate works in partnership across ELC and with CCGs to ensure that quality of provider services is proactively assured and scrutinised and improvements driven using all of the contracting levers available to us and provided benchmarking opportunities and a consistent approach to our major provider contracts - Bart's and the London, Homerton University Hospital Trust.

Triangulation of key quality issues on a monthly basis provides extensive quantitative and qualitative data collection and analysis to drive processes in place for monthly Clinical Quality Review Meetings (CQRM) with each provider attended senior clinical and managerial representatives. A forward plan is agreed with providers. The approach includes the dimensions of safety, experience, effectiveness and organisational integrity. We draw on the range of commissioner expertise to inform this process, e.g., workforce.

CASE STUDY

East London Foundation Trust – Following series of serious untoward incidents on Roman Ward at Mile end hospital, the quality team has worked closely with the Trust to improve the robustness of investigations undertaken and implementation of action plans, this culminated in a joint seminar on lessons learnt from the incidents. Key actions include:

- ✓ *Increase of nursing staff to adult inpatient wards*
- ✓ *Audit of supervision of staff*
- ✓ *Clear escalation procedure implemented*

This approach has enabled the commissioning teams to be clear about the quality issues for each of the organisations and to enact these priorities via the contracting round for 2011/12 using a variety of differing commissioning levers. With all the changes in the provider landscape as a result of the new NHS architecture quality is even more central to commissioning. There are more inherent risks that need to have effective responses to maintain and improve quality.

Determining our local priorities

As demonstrated there have been many advantages to working across the cluster allowing the ability to benchmark practice and spread improvements. Many of the priorities identified are also consistent across the sector, however each organisation will equally have areas which will need to have specific focus. Within this context, and knowing that we have a strong tradition locally of driving quality improvements, we hosted a Quality Summit to engage a wider stakeholder group in identifying and determining the quality priorities for 2012/13. We also hosted a safeguarding adults and safeguarding children's summit on 7th October 2011 and 6th September 20111 respectively

Quality priorities for 2011/12

Quality Summit

This year's summit, held on 13th October 2011, was attended by 70 people, which included a wide range of stakeholders; commissioning leads, CCG and borough teams, Local Improvement Networks (LINK) and CQC representatives. The summit built on a similar event held in December 2010 where quality priorities had been identified for local organisations and translated into the 2011/2012 contracting round. The tables below summarise the quality priorities identified and current position at BLT and CHS. ELFT priorities were determined for the organisation which covers the cluster.

2011/12 priorities	Bart's and the London Trust
Improvement of patient experience	Monitoring of mixed sex accommodation and agreement with exclusion criteria CQC National Inpatient Survey reported that: 22% (2010) v 30% (2009) of patients said that they used same bathroom/shower area as pt of opposite sex CQUIN 11/12 focus on improving patient experience
Infection prevention & control	BLT has breached the annual target for MRSA (6 per year) and now stands at 8 reported cases (Oct 2011), NHS ELC has agreed action plans with BLT to address compliance with targets
Maternity Services	Physical redesign of Talbot Ward (antenatal) to enhance patient experience. Royal Hospital London site new build design will enhance patients' experience of privacy and dignity CQUIN 11/12 agreed on patient experience in maternity PCT Survey 2011 of BLT's maternity service (10 Jan 2011 – 07 February 2011) showed improved results in patient's perception of: communication during labour, being involvement in decisions having confidence and trust in the staff
Discharge	CQUIN 11/12 agreed to focus on safer care – discharge communication - the current audit of discharges shows areas for improvement. In Q1 73% of summaries are judged as good quality but 23% were not received by GPs. Action plans are currently in place to address shortfalls in this process

Table 3: BLT Quality Priorities

Tower Hamlets Community Health Services	
• Written route map for transition period so patients are not adversely affected by changes • Information management strategy • Information sharing for benefit of patients, potential of networking, health directories, health activities • Sharing learning from incidents and use of data • Adults health and social care – planned information resource • Defining outcomes for each service and CHS as whole	CQUIN 11/12 agreed on: pressure ulcers, discharge, improving experience of patients and end of life care

• First response service in place for adults health and social care • Competence to support where complex care provisions by CHS as cost becomes closer to home • Develop reliable simple validated tool to measure patient satisfaction	

Table 4: CHS Quality Priorities

East London Foundation Trust	
Whole Systems Review (WSR) and the development of a shared model of care	Initial diagnostic phase of whole system review completed in May 2011 - fragmentation of primary – secondary pathway identified as one key issue Next phase includes deep dive into practice level activity & social care delivery, and development of new specifications for community MH services by march 2012
Focus on patient experience and engagement	CQC Community Patients Survey 2011 reported that: ELFT scored within the worst 20% of Trusts nationally. Top poor performing areas are: 44% of patients reported that they did not receive, but would have liked support finding/keeping accommodation, 44% felt their views were definitely taken into account when deciding what was in their care plan. A CQUIN 11/12 to focus on community patients' experience has been agreed with the Trust. A CQUIN 11/12 to focus on recovery and patient focussed care planning has been agreed
Monitor staff engagement and experience	Trust's owns staff safety culture survey showed positive results in terms of: Leadership, Safety culture, Staff engagement, Communication & Learning culture The CQC Workforce Survey 2010 reported that 52% of staff have well-structured appraisals in last 12 months 73% of staff were able to contribute towards improvements at work, overall staff engagement scored higher than the national average
Focus on effectiveness of Serious Incident investigations and other safety reporting to ensure organisational learning	Joint NHS ELC and ELFT thematic review of one year's mental health SIs to a focussed programme of work to improve staff's detection of a patient's physical deterioration and training re timely escalation for help, also to introduce SBARD tool to assist with improving communication between teams A joint NHS ELC/ELFT Roman Ward Learning from SI seminar was held in Sept 2011, assurance gained around implementation of action plans/learning from SIs Close work with ELFT to ensure increase in incident reporting rates and cross organisational learning from incident trends and action plans to address these. This has resulted in an 11% improvement to date in submissions within timescale. NHS ELC requested a repeat of the Trust's own staff safety culture survey – need for improved response rates

Table 5: ELFT Quality Priorities

Quality Measures: 2011/12 Commissioning for Quality and Innovation (CQUIN) Progress to Date

The following table shows the Commissioning for Quality and Innovation (CQUIN) progress against target for BLT up to August 2011.

National CQUINs	Metric	Apr	May	Jun	Jul	Aug	YTD	Trend	Trust Target
Patient Experience	Improve composite personal & responsiveness score on annual survey	**results available March 2012**						➡	65.80%
Reduce avoidable death, disability and chronic ill health from VTE	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using a National tool	**78.10 %**	**77.76%**	**76.55%**	**76.25%**	**79.21%**	**77.88%**	⬆	90%
Local CQUINs	**Metric**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**YTD**	**Trend**	**Trust Target**
CHS Patient Experience	Increase in patient satisfaction on local real time surveys (CHS 34)	**Baseline being gathered during Q1 & Q2**						➡	
Deteriorating Patients	Increase number of correct PAR scores in 48 hr period	**83%**	**80%**	**82%**			**82%**	⬆	95%
	90% of Emergency Admissions accessed by a consultant within 24hr								
Discharge Communications	Proportion of discharge summaries sent & meeting quality criteria	**Baseline being gathered during Q1 & Q2**						➡	
	Proportion of discharge summaries sent & received within 24 hours	**Baseline being gathered during Q1 & Q2**						➡	
	Improving the timeliness and quality of discharge information (CHS 37)	**Baseline being gathered during Q1 & Q2**						➡	
End of Life Care - all adults as	Liverpool Care Pathway to be	**Baseline being gathered during Q1 of 37%**						➡	5-10%

	documented in the patient record								
agreed on LCP	Improving end of life care for people with rollout of Liverpool Care Pathway and meeting patient choice of location. (CHS 38)	**Baseline being gathered during Q1 & Q2**						➡	
	Meeting patient choice – establish Multi-disciplinary Team (MDT). Also CHS target.	**Baseline being gathered during Q1 & Q2**						➡	
	Meeting patient choice – increase referrals to palliative care centre. Also CHS target.	**Baseline being gathered during Q1 & Q2**						➡	
	90% of cases discussed at an End of life MDT							□	
	90% referred to TH Palliative Care Centre							□	
Enhanced Recovery Scheme	National database completeness	**Q1 73%**						➡	70%
	Operated on day of admission	**Q1 70%**						➡	60%
	Fluid loading - colorectal only	**100%**	**100%**	**100%**	**100%**		**100%**	➡	95%
	Reduction in median length of stay: hips, knees, Hyst, Colectomy & excision							□	
Maternity	Composite index score of 5 birth choice questions	**10% improvement on baseline position agreed**							
	All new mothers have a standardised post natal discharge meeting documented	**90% by Q4 agreed**							
Outpatient Administration	All appointments to be made within 10 working days of registration	**Baseline of 83.5% established**						➡	90%
	All outpatient consults to have GP/patient note with 5-7 working days	**include core adult /paed medical & surgical patients**						➡	
Pressure Ulcers - decreasing the numbers of	<297 Hospital ~~acquired ulcers~~ grade 1 & 2 (20%	**40**	**49**	**42**	**42**	**32**	**205**	⬆	25

	reduction)								
	<23 Hospital acquired ulcers grade 3 & 4 (30% reduction)	3	3	2	1	1	10	➡	2
	20% increase in reporting of grade 1 & 2 pressure ulcers (CHS 35)	5	5	5	6	5	26	⬆	(58) +20%
	20% reduction in grade 3 & 4 pressure ulcers (CHS 36)	1	3	1	0	4	9	⬇	(21) - 20%

Table 6: National and Local CQUIN Year to Date progress from BLT

Safeguarding adults and children summits

Summits were held in September and October respectively to consider the risks that the significant changes to the NHS landscape pose and how to ensure that safeguarding is embedded in everything we do as commissioners and how we influence our providers. Safeguarding was considered across the cluster and reflects the complex multi agency and organisational approach.

The safeguarding children summit was held on 6th September 2011 and attended by around 70 stakeholders. These included representatives from commissioners, the borough teams, providers, the Local Safeguarding Children Boards and NHS London. The safeguarding adult's summit was held on 7th October 2011 and attended by around 50 stakeholders. These included representatives from commissioners, the borough teams, providers, the local authority Safeguarding Adults Boards and NHS London.

The aims of the summits were to:

- Gain an understanding of interfaces between agencies and identify cross-cutting system wide issues
- Begun to enable Clinical Commissioning Groups to understand their role and responsibilities in relation to safeguarding
- Increase the understanding and insight of commissioners so that safeguarding adults becomes integral to how they do business
- Agree a key list of priorities (see below)

Responsibility for developing the priorities into actions with measurable outcomes will be undertaken by the cluster Safeguarding Children Commissioning Group and Safeguarding Adults Commissioning Group.

Quality Priorities for 2012/13

The priorities identified below are undergoing validation via the borough teams and CCGs and have been discussed at the October Clinical Commissioning Committee. Further work is also required to determine the most appropriate commissioning levers to be used. There are also some contextual issues to be considered including the BELH merger, preparation for the Olympics and impact of

maternity caps at BHRT. Further guidance is awaited with regard to any mandatory national or regional CQUIN schemes and the publication of the NHS operating plan.

The approach we want to develop is to concentrate on fewer more specific areas which will show specific impact and have wider effect on the culture of organisations. The following detail outlines the priorities identified from the summits for Tower Hamlets Borough:

Table 7: Child Safeguarding priorities

	Contract requirement	CQRM	CQUIN	Project / Initiative	Other
Development of a governance framework that captures all aspects of the safeguarding children agenda across health				✓	
Agree a performance management metrics dashboard that explicitly embeds safeguarding children outcomes	✓	✓	✓		
Embed safeguarding children into commissioning (e.g. by using the results of the LSCB section 11 audits to inform contract planning)	✓			✓	
Development of a safeguarding children risk register				✓	
Create standardised pathways for the child. This will require: • more effective communication across agencies and • improved engagement with children and young people				 ✓ ✓	 ✓ ✓
Develop the skills and knowledge of staff through effective and tailored training and supervision				✓	

Table 8: Adult safeguarding priorities

	Contract requirement	CQRM	CQUIN	Project / Initiative	Other
Carry out a mapping exercise to identify what contracts and arrangements are in place, in terms of: • Places of care • Types of contract • If and how safeguarding is placed within the contract • Risk assessment arrangements	 ✓ ✓ ✓ ✓			 ✓ ✓ ✓ ✓	
Provide a detailed steer to contract leads about how to monitor these contracts		✓		✓	
Develop a tailored package of training for commissioners		✓		✓	
Circulate an analysis and report of the Safeguarding Adult summit				✓	
Improve links between NHS ELC and local authorities to develop an integrated response to reports of pressure ulcers				✓	

Table 9: Barts and the London and Community Health services

	Contract requirement	CQRM	CQUIN	Project / Initiative	Other
Quality of Care Delivery Maternity Services, maintaining improvements made		✓ ✓			

Care of Older People A&E	✓			✓	
Communication Clinician to Clinician Attitude Administration – improving appointments process and letters to patients	✓	✓ ✓	✓ ✓ ✓	✓ ✓	
Data quality, audit and evaluation Scrutiny of data Using clinical audit and NICE guidance		✓ ✓	✓		
Discharge and referral Improving discharge summary information Improving referral data Safety and experience issues at these interfaces	✓	✓ ✓ ✓	✓		✓
Improving patient and staff experience Defining standards Staff voice and engagement Health inequalities Linking outcomes to investment in health visiting Referral to smoking cessation prior to operations	✓	✓ ✓	✓ ✓	✓ ✓	
Transformation Workforce and change management CHS integration and 3 way merger maintenance of standards Maintaining quality in current economic and health service changes Virtual Ward model	✓	✓ ✓ ✓ ✓		✓	

The remaining tables describe the quality profiles for both mental health and primary care and are reported at a sector level

Table 10: Quality priorities mental health – cluster view

	Contract requirement	CQRM	CQUIN	Project/ Initiative	Other
Data quality: Addressing and defining requirements and using data to drive performance		✓			
Appropriate use of capacity: Charity of model and how resources are used across pathways Child and adolescent mental health services provision	✓	✓ ✓		✓ ✓	
Patient experience and effectiveness of intervention: Therapeutic value of interventions, perception of safety, physical healthcare PROMS		✓	✓	✓	
Interface with primary care: Shifting care closer to home, joint care planning – focused on risk management of individual patients Communication – processes and systems Medication management and integrated physical and mental healthcare		✓ ✓ ✓	✓ ✓ ✓	✓	✓
Interface with acute trust and local authorities Accident and emergency department relationships Care of older people (dementia services) Input to care homes, nursing homes, supported housing		✓ ✓ ✓	✓	✓ ✓	✓

Table 11: Quality priorities primary care – cluster view

	Contract requirement	Performance Management	Project / Initiative	Other
Improving access: Information, advice and responsiveness and waiting times		✓		
Communication Providing clear information about what the offer is and the quality of the service Being listened to, concerns taken seriously, attitude of staff, communicating with each other			✓	✓
Clinical quality: Appropriate consultation skills Access to interpreting and advocacy services Revalidation and accreditation, appraisals and peer review CQC registration and clinical governance – clinical audit, reporting and learning from incidents	✓			✓
Integration Right service, right place, right time – sign posting for patients Links and interfaces between services and clearer multidisciplinary pathways				
Quality of premises Quality of facility impacts on access and quality of consultation Child friendly spaces, confidentiality, infection control, disabled access				

FINANCIAL CHALLENGES

Summary of 2011/12 Financial Position

NHS ELC has a good track record of financial stability and compliance with statutory financial duties over the past ten years. However, that level of stability needs to be judged against the relatively high levels of funding settlement over the past two to three CSR's spending rounds. The average funding increase received by ELC PCTs in the previous CSR was around 5.5 %. This was even higher during the previous CSR at 9% and over. The current CSR is assumed to apply for the whole of the CSP refresh period to 2014/15 and has been set 1.96%-2.59% - the first figure being the current year and the second the end year growth received by ELC PCTs. This is the lowest historic level of growth in the NHS for the past 20 years.

Current Financial Position

The table below shows the Month 7 Financial position for the Cluster.

East London and the City Financial Position

Month 7 October 2011

Commissioner Function	EAST LONDON AND THE CITY				
	Annual Allocation £000's	Budget to date £000's	Actual to date £000's	Variance to date £000's	FCOT Variance £000's
Direct Commissioning					
GP Services	117,109	67,467	68,968	1,501	1,731
Dental Services	37,034	21,518	21,525	8	0
General Ophthalmic services	8,570	4,999	4,934	(65)	(109)
Community Pharmacy Services	24,628	14,366	14,616	250	417
GP ICT	1,670	974	974	0	0
Other Direct Commissioning Costs	12,996	7,942	6,977	(965)	(878)
Sub-total	**202,007**	**117,266**	**117,994**	**729**	**1,161**
Commissioning Support Services					
Learning Difficulties	11,329	6,608	6,695	87	149
Mental Health	188,532	111,656	111,782	126	140
Acute and General	669,704	397,852	401,303	3,452	5,992
Specialist and Tertiary	64,415	37,670	37,474	(195)	(464)
Community Services	170,004	99,025	99,028	4	6
Primary Care	21,039	13,778	13,825	47	100
Prescribing	101,103	58,889	59,967	1,078	1,482
Other Healthcare Purchased	61,151	37,785	39,523	1,736	3,342
	0	0	0	0	0
Sub-total	**1,287,277**	**763,263**	**769,597**	**6,335**	**10,747**
Corporate Services	50,959	30,582	29,181	(1,401)	0
Public Health	18,513	10,803	10,204	(599)	0
Reserves	51,169	0	(530)	(530)	(530)
Gross Expenditure	**1,609,925**	**921,914**	**926,446**	**4,534**	**11,378**
Total Resource Limit	(1,634,780)	(936,414)	(936,414)	0	0
(Surplus)/Deficit Commissioner Function	**(24,855)**	**(14,500)**	**(9,968)**	**4,534**	**11,378**

The cluster set a surplus budget of £24.8 million for the current year and expects to achieve this provided that there is no significant increase in the run-rate for acute over-performance during the second half of the year. Plans are phased to take account of seasonality. However, this is not a guarantee that costs can be contained within plan should there be more severe winter pressures than anticipated. At the end of month 7 there is a cluster ytd variance from plan of £4.5 million and a forecast year-end variance from plan of £11.4 million containable within existing contingencies

Plan variance is driven by overspends at Newham and Tower Hamlets PCTs. The overspends are within various directorates including Acute, Non Acute, Direct Commissioning and Prescribing.

The main risks for the cluster include:

- Acute contract potential over performance – this is currently an 'in year' problem at Newham PCT and an underlying problem at Tower Hamlets PCT. The potential 'unwinding' of non-recurrent tolerances next year would leave Commissioners with a significant QIPP issue for 2012/13 and this has been factored into the 'Do Nothing' financial gap.

- Over-spending against Primary Care budgets - in particular APMS agreements and PCT-run practices is an issue at all three PCTs.

- Prescribing- the use of PPA (Prescription Pricing Authority) forecasts suggest large potential overspends on prescribing budgets for which action plans have been developed.

- Non acute commissioning - There appears to be increased expenditure in the Cluster on all aspects of non acute commissioning including LD (Learning disability), Continuing Care and YPD (Young Physically Disabled). Recovery plans are in place to verify expenditure and determine where appropriate reductions and savings can be made.

Action plans have been developed within both PCTs to identify savings to reduce the level of overspend. The FIMS month 7 financial return forecasts that the cluster £24.8 million surplus will be achieved. The existing forecast adverse variance against plan is currently covered off with available contingencies plus budgetary slippage and other available flexibilities. It is assumed that this forecast variance will not significantly worsen. Additional benefits arising from in-year recovery plan savings for NHS Tower Hamlets and NHS Newham have not been factored in at this stage.

QIPP Delivery In-year

The Cluster 2011/12 QIPP Plan is a key element of its financial strategy. For month 7 the FIMs returns are not showing any material bottom-line movements in QIPP financial delivery.

Financial Planning Assumptions for 2011/12 to 2014/15

The financial planning assumptions used by the cluster are consistent with the NHS planning assumptions issued by the DH – see below. NHS ELC PCTs are assumed, for planning purposes, to be at 'floor' levels of NHS growth. Consequently, the current year average cluster growth is also assumed for years 2, 3 and 4 of the CSP.

Assumption	Source	2011/12	2012/13	2013/14	2014/15
Assumptions for adoption pan-London					
Base year	2011/12 Operating plans are to be the Base Year. These will be adjusted with current year experience of QIPP delivery, Over performance and agreed to the latest 2011/12 Forecast out turn				
Bottom Up Financial Plans	The plans will be built up from CCG level to PCT level to finally Cluster level				
Community providers	All clusters will have disposed their community arms apart from ONEL				
Running costs	For all clusters the **planned running costs after savings** will be assumed to carry on to 2012/13 and for the remaining years.				
Funding levels	Actual allocated growth for 2011/12.	1.96%	1.96%	1.96%	2.84%
	Social Care funding	Advised on a PCT basis	Advised on a PCT basis	tbc	tbc
Inflation – non-pay	2011/12 DH Operating framework assumption	2.50%	2.50%	2.50%	2.50%
Efficiency Assumption		-4.00%	-4.00%	-4.00%	-4.00%
Tariff inflator / deflator		-1.50%	-1.50%	-1.50%	-1.50%
Inflation – pay	1% assumed impact of increases for those earning less than £21k. 2013/14 per non-pay inflation.	1.00%	1.00%	2.00%	2.00%
		This is a holding assumption.			
Contingency Requirement	Standard requirement	0.50%	0.50%	0.50%	0.50%
Surplus Requirement	Standard requirement	Minimum 1.0% of RRL			
		Surplus from a previous can be carried forward to the next and spent and in following year a surplus > 1% should be generated			
Non-recurrent investment reserve	Standard requirement	2% of RRL			
		2% is assumed to be spent each year Non- Recurrently			
GP £2/ Head contribution	By List size	£2.00	£2.00		
		£2 per head assumed to be spent in respective years			
Inflation Prescribing	**Local discretion to be applied, subject to expected minimum of 4% growth. The data source must be provided and its use supported. Sign-off must be obtained from the cluster prescribing lead.**				
Demographic Growth	**Local discretion to be applied, subject to: A published data source being used, although GLA(revised) lower case is generally assumed to be the starting point. Clusters can increase to GLA Midrange provided this is signed of by their respective Director of Public Health.**				
Non-demographic Growth	**Local discretion to be applied, subject to: The data source being provided; The growth used is based on historical experience/evidence; There is a separation between elective, non-elective, outpatient and A&E Growth, community services, primary care and mental health and; The level of growth is approved and signed-off by clinicians, providers and the cluster.**				
Risk Pooling	***Local discretion to be applied, subject to:The level of risk pooling is approved and signed-off by clinicians, providers and the cluster.***				

The cluster has used the standard set of assumptions issued by NHSL to model finance and activity up to and including 2014/15. The assumptions are in two parts. The first set is pan-London assumptions that must be adopted (e.g. general inflation). The second set is for local determination within a defined methodology (e.g. demographic and non-demographic growth).

Pan-London/National Planning Assumptions

1. The baseline activity data used in the planning is 2011/12 actual plan. Compound annual growth rates are then applied across each year of the plan. These consist of;
    1.1. Demographic cost pressures caused by population growth. The Cluster has one of the highest projected population increases in England over the next ten years. More detail on this is supplied in the section on population growth.

1.2. Non-demographic components. Both the demographic and non-demographic CAGR uplifts are the same as those used in the current version of the CSPs and the H4NEL Business Case.
1.3. Inflation - assumed at 2.5% for planning purposes across all healthcare contracts.
1.4. Efficiency requirements – assumed at 4% on all healthcare contracts except Primary care.

2. All NHS Providers except GMS/PMS/APMS and GDS receive the same net inflation uplift as is applied to acute tariff activity costs. Net tariff deflation is therefore assumed at the same rate over the period as for the acute sector –minus 1.5% tariff deflator throughout the 4 year lifecycle of the CSP to 2014/15.
3. CQUIN remains at 1.5% but the national uplift to 2.5% in 2012 is a risk. However this may be offset by further tariff deflation so is left at 1.5% in the CSP.
4. For Primary care contracts a net uplift of 0.5% is applied per national guidance.
5. Inflation of 1.5% has been applied to the PCT running costs. All national running cost savings requirements have been delivered in full in 2011/12.
6. 0.5% of resources is required to be held as uncommitted contingency in each year of the plan.
7. A non-recurrent investment reserve of 2% is factored into each year of the plan.
8. A 1% target for surplus in each year is factored into each year apart from the current year where planned surpluses are included.
9. PCT-own CHS have been integrated with other Providers as at CSP plan date.

Cluster Assumptions

Summary CSP assumptions are shown in the Table below:

1. All PCT's are required to bridge their in-year or underlying financial gaps. It is not permissible to count the 2011/12 surplus against QIPP plans for 2012/13.
2. 2011/12 surplus carried forward may be allowed to fund both non-recurrent uncommitted contingency and for non-recurrent investment such as 'pump-priming' of QIPP initiatives
3. Demographic growth assumptions for each of the PCTs are as per the previous version of the CSP and agreed with Borough Directors of Public Health.

    a. City & Hackney PCT – GLA revised low population model
    b. Newham PCT – GLA revised low population projection model
    c. Tower Hamlets PCT – As per 2011/12 CSP - localised planning model developed in partnership with the Borough of Tower Hamlets.

    There is population growth of about 80,000 people during the CSP timeframe with total additional costs of ca £145 million by 2014/15.
4. Non-demographic growth assumptions are applied at a flat 1% in line with the H4NEL business case.
5. Demographic and non-demographic growth assumptions have been applied at POD, Speciality and HRG chapter level for acute activity. Default growth values are applied to all other acute activity. For all other activity Demographic growth factors are applied to the gross contract value.
6. Prescribing costs include demographic and non-demographic factors as well as inflation and are assumed to increase between 8% per annum net based on historic trends and before QIPP plans.

The table below summarises the planning assumptions within the PCT and Cluster CSPs

Summary Assumptions in the Cluster CSP

Growth Category	Setting	City & Hackney	Tower Hamlets	Newham	Cluster Average
Demographic	GP Core Contract services	2.56%	1.00%	1.00%	1.52%
	Other Primary Care	2.25%	3.00%	3.00%	2.75%
	Prescribing	9.08%	8.50%	10.50%	9.36%
	Acute	2.25%	5.15%	4.31%	3.91%
	CHS Community Services	0.50%	0.50%	0.50%	0.50%
	Mental Health	0.50%	0.50%	0.50%	0.50%
	Specialist & Tertiary	2.50%	2.50%	2.50%	2.50%
	Other Healthcare - NCA's etc	2.50%	12.07%	4.88%	6.48%
	Running Costs	0.00%	0.00%	0.00%	0.00%
	Public Health Admin/Team Costs	0.00%	0.00%	0.00%	0.00%
Non-Demographic	GP Core Contract services	1.00%	1.00%	1.00%	1.00%
	Other Primary Care	1.00%	1.00%	1.00%	1.00%
	Prescribing	1.00%	1.00%	1.00%	1.00%
	Acute	1.00%	1.00%	1.00%	1.00%
	CHS Community Services	1.00%	1.00%	1.00%	1.00%
	Mental Health	1.00%	1.00%	1.00%	1.00%
	Specialist & Tertiary	1.00%	1.00%	1.00%	1.00%
	Other Healthcare - NCA's etc	1.00%	1.00%	1.00%	1.00%
	Running Costs	0.00%	0.00%	0.00%	0.00%
	Public Health Admin/Team Costs	0.00%	0.00%	0.00%	0.00%
Inflation	GP Core Contract services	2.50%	2.50%	2.50%	2.50%
	Other Primary Care	2.50%	2.50%	2.50%	2.50%
	Prescribing	2.50%	2.50%	2.50%	2.50%
	Acute	2.50%	2.50%	2.50%	2.50%
	CHS Community Services	2.50%	2.50%	2.50%	2.50%
	Mental Health	2.50%	2.50%	2.50%	2.50%
	Specialist & Tertiary	2.50%	2.50%	2.50%	2.50%
	Other Healthcare - NCA's etc	2.50%	2.50%	2.50%	2.50%
	Running Costs	1.50%	1.50%	1.50%	1.50%
	Public Health Admin/Team Costs	1.50%	1.50%	1.50%	1.50%
Efficiency	GP Core Contract services	-2.00%	-2.00%	-2.00%	-2.00%
	Other Primary Care	-4.00%	-4.00%	-4.00%	-4.00%
	Prescribing	-4.00%	-4.00%	-4.00%	-4.00%
	Acute	-4.00%	-4.00%	-4.00%	-4.00%
	CHS Community Services	-4.00%	-4.00%	-4.00%	-4.00%
	Mental Health	-4.00%	-4.00%	-4.00%	-4.00%
	Specialist & Tertiary	-4.00%	-4.00%	-4.00%	-4.00%
	Other Healthcare - NCA's etc	-4.00%	-4.00%	-4.00%	-4.00%
	Running Costs	0.00%	0.00%	0.00%	0.00%
	Public Health Admin/Team Costs	0.00%	0.00%	0.00%	0.00%
Non-recurrent headroom		2.00%	2.00%	2.00%	2.00%
Uncommitted Contingency		0.50%	0.50%	0.50%	0.50%

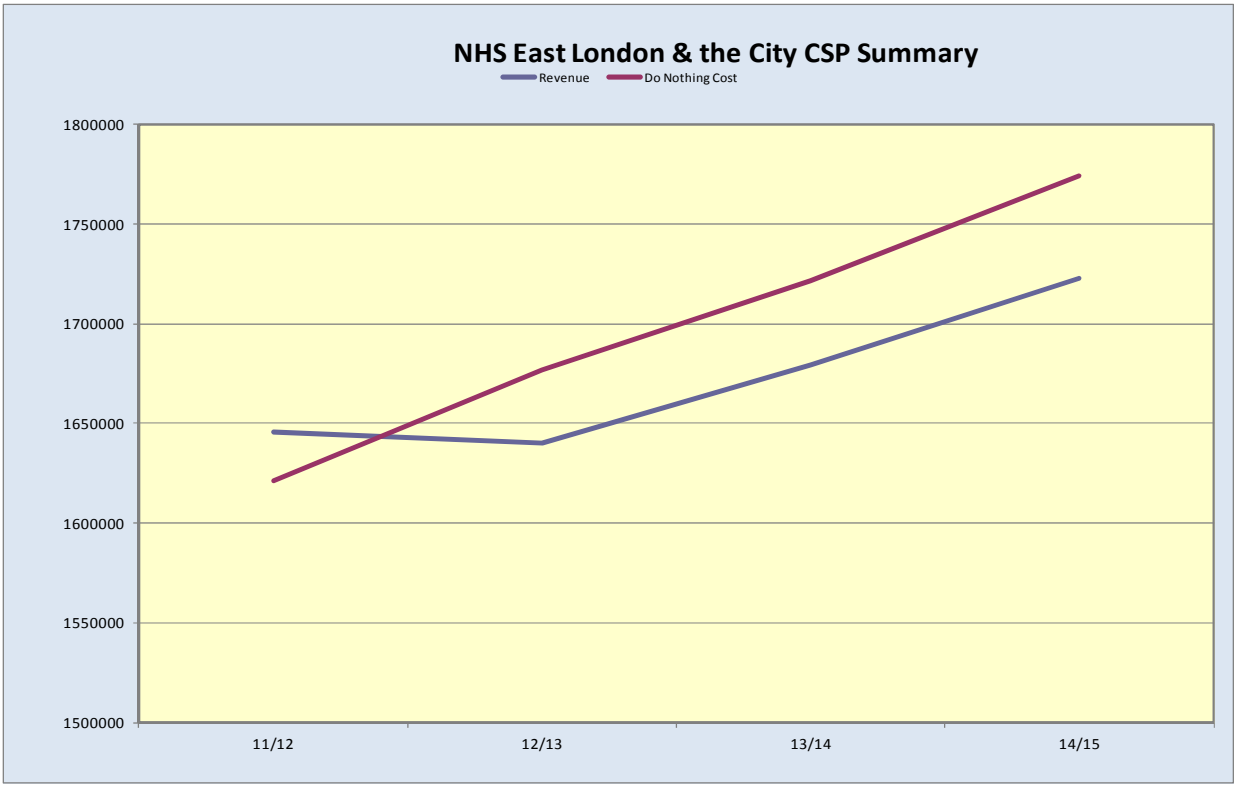
NHS ELC Cluster Financial Case for Change - CSP 2011/12 to 2014/15

The cluster has used the standard set of assumptions issued by NHSL for CSP planning but with local assumptions for the key demographic and non-demographic growth drivers which are outlined in the section on financial planning assumptions. Revenue assumptions are based on the formal Revenue Resource Limits - RRLs - plus the other ring fenced allocations in the exposition booklet,

uplifted by the growth contained in the CSP planning assumptions. The graph below shows the relationship between revenue and cost on a 'Do Nothing' basis.

Graph – Case for Change Financial Projections

The graph below shows the Cluster moving from surplus to deficit in 2012/13 and the in-year deficits growing bigger every year thereafter. The table below that gives the financial values for each year as well as the cumulative deficits across all four years of the CSP.



		11/12	12/13	13/14	14/15
Cluster	Revenue	1645920	1640343	1679579	1722711
Cluster	Do Nothing Cost	1621063	1676585	1721520	1773944
Cluster	In-year deficit	24857	-36241	-41940	-51233
Cluster	Cum deficit	24857	-11384	-53325	-104558

The current year surplus of £24.8 million becomes an in-year deficit of £36.3 million in 2012/13, rising to £51.2 million by 2014/15. The cumulative deficit for the cluster is £104.6 million by 2014/15. The Table below shows how these costs build up in each of the four years of the CSP period using the planning assumptions outlined in the section above.

NHS ELC - CSP Scenario Planning 2012-2015 Underlying baseline Position

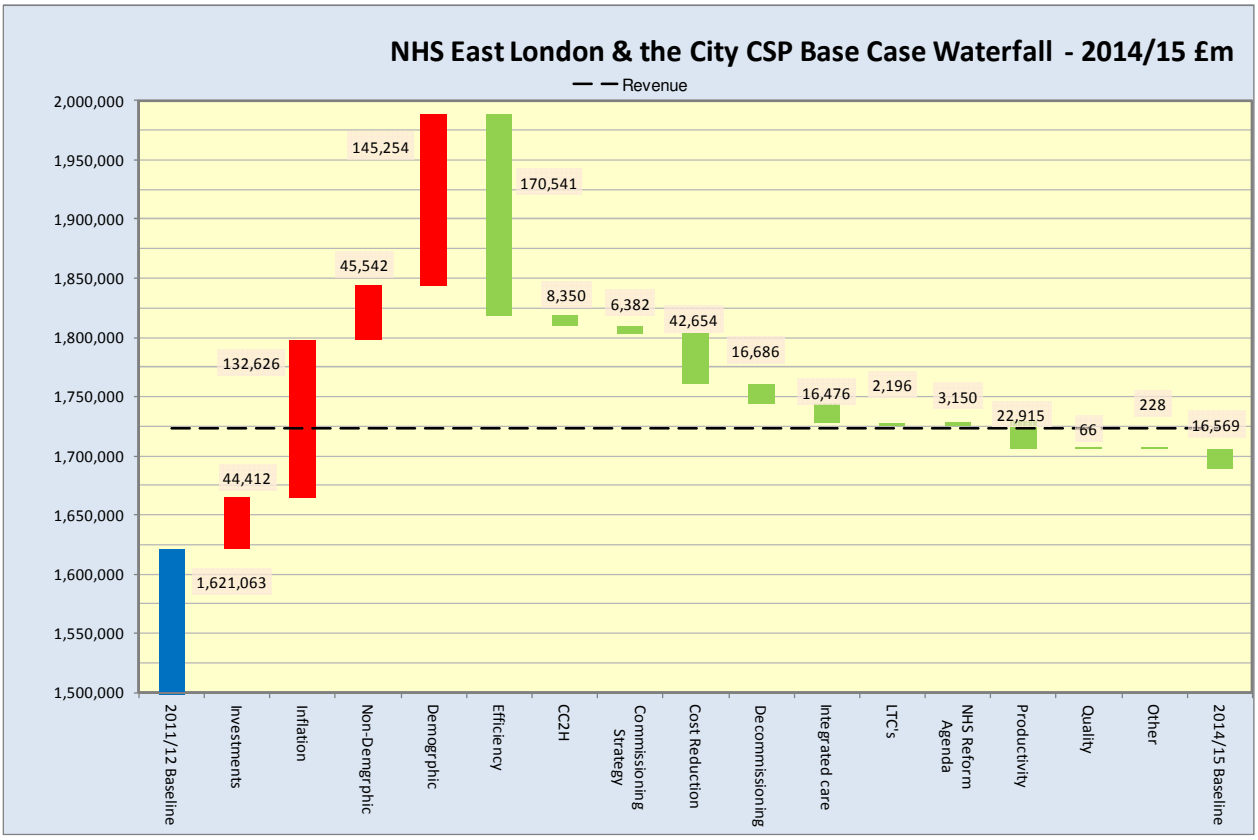
PCT	Expenditure Category	11/12	12/13	13/14	14/15
Direct Commissioning	GP Core Contract services	£117,608	£121,146	£124,644	£128,968
Direct Commissioning	Dental Contracts	£37,034	£37,784	£38,693	£39,793
Direct Commissioning	General Opthalmic Services	£8,570	£8,842	£9,055	£9,317
Direct Commissioning	Community Pharmacy Services	£24,628	£26,103	£27,221	£28,437
Direct Commissioning	GP ICT Services	£1,670	£2,004	£2,405	£2,886
Direct Commissioning	Other Direct Commissioning	£12,997	£13,296	£13,649	£14,032
CSS	Acute	£651,360	£673,479	£693,641	£718,639
CSS	CHS Community Services	£170,004	£170,004	£170,004	£170,004
CSS	Learning Difficulties	£14,679	£15,494	£15,881	£16,352
CSS	Mental Health	£187,587	£187,587	£190,401	£193,257
CSS	Prescribing	£103,440	£111,715	£120,652	£130,305
CSS	Specialist & Tertiary	£64,415	£65,703	£67,017	£68,358
CSS	Non-Core PCC - LES's, CC2H etc	£21,040	£21,513	£22,026	£22,610
CSS	Other Healthcare - NCA's etc	£62,012	£65,789	£67,477	£69,412
Corporate	Corporate Services	£51,542	£52,315	£53,100	£53,896
Corporate	Public Health Admin/Team Costs	£16,239	£16,483	£16,730	£16,981
Corporate	2% Non Recurrent Reserve	£30,594	£31,114	£31,852	£32,677
Corporate	0.5% Contingency	£8,230	£8,202	£8,398	£8,614
Corporate	Social Care Contribution	£11,141	£11,378	£11,648	£11,950
Corporate	Other	£26,273	£20,230	£20,230	£20,230
Corporate	1% Surplus Requirement	£0	£16,403	£16,796	£17,227
CH	Total Cost in Year	£1,621,063	£1,676,585	£1,721,520	£1,773,944
CH	Recurrent Revenue Funding	£1,645,920	£1,640,343	£1,679,579	£1,722,711
CH	Surplus/(Deficit) in Year	£24,857	(£36,241)	(£41,940)	(£51,233)
CH	Cum Surplus/(Deficit) inc carry over	£24,857	(£11,384)	(£53,325)	(£104,558)

The costs shown in the table above have been generated by the Cluster planning model. Costs are shown in-year and compared to revenue funding assumptions to produce a notional deficit in-year and cumulatively. For planning purposes they are currently grouped by 'end-state' category although this may change over the next months as greater detail emerges on the future NHS Operating Model. These are currently;

- Direct Commissioning – all contracts likely to be transferred to the national Commissioning Board. This includes; core GMS and APMS contracts, dental services, ophthalmology and community pharmacy.
- CSS – all contracts currently administered by the Cluster commissioning support services (CSS). Budgets which have been delegated to CCG's are included within this functional area as is specialised commissioning for the time being.
- Corporate – Public Health team costs, 'stranded function' costs, reserves, contingencies and non-CCG running costs

QIPP Plan

The bridge analysis below outlines how the 2011/12 cost baseline increases over the CSP period. The analysis also shows the impact of QIPP plans on the financial gap.



Cluster Summary Bridge Analysis	Running Total £K	Growth/Saving £K
2011/12 Plan Cost	**£1,621,063**	**£0**
Planned Investments	£1,665,475	£44,412
14/15 Inflation	£1,798,101	£132,626
14/15 Non-Demographic Growth	£1,843,643	£45,542
14/15 Demographic Growth	£1,988,897	£145,254
14/15 Efficiency Savings	£1,818,356	-£170,541
CC2H	£1,810,006	-£8,350
Commissioning Strategy	£1,803,624	-£6,382
Cost Reduction	£1,760,970	-£42,654
Decommissioning	£1,744,284	-£16,686
Integrated Care	£1,727,808	-£16,476
LTC's	£1,725,612	-£2,196
NHS Reform Agenda	£1,728,762	£3,150
Productivity	£1,705,847	-£22,915
Quality	£1,705,913	£66
Other Saving	£1,706,141	£228
2014/15 Projected Costs		**£1,706,141**

In this version of the CSP the bridge analysis and QIPP plan is grouped under the following summary headings but this will change if a London-wide taxonomy is issued for further versions;

- 2011/12 Plan cost – the current year plan which is £1.62 Billion.
- Planned investments – £44.4 million is the cost of new investments which support the QIPP plan. The main areas for investment of new QIPP funding being Urgent Care/Integrated Care, maternity and Cancer services. The non-recurrent investments for developing Integrated Care systems are reflected in the risk management section of this paper and will be developed further as commissioners work up their final QIPP plans.
- 14/15 Inflation – £132.6 million is the impact of inflation on the cost baseline across the three years of the CSP.
- 14/15 non-Demographic growth – £45.5 million is the cost impact of new technologies, NICE etc across the CSP period.
- 14/15 Demographic growth – £145.3 million is the impact of population growth in cost terms across the CSP period. This is the single most significant cost increase in the CSP and reflects the population projections for the Cluster.
- 14/15 Efficiency savings - £170.5 million is the total efficiency requirement in the plan.
- CC2H – £ 8.35 million of Care Closer to Home initiatives. These may be included under Integrated Care as plans are developed.
- Commissioning strategy – £6.4 million of savings from key strategic commissioning themes such as Urgent Care and the implementation of 111. Again, this may be reprofiled under the Integrated Care heading as plans are worked up.
- Cost Reduction – £42.7 million of savings including the reduction of Primary care prescribing budgets, a 'Star Chamber' review of existing expenditure plus re-procurement of existing contracts.
- Decommissioning – £16.7 million savings from the cessation of specific services hitherto commissioned.
- Integrated care – £16.5 million saving from Integrated Care plans. Detailed plans will be worked up over the next few months.
- Long-term conditions – £2.2 million QIPP plans focussed on delivering key benefits in the main LTC areas such as Diabetes, CHD and COPD. These will be moved into the 'Integrated Care' workstream as plans are developed.
- NHS reform agenda – £3.1 million net cost of QIPP initiatives associated with the DH Policy such as the increase in health Visitor numbers.
- Productivity – £22.9 million savings mainly from Acute Providers. This savings assumption does not impact Providers beyond existing CSP assumptions.
- Quality – a modest cost of initiatives intended to improve the existing quality of services.
- Other – all other QIPP initiatives.

Population Growth Costs and Funding in the CSP Model

It is worth noting that the financial impact of Demographic growth during the CSP is £145 million as shown in the Sector summary waterfall data table above. The projected population increase during

the CSP is shown in the table below which is an update of the GLA 2009 round central projection revised in August 2010. The extract shows an increasing Cluster population across the CSP period to 2015. The population increases by around 56,200 headcount in the GLA model and 22,100 in the ONS model. The bottom table shows the variation between GLA and ONS and this is a proxy for the extent to which there is no population growth funding within the allocations formula. The variation for the Cluster is an absolute figure of 80,000 headcount by 2015. At the same time ONS/GLA relationship for the projected population for London is shown as decreasing with less population assumed overall for London in the GLA model compared to ONS projections. However, if one compares the projected GLA population in 2015 for the Cluster of 802,600, with the ONS 2011 population of 704,500, the difference is 98,100. It is mainly this variation between projected population and the population assumptions in the national resourcing model, which drives demographic cost increases in the CSP.

Summary of GLA Low revised and ONS Populations

Data	BORO	2010	2011	2012	2013	2014	2015
GLA 2009 Round Central Projection - REVISED aug 2010	City and Hackney	238.5	241.2	243.2	245.2	247.2	249.2
	Newham	265.7	267.9	272.7	277.4	282.0	286.5
	Tower Hamlets	242.1	248.7	253.4	258.0	262.5	266.8
	INEL	746.4	757.8	769.3	780.6	791.7	802.6
	London	7745.5	7806.8	7861.9	7916.4	7970.3	8023.7
	England	52198.2	52577.1	52954.0	53332.0	53709.9	54087.9
ONS 2008 based estimates projections	City and Hackney	226.6	228.3	229.9	231.2	233.3	234.9
	Newham	239.9	239.1	238.4	238.3	237.6	237.5
	Tower Hamlets	233.7	237.1	240.5	243.5	246.8	249.9
	INEL	700.2	704.5	708.8	713.0	717.7	722.3
	London	7799.0	7868.0	7937.5	8006.5	8074.7	8140.9
	England	52198.2	52577.1	52954.0	53332.0	53709.9	54087.9
Total Sum of GLA 2009 Round Central Projection -REVISED aug 2010		**118665.7**	**119537.3**	**120401.7**	**121267.4**	**122131.9**	**122995.4**
Total Sum of ONS 2008 based estimates projections		**118638.6**	**119504.1**	**120367.0**	**121233.7**	**122098.6**	**122961.8**

GLA minus ONS 2001 to 2021	BORO	2010	2011	2012	2013	2014	2015
1.0	City and Hackney	11.9	12.9	13.3	14.0	13.9	14.3
2.0	Newham	25.8	28.8	34.3	39.1	44.4	49.0
3.0	Tower Hamlets	8.4	11.6	12.9	14.5	15.7	16.9
4.0	INEL	46.2	53.3	60.5	67.6	74.0	80.3
5.0	London	-53.5	-61.2	-75.6	-90.1	-104.4	-117.2
6.0	England	0.0	0.0	0.0	0.0	0.0	0.0

The analysis above shows that NHS ELC is carrying the impact of up to 100,000 headcount population growth in its CSP which has no obvious source of funding within the existing allocations formula. It is also worth noting that the revised ACRA modelling in the new weighted capitation formula further degrades the weighting of health Inequalities and poverty markers. The underlying principle of the weighted capitation formula is to distribute resources based on the relative need of each area for health services. For this reason, it is also sometimes referred to as a fair shares formula. The aim of the current formula is to enable PCTs to commission similar levels of health services for populations with similar need, with the further objective since 1999 of helping to reduce avoidable health inequalities.

The weighted capitation formula has informed recurrent revenue allocations of £85 billion to PCTs in 2011-12. Under the formula, PCT target shares of the available resources are based on their share of the England population, with these shares adjusted, or weighted, to account for their population's needs for health services relative to that of other PCTs.

Four elements are used to set each PCTs actual allocations:

(a) target allocations at the start of the year - determined by the weighted capitation formula. The formula sets each PCTs target share of available resources based on PCT populations adjusted for

- their age distribution (PCTs with more elderly populations have higher target allocations, all else being equal)
- additional need over and above that relating to age (PCTs with less healthy populations and higher levels of deprivation have higher allocations, all else being equal)
- unavoidable geographical differences in the cost of providing services.

(b) recurrent baselines at the start of the year – which are the previous year's actual allocations adjusted, for example, for any newly devolved central budgets and transfers of responsibilities and their associated budgets between PCTs.
(c) distances from targets (DFTs) – which are the differences between (a) and (b) above. If (a) is greater than (b), a PCT is said to be under target. If (a) is smaller than (b), a PCT is said to be over target.
(d) pace of change policy. PCTs do not receive their target allocations immediately but are moved towards their targets over a number of years. Pace of change policy sets the differential growth in allocations which PCTs receive each year. This typically entails a minimum, or floor, level of growth which all PCTs receive to deliver on national and local priorities, plus higher growth for under target PCTs. The PCTs furthest under target receive the highest growth to move them closer to their target allocations. Pace of change policy is decided by Ministers for each allocations round.

Below is a table tracking the movement in 'distance from target' allocations (DfT) for all London PCTs from 2006-07 to 2011-12. Target allocations are as calculated by the allocation formula in use at that time and are not the same as actual allocations. A 'pace of change' mechanism was in place to give 'under target' PCTs more growth funding and 'over-target' PCTs less up to 2007-08 but thereafter Cluster PCTs have received no further funding for either target funding or population growth. For 2008-09 the DH was debating the allocation formula at length and the allocations were issued late that year as a one-off due to the debate around the future of the allocation formula. No DfT data was issued therefore for 2008-09 and we have to assume it is the same as for 2007-08. The Allocation formula was issued for 2009-10 but with a fundamental shift in the relative weightings between the Elderly and multiple deprivation indices, shifting theoretical target allocations away from London PCTs in general (inner London ones in particular) to PCTs with higher elderly population elements outside London.

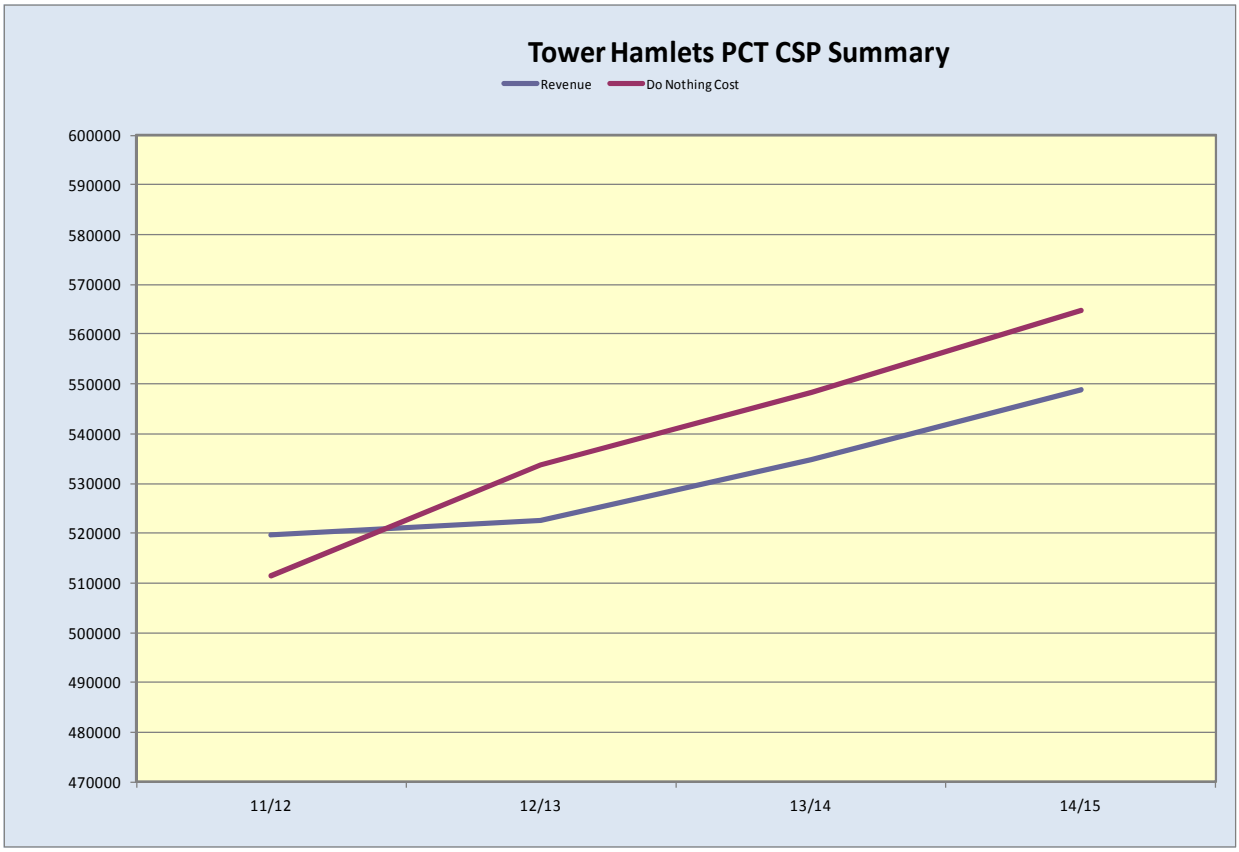
PCT	2006-07 opening DFT	2006-07 opening DFT %	2007-08 opening DFT	2008-09 No data produced	2009-10 opening DFT	2010-11 opening DFT	2011-12 opening DFT	2011-12 closing DFT	2011-12 closing DFT %
City and Hackney	-12,659	-3.5	-13,777		27,829	30,733	43,799	43,387	9.4%
New ham	-13,635	-3.5	-13,707		13,501	6,086	64,296	64,242	13.5%
Tow er Hamlets	-13,033	-3.8	-14,575		21,594	16,069	40,933	40,533	9.3%
Total	**-39,328**		**-42,059**		**62,925**	**52,889**	**149,028**	**148,162**	

Between 2006-07 and 2009-10, London moves by £436 million over-target capitation from a 2006-07 baseline of £520 million over target. During the same period, NHS ELC moves from under target capitation in 2006-07 of £39 million to 2009-10 total of £63 million over target closing 2009-10 and theoretically 'lost' £103 million recurrent target funding in terms of the allocation formula changes. This initial amendment to the allocation formula in 2008-09 was then followed by a further amendment in 2011-12 which has moved NHS ELC PCTs further over target funding to a closing figure of £148 million over target. This is a total shift in target resources during the period 2006-2011 of £187 million away from NHS ELC PCTs. At the same time, NHS ELC PCTs receive minimal NHS growth as they are now deemed 'over target capitation funding'. What it means is that London PCTs in general and ELC specifically have the minimum NHS growth possible over the cycle and will be subject to pace of change movements over the longer term which may reduce future Allocations.

NHS Tower Hamlets Financial Case for Change - CSP 2011/12 to 2014/15

The graph below shows the 'do nothing' scenario for the PCT - moving from surplus to deficit in 2012/13 and the in-year deficits growing bigger every year thereafter. The table below that gives the financial values for each year.

Graph – Case for Change Financial Projections



		11/12	12/13	13/14	14/15
TH	Revenue	519577	522491	534874	548728
TH	Do Nothing Cost	511577	533819	548202	564766
TH	In-year deficit	8000	-11328	-13328	-16039
TH	Cum deficit	8000	-3328	-16656	-32695

The current year surplus of £8 million becomes an in-year deficit of £11.4 million in 2012/13, rising to £16 million by 2014/15. The cumulative deficit for Tower Hamlets is £32.7 million by 2014/15. The Table below shows how these costs build up in each of the four years of the CSP period using the planning assumptions outlined in the section above

Tower Hamlets PCT - CSP Scenario Planning 2012-2015 Underlying baseline Position

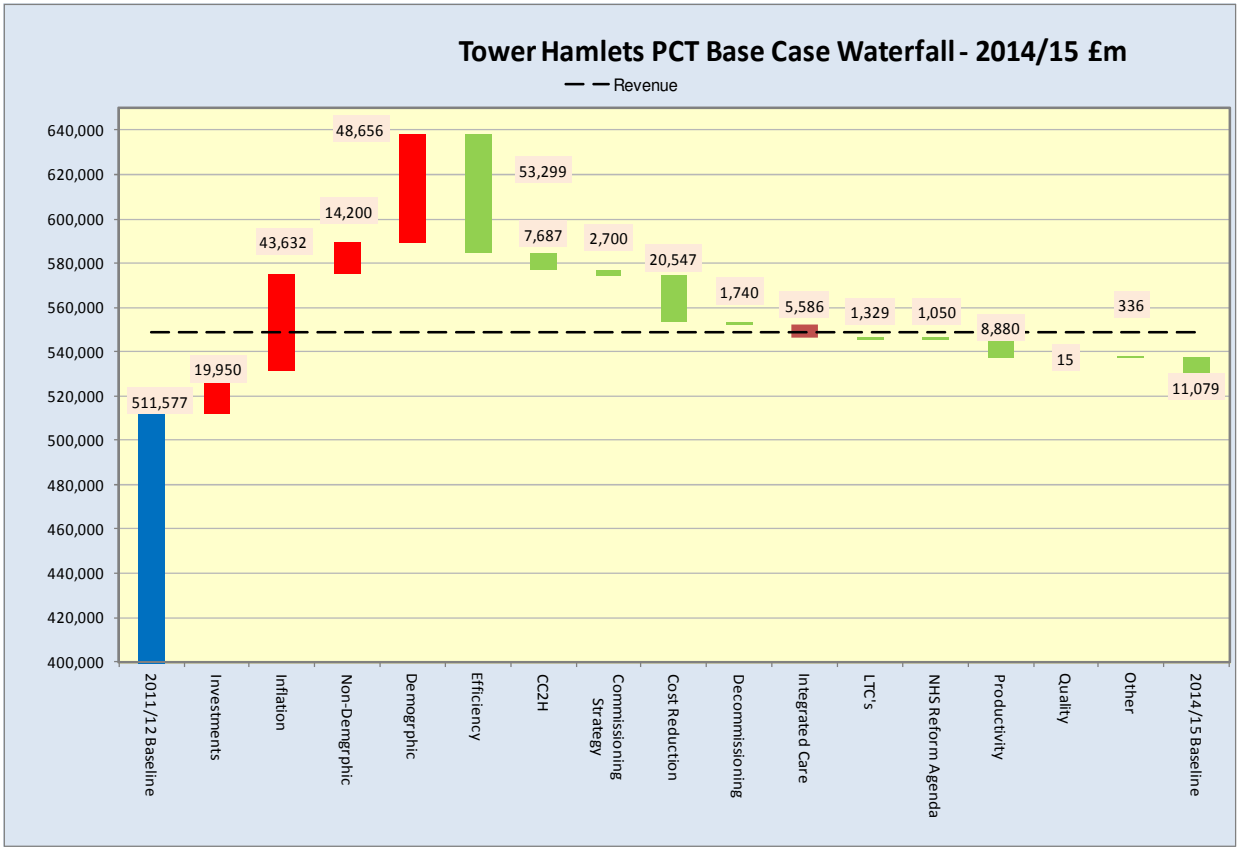
PCT	Expenditure Category	11/12	12/13	13/14	14/15
Direct Commissioning	GP Core Contract services	£36,118	£37,021	£38,095	£39,390
Direct Commissioning	Dental Contracts	£11,093	£11,329	£11,598	£11,898
Direct Commissioning	General Opthalmic Services	£2,010	£2,053	£2,101	£2,156
Direct Commissioning	Community Pharmacy Services	£7,507	£7,882	£8,276	£8,690
Direct Commissioning	GP ICT Services	£398	£478	£573	£688
Direct Commissioning	Other Direct Commissioning	£5,534	£5,672	£5,814	£5,960
CSS	Acute	£190,315	£199,242	£205,717	£213,637
CSS	CHS Community Services	£65,468	£65,468	£65,468	£65,468
CSS	Learning Difficulties	£3,350	£3,434	£3,520	£3,608
CSS	Mental Health	£56,037	£56,037	£56,878	£57,731
CSS	Prescribing	£31,968	£34,525	£37,287	£40,270
CSS	Specialist & Tertiary	£18,455	£18,824	£19,201	£19,585
CSS	Non-Core PCC - GP Presc., etc	£12,954	£13,278	£13,610	£13,950
CSS	Other Healthcare - NCA's etc	£17,252	£19,527	£20,094	£20,777
Corporate	Corporate Services	£19,547	£19,840	£20,138	£20,440
Corporate	Public Health Admin/Team Costs	£7,720	£7,836	£7,953	£8,073
Corporate	2% Non Recurrent Reserve	£9,545	£9,748	£9,979	£10,238
Corporate	0.5% Contingency	£2,598	£2,612	£2,674	£2,744
Corporate	Social Care Contribution	£3,725	£3,804	£3,895	£3,995
Corporate	Other Reserves	£9,983	£9,983	£9,983	£9,983
Corporate	1% Surplus Requirement		£5,225	£5,349	£5,487
CH	Total Cost in Year	£511,577	£533,819	£548,202	£564,766
CH	Recurrent Revenue Funding	£519,577	£522,491	£534,874	£548,728
CH	Surplus/(Deficit) in Year	£8,000	(£11,328)	(£13,328)	(£16,039)
CH	Cum Surplus/(Deficit) inc carry over	£8,000	(£3,328)	(£16,656)	(£32,695)

The costs shown in the table above have been generated by the Cluster planning model. Costs are shown in-year and compared to revenue funding assumptions to produce a notional deficit in-year and cumulatively. For planning purposes they are currently grouped by 'end-state' category although this will potentially change over the next months as greater emerges on the future NHS Operating Model. These are currently;

- Direct Commissioning – all contracts likely to be transferred to the national Commissioning Board. This includes; core GMS and APMS contracts, dental services, ophthalmology and community pharmacy.
- CSS – all contracts currently administered by the Cluster commissioning support services (CSS). Budgets which have been delegated to CCG's are included within this functional area as is specialised commissioning for the time being.
- Corporate – Public Health team costs, 'stranded function' costs, reserves, contingencies and non-CCG running costs

QIPP Plan

PCT's are required to bridge their in-year or underlying financial gaps with their QIPP plans. It will not be permissible to count the brought forward 2011/12 surplus against QIPP plans for 2012/13.2011/12 surplus carried forward may be allowed to fund both non-recurrent uncommitted contingency and for non-recurrent investment such as 'pump-priming' of QIPP initiatives. The bridge analysis below outlines how the 2011/12 cost baseline increases over the CSP period. The analysis also shows the impact of QIPP plans on the financial gap.



Tower Hamlets Summary Bridge Analysis	Running Total £K	Growth/Saving £K
2011/12 Plan Cost	**£511,577**	**£0**
Planned Investments	£531,527	£19,950
14/15 Inflation	£575,159	£43,632
14/15 Non-Demographic Growth	£589,359	£14,200
14/15 Demographic Growth	£638,015	£48,656
14/15 Efficiency Savings	£584,716	-£53,299
CC2H	£577,030	-£7,687
Commissioning Strategy	£574,330	-£2,700
Cost Reduction	£553,783	-£20,547
Decommissioning	£552,043	-£1,740
Integrated Care	£546,457	-£5,586
LTC's	£545,128	-£1,329
NHS Reform Agenda	£546,178	£1,050
Productivity	£537,298	-£8,880
Quality	£537,313	£15
Other Saving	£537,649	£336
2014/15 Projected Costs		**£537,649**

In this version of the CSP the bridge analysis and QIPP plan is grouped under the following summary headings but this will change if a London-wide taxonomy is issued for further versions;

- 2011/12 Plan cost – the current year plan which is £511.5 million.
- Planned investments – £19.9 million is the cost of new investments which support the QIPP plan. The main areas for investment of new QIPP funding being Urgent Care/Integrated Care, maternity and Cancer services. The non-recurrent investments for developing Integrated Care systems are reflected in the risk management section of this paper and will be developed further as commissioners work up their final QIPP plans.
- 14/15 Inflation – £43.6 million is the impact of inflation on the cost baseline across the three years of the CSP.
- 14/15 non-Demographic growth – £14.2 million is the cost impact of new technologies, NICE etc across the CSP period.
- 14/15 Demographic growth – £48.7 million is the impact of population growth in cost terms across the CSP period. This is the single most significant cost increase in the CSP and reflects the population projections for the Cluster.
- 14/15 Efficiency savings - £53.3 million is the total efficiency requirement in the plan.
- CC2H – £7.6 million of Care Closer to Home initiatives. These may be included under Integrated Care as plans are developed.
- Commissioning strategy – £2.7 million of savings from key strategic commissioning themes such as Urgent Care and the implementation of 111. Again, this may be reprofiled under the Integrated Care heading as plans are worked up.
- Cost Reduction – £20.5 million of savings including the reduction of Primary care prescribing budgets, a 'Star Chamber' review of existing expenditure plus re-procurement of existing contracts.
- Decommissioning – £1.7 million savings from the cessation of specific services hitherto commissioned.
- Integrated care – £5.7 million saving from Integrated Care but this may increase as plans are worked up and other programs such as CC2H are absorbed into this workstream.
- Long-term conditions – £1.3 million savings plans focussed in the main LTC areas such as Diabetes, CHD and COPD. These will be moved into the 'Integrated Care' workstream as plans are developed.
- NHS reform agenda – £1 million net cost of QIPP initiatives associated with the DH Policy such as the increase in health Visitor numbers.
- Productivity – £8.8 million savings mainly from Acute Providers. This savings assumption does not impact Providers beyond existing CSP assumptions.
- Quality – a modest cost of initiatives intended to improve the existing quality of services.
- Other – all other QIPP initiatives.

Summary

- Tower Hamlets PCT is required to make savings of £11 million in 2012/13 and ca £33 million across the CSP period to ensure financial balance.

- The current bridge analysis shows that the PCT forecast costs with QIPP plans are ca £11 million below the indicative revenue funding for 2014/15. This position includes:
    - 1% surplus in all years
    - 2% NR transition fund in all years
    - 0.5% uncommitted contingency in all years.
- Financial stability is crucial for a strong health economy and to enable Clinical Commissioning Groups to operating on a secure financial footing.
- CCGs will play a central role in the financial management and planning of health service/initiatives.
- The Tower Hamlets CSP submission and subsequent 2012/13 Operating Plan will be a crucial test for authorising the CCG for April 1st 2012.

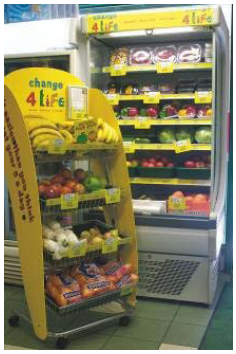
OUR PRIORITIES

		Health	Quality	Savings
Staying Healthy	Stop people, particularly young people, from starting unhealthy behaviours	✓	✓	✓
	Create a supportive environment that helps promote healthy lifestyles	✓	✓	
Patient and Public Involvement	Set up patient champions in each GP practice to support patient involvement with CCG and commissioning		✓	✓
Community Health Services	Extend the coverage of the Community Virtual Ward from one locality to cover the whole borough.	✓	✓	✓
	Review all service specifications to ensure that they comply with national standards, and maximise the effective use of Community Health Service resources.		✓	✓
Integrated Care	Roll out our Community Virtual Ward pilot across the borough, to reduce unnecessary hospital admissions	✓	✓	✓
	Support the development of Multi-Disciplinary Team working to support people with Long Term Conditions.		✓	✓
	Work with our partners in London Borough of Tower Hamlets, we will align the changes in personalisation with our care packages	✓		✓
Improving Primary Care	Independent contractors continue to improve the quality of, and access to, their services			✓
	Open 2 new primary care premises	✓	✓	
	Roll-out improvement in IT services for general practice.	✓	✓	
Planned Care	Continue our programme of delivering care pathways that are streamlined, cost-effective, and secure improved health outcomes for our population.	✓	✓	✓
	Review our pathways for the management of persistent pain	✓	✓	✓
	Review the service alert system to ensure effective interface between the primary and secondary care elements of our integrated care pathways		✓	✓

Urgent Care	Implement a new model of urgent care, linking with the East London and City early implementation of the new 111 phone system.	✓	✓	✓
	Expand our successful GP Streaming programme to include children	✓	✓	✓
	Review the Urgent Care Strategy, and the role of Walk-In centres	✓	✓	✓
Continuing Care	Fund continuing care for children, people with learning disabilities and older people	✓	✓	✓
	Review the planning and delivery of continuing care.	✓	✓	✓
Mental Health	Continue to implement the findings of the Whole Systems Review, through a range of initiatives, including the development of a new primary care mental health function.	✓	✓	✓
	Continue to implement our Dementia Strategy in partnership with the London Borough of Tower Hamlets	✓	✓	
	Review and redesign our substance misuse treatment services	✓	✓	✓
Maternity Services	Continue to improve maternity services to improve quality for pregnant women in Tower Hamlets	✓	✓	✓
	Introduce “centred” ante-natal and post-natal appointments into groups to help reduce pathway costs	✓	✓	✓
Prescribing	Continue to ensure that our prescribing practices are evidence based, and make the most appropriate use of medications for our population.	✓	✓	✓
	Investigate and implement new models of service delivery of nutritional supplies to improve medicines distribution and saving costs.	✓	✓	✓
Provider Efficiencies	Continue to improve the effectiveness and efficiency of our providers. and monitor new:follow up ratios.		✓	✓
	Review direct access pathology services to ensure both value for money and minimising duplication of requests.		✓	✓
	Decommission spinal injections in line with NICE guidance	✓	✓	✓

STAYING HEALTHY

In line with the framework of our JSNA and the Marmot review, our approach to health takes a whole of life perspective and examines the key commissioning priorities for each of these life stages. Irrespective of the life stage, we are working to address the environmental and community factors impacting on health in Tower Hamlets (e.g. food environment, built environment and exposure to second hand smoke)



We will do this by improving the food environment, physical environment and strengthening ownership and influence of communities and parents in overcoming barriers to tackling obesity through the Buywell scheme (improving provision of fresh fruit and vegetables in convenience stores), Food for Health awards, Can Do grants (grass roots, community led solutions), Food Growing programmes

We will also maximise the impact of the smoking ban on smoking prevalence by prioritising enforcement and with promotion of smoking cessation e.g. in workplaces and public facilities

Being born and early years in Tower Hamlets

We will be improving maternal health, infant nutrition (including breast feeding) and oral health and reducing obesity by age 4-5.

To help us achieve our priorities we will commission the following initiatives:

- ✓ Reduce smoking in pregnant women through Smoking Cessation in Pregnancy service
- ✓ Identify haemoglobinopathies /provide support through Counselling service
- ✓ Improve initiation and continuation of breast feeding through the Baby Friendly Initiative
- ✓ Improve nutrition in mother and baby through Healthy Start scheme
- ✓ Prevent obesity in early years through the Healthy Early Years accreditation, Cook and Eat, and Active Play programmes
- ✓ Improve oral health in children through the Happy Smiles and Brushing for Life programmes
- ✓ Implement the requirements of the Department of Health's 'A Call to Action' to expand and strengthen health visiting services, to support the delivery of the Healthy Child Programme (HCP), provide greater support and develop local community capacity that can support children and families. A review of existing specifications with community service providers to ensure a coherent fit between the Call to Action strategy and local needs, will continue, and will support planning for future health visiting requirements and expanded service coverage. A commissioning strategy will be developed for delivery in 2012/13 which will also reflect the requirements to increase a year on year planned workforce increase of 30% and to achieve this we will also work closely with NHSL in developing local plans for recruitment, return to practice placements and through the Director of Workforce and Organisational Development, the commissioning of new student placements
- ✓ Continue to commission the Family Nurse Partnership service of intensive support to vulnerable mothers from pregnancy up to the end of the first two years' of a child's life. Part of this years

plan is to utilise the JSNA to map out birth rates and demand and specifically identify issues regarding children and families. There is also an opportunity to share learning from the FNP pilot in Tower Hamlets and the Early Implementer pilot in City and Hackney.

Growing up in Tower Hamlets – children and young people

We will invest in addressing future risk factors for health (smoking, poor diet, low physical activity, obesity, problem drinking, drugs, high risk sexual behaviours) through whole systems approaches to the health of our children and young people

- ✓ Reduce childhood obesity through Active Play, Active Travel, Health Breakfast Club, Health Families, Weight Management programmes
- ✓ Reduce smoking in schoolchildren through the ASSIST Smoking Prevention programme and prioritisation of preventing underage sales of tobacco
- ✓ Prevent teenage pregnancy, support teenage parents and promote sexual health through the ASPIRE (targeted support to highest risk), Sex and Relationship Education (SRE) in school/community settings, SRE Peer- led education programmes (school/community)- Improving accessibility to sexual health services for young people through the You're Welcome (accreditation for primary care services) and C- Card (condom distribution scheme) programmes
- ✓ Review delivery of the Chlamydia Screening Programme for 15-25 year olds to increase patient treatment rates so that they to meet or exceed the London average; and to maximise the number of positive screens achieved
- ✓ Reduce alcohol and drug misuse by mainstreaming effective education in schools, improving identification and response to substance misuse in schools
- ✓ Improve health and future health of Tower Hamlets schoolchildren through the Tower Hamlets Health Schools Programme and support our vision by working with our partners in schools.

Being an adult in Tower Hamlets

Addressing behavioural risk factors for health (smoking, poor diet, low physical activity, obesity, problem drinking, drugs, high risk sexual behaviours), early identification and effective management of cancer, early identification and effective management of infectious diseases (sexually transmitted infections, HIV, TB)

To help us achieve our priorities we will commission the following initiatives

- ✓ Help people stop smoking or using oral tobacco through provision of accredited cessation services provided across a range of settings (pharmacy, general practice, community, workplace, faith based)
- ✓ Help adults in Tower Hamlets in areas of greatest deprivation lead healthier

lives through the Health Trainers and Health Champions programmes (evidence based individual and group level support delivered in community settings)

- ✓ Ensure effective and equitable delivery of the NHS Health Checks programme in partnership with primary care commissioning
- ✓ Help adults with particularly high levels of risk factors for major disease (e.g. cardiovascular disease, cancer) lose weight and increase physical activity through the Jump Start (exercise on referral), My Weigh (weight management) and Tier 3 Obesity (targeted at morbidly obese) programme**s**
- ✓ Improve early identification of HIV and sexually transmitted infections through point of care testing in Africans, men who have sex with men and intravenous drug users (both clinical and community settings)

Growing old in Tower Hamlets

To promote healthy lives in older people in Tower Hamlets we will:

- ✓ Continue to ensure older people have access to all the adult initiatives outlined in the previous section.
- ✓ This year there are no specific public health commissioning initiatives targeted at older people (i.e. commissioned by public health) although Linkage Plus has a strong public health element.
- ✓ It is an important priority for 12/13 to ensure that the programmes set out for adults (particularly health trainers, smoking cessation, weight management, and sexual health services) are serving older people in Tower Hamlets equitably.
- ✓ We will be reviewing the entire care of the elderly pathways in 2012/13, with a focus on ensuring that the care pathways are aligned the needs of our older residents.
- ✓ Continue to implement our Dementia Strategy

STAYING HEALTHY			
New Investment 2012/13	£100,000 Family Nurse Partnership £350,000 Health Visitors		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£ 500,000	£500,000	£500,000
Anticipated health and quality improvements	• Improved contractual arrangements via re-procurement will lead to more efficient services • As described in above section		

PATIENT AND PUBLIC INVOLVEMENT

INTRODUCTION

As outlined in our vision, the voice of our local residents is critical to our identification of local health needs, feedback on how our health and care services are performing and how to continuously improve services. We want to ensure that we have robust processes for ensuring that the views and experiences of our local residents inform all aspects of our commissioning.

Our local involvement network, the Tower Hamlets Involvement Network (THINk) has played an active part in canvassing local residents' experience of service, or carrying out Enter and View visits on local providers, and continues to contribute to the quality improvement agenda

2012/13 INITIATIVES

In 2012/13 as part of the restructure of health services, LINk's will be formally changing their status to bodies called 'HealthWatch' who will continue to carry on a quality monitoring function.

To support this, and to ensure the widest range of patient and public views into clinical commissioning, we will commission a new engagement infrastructure. Each GP practice have a patient group, led by a Practice Champion who will support patient engagement in our transformational programmes, as well as ensuring that local issues are dealt with effectively. These champions will in turn, through larger scale events, ensure that the patient view is clearly articulated and an integral part of the CCG processes.

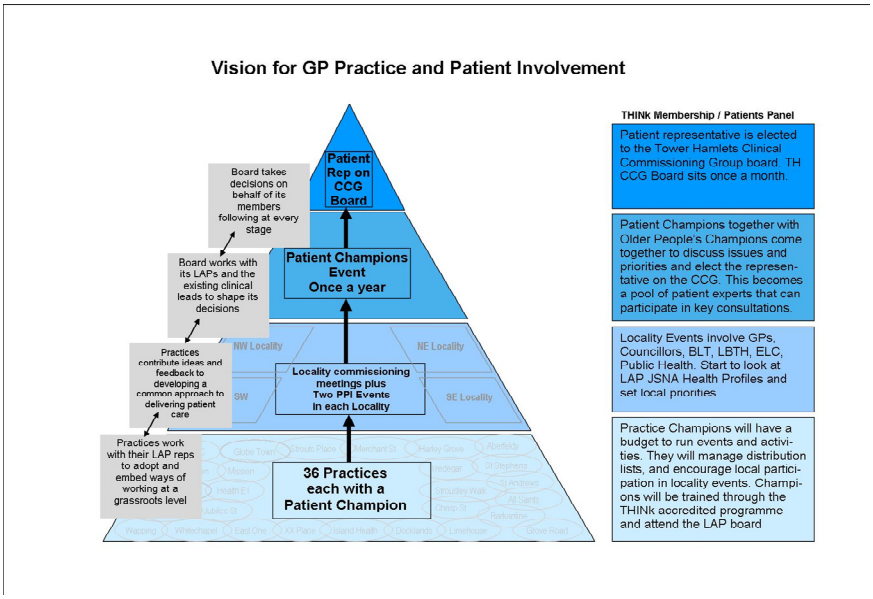


Table 12: Proposed Structure for Patient and Public Involvement

We also believe that stronger infrastructures can support patients to be able to deliver key messages within and across the Tower Hamlets community. There is the potential to add additional support to

other initiatives across our CSP. For example, if we were to use this new infrastructure to cascade messages about the cost impact of unnecessary A&E attendances, we could expect to see increased awareness and changed behaviour at practice level. Similarly embedding key commissioning messages at community level could see better medication compliance as a consequence of better understanding and education.

PATIENT AND PUBLIC INVOLVEMENT			
New Investment 2012/13	£112,000		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	- £12,000	£50,000	£110,000
Anticipated health and quality improvements	• Improved engagement of patients and the public in commissioning • Better compliance with medicines resulting in reduction in unused medications • Less A&E attendances as a result of a better informed patient community • Fewer unplanned admissions		

COMMUNITY HEALTH SERVICES

INTRODUCTION

In July 2011 Community Health Services (CHS) transferred to Barts and the London NHS Trust (BLT) through a Business Transfer Agreement and became the Trust's Community Health Division. As part of this process the Wound Care and Lymphoedema Service transferred to being a social enterprise and from November 2011 is a stand alone service outside of Barts and the London.

For 2012/13, any alteration in the BLT CHS delivery and contracting is bound by the terms of the business transfer agreement signed in July 2011. This allows the service an 18 month period of financial stability post transfer into Barts and the London Hospital NHS Trust. As a result, there are no major new developments or changes to the service but there will be a process of consolidation and a move towards a stronger commissioning position for 2013.

In 2012/12 we will build on the work already underway as part of the implementation of LTC care packages to realise the opportunities for integration of care across CH and BLT teams. We will facilitate the development of specialist teams with a broader skill mix and access to consultant level support. We will also commission community nursing as a consolidated service rather than a series of individual services, aiming to manager the health of the population we serve.

2012/13 INITIATIVES

Cost-Related Efficiency Savings (CRES)

A 2% CRES saving is being applied to BLT CHS services and during the year there will be ongoing work to increase productivity of all services provided. This productivity work will focus on:

Interpreting and Advocacy:

This initiative focuses on the existing Bilingual Health Interpreting and Advocacy Service (BHIAS). We will re-specify the level and delivery of advocacy and interpreting service, with the aim of empowering patients and ensuring an efficient and sustainable service. In 2012/13 two new specifications for 'advocacy' and 'interpreting' services will be introduced designed to meet patient's requirements and local need in a more efficient manner. Within the Advocacy and interpreting specifications we will be monitoring service transformation, use of new services, improved access to service, and carrying out activity:cost analysis so that we can verify that we receive service at the cost per activity which we have set against London benchmarked costs.

Mile End Hospital Beds

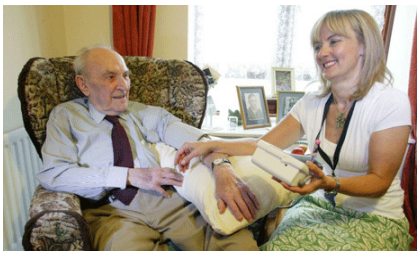
The 2009 review of Mile End Hospital (MEH) Beds showed that there were efficiencies to be made in the use of in patients' beds. CSS will work with BLT CHS to increase efficiency in bed use by ongoing review of vacant beds and improving patient flows between BLT and MEH (especially in relation to the older peoples

pathway) and developing a long term plan for an integrated older people's service in 2013/14.

Community Virtual Wards

In order to support integration into primary care settings in addition to secondary care we will continue to embed Locality Partnership Groups which bring together CHS, primary care and social care to discuss and improve services to the locality population aiming to reduce hospital admission and unnecessary use of Accident and Emergency (A&E) services. We will implement community virtual wards in Tower Hamlets to work with the patients most vulnerable to repeated hospital admission. The virtual wards allow a case management approach to identify and care for vulnerable Tower Hamlets residents at highest risk of admission and readmission. Following on from the pilot in 2011, the community virtual ward will be rolled out into the remaining 3 localities in a phased manner during 2012/13. Areas for development in the coming year include:

- ✓ The procurement and implementation of an IT interface system between secondary care and community care data
- ✓ The further involvement of social care and mental health services in the model
- ✓ The development of information sharing protocols between primary and community care with a view to expanding to social care



- ✓ Developing the use of the ward in the four localities and increasing primary and social input into the wards' patients.

We will continue to evaluate the effectiveness of the virtual ward with regards to both outcomes and process measures, both of which are reflected in the Key Performance Indicators (KPIs).

Service Specifications

Productivity will also be achieved through a re-specification of some BLT CHS services and review of service agreements. During 2012/13, we will review all service specifications within BLT CHS to ensure that they are patient-centred, compliant with national guidelines, promote the use of the BLT CHS services effectively and identify improved clinical outcomes. The aim will be to specify services which are integrated and allow for cross organisation working between acute, community and borough based services. The main areas of review and re-specification will include:

- ✓ Specifying health promotion activities (such as smoking cessation) as a core element in all services
- ✓ Embedding flu vaccination as a core role of Adult Community Nursing Service (ACNS)
- ✓ Re-specifying ACNS, and specialist nurses roles into an integrated service
- ✓ Developing service specification for an integrated cardiac service and pathway across acute and community services

- ✓ Reviewing and re-commissioning community rehabilitation services
- ✓ Reviewing the Pain Service
- ✓ Reviewing children's CHS services

Health visiting

As already mentioned in the preceding Staying Healthy section, we will continue to work with BLT CHS to develop the health visiting service to ensure that we offer an efficient and proactive service to vulnerable mothers and to young children in our borough. We will work with the health visitors to enable them to meet the national targets and also develop closer working relationships with the GP's in their area to ensure integrated working practices

End of Life Care

In parallel to the development of Integrated Cancer System (ICS) known as London Cancer, we will explore in 2012/13 the development of a lead provider for End of Life Care (EOLC) in East London and the City, to bring together all providers and engage with the ICS on end of life care services

The Delivering Choice Programme is reaching the end of stage 3 which was piloting a palliative care centre in Tower Hamlets to coordinate care and maintain a register of palliative care patients. For 2012/2013 we will confirm the method of coordinating palliative care within Tower Hamlets working alongside the ELC End of life care group and Clinical Lead. The End of Life Care facilitators in community, acute and care homes will continue in 2012/13 working with providers to develop best practice around the Liverpool care pathway, the gold standards framework and preferred place of care/death and facilitating patient's choice in their place of care.

We will continue the Tower Hamlets Locally Enhanced Scheme for palliative care in primary care to support community based services and ensure patients access best care from their primary care providers with the aim of reducing hospital admissions and deaths in hospital. This links with work in BLT to reduce the number of expected deaths in hospital

Work in Tower Hamlets will tie in with the work across ELC to develop pathways and services delivered by Specialist palliative care providers (St Josephs) which meet local need. In addition, a national roll out of the palliative care register is being coordinated alongside the 111 work with a later implementation date.

In parallel to the development of London Cancer, it is proposed to explore in 2012/13 the development of a lead provider for EOLC in ELC, to bring together all providers and engage with the ICS on end of life care services.

Outcomes and Key Milestones

Outcomes/targets	Key Milestones	Dates
Interpreting and Advocacy Services		
New specifications introduced	Renegotiate service specifications with CHS	Mar 2012
Planning	CHS start to prepare for new service provision	Mar 2012
Implementation	New service delivery commenced	April 2012
Monitoring	Quarterly monitoring of activity, service development, cost: activity ratio	Throughout 2012/13
Mile End Hospital Beds		
Reduction in bed base	Renegotiate bed base with CHS	Feb 2012
Implementation	Reduced bed base operational	April 2012
Improving patient flows	Ongoing work with older people pathway redesign group	Ongoing
Community Virtual Ward		
<15 bed days per year, per patient	Full roll out	April 2012
<10 30 day readmissions per year for TH caseload	Roll out of IT interface tool	April 2012

COMMUNITY HEALTH SERVICES			
New Investment 2012/13	£0		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£1,080,000	£1,500,000	£1,500,000
Anticipated health and quality improvements	• Cost Related Efficiency Savings of 2% achieved • District nurses to deliver flu vaccination to housebound • Increase number of people dying in the place of their choice • Reduction in unscheduled hospital admissions for flu • Reduction in unscheduled emergency admissions		

INTEGRATED CARE

INTRODUCTION

Following our participation in the Department of Health Integrated Care Pilot, integration continues to be a key priority with regards to the planning, commissioning and delivery of services. Where appropriate we are working across health and social care to align the objectives of services and ensure that providers are supported to deliver seamless care through the implementation of IT solutions and new ways of working. This approach will enable a greater number of residents to live independently in the community and reduce avoidable hospital activity.

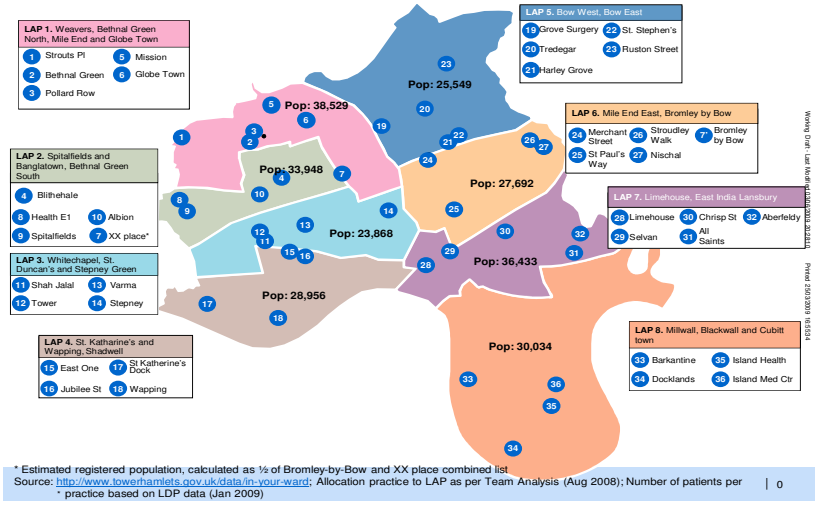
We also continue to build on the vision set out in the "Improving Health and Wellbeing Strategy" of integrated networks delivering health and wellbeing services investing over £6 million in a new model for the delivery of primary care. Our eight networks are currently delivering a range of services relating to long term conditions, health promotion and care that would previously been delivered in a hospital setting such as minor surgery, phlebotomy and anti-coagulation. These services are also designed to support the integration of care between specialist and generalist clinicians with input from hospital consultants and specialist nurses key to the delivery of the packages of care.

We will look to further embed the principles of the networks including:

- ✓ Information sharing
- ✓ The use of data to support quality improvement
- ✓ Commissioning for health outcomes
- ✓ A multi-disciplinary approach to the delivery of care
- ✓ The targeting of resource at the areas of greatest need

We will roll these principles out across a wider spectrum of primary and community care services , specifically focussing on Healthcare for Older People, to integrate further with social care through the development of integrated information sources and closer working within geographical teams.

The 36 Tower Hamlets practices and the 8 network boundaries



* Estimated registered population, calculated as ½ of Bromley-by-Bow and XX place combined list
Source: http://www.towerhamlets.gov.uk/data/in-your-ward; Allocation practice to LAP as per Team Analysis (Aug 2008); Number of patients per * practice based on LDP data (Jan 2009)

Current plan/initiatives/outcomes

Long Term Conditions

The networks are delivering a number of care packages designed to prevent and more proactively and consistently manage a range of long term conditions including Type 2 Diabetes, Cardiovascular disease and COPD. These packages also ensure that the patient is placed at the centre of their care through the adoption of 'care planning' processes to identify and support the achievement of goals co-owned by the patient and the health professional supporting them. Through adopting a more proactive, integrated and multidisciplinary approach to the commissioning of services for those with long term conditions we are continuing to build on a strategy to enable residents to stay in the community and avoid admissions to hospital.

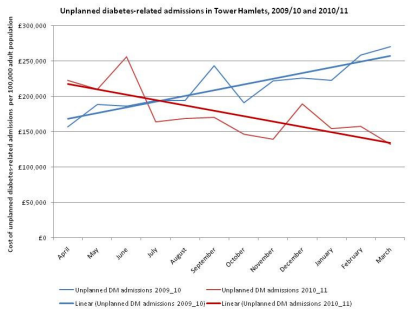
As part of this process we are strengthening relationships between primary, community secondary care, social care and mental health services. We are continuing the implementation and monitoring of the care packages and integrating care pathways around the needs of patients. We are incorporating evidence driven best practice guidance from the National Institute for Health and Clinical Excellence (NICE).

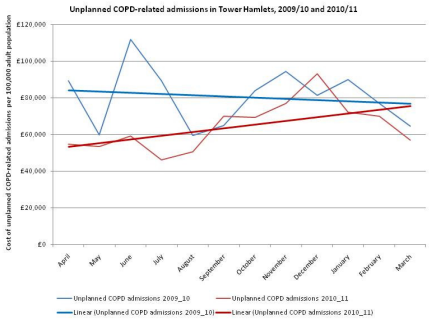
Many of the residents of Tower Hamlets living with long-term conditions have previously had admissions into hospital that may have been avoided if supported by an integrated community approach. In 2011/12 we assessed one such community model, the establishment of a Community Virtual Ward led by community matrons and with close multi-disciplinary working. The pilot took a multi-disciplinary case management approach to identifying and caring for vulnerable Tower Hamlets residents at highest risk of readmission

Care Packages

We are continuing to implement, develop and monitor the care packages (Diabetes, CVD Secondary Prevention, Hypertension, NHS Health Checks and COPD.) This will continue to focus on reducing secondary care activity through the reduction in emergency attendances and admissions due to more systematic and consistent quality of care delivered across the borough. There will also be less outpatient activity through the use of secondary care clinical expertise in community settings and support for primary and community care clinicians

The Diabetes care package was initially implemented in September 2009. Preliminary data shows that there has been a reduction in non-elective activity related to Diabetes and COPD over the past 2 years whilst activity for non-Diabetes related activity has increased as shown by the first two charts below. Both the Diabetes and COPD care packages are also showing improvements in health outcomes for patients with LTC.

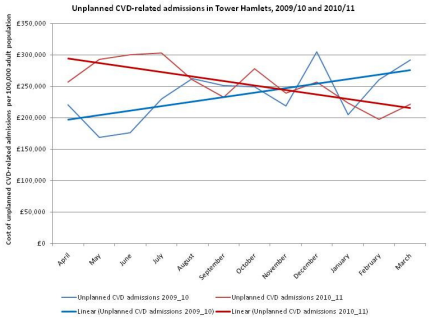




Graph 2: Unplanned Diabetes related hospital admissions

Graph 3: Unplanned COPD-related hospital admissions

In comparison the COPD admissions over the same time scale show no comparable reductions. We are currently rolling out a COPD care package and will monitor its impact in the same manner



Graph 4: Unplanned CVD-related admissions

2012/13 INITIATIVES

Long Term Conditions

Following the success of the pilot, the community virtual ward will be rolled out into the remaining 3 localities in a phased manner during 2012/13.

To help strengthen the community virtual ward in the coming year we will:

- ✓ Procure and implement of an interface system between secondary care and community care data
- ✓ Expand the model to include the involvement of social care and mental health
- ✓ Develop information sharing protocols between primary and community care with a view to expanding to social care
- ✓ Continue to evaluate the outcomes of the virtual ward looking at both outcomes and process measures, both of which are reflected in the Key Performance Indicators.

Through adopting a more proactive, integrated and multidisciplinary approach to the commissioning of services for those with Long Term Conditions we are continuing to build on a strategy to enable residents to stay in the community and avoid admissions to hospital.

As part of this process we are continuing to strengthen relationships between primary, community secondary care, social care and mental health services. We are continuing the implementation and monitoring of the care packages and integrating care pathways around the needs of patients. We are incorporating evidence driven best practice guidance from the National Institute for Health and Clinical Excellence (NICE)

Care Packages

We will continue to review the effectiveness of the care package specifications in line with NICE guidance. Recommendations will also continue to be considered from the Vascular Care Quality Group and Respiratory Strategy Group respectively.

Development of the Multi-Disciplinary Team Approach

We will continue to develop and help facilitate multidisciplinary input from clinicians across primary, community and secondary care to ensure effective outcomes. This will include:

- ✓ Supporting the continued embedding of MDT meetings at network level, as part of the COPD care package
- ✓ Sustaining MDT meetings at a network level for the other more established care packages.

We will continue to support the establishment of effective Multi –Disciplinary Teams (MDT) as part of the Community Virtual Ward and to engage key stakeholders from primary, community and secondary care as well as mental health and social care.

The work will continue to focus on reducing admissions and improving the quality of care for high risk patients with two or more LTCs. We will ensure high levels of clinical engagement, stakeholder engagement and adherence to best practice

Healthcare for Older People

During 2011/12 we have established an Older People's Delivery Group spanning, primary secondary, community and social care to review the services that are provided for and used by older people within the borough. We will be developing the remit of this group during 2012/13 and ensuring that we apply the principles embodied within the long term conditions care packages set out above to ensure a more seamless and integrated pathway for older residents. We plan to implement this work in 2013/14 with next year providing an opportunity for thorough scoping and planning of the workstreams. Specifically workstreams will look at:

- ✓ Supporting nursing and care homes to provide high quality health care for their residents
- ✓ Reviewing the pathways for older people through secondary, community, primary and social care

- ✓ Making and overseeing commissioning recommendations for the integration of pathways and a multi-disciplinary approach to care for older people

In relation to nursing homes we are looking to address the following 5 key priorities

Nursing Home priorities	
1.	Develop a joint commissioning strategy with LBTH to ensure we commission high quality services in an integrated fashion
2.	Review and refresh our current LES in line with developments in related services
3.	Develop a consistent reporting process
4.	Track action plans developed by the networks to code and report relevant activity
5.	Review the top 3 reasons for admission and develop plans to mitigate against the activity identified.

Re-ablement and Single point of access

Through adopting an integrated approach to the commissioning and provision of services across health and social care we are continuing to embed a joint strategy to support our residents to stay out of hospital and live independently in the community. Reablement continues to be both a national and local priority, the initiatives we will be implementing are critical to the reduction of non-elective activity in acute care and form a crucial element of our strategy to manage emergency activity.

The development of integrated ways of working across health and social care will enable us to learn from the personalisation work undertaken by London Borough of Tower Hamlets. As the personalisation agenda develops we will look to align it with the model of care provided by the networks and ensure that it supports and builds on the 'care planning' patient-centred approach embedded within the long term condition care packages.

INTEGRATED CARE			
New Investment 2012/13	£0		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£2,242,000	£2,242,000	£2,242,000
Anticipated health and quality improvements	• Reduction in non-elective activity for CVD and diabetes • Reduction in re-admissions for COPD • Increased percentage of patients with self-management plans • Improved control of blood pressure and cholesterol for patient with CVD • Improved control of blood pressure, cholesterol and HbA1c for patients with diabetes • Increased uptake of pulmonary rehabilitation		

IMPROVING PRIMARY CARE

East London and the City

In order to align with the NHS Commissioning Board functions, in 2011/12 we formed a single Primary Care Commissioning Directorate that spans the 4 local authority areas of East London and City. This new arrangement has seen the synthesis of individual borough processes into a single process across all independent contractors in general practice, dentistry, optometry and pharmacy.

We have unified the contract review process for each of these independent contractors and now use a single review process that assesses the contractual and quality components of the respective contracts. For each group of primary care contractors a quality scorecard has been developed. Similarly we have re-designed the processes for key annual activities such as the Quality and Outcomes Framework (QoF).

As a sector, we are improving the quality of independent contractors' services by examining the variation in financial and contractual performances across the sector, and taking steps to reduce this variation.

Tower Hamlets

In Tower Hamlets we continue to implement the IHWB using our models of networks to bring together all providers in the delivery of integrated care. We will also continue to focus on the implementation of the pharmacy and eye health strategies and roll out standardised performance scorecards

Primary Care Strategy

Over the past two years we have undertaken and extensive investment and transformation programme focused on the development of networks of providers delivering services for, and taking ownership of, the health of their local populations. We will continue to develop and roll out this mode ensuring that resources are targeted at areas of greatest need.

Drivers for change

Increased Role for Primary Care providers:

General Practice is delivering a wider range of services in primary care settings including the management of long-term conditions and is increasingly playing an important role in co-ordinating care provided in other settings. Our long-term conditions care packages cover Type 2 Diabetes, Cardio-vascular Disease (COPD) and Chronic Obstructive Pulmonary Disease (COPD) and knit together primary, secondary and community care to deliver an integrated service to Tower Hamlets residents.

Variability in Quality of Primary Care:

Quality of primary care continues to be variable across Tower Hamlets, as in the rest of the sector. There are examples of some excellent practice together with some practice that falls below

acceptable standards. It is critical to the success of the health strategy that this variability in quality of provision is reduced by tackling providers whose performance falls below standards. This will sit alongside a quality improvement approach that brings these providers up to the standards of the best. We will also continue to implement the principles of the care packages of using data and information to monitor and maintain the delivery of standardised services.

Improvements in Access:

Levels of satisfaction with primary care providers in East London are high but there are continuing concerns amongst the local population about the difficulties of accessing primary medical and dental services and the responsiveness of these services. This will continue to be a priority over the coming years.

East London and the City initiatives

This year, as part of our preparation for the National Commissioning Board we will carry out a review of local processes to support the national requirement for general practitioners to complete revalidation and offer support to any practitioners where there are concerns.

Primary Care Quality Initiative

Since being developed in the CSP for 2011-15 this initiative is based on developing quality scorecards that can be used by primary care commissioners as performance management tools to tackle the lowest performers and by primary care providers as quality improvement tools to bring up the quality of those performing around the average. This data-driven approach to improving quality is supported by the recent Kings Fund report on Improving Quality in Primary Care. The tool is being used to target resources of the Primary Care Commissioning team at performance managing those practices with the lowest levels of performance. The proposed approach for is for the quality improvement to be led by the Primary Care Commissioning Directorate, supported by the CCGs. It will focus on performance management and supporting CCGs in developing this approach and their leadership role in quality improvement during the transition period.

GP Quality Scorecard:

NHS East London and the City started to develop a GP quality scorecard for the cluster in September 2010. However, this has since been superseded by the development of London GP Outcomes Standards, due in December 2011. The City and East London Local Medical Committee have accepted the London standards as our local GP quality indicators.

In the interim the Primary Care Commissioning Directorate has used the data from the locally developed GP Scorecard data to inform our Primary Care Commissioning decisions as to which practices receive a targeted approach to performance management whilst the London scorecard is tested and developed.

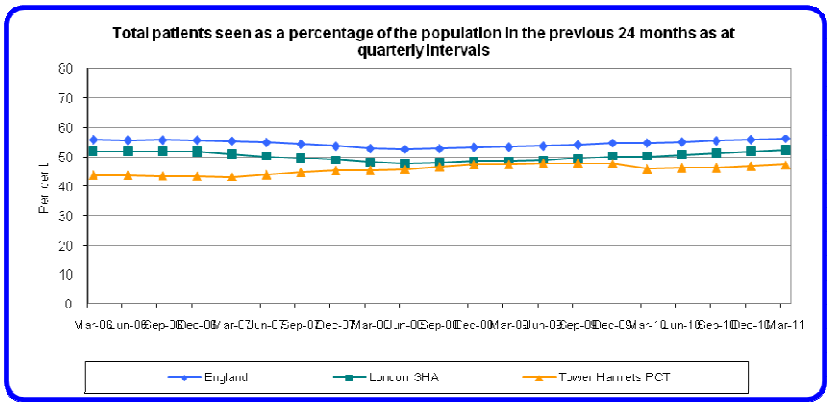
Dental Quality Scorecard:

NHS East London and the City's primary care commissioning team have been negotiating a dental quality scorecard with local dental representatives. The local scorecard, along with those used in other clusters, across London is currently being used to inform the development of a Pan-London dental scorecard with the intention that a single scorecard and performance framework will be

implemented across London before the end of 2011/12. To this end formal sign off on a local scorecard has been put on hold pending the pan-London outcomes.

The NHS East London and the City dental commissioning team continue to monitor the indicators using the local scorecard in order to inform contract monitoring and performance management processes. This will continue until formally superseded by a London framework.

Access to dental care continues to be a challenge particularly with respect to take up of dentistry on the NHS in East London. Whilst improvements in the numbers of patients who have seen a dentist within the last 24 months continue to be made in each of the 3 PCT areas a further step change is required.



Graph 5: Dental Access rates in Tower Hamlets

Pharmacy Scorecard:

The Community Pharmacy contract provides a national framework for the delivery of pharmacy services. The approach to quality for community pharmacy services being taken in East London is based on quality measures that can be identified through contract monitoring (including participation in health promotion campaigns), quality of premises, quality markers in Enhanced Services and patient feedback on their experience. This approach has been developed in a quality scorecard that is ready to be implemented from January 2012.

Ophthalmic Scorecard:

The approach to quality improvement for ophthalmic services is similar to community pharmacy services. The quality scorecard is based on a combination of contract monitoring and quality measures in Enhanced Services and patient experience. This scorecard is also planned to launch in January 2012.

We have written a sector Eye Health Strategy that articulates our ambitions not only to drive up quality, but also to improve the eye health of the local population.

Development of Local Professional Networks:

The Future Forum report developed proposals for the engagement of a wider group of clinicians in the commissioning process. An element of these proposals was the establishment of Local Professional Networks (LPNs) of dentists, pharmacist and optometrists to provide a forum for clinical engagement of these health professionals in the commissioning of these primary care services that

they provide but also in the wider process of commissioning. NHS East London and the City is engaging with local representatives of clinicians from these professions to establish LPN pilots in 2012-13 to support the quality improvement agenda for community pharmacy, dental and ophthalmic services.

Tower Hamlets initiatives

To ensure compliance with contracts and that practices whose performance is below acceptable standard improve the Primary Care Commissioning directorate will be carrying out annual contract reviews with all practices and effectively performance managing those where there is a cause for concern identified through performance against the London outcome standards and their compliance with the core contract standards.

Primary Care Clinical Networks

Developing high quality primary care requires effective team-working within General Practice and will require new models of shared care to be developed with other primary care, community health services and acute and specialist health care professionals. Our primary care networks are delivering measurable health outcomes for our population. By bringing together local providers we have developed dynamic primary care clinical networks who deliver effective and innovative care packages.

Patient Experience of GP Services:

The Tower Hamlets Local Involvement Network (THINk) has prioritised improving the patient experience in General Practice as one of the key quality improvements that NHS East London and the City should work on. There are measures within the London GP Outcomes Standards that use data from the GP Patient Survey run by MORI. They will form part of the whole picture of practice performance provided by the outcomes standards. Similarly there are GP access measures in these outcome standards.

The performance of practices in NHS East London and the City against the national measures of primary care access has plateaued with the percentage of patient reporting being able to see a GP within 48 hours of booking remaining at 75% at the end of 2010-11. There continue to be problems for patients in seeing their preferred GP (65%) and getting through on the telephone (69%). Whilst performance remains at or close to the London average it is still significantly below the national average in every measure. Improving access to primary care and how the public see access will continue to be a priority during 2011/12.

2012/13 INITIATIVES

Primary Care Productivity

To help improve productivity in 2012/13, we will roll out a review of Primary Medical Services contracts using the approach implemented in Newham in 11-12 and the NHSL "Once for London" programme on PMS reviews. The aim of this is to review contracts to the mean, standardise additional services commissioned and improve quality / productivity through a set of standard

stretch Key Performance Indicators (KPIs). This is delivered across the four primary care contractor groups – Primary Medical Services, Dental Services, Pharmacy Services and Ophthalmic Services.

General Practice

We will be contracting with NHS Shared Business Services to carry out our list maintenance on a 2 year programme and will follow the "Once for London" protocol agreed with London-wide Local Medical Committees (LMC). Any savings identified as part of this process will be applied to offset the annual list growth increase.

Preparing for convergence with the NHS commissioning Board, we will require review of any local payments that are outside the statement of fees and entitlements or nationally agreed payments mechanisms. This will require review of all independent contractor Locally Enhanced Services schemes and any variation in discretionary payments, in particular reviewing / scaling back of those locally enhanced Direct Enhanced Services schemes. This will require modelling system impact, liaison with key stakeholders and ultimately giving notice to providers within the terms of their contract / Service Level Agreement where decommissioning is planned.

Dental

Working with dental contractors we will review and develop Dental Practice Based Commissioning (DPBC) shift initiatives e.g. Minor Oral Surgery. Tower Hamlets DPBC initiatives have been successful in recent years and there is significant scope to build on this work during 2012/13.

Optometry

We will begin to implement the recommendations of our Eye Health Strategy. As for general practice we will be carrying out a review of optometry and eye care locally enhance services such as low vision, equipment supply or direct cataract referral schemes. The Moorfields Primary Care Clinic was audited in 2011/12, this identified that 65% of patients were being incorrectly referred the clinic rather than direct to a specialist clinic, creating a longer more costly patient pathway. Pathway redesign of this clinic, based upon the audit, could achieve circa £300k+ savings within the Cluster.

Pharmacy

A similar review of pharmacy locally enhanced services will be carried out, such as the Minor Ailments Scheme. The impact of the national New Medicines Service and Medicines Use Review are likely to reduce cost pressures within the health economy by reducing waste, increasing compliance taking medicines, and therefore, longer-term reducing the intervention of secondary care

Procurements

Key procurements or re-procurements are planned in general practice, community pharmacy or dentistry during Q4 11/12 or 12/13. The aim of each procurement is to deliver a timely service, within budget against a service specification that meets the needs of those using the services now or in the future. They are

- ✓ Health E1 – GP services to the vulnerably housed or street homeless. This is part of a 3 borough review of such services. Procurement by September 2012
- ✓ All Saints – GP - re-procurement by March 2013.
- ✓ Whitechapel – GP - turn-around contract the end of the 2011/12. Re-procurement by March 2012.
- ✓ St Pauls Way – GP - Re-procurement by March 2012
- ✓ Island Medical Centre – GP - Re-procurement by March 2012
- ✓ St Andrews – community pharmacy – Local Pharmacy Services contract by June2012

In addition, the following sector initiative will impact on Tower Hamlets:

- ✓ Emergency Dental Services – September 2012. This is a pan North East London initiative led by City and Hackney

Key enablers

General Practice IT

Primary Care Improvement and facilitation, has seen the deployment of eTTA's (Electronic delivery of Discharge Summaries) from BLT to 34 out of 36 GPs since June 2011, this will be extended to include a delivery of eTTA's from neighbouring Trusts and Acute Hospital Trust's throughout 2011/12.

We are also working closely with BLT to ensure the timely delivery of pathology / radiology results to GPs. As part of NHS ELC's IT strategic development for Tower Hamlets a project is running that will see all of the GPs within the borough standardised on Emis's fully hosted Clinical system Emis Web by April 2013. ELC IT Training and facilitation is continually developing a range of training that it is targeting the ever changing technological and business needs; we offer a range of learning programmes that support the developmental requirements of GPs and staff covering national and local applications such as; C&B, EPS, tQuest, Microsoft MOST, Clinical system and application support, these are delivered in a variety of ways to suit the business; classroom, onsite, elearning and refresher.

We are working closely with Primary Care Commissioning and the Networks with the establishment of NIS's.

Primary Care Estate Improvements

Two new developments are planned to be commissioned during June / July 2012/13. These are Newby Place in the South East Locality and St Andrews in the North East Locality. These facilities will be key to delivery of clinical commissioners local care strategies. The developments will bring together providers from a range of local health and social care services in modern premises

designed to meet the needs of the local populations, giving opportunity for more co-ordinated care and providing a setting for increased care outside hospital.

Architects Impression of Newby Place

Merchant Street Practice is currently investigating necessary improvements to their practice premises with the support of the PCT Primary Care and Estates teams. Options are being assessed to provide the best route to enable them to continue to provide essential services in suitable premises and potential to expand in the future to meet the needs of the growing local population.

CONTINUING CARE

Continuing health care for adults and children will continue to be a priority for development.

Children and Young People

We will continue to fund "continuing health care (CHC)" for severely disabled children and children with life-limiting allowing them to be cared for in the family home and supporting their parents and families to manage the burden of care. This care has been re-commissioned by the Borough to be provided by individually trained and professionally supervised and supported health care assistants. These new arrangements are expected produce savings of up to £250,000 per year.

Learning Disability

In 2010, we undertook 'the big health check; for learning disabilities which included health and social care professionals and a large input from service users as part of a NHS London programme. While we met many targets, there were clear areas which could be improved which included access to annual health checks for people with a learning disability, use of a hospital passport and improving how we present health promotion messages to the service users.

Continuing care - older people and young people with disability

In 2011, we reviewed our processes for planning and delivering continuing care across Tower Hamlets in conjunction with BLT CHS and LBTH. In 2012 we will ensure our processes are clear and follow the nationally set Continuing Health Care Pathways. We will work alongside City & Hackney and Newham to rationalise the service and ensure we maximise our investment and provide best quality for our patients.

Carers

We will continue to work closely with the London Borough of Tower Hamlets to support the implementation of the carers' strategy and ensure that the carers' needs assessment is taken into consideration as part of our commissioning process. Key recommendations from the needs assessment include:

- ✓ Enabling a broader uptake of services for carers, particularly amongst Asian carers and those who care for people over 65 with a disability
- ✓ Ongoing assessment and review of the health and wellbeing needs of carers
- ✓ Better marketing of carers' services within the borough
- ✓ Better identification of mutual caring relationships i.e. older people who care for those with learning disabilities
- ✓ Through ongoing consultation with the carers' strategy group we will continue to ensure that the services we commission in partnership with London Borough of Tower Hamlets meet the

needs of our carers and enable them to continue to provide the crucial support and care they give to those whom they look after. This will include supporting further funding of the health checks for carers project through the Reablement workstream as set out below.

Enablers

The implementation of these initiatives will be overseen by a group jointly formed from THCSS and London Borough of Tower Hamlets and will also draw on input from the lead clinical commissioners

Outcomes/targets	Key Milestones	Dates
Healthcare for Older People		
Reduction in emergency admissions for Urinary Tract Infections (UTI)	Implementation of agreed pathway	July 2012
Carers		
Increased uptake of care's breaks	Reestablishment of carers' health check programme	April 2012

CONTINING CARE			
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£50,000 Reduction in contribution (being picked up by LBTH) £150,000 Children £443,000 Managed care	£150,000 Children £443,000 Managed care	£150,000 Children £443,000 Managed care
Anticipated health and quality improvements	• Continuation of the LinkAge Plus Partnership • Improved health for carers • Packages of care appropriate to needs of patients • Improved experience of care for people with learning disabilities		

PLANNED CARE

Introduction

Providing efficient services that best meet the need of the population is the focus of our planned care initiative. Clinicians from the CCG Board have worked with lead clinicians from primary, community and secondary care to implement new pathways for priority specialties that support best practice guidelines and ensure an appropriate mix of skills within each specialty team so that patients are seen by the right professional within an acceptable timescale. This approach is also supported by a primary care enhanced service that includes ongoing referral audit and feedback processes led by referral champions within each network.

Current plan/initiatives/outcomes

As part of our on-going programme of service improvement, we redesigned pathways for four planned care specialities: trauma and orthopaedics, dermatology, urology, and ear, nose and throat (ENT) to ensure that we reduced the number of inappropriate referrals to hospital. Reductions in referral rates have been seen in each of these specialities. We have worked with Barts and the London Trust and general practice to develop standardised referrals and by increasing the levels of consultant support and sessions in networks in these key specialities. This has had an impact on the rate of GP referrals to BLT as shown in Chart 6, and is also reflected in the targeted specialities seen in Charts 7 and 8.

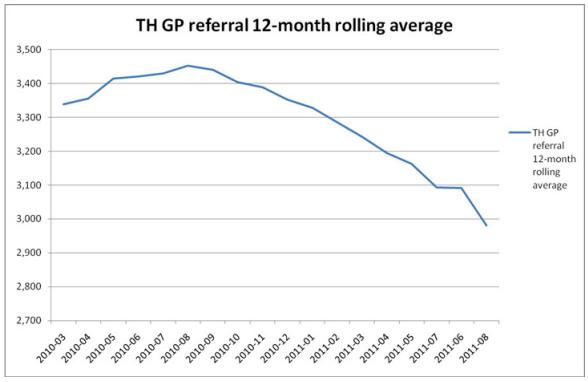
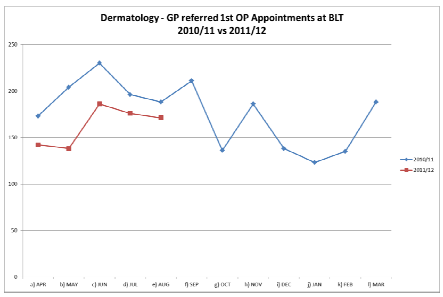


Chart 6: Referrals to BLT by Tower Hamlets GP Practices



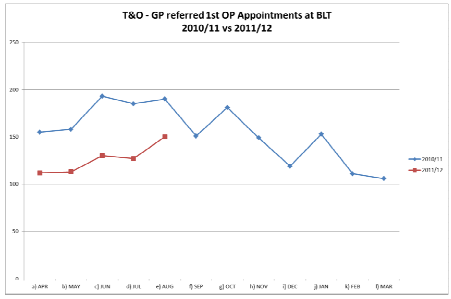


Chart 7: YTD reductions in dermatology referrals *Chart 8: YTD reductions in Trauma and Orthopaedic referrals*

In developing this approach over the next 3 years we will embed the key principles of the programme through the following contractual mechanisms:

- ✓ Education and Training. The provision of support for primary and community care clinicians to improve capacity and capability
- ✓ Referral champions within each network to oversee referral audits and provide guidance and feedback on referral standards
- ✓ Standardisation of referral forms
- ✓ Management of referrals by secondary care to ensure referral reach the right clinician first time, and at the right time

2012/13 INITIATIVES

Continued roll-out of service improvement programme

In the coming year we will look at extending our programme of service transformation to other high activity, high cost clinical specialities such as respiratory medicine and unscheduled admissions for patients with Urinary Tract Infections, through the development and introduction of standardised referral forms. This will be supported by the provision of guidance to referrers about what constitutes a clinically indicated referral to secondary care and improving discharge summaries. This approach will be supported by referral champions in primary care, clinical audit and regular feedback to referrers in the form of a dashboard.

Service Alert System

We will be reviewing our existing service alert process to ensure that we improve the interface between the primary and secondary care elements of pathways, as well as fostering shared learning, implementing quicker resolution to issues and continue to improve service quality and the patient experience.

Review of Persistent Pain Pathways

Separately we will be reviewing the existing persistent pain pathways. New NICE guidance on the management of lower back provides a set of best practice guidance which we will be implementing in 2012/13. In line with the recommendations of the guidance we will no longer commission spinal injections, and will look at making sure the care pathway for chronic pain offers patients the right level of physical and psychological interventions.

PLANNED CARE			
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£ 2,480,000	£2,800,000	£3,000,000
Anticipated health and quality improvements	• Better triaging and referral management • Patients seen in the most appropriate setting in the fastest possible time • Reduced health care acquired infections through keeping people away from the hospital setting where appropriate • Better ownership of patient care by primary care		

URGENT CARE

INTRODUCTION

There is a comprehensive urgent care strategy to which Tower Hamlets has been working since 2008 and this is now in its final phase of implementation. This has been aided by this year's integration of Community Health Services into Barts and the London Hospital, particularly the Whitechapel Walk in Centre and the GP Out of Hours service. The opening of the new Royal London Hospital in December adds to this to provide an opportunity to deliver a more seamless urgent care service. The development of the 111 service as part of the national and ELC wide strategy will also provide an opportunity to provide the 'Phone Before You Go' element of the plan which aims to ensure people utilise urgent care services in the most appropriate way.

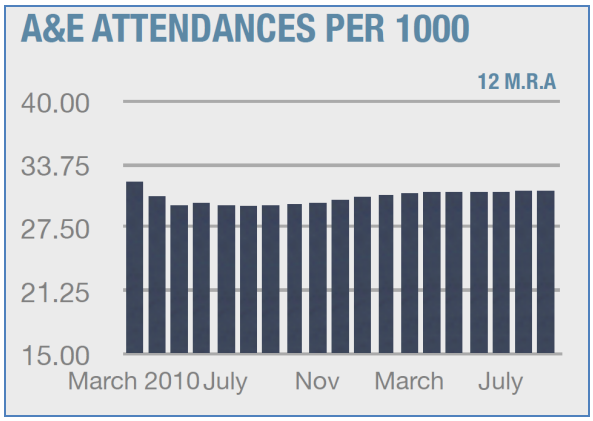
Together with services run from The Royal London Hospital there are two other walk in centres locally, the Barkantine and St Andrew's Health Centres. The Whitechapel Walk-In Centre will close in December and will be re-commissioned as an urgent care centre, incorporating Minor Injury services

Since 2008 we have had a GP streaming service in place, within A&E Department at the Royal London helping to stream adults. This will continue to be provided with plans to extend the service to include children from 2012.

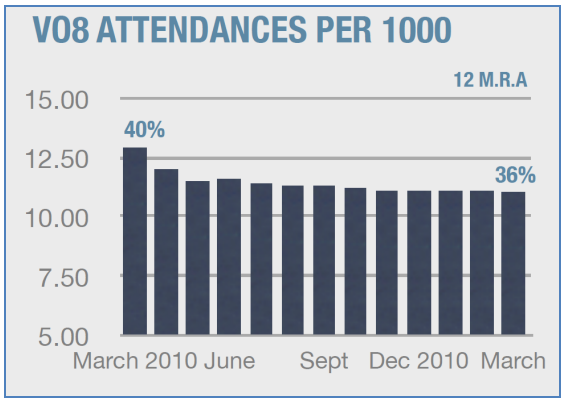
Table 12: Urgent Care Activity

Service	Type	Daily (average)	Annual
GP out of hours service	Contacts of which: - Face- to-face - Calls only - Home visits	62 19 39 4	22,774 7,078 14,356 1,340
Walk in Centres (WiCs)	Attendances: Barkantine (as of 10 October 2011) St Andrew's (as of 16 May 2011) Whitechapel	190 47 50 93	69,331 17,115 18,258 33,959
Emergency ambulance (London Ambulance Service)	Contacts of which: - Conveyed Not conveyed/treated at scene Other		
A&E Attendances (Total)		365	133,600
GP A&E Streaming		77	28,000
Unplanned acute admissions		40	14,600

Attendances to the Royal London A&E department have, against a backdrop of an increased population, remained relatively stable with a 2% increase since April 2011



The number of patients attending with a V08 code (discharged without any intervention) which is used as an indicator of patients attending with primarily primary or self care problems has decreased. A large proportion of these will be managed by the GP streaming service.

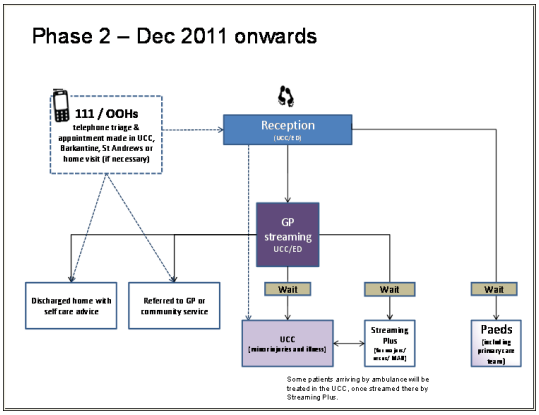


There are, however, a significant amount of children (0-5s especially) who are attending with primary or self care problems and the expansion of the GP streaming service in the new year aims to address this as well as specific practice based work to identify any key areas for further pathway work between secondary and primary care.

2012/13 INITIATIVES

Integrated model of Urgent Care Services

As previously raised, during 2012/13, building on our experience from GP streaming, we are building an integrated model that links effectively with the new 111 system being implemented across the sector. The new model supports access to primary care and makes the best use of the clinical skills across both primary/secondary services. This is shown in the accompanying chart



Once implemented the new 111 service will operate 24/7 and provide assessment of need and signpost callers to the most appropriate service to meet their need (self care, pharmacy, primary community and mental health services etc). Potential links to social care and voluntary sector services will also be explored at a later stage. A locally developed and maintained (electronic) 'directory of service' will help to ensure that patients are directed to the most appropriate local service to meet needs.

Community Walk-in Centre / GP Led Health Centre Review

We are currently undertaking a review of the Urgent Care Strategy for the Borough. As the new build progresses at BLT services there will be reconfigured to consist of a fully integrated Urgent Care Centre (UCC) service on the Whitechapel site. Changes such as the development of 111 telephone services and new build at Newby Place and St Andrews (opened in May 2010) make it timely to consider the way in which the services in the community interface with the new UCC and each other. There are also significant affordability pressures in the urgent care system that will require addressing through the review. Any change to contracts would not take effect before October 2012 due to the requirement for stable Walk-In Centre services during the London 2012 Olympic Games.

Outcomes and Key Milestones

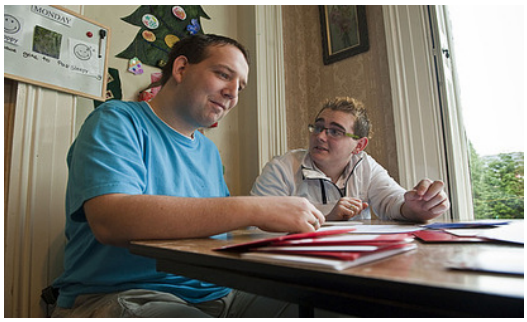
INITIATIVE	TIMELINE
System redesign linked to co-location of GP OOH / UCC and A&E.	Co-location from Dec 2011with opening of new hospital / A&E and UCC. Paediatric GP streaming pilot from Feb 2012. Strategic review and integration programme Q4 2011/12 and Q1 and 2 2012/13.
Review to be undertaken of the Urgent Care Strategy (including WiC's) for the Borough	January 2012
Olympics	Summer 2012
111 Pilot	Implementation from Q4 - 2012/2013

URGENT CARE			
New Investment 2012/13	£200,000		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£900,000	£900,000	£900,000
Anticipated health and quality improvements	• More integrated service • Improved patient experience • Timely access to urgent care services • Reductions in emergency hospital admissions.		

MENTAL HEALTH

INTRODUCTION

Tower Hamlets has amongst the highest levels of mental health need in the country. With a growing population, particularly young people, the challenge to ensure that we commission the very best of mental health services is significant. To meet the challenge, we are currently working to deliver a range of improvement projects, including the primary/secondary care interface, services for working age adults, services for people who misuse drugs and/or alcohol, and for children and young people. Our plans for improving services for people with dementia are now well advanced, with a range of new services opening during 2011/12 which we are confident will significantly improve outcomes for people with dementia and their carers. This section details how we will continue to work with our partners to improve mental health services for all residents.



ELC position

During 2011/12, in partnership with the five Clinical Commissioning Groups and three local authorities in the Inner North East London area, NHS East London & The City has finalised an east London wide Whole Systems Review of mental health services for adults of working age and older adults. The Review found that whilst there are many strengths in the mental health system in East London, there are also significant opportunities for improving quality and value for money. In line with the findings of the London Health Programmes Mental Health Models of Care Project, the Review found that system re-design is needed with a shift towards primary care based provision, under-pinned by clear and robust health and social care pathways in the community for service users with a mental health problem, and a strengthened approach to primary and secondary prevention.

Current plan/initiatives/outcomes

Improving Service User Experience

Considerable progress has been made during 2011/12 with improving service user experience, and safety, in acute in-patient services for people of working age. For example, NHS East London & The City this year invested in additional PICU bed capacity and in extra nursing staff on the wards. However pressure on beds has continued during the course of 2011/12, with occupancy breaching the 93% contractual target on several occasions.

Dementia

Through the partnership Commissioning Strategy for People with Dementia and their Carers (2010-13), NHS East London & The City has invested significantly in services for people with dementia over the past two years. In Tower Hamlets, as a result, we have a new Diagnostic Memory Service,

Community Dementia Team, Dementia Adviser Service, and Dementia Liaison Service at the Royal London Hospital.

Child and Adolescent Mental Health Services

During 2011/12, East London Foundation Trust in partnership with health and social care commissioners designed a new model for the organisation and delivery of Child and Adolescent Mental Health Services in Tower Hamlets, with larger front-line multi-disciplinary teams and fewer specialist teams. As a consequence, access to CAMHS services for children and young people, parents, and referrers will be more straightforward, and pathways within secondary care smoother.

2012/13 INITIATIVES

Implementation of the Whole Systems Review

During 2012/13, we will continue to implement the findings of the Whole Systems Review by:

- ✓ improving the mental and physical health of people with severe and enduring mental health problems through working with East London NHS Foundation Trust to develop primary/secondary health and social care pathways, including improving communication, and the systems and processes that support good communication
- ✓ developing a new primary care mental health function, including a Network Improved Service, to support primary care with service users discharged from secondary care, including service users currently supported in community team and out-patient settings. The development of the new primary care mental health functions will be informed by a pilot exercise to profile mental health need at practice level which, if successful, we will roll out to practices in a regular report. We will work with East London NHS Foundation Trust to carry out a specific clinically led audit of out-patient services
- ✓ working with East London NHS Foundation Trust to improve productivity of secondary care psychological therapies and community personality disorder services
- ✓ developing an Inner North East London Prevention Strategy, with a focus on building on the strengths of our current third sector market to improve approaches to prevention
- ✓ working with East London NHS Foundation Trust to deliver a pharmacy QIPP programme, and to develop a shared drug formulary
- ✓ embedding the recovery approach across the mental health system, with a focus on developing routine use of patient reported outcome measures, and working with East London NHS Foundation Trust and local authority partners to support the roll-out of their transforming adult social care programmes in mental health.

Improving Service User Experience

During 2012/13 we will continue to work proactively with East London NHS Foundation Trust to manage bed occupancy to keep it to an acceptable level.

Dementia

During 2012/13, we will work with local authority colleagues to continue to implement the Commissioning Strategy.

Child and Adolescent Mental Health Services

During 2012/13, commissioners will continue to work with ELFT to embed the new pathways, and ensure that they are responsive to the needs of the people who use them, and to referrers.

Substance Misuse

The Tower Hamlets Clinical Commissioning Group and NHS East London & The City are currently working with partners through the Drug & Alcohol Action Team to undertake a treatment system re-design project, to inform the future design of the drug and alcohol treatment system in the borough, which reflects national and local clinical and service user priorities for change, with a view to moving to the procurement of a re-designed treatment system by 1 October 2012.

Enablers

To support a coordinated approach to delivering our improvement priorities for mental health services, we have developed an East London & The City Mental Health Commissioning Board. Led by the Clinical Commissioning Groups, the Board also includes local authority and service user leads.

We will develop a Tower Hamlets Partnership Group which will comprise key local stakeholders including front-line clinicians, service users, and the third sector, to drive local implementation of our priorities in aligned way across partners.

Outcomes and Key Milestones

Mental Health		
Outcomes/targets	**Key Milestones**	**Dates**
Work with East London NHS Foundation Trust to develop primary/secondary health and social care pathways, including improving communication, and the systems and processes that support good communication.	Support primary and secondary care clinicians to lead on development of improved communication and processes at network level Develop CQUIN's to support good communication across primary and secondary care by 31/3/12	2012/13 February 2012
Develop a new primary care mental health function, including a Network Improved Service, to support primary care with service users discharged from secondary care, including service users currently supported in community team and out-patient settings.	Network Improved Service for the management of service users with severe and enduring mental health problems in primary care developed and in place Development of primary care liaison service These developments will be led by CCG's	March 2012 March 2012

	with the support of CSS, and informed by a pilot exercise to profile mental health need at practice level which, if successful, we will roll out to practices in a regular report	March 2012
Work with East London NHS Foundation Trust to carry out a specific clinically led audit of out-patient services With a mature Network Improved Service and primary care liaison service in place, we will during 2012/13 and beyond to support more service users in a primary care setting, with a focus on designing new pathways for people who may previously have had significant out-patient contact	Clinically led audit of admissions to hospital	March 2012 March 2014
Work with East London NHS Foundation Trust to improve productivity of secondary care psychological therapies and community personality disorder services	Redesign of secondary care clinical psychology and psychotherapy pathways including the personality disorder service	March 2012
Develop an Inner North East London Prevention Strategy, with a focus on building on the strengths of our current third sector market to improve approaches to prevention	Develop Prevention Strategy Undertake review of third sector day opportunities and support services with a view to developing a new model for a third sector prevention pathway in line with the findings of the whole systems review and the Transforming Adult Social Care agenda Deliver Mental Health Accomodation Strategy	March 2012 October 2012 March 2015
Work with East London NHS Foundation Trust to deliver a pharmacy QIPP programme, and to develop a shared drug formulary	Develop pharmacy QIPP programme and shared drug formulary	TBD
Embed the recovery approach across the mental health system, with a focus on developing routine use of patient reported	Develop consensus on approach to outcome measurement that embeds the recovery approach	October 2012

outcome measures		
During 2012/13 we will continue to work proactively with East London NHS Foundation Trust to manage bed occupancy to keep it to an acceptable level	Clinically led audit of admissions to hospital Commission an external review/analysis of occupancy, including adult acute & female PICU	March 2012 March 2012
Redesign drug and alcohol treatment system with a view to moving to the procurement of a re-designed treatment system by 1/10/12.	Re-designed treatment system procured.	October 2012
During 2012/13, we will work with local authority colleagues to continue to implement the Commissioning Strategy for people with dementia.	Recommendations to the NHSELC Board regarding the outcome of the consultation on modernising inpatient assessment services for people with dementia Delivery of partnership Dementia Strategy action plan	January 2012 March 2013

MENTAL HEALTH			
New Investment 2012/13	£100,000		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£900,000	£900,000	£900,000
Anticipated health and quality improvements	• More effective drug and alcohol treatment network • Improved management of out of area patients • More effective management of mental health issues in primary care via NIS		

MATERNITY SERVICES

ELC position

Across the sector, we are developing and expanding midwifery-led units, alongside obstetric-led units at all three trusts. This will not only increase choice for women, but will see the proportion of midwifery-led births rise to between 30-40% of all births.

Current plan/initiatives/outcomes

This year we are developing standardised pathways of care that are midwifery coordinated (with GP input) which have a focus on promoting early access for all, but are especially targeted to those women who are less likely to book before their 13th week of pregnancy.

As part of this work we are putting in place clear protocols for transfer or referral to specialist care based on an ongoing risk assessment of clinical, psychological and social need.

These new pathways will be supported by the inclusion of appropriate contractual and performance management mechanisms into 2011/12 provider contracts.

We are working to increase the proportion of ante-natal and post-natal care services available outside of the hospital setting with more services available in appropriate community settings, such as GP clinics and children's centre. Our ambition is to increase the number of births outside of hospital (i.e. at home or in Family-centred Maternity Units) to reach a level of 10% by 2015/16

2012/13 INITIATIVES

In 2012/13 we are expecting a continued increase in projected birth rate in Tower Hamlets. Like all services where some of the care pathway involves hospital-delivered services, we expect maternity services will also be impacted on by the proposed merger of the three local acute trusts.

There are significant cost pressures within the maternity system in Tower Hamlets and these will be managed by through transformational initiatives that can be delivered through a more efficient use of the existing resources. We will be introducing a "centring" model which will see ante-natal and post-natal appointments delivered in groups, and will have a consequent reduction in cost of the antenatal and postnatal pathway.

We intend to develop an obstetric outpatient triage system in conjunction with primary care to reduce unnecessary outpatient appointments in hospital.

In all these initiatives we will be striving to continue to improve that quality of maternity services, and in particular improve the patient experience

Enablers

We are also forming a Cluster Maternity Services Liaison Committee (MSLC), due to launch in April 2012 and a Cluster maternity commissioner led network arrangement to provide a coordinated

mechanism for receiving and responding to patient feedback and managing performance, quality, standards, training and communications in maternity and newborn care

Outcomes and Key milestones

Maternity		
Outcomes/targets	Key Milestones	Dates
Maternity service specification with maternity pathways and quality and performance requirements developed and incorporated into 2011/12 provider contracts	Maternity Service specifications complete and embedded in contract	Mar 2012
Project plan for Maternity transformation programme	Cluster wide review of maternity services, including compliance with maternity pathway completed	Jan 2012
Communications and engagement plan for delivery of maternity pathways and early access target agreed and launched	Engagement plan complete and incorporated in Tower Hamlets Maternity action plan	Jan 2012
Baseline of current maternity outpatient ,Emergency admissions and Community Maternity appointments	Baseline complete	Apr 2012
Cluster wide MSLC launched with agreed programme of work to drive up quality, standards and patient experience	1st Maternity Service Liaison meeting	Apr 2012
Action plan to improve compliance with pathways and drive up performance, quality and patient experience developed and agreed	Action plan complete	Jan 2012
Obstetric outpatient triage system	Scoping exercise Project plan complete Project initiation	Jan 2012 Apr 2012 July 2012
Evaluation of "Centring" model of antenatal Project	Scoping Exercise Project plan complete Project Initiation	Dec 2011 Jan 2012 July 2012
Promote development of a Maternity provider network to support implementation of the Health for North east London proposals		April 2012

MATERNITY			
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£82,5000	£82,5000	£82,5000
Anticipated health and quality improvements	• Improved triage of obstetric referrals • More efficient delivery of ante- and post-natal care • Improvement in patient satisfaction as measured in CQC and Trust Surveys • An increase of women choosing midwifery led care either in a standalone or alongside birthing unit • Maintenance or reduction in the amount of women who have an caesarean section from 2011/12 baseline		

PRESCRIBING

INTRODUCTION

One of the main objectives of the Tower Hamlets Medicines Management team is to optimise the use of medicines to improve patient outcomes and increase productivity.

National guidance has strongly supported collaborative approaches to the commissioning of medicines. NHS ELC has a strong governance structure around medicines that include local Joint Prescribing Committees across primary care and local acute trusts. To ensure uniformity of provision of medicine across north east London we also have the North East London Medicines Management Network (NELMMN) which is a joint strategic medicines meeting with outer north east London PCTs and related acute trust where commissioning discussions on medicines are made, especially those in complex and specialist areas. These governance arrangements on medicines management have allowed effective decision on medicines which form part of the wider contracts.

Primary Care prescribing

High quality safe evidence based prescribing in NHS Tower Hamlets has been the underpinning principle of the work of the prescribing department. This has been achieved in primary care by producing clinical guidelines, formulary development including agreement with BLT on managing specialist medicines, supporting educational sessions, providing a medicines information service, implementing NICE guidance and monitoring via audits. We have also worked closely with community pharmacists who support prescribing and medicines management work in general practice and community clinics. This has delivered high quality evidenced based prescribing in our Borough. The three Better Care Better Value indicators for prescribing show Tower Hamlets to be in the Top 25th centile of all PCTs for Q2 2011/12.

The NHS London Medicines QIPP dashboard, introduced this current financial year, also reflects the achievements of the department and engagement from the majority of practices. The QiPP dashboard Red-Amber-Green (RAG) rates PCTs on 11 prescribing indicators. September 2011 prescribing data shows the following prescribing achievements for Tower Hamlets.

Rating	Tower Hamlets Rating for Sept 11
Green	7 indicators
Amber	1 indicators
Red	3 indicators*

The biggest issue that is rated red is “specials” prescribing

The Amber and Red areas present areas for savings and lost opportunity. The prescribing team are supporting practices to meet targets by incorporating the QiPP indicators as part of the medicines

aspects of the GP QoF agreements as well as a Network Incentive Scheme. This is producing positive results over the year.

Management of acute and specialist medicines

The ELC Prescribing team support the management of high cost drugs by providing professional input into the North East London Medicines Management Network. This group considers high-cost low volume medicines which are excluded from Payment by Results (PbR) and which have not received formal guidance from NICE. We are mindful of therapeutic areas including cytokines and antifungals which may exceed current contract arrangements. This highlights the importance of rigorous, evidence based negotiations for the 2012/13 contract and the need for collaborations between the prescribing team, CCGs and the CSS contracting team.

NHS ELC funds all drugs included in the PbR tariff, has mechanisms in place for agreeing funding of PbR excluded drugs, has encouraged providers to submit business cases for those drugs and patient cohorts not addressed within these commissioning intentions, and has a robust Individual Funding Request (IFR) process for addressing individual patient requests.

Drivers for growth of primary care prescribing budget

A key challenge in demonstrating release of savings in prescribing budget is the impact of various drivers for growth in prescribing.

At this time it is not possible to estimate actual cost impact of all drugs which will be licensed during 2012/13. Some of the reasons for this are:

- There is no guarantee that the EMEA will grant a licence or if the licence date will definitely be in 2012/13
- Drug companies do not release information as to what the cost of their new drugs will be pre-launch
- Recommendations from NICE, post launch of new drugs, has significant impact on uptake of new drugs
- Interest from local specialists in using these drugs
- Outcome of discussions from local joint prescribing groups

It would be prudent to plan for at least £1M for introduction of new drugs prescribed by primary care clinicians in Tower Hamlets. An example to illustrate the impact of new drugs and NICE guidance is the extension in the licence for use of dabigatran. Preliminary NICE guidance recommends the use of dabigatran as an alternative to warfarin for stroke prevention, which would have a significant impact on the prescribing budget.

PRIMARY CARE PRESCRIBING BUDGET DRIVERS

- New drugs
- National guidance and guidelines – in particular National Institute for Health and Clinical Excellence (NICE)
- Quality and Outcomes Framework
- Improvements in diagnosis
- National public health campaigns on increasing awareness
- Tighter treatment targets
- increase in demand and redesign of clinical services
- Expanded indications and increase in eligible population
- Displacement of old (and lower cost) drugs with newer drugs at higher acquisition costs
- New drug combinations
- Ageing population
- 'Medicalisation' e.g. treatment of social phobia

It is important to note that managing new treatments is different from managing other service developments. The NHS Constitution gives patients the right to expect local decisions about funding medicines and treatments to be made rationally so there is a need for high quality, evidence-based and systematic decision making.

It is thus imperative to continue and build on the strength of local decision making bodies and advisory committees to ensure that we are prioritising funding for drugs that will reduce costs of morbidity and mortality for our patients.

There is, each year, a cost pressure on primary care prescribing budgets and most new drug introductions have been more expensive substitutions for (or additions to) cheaper existing drugs. In 2011/12, the impact of new drugs (for drugs prescribed in primary care) was not as significant as we are likely to have this year as a consequence introduction of drugs such as dabigatran. There were very few new drugs launched during 2011/12 that were drugs able to be prescribed by GPs. There may not be the case in 2012/13

Table 13: New drugs due for licensing in 2012/13 that may be prescribed in primary care

Drug	Condition
Apixaban, rivaroxaban	Prevention of stroke in patients with Atrial Fibrillation
Ivabradine	Chronic heart failure
Insulin degludec	Management of Type 1 & 2 diabetes
Dapagliflozin	Type 2 diabetes
Strontium ranelate	Osteoarthritis
Nalmefene	Alcohol dependence
Vorapaxar	Secondary prevention of CVD
Aclidinium	COPD
Asenapine	Bipolar disorder
Hydrocortisone	Adrenal insufficiency
Intranasal influenza vaccine	Influenza prophylaxis in children

Managing increase in demand and redesign of clinical services.

We need to also be mindful of the impact of service redesign – such as care closer to home and other QiPP workstreams associated with a shift of prescribing (and associated prescription costs) from hospital to primary care. The previous example of dabigatran could also be used to illustrate this, as use of this drug would enable patients to be managed closer to home (as dabigatran unlike warfarin does not require frequent attendance at anticoagulation clinics).

Current Plans/initiatives/outcomes

We will continue to support local priorities as per those areas identified in the 2011/12 recovery plan. These include continued review of the management of Vitamin D deficiency, “specials”, diabetes and oral nutritional supplements.

2012/13 Initiatives

Prescribing Plan

In 2012/13 we will continue to support the Quality Innovation Productivity and Prevention agenda in line with the priority areas of the London Procurement Programme (LPP) and the National Prescribing Centre. We will work with Clinical Commissioning Group to agree a prescribing work plan for 2012/13 which incorporates the LPP, QIPP agenda and local priorities.

This work will entail continued:

- ✓ Implementation of formulary and prescribing guidelines
- ✓ Focused 3 key messages developed with relevant stakeholders, distributed to prescribers and monitored for impact.
- ✓ Clinical engagement with CEG, CCG, prescribing leads and secondary care colleagues to agree clinical guidelines and agree prescribing choices.
- ✓ Engagement with key stakeholders including local acute trusts, Moorfields Eye Hospital, Mental Health Trust, Cardiac and Stroke Network to agree position statements that will enable improvements in use and recommendations to use more cost effective drugs in order to realise savings
- ✓ Continued engagement in service redesign via care package or CC2H work.
- ✓ Support of non medical prescribers
- ✓ Promotion of integration of community pharmacy services e.g. new medicines service and targeted medicines use review with general practice and secondary care to support patient concordance and manage waste.
- ✓ We will review the distribution systems for nutritional supplements in line with the model previously employed by the wound care and Lymphoedema service.

We will manage the growth of prescribing costs to within a cap of 6%, which will mean a saving on the predicted growth (8%) of around £688,000.

Outcomes and Key milestones

Prescribing		
Outcomes/targets	**Key Milestones**	**Dates**
Reduction in both cost and volume of items prescribed as "Specials" including Vitamin D with a target of <£200/1000 pts /month to produce net savings of £450,000. *Continuation of 2011/12 recovery plan.*	Production of updated Vitamin D guidelines Promote awareness of Vitamin D management amongst patients	March 2013
Reduction in volume of oral nutritional supplements prescribed to produce net savings of £150,000 *Continuation of 2011/12 recovery plan.*	Regular review before initiating and during prescribing of ONS products Optimisation of the prescribing of high calorie feed i.e. 1.5kcal/ml	Sept 2012
Reduce blood glucose testing strips by volume by 10% year on year (from baseline) for patients with Type 2 diabetes. Promote metformin and sulphonylureas as first line oral anti-diabetic drugs. Less than 10% of oral hypoglycaemic prescribing should be for items other than metformin or sulphonylureas Review initiation of prescribing of glargine and detemir in people with type 2 diabetes. Non analogue insulin as a percentage of all insulins should be ≥ 48%. *Continuation of 2011/12 recovery plan.*	Promote CEG guidance on blood glucose testing strips and audit implementation. Provide TH blood glucose testing strip patient information leaflets to practices, patients and GPs. Diabetes specialist nurses to routinely use and recommend human insulin over analogue insulins in patients with type 2 diabetes and to educate and promote this practice at MDTs.	Dec 2012
Promote switch from Seretide evohaler 250 2pbd to Seretide Accuhaler 500 bd (in appropriate patients) to 80% use of accuhaler. Review all patients especially children prescribed high dose inhaled corticosteroid Minimise use of prednisolone ec (use plain) target 95% prednisolone plain *Continuation of 2011/12 recovery plan.*	Prednisolone plain tablets to be used in emergency packs for COPD. BLT, GPs and practice nurses to prescribe Accuhaler device in appropriate patients. Community pharmacists to support training and inhaler technique.	June 2012

Procure and install scriptswitch if business case merits it.	Monthly monitoring of use (acceptance and rejection) by prescribers. Acceptance rate of 35%	April 2012

PRESCRIBING			
New Investment 2012/13	£200,000		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£1,288,000	£1,288,000	£
Anticipated health and quality improvements	• Using evidence based medicines in diabetes, respiratory and oral nutritional supplements • Improved medicines optimisation through patient engagement and associated improved concordance • Reduction in wasted medicines. • Reduction in use of unlicensed medicines • Using evidence based medicines in line with NICE guidance provides optimal care for patients. • Reduction in side effects from unnecessary medicines or high doses (e.g. high dose inhaled corticosteroids) • Reduction in unnecessary or inappropriate testing of blood glucose		

PROVIDER EFFICIENCIES

East London and The City

The approach to provider productivity with Trusts in ELC is based on reducing unnecessary patient visits to hospital. For key areas benchmarked data is used where available and/or directed audits to inform what level of commissioning levers are introduced into the acute contracts to enforce a reduction in unnecessary activity. This is supported by the setting up of joint clinical forums whereby secondary and primary care clinicians can agree pathways of care that are supported by the contract.

Our ambitions for improving Acute Provider Productivity and Decommissioning are building on our programme of existing change. For 2012/13, this programme will be affected by the planned merger of community services with BLT and potential merger with Whipps Cross and Newham Hospitals to form Barts and the East London Hospital Trust. The move of acute services into the new build at the Royal London site also affects the approach for 2012/13

Tower Hamlets

Decommissioning of acute care and re commissioning different pathways is ongoing in Tower Hamlets. The opportunities for the health economy in the merger of community services with acute at BLT is highlighted above in the approach to scheduled outpatient pathways. The move to the new build on the Royal London site also affects the decommissioning of A&E activity and the re commissioning of urgent care services within the new build. As outlined in the urgent care section, a new model of urgent care has been developed and implemented for December 2011 with an onsite primary care service at the front end of Accident and Emergency (A&E)

2012/13 INITIATIVES

Efficiencies as a result of the TH Community Health Services transfer

With the merger of the Tower Hamlets Community Services with BLT the potential of shared productivity savings will also be investigated in areas such as community bed utilization and their potential effect on shortened length of stay and bed numbers for the Trust. In addition, service redesign at Tower Hamlets led to the development of many primary care services aligned to the n Community Service (via the care closer to home programme) which reduced the need for local patients to visit hospital as out patients. The productivity benefits from managing the operational pathway within BLT will also be discussed in terms of seeing more patients in a primary care setting at a lower cost.

Consultant to consultant referrals (C2C)

Reductions in consultant to consultant led appointments has been approached by an initial GP led audit to inform the 2011/12 contract and is now supported by an agreement by the Trust to follow the contractual protocol for inter departmental referrals. In support of reduced activity a series of

GP audits in certain specialties is also being carried out to identify issues around intra departmental referrals caused by booking inefficiencies. Agreed referral templates and discharge communication is also being developed via the Joint Clinical Forum.

First to follow up appointment ratio (NFUp)

For the last two years the Commissioning Support Service has continued to embed a reduction in New Follow Up (NFUp) ratios and consultant to consultant referrals within this framework. The Commissioning Strategy over the last two years highlights the drive to commission providers who perform at the same productivity levels as the top 25% of trusts, with a move towards being in the top 10% nationally. For 2012/13 at BLT we intend to maintain the drive within the contract towards being in the top 25% New Follow Up ratios in the country. We will be refreshing our benchmarking to assess whether other Trusts have improved quicker than our Trust or whether we can increase in some specialties to achieve top 10%.

Procedures of Low Clinical Value (POLCV)

Decommissioning of POLCV is already within the BLT contract and will continue to be embedded into day-to-day operations at BLT with agreed discharge criteria and letters already developed between clinical teams in key specialties. The sector has a unified policy within the contract and Individual Funding Request process for exceptional cases. Continual refinement of the policy and areas to decommission are ongoing.

Direct Access Pathology

Together with local GPs we will review the impact of our care packages to ensure that we are not generating additional unnecessary requests for pathology investigations to manage demand for Direct Access Pathology. In parallel to this, we will be negotiating to reduce the unit costs based on benchmarked costs and the proposed rationalisation of services via the Modernising Pathology work programme in North East London.

Decommissioning Spinal Injections

This year we will implement the NICE Guidance which advises there is no clinical indication for the injection of therapeutic substances in the spine. In 2012/13 we will reduce this by 90% at BLT and by 100% in 2013/14.

Outcomes and Key Milestones

Provider productivity		
Outcomes/targets	**Key Milestones**	**Dates**
Agree contractual basis of present service redesign areas post CHS merger	Contractual negotiations agreed	Feb 2012
Negotiate NFUp ratio targets for 12/13 Contract	Review present performance and revise benchmark ratios – decide on ratios Negotiate contractual targets	Nov 2011 Feb 2012
Review and strengthen referral pathways with GPs to accommodate C2C referral reduction	Agree process of monitoring C2C referral reduction with Trust for 2012/13 Negotiate baseline reduction from 2012/13	Nov 2011 April 2012

PROVIDER EFFICIENCIES			
New Investment 2012/13	£0		
Anticipated Savings (non-cumulative net)	2012/13	2013/14	2014/15
	£2,700,000 C2cEtc £500,000 Pathology £2,480,000 CC2H £480,000 spinal	£2,300,000 (Improved performance) £500,000 pathology 2,800,000 CC2H	£2,700,000 (new productivity measures £3,000,000 CC2h
Anticipated health and quality improvements	• Compliance with NICE guidance on managing back pain • More effective use of secondary care resources • Reduction in unnecessary hospital appointments for patients • Support for developing integrated care pathways		

STRATEGIC RISK AND MITIGATION

The following table looks at the risks and mitigations for this CSP.

Risk	Rating		Mitigation
	Likelihood	Impact	
Engagement and ownership of the CSP by the broader clinical commissioning community	Medium	High	• Strong engagement strategy operational consisting of ○ Strong Clinical Leadership ○ Locality Commissioning Groups ○ CCG Board Practice visits ○ Monthly CCG newsletter cascaded across all practices ○ Strong links with GP Forum
Integration of CHS into BLT	Medium	Medium	• Revision of service specifications to ensure clear KPIs that reflect the patient pathway • Good engagement at a clinical level which ensures that impact at the patient level is minimised
Merger of BLT, NUHT and WCUH and provider sustainability	Medium	High	• Our existing CSP assumptions on finance and activity are aligned fully with the BELH business case. • Our innovative finance and activity model gives providers a detailed breakdown of the impact on income. This is shared with providers through our monitoring and planning processes (including contract negotiations)..
QIPP and affordability levers do not deliver the required productivity improvements or financial savings	Medium	High	• We have a track record of robust financial management. • Strong background of clinical review and management. • Our performance management framework sets out the monitoring and managements standards and processes to ensure delivery
Anticipated changes in patient behaviour do not occur	Low	Medium	• Investment in engagement infrastructure that feeds into every level of service planning and delivery

DELIVERING THE COMMISSIONING STRATEGIC PLAN

Tower Hamlets Clinical Commissioning Group

Following consultation with all General Practices in Tower Hamlets and a ballot of all General Practice partners, salaried and sessional GPs, it was agreed that NHS Tower Hamlets Clinical Commissioning Group (CCG) would be led by a democratically-elected Board. This Board would be made up of GPs and other health professionals representing (coterminous with the borough) the eight Local Area Partnership (LAP) geographical areas in Tower Hamlets and other significant stakeholders. The Board meet on a monthly and over time will take on delegated responsibility for commissioning throughout 2011/12 through the delegation process managed by East London and the City.

The CCG have participated in the Organisational Development programme (OD) commissioned by NHS London. We have jointly agreed our requirements with our provider alliance and are underway with the plan.

Delegation of commissioning responsibilities in shadow

NHS Tower Hamlets CCG has undertaken delegated responsibility for non-elective (Including Maternity) from 1st October 2011. A robust performance and financial management process is currently in place supported by a set of performance matrix, papers, alerts and regular meetings. A joint escalation process is agreed with Commissioning Support Services (CSS) from level 1-4 with the Chief Operating Officer engaged at all levels and the Clinical Chair engaged at level 4. The CCG will undertake further delegation during 2011/12 and aim to have full deletion responsibility in shadow form by 2012/13, as well as achieving authorisation

Commissioning Support Services (CSS)

The CCG will continue to work closely with the CSS to ensure the right support is delivered for effective commissioning in Tower Hamlets. A strong borough team is an important link to the wider support services provided by CSS. During 2012/13 more work will be undertaken to review what the CCG want to buy, share or do and will ensure this is deliverable within the management costs made available to CCGs.

NHS Tower Hamlets Clinical Commissioning Group has a robust process in place for clinical leadership. During 2012/13 the Clinical Leads Programme will be reviewed and re-aligned. Each Clinical Lead will be assigned to a CCG Board Member and their work programmed aligned to the key commissioning priorities. Clinical Leads will support service re-design, improve quality of service delivery and provide expert advice to the CCG Board.

Engagement with Practices and patient Involvement

Engagement with the grass root members of the clinical commissioning group is critical to the success of commissioning in Tower Hamlets. During 2011/12 the CCG have develop a range of methods to ensure this is delivery effectively. A regular monthly newsletter and dashboards supports the locality structure of monthly meetings with peers to discuss locality or borough issues. Further work during 2012/13 will be undertaken to consider establishing a CCG Counsel along with more work to develop patient and public engagement.

Working with other Clinical Commissioning Groups

We will also be looking to maximise improvements by working co-operatively with our neighbouring Clinical Commissioning Groups. We see this as a critical lever to ensure where appropriate we can develop strategies or initiatives that cover a larger geographical area. We are already working with our CCG colleagues from Newham and City & Hackney, and have aligned our Commissioning Strategic Plans to strengthen commissioning, particularly for the acute sector.