TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 23 March 2010 at 6.30 p.m.

A G E N D A

VENUE
M72, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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

	Deputy representing Councillor Abjol Miah)

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

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

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Zoe Folley, Democratic Services,
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LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 23 March 2010

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

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

		PAGE NUMBER	WARD(S) AFFECTED
3.	**UNRESTRICTED MINUTES**	**3 - 10**	
	To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 26th January 2010.		
4.	**REPORTS FOR CONSIDERATION**		
4.1	**Health Scrutiny Panel Evaluation Report and Presentation**	**11 - 56**	
4.2	**Care Quality Commission Presentation**	**57 - 86**	
4.3	**Excellence in Quality Strategy – Report and Presentation, Barts and the London NHS Trust**	**87 - 100**	
4.4	**Operating Plan NHS Tower Hamlets – Report and Presentation**	**101 - 172**	
4.5	**Overview of Integrated Care – Presentation - NHS Tower Hamlets**	**173 - 188**	
5.	**ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT**		

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DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

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

Declaration of interests for Members

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

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

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

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

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

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

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

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

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

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

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

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

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

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT TIME NOT SPECIFIED ON TUESDAY, 26 JANUARY 2010

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

Members Present:

Councillor Tim Archer (Chair)

Councillor Ann Jackson (Vice-Chair)
Councillor Abjol Miah
Dr Amjad Rahi
Councillor Bill Turner

Other Councillors Present:
Nil

Co-opted Members Present:

Dr Amjad Rahi	–	(THINk Interim Steering Group Member)

Guests Present:

Dr Peter Bell	–	Lead Clinician (Tower Hamlets), East London NHS Foundation Trust
Deb Clarke	–	Director of Human Resources, NHS Tower Hamlets
Jeremy Gardner	–	Head of Communications & Engagement, NHS Tower Hamlets
Mabli Jones	–	Associate Director, Primary Care Commissioning
Michael McGee	–	Service Director for Older People, East London NHS Foundation Trust
Andrew Ridley	–	Deputy Chief Executive, NHS Tower Hamlets
Alan Steward	–	Deputy Director, Corporate Development & Performance, NHS Tower Hamlets
John Wilkins	–	East London NHS Foundation Trust

Officers Present:

Afazul Hoque	–	(Scrutiny Policy Manager, Scrutiny & Equalities, Chief Executive's)
Katharine Marks	–	Acting Service Head, Disabilities & Health
Katie McDonald	–	Scrutiny Policy Officer
Alan Ingram	–	(Democratic Services)

1. APOLOGIES FOR ABSENCE

Apologies were submitted on behalf of Councillors Lutfa Begum, Stephanie Eaton and Alexander Heslop.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. UNRESTRICTED MINUTES

The minutes of the inquorate meeting of the Panel held on 20 October 2009 were agreed as a correct record and the comments made with regard to reports/presentations submitted were ratified.

4. REPORTS FOR CONSIDERATION

4.1 Review of Older Peoples Services - Presentation

Mr John Wilkins, East London Foundation Trust, introduced a report relating to the redesign of older people's services at East London NHS Foundation Trust.

Mr M. McGee made a detailed presentation of the proposals, which had been accepted by the Trust Board in July 2009. It was proposed that a reduction in overall bed numbers would increase reinvestment in specialist community services, developing a wider range of community options for older people with mental health issues. It was also considered that flexibility of services for older people would be improved. Mr McGee set out details of the consultation procedure adopted; options and proposals for bed configurations, proposed service and staffing structures and objectives to bring mental health provision in Tower Hamlets to a par with the City of London, Hackney and Newham. He added that a principal aim was to allow more people to remain at home for treatment, rather than being admitted to hospital.

Messrs McGee and Wilkins and Dr Peter Bell then answered questions put by Panel Members on:

- The numbers of older people needing access to in-patient treatment.
- National and local prevalence rates for dementia sufferers and the additional elements of ethnicity and poverty.
- Effective diagnosis of dementia through various age groups and its impact on preparation of individual care packages.
- The improvement of community resources arising from financial savings anticipated from service realignments.
- Monitoring of service provider contracts and the limiting of carer numbers for the benefit of dementia sufferers.

- The likely pressure on services (including respite care) as the number of older people in the population increases.
- The effects of the proposals on NHS staffing levels and configurations.

It was **agreed**

(1) That a further report be made to the Panel when the results of the further consultation measures are available.
(2) That Members pass details of any vulnerable people they may contact to Afazul Hoque, Scrutiny Policy Manager, for onward transmission to East London NHS Foundation Trust staff.

The Chair then thanked the East London NHS Foundation Trust representatives for their contribution to the meeting.

4.2 Transformation from Under 18 to Adult Autism Services - Presentation/Verbal Update.

Ms Katharine Marks, Acting Service Head Disabilities & Health, reported that the most recent development in the Transition Service had been the establishment in January 2010 of a multi-disciplinary Transition Team. A pathway specific to autism had not yet been developed but work on this was underway. The Government would be publishing a National Autism Strategy by April and when this information was received, more progress would be made. A further report could be made thereafter.

It was **agreed**

(1) That Ms Marks arrange a briefing on this subject for Councillor Heslop.
(2) That Ms Marks contact Councillor Turner for details of a relevant family in his Ward.
(3) That the matter be included on a future Health Scrutiny Panel agenda when appropriate.

The Chair thanked Ms Marks for her presentation.

4.3 Update on GP Cleansing List Process

Ms Mabli Jones, Associate Director, Primary Care Commissioning, introduced a report as requested at the last meeting of the Panel, on the matter of women's names being erroneously removed from GP list during a list cleaning exercise. Ms Jones indicated that the problem had principally affected women who were part of a breast screening programme and had occurred when inadequately addressed letters had failed to be delivered, with the result that 280 women (out of some 9,000 invited) had been removed from their GP list when no reply from them had been received. She added that a Contract Manager, Bill Cane, had been appointed in 2010 and would be agreeing a list cleaning protocol and formulising appropriate procedures to ensure the situation would not recur.

Members expressed the view that GP lists in the Borough continued to be a problem and were consistently not managed correctly. Questions were then put by Panel Members, to which Ms Jones responded as below:

- Prior to the problem occurring, there had been no list cleaning for five years and arrangements were being made for this to be managed as an annual routine.
- There had been recent agreed changes to the policy for registering with GPs, requiring less proof from patients to make the process easier. A "Find a Doc" service was available to assist patient choice.
- All GPs had to be able to undertake home visits to patients in their catchment areas – if a patient moved from that area, they would have to re-register elsewhere. However, there was usually good overlap of catchment areas.
- GPs also had the right to off-list patients, where relationships had broken down or a patient was violent. Nevertheless, measures were taken to ensure the patient could re-register in an alternative location and a mediation service was also available.
- Changes to practice boundaries had to be agreed by the PCT, to ensure reasonable cover in all areas.
- GPs had to write to patients who had not made contact for some time but some practices had up to 42% annual turnover, which resulted in much work to keep lists accurate.

The Chair commented that the process that was used where people had been removed seemed to have been heavy-handed. An assurance was needed for consultation on the new procedure with THINk members to make sure that there was no recurrence. There was a need for cross-referencing of data and a more robust process. Ms Jones indicated that Vivienne Cencora, Associate Director, intended to have dialogue with various forums and there would be an annual process for list cleansing that would involve THINk.

The Chair remarked that the report submitted to the previous meeting had been of little value owing to the lack of numerical details and a full report was needed explaining the new process and wider issues around off-listing (i.e. how many people were off-listed annually), patient choice, etc. A map showing GP catchment areas in the Borough should also be included.

Ms Jones **agreed** to provide such a report to a future meeting.

4.4 Tower Hamlets Primary Care Trust Workforce to Reflect the Community - Presentation

Deb Clarke, Director of Human Resources, NHS Tower Hamlets, made a detailed verbal, slide show and video presentation on the PCT workforce and made points including:

- The NHS was the largest employer in the country and encompassed a whole range of careers. NHS Tower Hamlets employed about 1400 full time posts.
- Aims of the organisation were to employ more local people at all levels and in all professional areas; to address all strands of equality; to grow

and develop the careers of their own staff; to increase the levels of BME (particularly Bangladeshi) staff.

- 50% of the Tower Hamlets NHS workforce was BME, with 13%-14% Bangladeshi and it was hoped to reflect all aspects of diversity in top management.
- 12% of staff had declared themselves as disabled and the organisation had been recognised by Stonewall as being in their top 50 London employers. NHS Tower Hamlets also subscribed to the double-tick disability symbol.
- A whole range of apprenticeships was available to allow people to access NHS careers and there was also close liaison with Tower Hamlets College and the Central Foundation Girls' School.
- Senior management had introduced a breaking through top talent to NHS programme and this had supplied solely female Bangladeshi staff in 2009/10. A website was also available to help local people into the NHS economy, as they could apply for posts or register to acquire skills that would enable them to do so.
- A scheme existed to assist local graduates into commissioning roles and work was in progress on establishing a joint scheme with the Council.
- There was a Tower Hamlets youth intake every year and a good practice recruitment guide had been implemented for managers.

Replying to questions and points made by Panel Members, Ms Clarke added that a range of courses was available for various career paths and the organisation was flexible about how ongoing staff development could continue. 50-60 local Bangladeshi girls had recently been awarded qualifications to pursue a career in nursing/midwifery. Other options than an academic route to these careers were also being pursued.

Ms Clarke **agreed** to forward details of all current employment schemes to Afazul Hoque, Scrutiny Policy Manager, for onward transmission to the Panel.

The Chair thanked Ms Clarke for her comprehensive presentation.

4.5 Health for North East London - Local Consultation Plan

Mr Jeremy Gardner, Head of Communications & Engagement, NHS Tower Hamlets, introduced a report detailing a consultation programme on proposals that aimed to:

- Improve the quality and safety of hospital care.
- Develop more care in the community through investment in primary care and the delivery of new and improved health facilities.
- Make health services more accessible by moving them closer to people's homes.
- Improve the treatment for people with long-term conditions.

The programme would include an on-line questionnaire; meetings with forums at government and local levels; meetings with local traditionally under-represented groups and a series of public roadshows.

In response to queries from Panel Members, Mr Gardner indicated that:

- The website questionnaire was quite involved but sought to obtain people's views and reasons for giving particular answers, rather than being just a form of vote.
- Bi-lingual staff would be available at all roadshows and the events would be aimed at a range of BME groups, not only Bangladeshi.
- There was a strong case for centralising certain services, such as the cardiac care at the London Chest Hospital and other trauma units. Staff would be encouraged to obtain additional skills.
- Health inequalities were being approached across the board, but not necessarily all groups in all Boroughs: e.g. white disengaged working class were being targeted but not specifically in Tower Hamlets.
- The driving force behind the proposals was that the quality of skills and care available in individual hospitals was inconsistent and was not successful financially or in allowing staff to develop specialist skills.
- The whole picture of the NHS would be changing in nature and care provision would move increasingly closer to the home.

It was **agreed** that Afazul Hoque, Scrutiny Policy Manager, would look into means of encouraging LBTH staff to engage with and completed the on-line questionnaire.

4.6 Commissioning Strategic Plan

Mr Andrew Ridley, Deputy Chief Executive NHS Tower Hamlets, introduced a report and tabled paper on the preparation of the Commissioning Strategy Plan for the next five years. He made the point that health care inflation was particularly problematic as 70% of total expenditure was accounted for by wages/labour costs and ran at a much higher rate than normal. However, this did not alter strategic service aims. The 10 strategic goals were set out in the tabled paper, along with measures to deliver the NHS vision and save money while improving services. The process of forming polysystems was continuing and GP were now formed into Networks that were co-terminus with LAPs. The aim was that in three to four years there would be a much improved primary care system, thus necessitating fewer hospital admissions.

Mr Ridley and Mr Alan Steward, Deputy Director, Corporate Development & Performance, responded to questions from the Panel, commenting that:

- There was needs information for all LAPs but the CSP document used LAPs 7 and 8 to illustrate both the data available and the planned polysystem. The PCT benchmarked its service quality, performance and data against other London PCTs, nationally and internationally to drive service and outcome improvements.
- For the first time a structure existed that matched that of the Council's administrative arrangements.
- GP list turnover could be high, reflecting the mobile local population, but was more stable in some areas of the Borough.
- There was a severe lag in the national budget allocation process reflecting the impact of population growth. Currently, some 243,000

patients were registered in the area but the Department of Health still worked from the last census figure of 205,000. In addition, there were large, rapid developments in some parts of the Borough that were not adequately reflected in the NHS budget allocation process.

Mr Steward **agreed** to make the full Commissioning Strategic Plan available to Afazul Hoque, Scrutiny Policy Manager, for onward transmission to the Panel.

The Chari thanked Messrs. Ridley and Steward for their contribution.

4.7 Update on Health Scrutiny Panel Work Programme 2009/10

The Chair indicated that the last inquorate meeting had been unable to approve the work programme and this was further submitted for comment.

It was **agreed** that the proposed Health Scrutiny Panel work programme 2009/10 be approved for action.

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

The Chair reported that the following events were imminent:

- Health Scrutiny Review on Childhood Obesity – 6th February at Toby Lane Depot.
- Inner North East London Joint Overview & Scrutiny Committee – 11th February at 9.30 a.m., Newham Town Hall

The meeting ended at 9.15 p.m.

Chair, Councillor Tim Archer
Health Scrutiny Panel

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**23 March 2010**	**Unrestricted**		**4.1**
Report of: **Tim Young – Associate for the Centre for Public Scrutiny**		**Title:** **Health Scrutiny Panel Evaluation** **Ward(s) affected:** All		

1. Summary

As the Health Scrutiny Panel's four- year work programme approached its end, it was agreed in October 2009 that it would be beneficial for an external evaluation.

LB Tower Hamlets commissioned Tim Young, Associate for the Centre for Public Scrutiny, to carry out the evaluation and submit a report in February 2010.

The review is based on the Centre for Public Scrutiny's principles of good scrutiny and the evaluation tested views from across the authority and its partners on the effectiveness of the four-year programme. The bulk of the work involved in this evaluation took place in January and early February 2010. The approach was based on a review of extensive documentation from the Council and all health partners; a range of interviews with Members, council officers and health partners' personnel as well as an observation of the Health Scrutiny Panel meeting on 26th January 2010.

It is an important piece of work identifying both strengths and weaknesses as well as providing recommendations for improvements to the HSP as we look to the 2010/2011 programme.

The report provides an executive summary and is structured around the four key benchmark areas for a health scrutiny programme: Aims; Accountability, Coherence and Balance; Partnership and Outcomes.

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the report and its recommendations.

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An evaluation of the London Borough of Tower Hamlets' health scrutiny programme

March 2010

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Summary

Much has been done to build the credibility and effectiveness of scrutiny in Tower Hamlets in the past few years. It is evident from the work conducted for this evaluation that the practice of health scrutiny has contributed significantly to scrutiny's current overall standing and achievements in Tower Hamlets. Health scrutiny is recognised as a lever for change at strategic and local delivery levels, by increasing the visibility of issues and helping to make them a higher priority for health partners or the Council. Health partners have played their role in this journey, by taking health scrutiny seriously and investing time and effort in working with Health Scrutiny Panel (HSP) members and scrutiny officers.

As a result, the health scrutiny programme – a unique four year initiative aimed at tackling local health and health-related issues jointly across local agencies – has been a vehicle for challenging and addressing health inequalities and underperformance. There have been a number of successes in contributing to the shaping and improvement of service strategies and provision, through, for example, the access to GP and dentistry services and tobacco and smoking cessation reviews. Information available to local people regarding health services has been improved. Elected members are also engaging more effectively with service users and NHS trusts across the borough. This is a strong platform on which to build, particularly given the enthusiasm and willingness of the Trusts to engage.

The health scrutiny programme work has been carried out with an understanding that the primary aims of health scrutiny are to identify whether health and health services reflect the views and aspirations of the local community and ensure that all sections of the community have equal access to services and an equal chance of a successful outcome from services. An extensive induction and planning process in 2006 agreed three broad cross-cutting themes for its work programme:

- health promotion and prevention through work with health partners and other third sector organisations
- developing better integration and partnership to improve joint service provision
- improving access to services as a key way of tackling health inequalities

Alongside these themes, it identified three specific health issues as priorities for the borough – smoking, heart disease and mental health – that reflect local circumstances and the needs of local people.

A coherent programme of health scrutiny

The HSP has worked hard to construct a coherent scrutiny programme, taking account of other audits and reviews, and has sought to provide effective public accountability. Over the four years it has also had to take on board substantial pieces of work, not easily anticipated, involving joint health overview and scrutiny committees on a sub-regional and pan-London basis, although Members have

not always prioritised some of this work. One of the HSP's strengths is that it has been broadly effective at 'the reactive agenda' – in picking up and dealing with local residents' pressing health issues – although there is more that could be done to ensure that the HSP is aware of patients' and residents' problems that are being raised through other means, especially via the Tower Hamlets Local Involvement Network (THINk).

There have been issues, however, that have inhibited the effective delivery of a coherent and proportionate programme of health scrutiny. Firstly, the sheer scale of health problems and inequalities in Tower Hamlets has posed problems for the HSP in constructing and prioritising its agenda. The HSP is inclined towards employing a 'broad and shallow' as opposed to a 'narrow and deep' approach, and a result rigorous scrutiny and holding to account can suffer. There are concerns, therefore, that very important health issues and developments have not always received the attention they have merited.

Secondly, the HSP has not always chosen to keep strictly to the broad topics agreed at the start of the programme. This has meant that the four year programme has been perceived by some as functioning in some respects more as a year by year programme, with annual refreshing. For the future, the greatest benefit can be expected from a four year health scrutiny programme that starts with a clear framework, set of priorities and topics for its work, but there can be a danger in an over-rigid approach. Some flexibility therefore in the choice of scrutiny reviews is important, but it is vital to ensure that any recasting of the programme is firmly based on objective evidence about local priorities.

Once reviews have been decided, though, the scrutiny process has been robust. But in future, there may be possibilities for improvement in the review process, and ultimately review outcomes, by taking more of a cross-sectoral view when examining health issues. This would tie in well with a 'Total Place' approach to investigating new approaches to efficient use of resources through integration and targeting to produce service improvements.

The practice of doing only one review a year might also be reconsidered, since two more focused reviews, completed in a shorter timescale, might be of greater value. This may have implications for staffing, with a need for the scrutiny officer currently supporting the HSP to become fully dedicated to health scrutiny. In addition, there is some scope for improving the quality of the recommendations produced, to enable clearer measures of success to be drawn and to improve monitoring and holding to account.

There are also improvements that the HSP could make to planning and managing its agenda. Health partners are willing to have planning conversations at a higher level to try to ensure that agendas can do justice to the 'big issues' in health. There is a case for following a 'less is more' approach, to ensure more manageable agendas lead to more robust scrutiny, which should have more

impact in adding value. The HSP also needs to revisit its earlier consideration of other ways for the HSP to carry out its work without putting items on panel agendas or making them the subject of scrutiny reviews.

There are further improvements that the HSP might consider in order to make its meetings more effective. Being briefed about the key issues, drawing more fully on patient and service user experiences, and developing questioning strategies before the meetings take place would enable HSP members to offer a more robust 'critical challenge' to the professionals.

A partnership approach

Over the past four years, and in particular the last two, the HSP has successfully pursued a partnership approach to its scrutiny programme, although more could be done on bringing effective working relationships with all partners up to the level of the best. For the new HSP work programme beginning in May 2010 with a new administration, it will be important to draw on previous experience to employ the most effective ways of engaging HSP members – including the Panel's co-optees – and health partners in its planning. There is further potential in developing the HSP's working relationship with THINk over the next four years, to make use of its gathering of patient and public experiences of health and social care services.

The process of holding extensive open discussions about what the new health scrutiny programme's priorities and content and debating the merits of various suggestions should help to make the programme not only as relevant as possible but also to increase the likelihood of agency buy-in and co-operation. Resource limitations will mean that the programme will need to rein in 'ideal world' proposals: the aim should be to have realistic but nonetheless challenging expectations of what the programme can undertake and deliver.

The programme should also seek to mainstream health inequalities work, particularly in view of the Marmot review's focus on policies and interventions that address the social determinants of health inequalities. Current moves to work with the Community Plan Delivery Groups to find ways of strengthening the relationship between Overview and Scrutiny and the Tower Hamlets Partnership to help deliver the Community Plan's priorities are a welcome sign of an ongoing commitment to strengthen partnership involvement in health scrutiny and vice versa.

The HSP also needs to capitalise on the bipartisan approach to health issues and provision in Tower Hamlets. There is scope for it to do more to develop and use its relationship with the Lead Member for Health and Wellbeing as a way of firming up the strong leadership and vision needed as one of the 'strategic levers' underpinning the successful tackling of health inequalities.

Through the Overview and Scrutiny Committee and its Scrutiny Leads, the HSP should press to ensure that that the health dimension is considered in all scrutiny reviews and that health impacts of strategies, policies and services are given full consideration across all council directorates. Partnership working with NHS colleagues and other working in the health and social care field should be encouraged not just at the strategic and most senior levels but also lower down the officer structure. In particular, the HSP needs to strengthen its links with both the Adults' Health & Wellbeing and Children, Schools & Families Directorates to ensure they are as fully engaged as possible in its work.

The community leadership role
Particular attention needs to be directed as well to the way in which Members' role as community leaders in constructively informing and shaping proposed changes to service provision might be supported and enhanced. A wider appreciation of how Members can use their community leadership role and skills as part of the problem-solving process will be particularly important in view of the likely service reductions and changes over the next five years that are forecast under the PCT's new Commissioning Strategic Plan.

Of direct relevance here is the recent Scrutiny Review Group's report on Strengthening Community Leadership, which makes proposals for developing a new model of community leadership with an accent on a more dynamic problem-solving approach; increasing resident participation; and increasing engagement through partnership. Its recommendations link strongly with several in this report. The two pieces of work should therefore be considered in tandem in order to reinforce each other.

It is critical that all the above developments are accompanied by both a strong degree of continuity in the membership of the HSP over the lifetime of the forthcoming new administration and a degree of extra commitment by Members. The aim here is twofold: to ensure that HSP members can play the fullest part as strategic leaders in public health, exercising the community leadership role of local government to improve health and address health inequalities in their widest aspects; and to ensure that in doing so the burden of health scrutiny does not fall on just a few shoulders.

Efforts to engage patients and residents in scrutiny reviews should continue, and a number of measures are proposed to help enhance the level of public engagement with health scrutiny. A clearer understanding about areas of responsibility and operation between the HSP and THINk could help to reap the benefits of effective joint working through co-ordination of effort. More use too could be made by health scrutiny of the eight Local Area Partnerships (LAPs), which play a role in identifying and communicating local priorities and holding health services (amongst other public providers) to account for the quality of services in the area.

Conclusion

Tower Hamlets has built strong foundations for its health scrutiny function but recognises that there are improvements that can be made. The suggestions in this evaluation of the health scrutiny programme are offered to assist Members and all health partners to make the journey, as one contributor put it, “from good to great.”

Recommendations

We believe our recommendations set out below will help overview and scrutiny to improve the effectiveness of the health scrutiny programme. The main body of the report also contains some suggestions for what it might focus on in future.

Ensuring scrutiny incorporates best practice in addressing health inequalities

i) ensure the implications of the Marmot report are incorporated into the HSP's thinking about the aims of the new health scrutiny programme and the content of the programme itself (paragraph 38)

ii) benchmark the HSP's work and that of Tower Hamlets against those authorities which have been awarded Beacon status for reducing health inequalities, to learn lessons from their best practice, including ways of focusing on internal health inequalities (paragraph 39)

Improving the approach to programming health scrutiny and carrying out reviews

iii) try new ways of carrying out and gathering evidence for scrutiny reviews, to help keep the approach fresh, innovative and securely evidence-based (paragraph 57)

iv) consider taking a cross-sectoral, 'Total Place' approach to the overall framing of the new health scrutiny programme for 2010-2014, as well as individual pieces of work, to ensure that all health partners, the Council and the voluntary and community sector in Tower Hamlets are able to play their part in addressing the key health issues that the borough faces (paragraph 60)

v) review the practice of doing only one HSP scrutiny review a year, to see if two more focused reviews, completed in a shorter timescale, might be of greater value (paragraph 62)

vi) consider making improvements in the quality of the recommendations that the HSP produces in its work, to enable clearer measures of success to be drawn from the recommendations and facilitate more effective monitoring and holding to account of Cabinet, Council officers and health partners (paragraph 63)

Improving the partnership approach to health scrutiny

vii) explore holding agenda planning conversations with health partners at a higher level to try to ensure that agendas can do justice to the 'big issues' in health (paragraph 66)

viii) explore following the 'less is more' approach to agenda planning in order to add more value by giving fewer but better resourced work items more robust scrutiny (paragraph 67)

ix) explore using the most appropriate method for considering different scrutiny items, in order to use the HSP's time and resources more effectively (paragraph 68)

x) ensure the induction programme for new HSP members (including the Panel's co-optees) in 2010/11 draws on the experience of previous inductions to employ the most effective ways of engaging HSP Members and enabling them to a) acquire a clear picture of current health issues and strategies; and b) start to develop effective working relationships with key health partner contacts (paragraphs 73, 74)

xi) ensure the induction process for new councillors includes discussions with Tower Hamlets Local Involvement Network (THINk) and consider ways to share information collected by THINk from patients and the public (paragraphs 76, 77)

Mainstreaming health inequalities and health scrutiny work

xii) allied to efforts to strengthen the relationship between health partners and health scrutiny, continue to seek ways to strengthen the relationship between Overview and Scrutiny and the Tower Hamlets Partnership to help deliver the priorities of the Community Plan (paragraph 78)

xiii) review how the HSP could do more to develop and use its relationship with the Lead Member for Health and Wellbeing, as a way of firming up the strong leadership and vision needed as one of the 'strategic levers' underpinning the successful tackling of health inequalities (paragraph 82)

xiv) promote consideration of the health impacts of strategies, policies and services by all council directorates, as a method of mainstreaming health inequalities work (paragraph 83)

xv) request Executive Leads to encourage partnership working with NHS colleagues and other working in the health and social care field not just at

the strategic and most senior levels but also lower down the officer structure (paragraph 83)

xvi) promote the development of a core group of public health champions in decision-making positions across all functions, through the use of a health training course for senior/third tier managers (paragraph 84)

xvii) ensure that a health dimension is included in the Overview and Scrutiny Committee's considerations of topics for scrutiny reviews and that its Scrutiny Leads are aware of what is available in terms of evidence sources and witnesses, from inside and outside the Council, to make reviews as soundly-based as possible in terms of health impacts (paragraph 85)

xviii) ensure that the relevant council directorates, in particular the Adults' Health & Wellbeing and Children, Schools & Families directorates, are as fully engaged as possible in the HSP's work directly and that directorates are made aware of the criteria which the HSP uses to assess whether topics are sufficiently important to be included in the work programme (paragraphs 86, 87, 90)

xix) ensure the new 2010-2014 health scrutiny programme is 'an informed joint enterprise' by holding extensive open discussions about its priorities and content, to produce a realistic but challenging programme and increase the likelihood of partners' buy-in and co-operation (paragraph 91)

Developing the Health Scrutiny Panel's abilities and Members' community leadership role

xx) explore opportunities to increase the HSP's 'critical challenge' function through topic briefings, holding all-party pre-meetings to develop questioning strategies in advance and attending a questioning skills development session (paragraph 94)

xxi) consider co-opting a representative from the East London NHS Foundation Trust's Council to bring in particular experiences that might otherwise be lacking on the HSP panel (paragraph 94)

xxii) explore how to develop a wider appreciation of how Members can use their community leadership role and skills as part of the problem-solving process in health and social care (paragraph 96)

xxiii) ensure that the recommendations of the Scrutiny Review Working Group on Strengthening Local Community Leadership are considered in tandem

with this report's, so that there is a health dimension to this developing work on community leadership (paragraph 97)

Laying foundations for the next four year health scrutiny programme

xxiv) ensure that in the HSP's future work programme account is taken of the strong possibility the further pan-London and sub-regional health service changes may require a substantial investment of time and effort participating in Joint Health Overview and Scrutiny Committees (paragraph 99)

xxv) continue efforts to engage patients and residents in scrutiny reviews, while considering other means of public engagement, such as co-options, holding some HSP meetings in more geographically accessible locations, increasing dialogue with THINK's membership and increasing the publicity effort for health scrutiny (paragraphs 104, 105)

xxvi) review the HSP's relationship with both LAPs and THINk to develop clarity about respective roles vis-à-vis holding health and social care services to account, and to reap the benefits of effective liaison and joint working (paragraphs 106, 107)

xxvii) consider increasing the scrutiny staffing resources so that there is a dedicated health scrutiny officer, as is common in a number of other authorities of comparable size to Tower Hamlets, to enable the post to assume a more strategic role around workload planning, prioritisation, analysis of information, commissioning of additional research and providing support for HSP members (paragraph 108)

xxviii) explore how to achieve the necessary high degree of continuity in the membership of the HSP over the life of the next four year programme and how to facilitate HSP members' input and engagement with the work for maximum effectiveness (paragraphs 110, 113)

Background and context

1. Tower Hamlets is a small, densely populated borough. Its current population of around 235,000 is expected to reach 300,000 by 2020. The borough is made of a number of long-established communities as well as more recent neighbourhoods created by the regeneration of the old docks.

2. Tower Hamlets is one of the most diverse boroughs in the country. Almost half the population are from a minority ethnic group, and around 110 different languages are spoken by its school pupils. Nearly one in three people come from a Bangladeshi background and there are significant numbers of Somalis, Lithuanians and Romanians in the borough. It is a very young borough, with 35% of the population aged between 20 and 34 (compared to the 18% average for the rest of inner London). Over 70% of its young people are from minority ethnic backgrounds.

3. Immense wealth sits side by side with serious poverty. The continued development of Canary Wharf has brought much economic growth and many highly paid jobs into Tower Hamlets, lifting the average salary for people who work in the borough to nearly £69,000. But unemployment is high and almost two in five households live on less than £15,000. As a result, many children live in poverty and a lot of people suffer from poor health.

4. Expensive new private riverside housing developments sit alongside social housing estates. Housing affordability is low by national standards - with an average price of £380,835 which is more than double the average in England and Wales - and out of reach for most local people. Overall, Tower Hamlets is the third most deprived borough in the country.

5. Residents' health is a concern locally, since in general it is poorer than in the rest of England. People in the borough are more likely to experience conditions such as cancer, diabetes, stroke and heart disease. There is also a worryingly high rate of obesity for some children, with the borough having the fifth highest rate in the country at reception year and sixth highest in year 6.

6. Residents do not live as long as people in other parts of the country: average life expectancy at birth is 75 for men and 80 for women, ranking Tower Hamlets 383rd and 361st respectively, out of 432 local areas. Death rates are falling steadily from year to year, but there is little evidence of a reduction in the gap between Tower Hamlets and the rest of the country. There are also inequalities within the borough: the life expectancy of a boy born in Bethnal Green North is 8.5 years less than that for a boy born in Millwall, and that of a girl born in Limehouse is 5.7 years less than for a girl born in Bromley-by-Bow.

7. The Tower Hamlets Partnership Is working hard to improve residents' health, including tackling the underlying causes such as poverty, poor housing and unemployment. In addition, the borough has been awarded 'Healthy Town' status. It is one of only nine partnerships nationally and the only London Borough to secure extra government funding to encourage residents to eat more healthily and participate in more exercise.

8. Tower Hamlets' sustainable community strategy has recently been revised to become the 2020 Community Plan. The overall aim of the new plan is to "improve the quality of life for everyone who lives and works in the borough". Underpinned by a desire to build 'One Tower Hamlets' the borough's new priorities have been developed under four new themes:
   - a great place to live;
   - a prosperous community ;
   - a safe and supportive community; and
   - a healthy community

9. The Council currently has a Leader and Cabinet model of governance. Fifty one councillors represent 17 wards across the borough. There are 32 Labour, 9 Conservative, 4 Liberal Democrat and 6 Respect councillors. The Cabinet comprises the Leader and Deputy Leader and eight other portfolio holders, as follows:

   - Resources and Performance
   - Children, Schools & Families'
   - Cleaner, Safer, Greener
   - Culture and Leisure
   - Housing and Development
   - Employment and Skills
   - Health and Well-being
   - Regeneration, Localisation and Community Partnerships

10. The Overview and Scrutiny function is provided by the Overview and Scrutiny Committee which coordinates all overview and scrutiny work. It has nine councillors, reflecting the overall political balance of the Council, and provision for five co-optees with specific responsibilities for education. The Chair of the OSC oversees the work programme of the committee as well as taking a lead on monitoring the Council's budget. There are also are five 'scrutiny leads' - one for each of the themes in the Tower Hamlets Community Plan, with a further lead on 'Excellent Public Services'. The Scrutiny Lead for the 'Healthy Communities' theme is also Chair of the Health Scrutiny Panel.

11. The Health Scrutiny Panel (HSP), formally a Sub-Committee of the Overview and Scrutiny Committee, discharges the Council's specific

statutory responsibilities for health scrutiny. The HSP can look at any matter about health services within the borough including hospital and GP services, health promotion and prevention. This includes the way that health services are planned, how services are provided and how NHS organisations consult with local people.[1]

12. The HSP is chaired by Councillor Tim Archer and the Vice-Chair is Councillor Ann Jackson. It has a further five councillors sitting on it, as well as three co-optees – two from Tower Hamlets Local Involvement Network (known as THINk) and one from the Future Women Councillors Programme.

13. The scrutiny support function is located in the Chief Executive's Directorate, reporting to the Service Head of Scrutiny and Equalities. The Scrutiny Policy Team consists of a Scrutiny Manager and three scrutiny policy officers, one of whom is responsible as part of her job for servicing the Health Scrutiny Panel.

14. The borough has been divided into eight local Area Partnerships (LAPs), based on local wards. Each of the LAPs provides a platform for local residents to have their say on the improvements in their area, and to influence how the changes are carried out.

15. Each LAP has a steering group made up of around 15 local residents, six ward councillors and six service provider representatives. As a group they have a number of aims, including to:

- help deliver the Tower Hamlets Partnership's objectives and contribute to performance against the targets set out in the Local Area Agreement (LAA)
- develop innovative approaches to the delivery of key targets at a local level based on gathering intelligence, promoting joint working and joint problem solving

[1] The Health Scrutiny Panel's formal terms of reference are:

(a) To review and scrutinise matters relating to the health service within the Council's area and make reports and recommendations in accordance with any regulations made thereunder;

(b) To respond to consultation exercises undertaken by an NHS body; and

(c) To question appropriate officers of local NHS bodies in relation to the policies adopted and the provision of the services.

- work with the Community Plan Delivery Groups to agree local activities and projects linked directly to the LAA targets most relevant for their LAP area
- review and monitor local evidence on performance and outcomes to inform action planning
- develop local participation and empowerment
- help build local capacity
- channel entrepreneurial energy

16. Tower Hamlets Council is a major authority which employs around 10,500 staff, around 4,800 of whom are based in schools (including teachers), and has a revenue budget of over £500 million (including schools). The Council's Corporate Management team is headed by the Chief Executive and includes five Corporate Directors and two Assistant Chief Executives. The joint appointment of a Director of Public Health with the Primary Care Trust demonstrate a willingness to adopt a cohesive approach to planning across organisational boundaries.

17. Under the recent Comprehensive Area Assessment (CAA), Tower Hamlets Council scored 3 out of 4 in the assessment for its use of resources and was judged to be good at managing its money, assets and natural resources. It also scored 3 out of 4 for managing its performance. For the previous four years the Council's social care services for adults and older people had been assessed by the Care Quality Commission as 'performing excellently' and its services for children and young people had been assessed by Ofsted as 'excellent'. In addition, Tower Hamlets was awarded a 'Green Flag' for its exceptional performance or innovation in engaging and empowering local people.

18. The CAA also noted that the Tower Hamlets Partnership is making a good contribution to meeting ambitious strategic and partnership targets, with about two thirds of those targets within the Strategic Plan and the Local Area Agreement (LAA) on track to be met. Targets at risk of not being met included some health targets, such as childhood obesity and teenage pregnancy.

19. The CAA for Tower Hamlets also included an assessment for the Primary Care Trust (PCT), which rated the quality of commissioning of services for its local population by the PCT Care Trust as 'weak', and the financial management for the organisation as 'good'.

Background to the evaluation

20. The overall overview and scrutiny function at Tower Hamlets is evaluated on an annual basis through holding an evaluation meeting for scrutiny

members, with facilitation. These evaluations have included consideration of the health scrutiny function and have contributed to learning and development. Nearing the end of the health scrutiny four year programme, however, it was felt that a more extensive, focused review specifically of health scrutiny would enable the borough to check how effective its practice has been and consider any recommendations for how it might achieve better outcomes. An external scrutiny consultant (with some experience of overview and scrutiny in Tower Hamlets) was commissioned in order to provide greater challenge and to bring experience of relevant good practice in the field of health scrutiny from elsewhere.

Methodology

21. The objective of this evaluation exercise has been to help the authority to assess its current strengths, potential areas for improvement and its capacity to change. The approach has been a supportive one, undertaken by a 'critical friend' with practical experience of both overview and scrutiny work in other authorities and current developments in health scrutiny. The intention has been to help the council – and its partners – to identify both current strengths and what could be improved.

22. Evaluation of a council's overview and scrutiny function characteristically uses the Centre for Public Scrutiny's four principles of good public scrutiny as a benchmark, [2] and considers the roles and relationships, process and practice, and skills and support in place to enable effective scrutiny to operate. These principles have formed a backcloth to this evaluation.

23. But since this has been an evaluation of *health* scrutiny in Tower Hamlets and its four year health scrutiny programme, another set of benchmarks specifically developed for evaluating health scrutiny has been used. The Centre for Public Scrutiny's Health Scrutiny programme [3] uses the

[2] The four principles are:
- provides 'critical friend' challenge to executive policy-makers and decision-makers
- enables the voice and concerns of the public
- is carried out by 'independent-minded governors' who lead and own the scrutiny role
- drives improvement in public service

[3] Since 2004, the Centre for Public Scrutiny has also been running a Department of Health funded support programme for the 150 health overview and scrutiny committees of social services authorities – see www.cfps.org.uk/what-we-do/

following set of principles as benchmarks against which to assess a health scrutiny programme:

Aims
- taking account of and seeking to redress health inequalities
- promoting health and well-being in response to local circumstances and the needs of local people

Accountability, coherence and balance
- providing the conditions for effective local accountability to local people in relation to their health and well-being
- a coherent and proportionate programme which has taken account of other audits and reviews
- reflecting a proper balance between 'mainstream scrutiny of public health issues and scrutiny of specialist areas of health
- reflecting the complex solutions required for cross-cutting issues which impact on health and well-being

Partnership approach
- an informed joint enterprise between the Health Scrutiny Panel (supported by the Overview & Scrutiny Committee) and partners in the health economy
- recognising the range of settings and providers on the 'patient journey', including the contribution of the voluntary and private sectors
- constructively informing and shaping proposed changes to health service provision which affect residents in Tower Hamlets

Outcomes
- resulting in local action and improvements to local service delivery
- producing outcomes which have helped to improve the health and well-being generally of local people

24. The bulk of the work involved in this evaluation took place in January and early February 2010. The approach was based on a review of extensive documentation from the council and all health partners; a range of interviews with Members, council officers and health partners personnel (see Appendix 1 for details); and observation of a Health Scrutiny Panel meeting on 26th January 2010. This has helped to identify strengths in the health scrutiny programme and how it has been carried out and areas for further consideration and improvement.

25. This evaluation was undertaken by Tim Young, a Centre for Public Scrutiny associate, assisted by Graham Peck of Peck and Company. We have appreciated the welcome and hospitality provided during this

evaluation and would like to thank everybody that we met during the process for their time and contributions, particularly Katie McDonald who supplied all the background documents and arranged all our interviews.

26. This report is structured around the four key benchmark areas for a health scrutiny programme mentioned above: aims; accountability, coherence and balance; partnership; and outcomes.

Aims of the health scrutiny programme

Has the programme:
- taken account of and seeking to redress health inequalities?
- promoted health and well-being in response to local circumstances and the needs of local people?

"Health scrutiny is both a challenge and an opportunity for local authorities and the NHS. Its primary aim is to act as a lever to improve the health of local people, ensuring that the needs of local people are considered as an integral part of the delivery and development of health services."

Department of Health, *'Overview and Scrutiny of Health – Guidance'* (2003), para.1.1

27. The overview and scrutiny role was introduced in local authorities by the Local Government Act 2000 to complement changes in executive arrangements, but the specific powers for the additional role of scrutiny in relation to health were not formally granted until a year later, by the Health and Social Care Act. Guidance on the exercise of these powers did not appear until 2003. During this gestation period and since, debate and discussion among agencies and practitioners have helped clarify the role of health scrutiny. We can summarise this in a series of propositions:

- The role of health scrutiny is to improve the health of local people, by ensuring that their needs are considered as an integral part of the delivery and development of health services
- But the power to scrutinise health services should be seen and used in the wider context of the local authority role of community leadership and of other initiatives to promote the social, environmental and economic well-being of an area - health scrutiny members have a role as 'strategic leaders in public health'
- Health scrutiny should therefore also be linked to scrutiny of local authority services and actions that relate to the broader determinants of health, and its role is to ensure that local health and health-related issues are being tackled jointly across local agencies
- Scrutiny should therefore be part of a positive approach to partnership working and a vehicle for local authority involvement in health planning and tackling health inequalities and wellbeing issues
- Taken overall, health scrutiny offers local councillors a way to hold health services to account, to respond to the health and wellbeing concerns of their residents and to offer practical solutions or ways forward

28. How then does the Health Scrutiny Panel's work measure up to this role, with particular regard to taking account of health inequalities and promoting health and well-being locally?

29. The most striking aspect of the Health Scrutiny Panel's work is the uniqueness of its initiative in developing a four year programme to tackle health inequalities in Tower Hamlets. Other boroughs have shared Tower Hamlets' desire to focus on health inequalities [4] but a key defining factor in the HSP's approach has been to focus on tackling health inequalities on a systematic basis over the lifetime of an administration. As we shall see, it has not always been possible to hold fast to the broad programme for various reasons. But from the outset, the programme has been based on a commitment to seek to redress health inequalities and promote the health and well-being of local people in response to local circumstances and needs.

30. The starting point for this assessment of the aims of the health scrutiny programme lies in the work undertaken to construct a new health scrutiny programme after the municipal elections in May 2006.

31. In the two years prior to May 2006, the HSP had largely delivered on a work programme which had included:
- three well-received reviews on diabetes, sexual health services and delivering 'Choosing Health', using obesity as a case study
- the first year of Annual Health Checks – including joint meetings with health scrutiny in Hackney and Newham relating to East London and the City Mental Health Trust
- working to improve relationships between the HSP and local health partners

32. This work was carried out with an understanding that the primary aims of health scrutiny are to:
- identify whether health and health services reflect the views and aspirations of the local community
- ensure all sections of the community have equal access to services
- ensure all sections of the community have an equal chance of a successful outcome from services

33. Through an extensive induction programme involving both HSP members and health partners at the beginning of the new council administration in May 2006, this understanding was carried over and taken on board by the new membership of the Health Scrutiny Panel, which endorsed the

[4] See examples in Lucy Hamer, *Local government scrutiny of health: using the new power to tackle health inequalities* (HAD, 2003)

proposition that "addressing health inequalities was and remains a key challenge for Health Scrutiny."[5] The broad cross-cutting themes agreed for the new work programme were:

- health promotion and prevention through work with health partners and other third sector organisations
- developing better integration and partnership to improve joint service provision
- improving access to services as a key way of tackling health inequalities

34. Alongside these themes, three specific health issues were identified as priorities for the borough: smoking, heart disease and mental health. These clearly reflect local circumstances and the needs of local people, although it is true to say that there are, unsurprisingly in an area such as Tower Hamlets, a number of other key health issues which the HSP could have chosen to focus on.[6]

35. Indicative of the concern, however, of the HSP to ensure that it addresses the health needs of local people was the inclusion of a piece of work to look at how local residents accessed health services, specifically GP and dentistry services. Councillors' local knowledge led to their awareness that many residents were unable to access effectively the appropriate form of service, with consequent effects on their health, and it was judged that helping to address this would provide a useful first step to challenging local health inequalities.

36. We will examine in more detail the content of the programme and how effective it has been in terms of outcomes in the next three sections.

37. Looking forward, there will be significant challenges posed by the changing landscape for local health services in Tower Hamlets that the HSP will need to take account of in thinking about its aims and how to realise them through a new work programme. These changes include:

- the development of an integrated sector plan for the East London and City Alliance (covering City and Hackney, Newham and Tower Hamlets), of which Tower Hamlets PCT's new Commissioning Strategic Plan (CSP) is a part
- the requirement for all PCTs to agree proposals for the future organisational structure of PCT-provided community services with their Strategic Health Authority by March 2010

[5] *Health Scrutiny Panel Work Programme 2006/07 – 2007/08 report*, Health Scrutiny Panel.
[6] See, for example, *Time for health: The annual report of the Joint Director of Public Health 2008- 2009*, which focuses on obesity and alcohol as well as tobacco usage.

- the further possibility of change to Tower Hamlets PCT through the amalgamation of borough-based London PCTs, breaking the current borough-PCT coterminous links
- the renewed bid by Barts and the Royal London NHS Trust to become a Foundation Trust, coupled with major service developments at its new hospital
- the drive to implement Healthcare for London, including the Darzi pathways and shift of care closer to home
- the financial pressures on the Council, the PCT and other public sector partners
- the likely service reductions and changes that are forecast under the PCT's new Commissioning Strategic Plan, and the considerable financial risk to the PCT if the required productivity growth and savings are not realised
- the significant patient and public involvement that these changes will require, in which the HSP will be expected to play an important role

38. A further important development is the publication of the Marmot report - the independent review commissioned to propose the most effective strategies for reducing health inequalities in England from 2010. [7] It will be important to ensure the implications of the Marmot report are incorporated into the HSP's thinking about the aims of the health scrutiny programme and the content of the programme itself. This will require dialogue between the HSP and its health partners, particularly the PCT's Director of Public Health.

39. The HSP could also usefully benchmark its work and that of Tower Hamlets against those authorities which have been awarded Beacon status for reducing health inequalities.[8] One aspect of the work of several

[7] *Fair Society, Healthy Lives: The Marmot Review Final Report on Strategic Review of Health Inequalities in England post 2010* (February 2010). The review had four tasks:

i) identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action
ii) show how this evidence could be translated into practice
iii) advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy
iv) publish a report of the Review's work that will contribute to the development of a post-2010 health inequalities strategy

[8] In 2008, six local authorities and one Fire & Rescue authority received the Beacon Award for their excellent work in reducing health inequalities. They were: Coventry City Council, Derwentside Council (now part of Durham County Council), London Borough of Greenwich, Sheffield City Council, and Sunderland City Council, plus Merseyside Fire and Rescue Service. See *'Reducing health inequalities: Beacon and beyond'* (IDeA, November 2009).

of these authorities was their focus on addressing internal health inequalities and the particular programmes they devised to tackle this issue. The desirability of a more explicit focus in a new health scrutiny work programme on the internal health inequalities which exist in Tower Hamlets was a point made to us by both the current Chair of the HSP and the Director of Public Health, and there may be lessons to learn from the Beacon authorities in this regard.

Accountability, coherence and balance

Has health scrutiny :

- devised a coherent and proportionate programme which has taken account of other audits and reviews?
- reflected a proper balance between 'mainstream scrutiny of public health issues and scrutiny of specialist areas of health?
- reflected the complex solutions required for cross-cutting issues which impact on health and well-being?
- provided the conditions for effective public accountability to local people in relation to their health and well-being?

40. There is evidence that the health scrutiny programme has mostly been constructed in a coherent fashion, taking account of other audits and reviews, and has sought to provide effective public accountability. The bulk of the programme's reviews and work clearly follows the priorities set out in the original proposals for the programme in 2006/7. Other pieces of work programmed in for the first two years, in keeping with health scrutiny's statutory responsibilities, included consultation by the PCT on maternity services, palliative care and the treatment of long-term conditions, and consultation by the East London and the City Mental Health Trust on the closure of a ward in St Clements Hospital.

41. This type of programming has continued over the life of the HSP's work programme. Most recently, in its last two meetings the HSP has examined reports on a range of issues including the review of Older People's Services; the annual report of the Safeguarding Adults Board; the Health for North East London local consultation plan; the Mental Health Care of Older People Strategy's redesign of older people's services at East London NHS Foundation Trust; and the PCT's Commissioning Strategic Plan for 2010/11 to 2015/6.

42. Other significant pieces of work which fall within the HSP's statutory responsibilities and have been programmed in over the period are the Annual Health Check process; two pan-London Joint Health Overview and Scrutiny Committees (JHOSCs) on consultation responses to the Healthcare for London strategic proposals and subsequently the significant changes to the delivery of major trauma and stroke services in London; and the sub-regional Health for North East London JHOSC.

43. We found acknowledgement in interviews we conducted that the HSP was also broadly effective at 'the reactive agenda' – in picking up and dealing with local residents' pressing health issues. One such example was the way the HSP took on board the issues relating to the appointments system, physical accessibility and treatment of patients at the Shah Jalal Medical Centre, and brought them to the attention of health commissioners and providers.

44. However, we found evidence of four particular issues affecting the HSP's delivery of a coherent and proportionate programme of health scrutiny.

The problem of prioritisation

45. Firstly, the sheer scale of health problems and inequalities in Tower Hamlets has posed problems for the HSP in constructing and prioritising its agenda – as one councillor put it, "we don't know what to cut out in order to focus on particular issues."

46. One result of the resulting 'broad and shallow' as opposed to a 'narrow and deep' approach is that rigorous holding to account can suffer. For example, Barts and the Royal London Hospital's view of the health scrutiny programme was that they did not feel particularly scrutinised and held to account, and that therefore health scrutiny had not been particularly meaningful for it, although it was acknowledged that the responsibility for changing this partly lay with the provider to become more engaged.

47. However, as a HSP councillor explained, it is difficult to challenge and hold to account a complex, enormously important, world leading health provider such as Barts and the Royal London. But even where the issues are of a smaller scale, such as a ward closure by the East London NHS Foundation Trust, we heard that its perception was that the HSP's questioning was not very searching and did not provide a 'critical challenge to match the thorough information provided. We will make recommendations about how to tackle this at a later point.

48. In a situation where health problems and issues are numerous, the necessity of prioritisation becomes even more acute. There is a balancing act to be maintained between spending time and resources on those

issues which are recognised as the most serious (as the original programme set out to do) and also dealing with other issues of public concern that may crop up, such as swine flu. We found some concern among health service mangers that the amount of attention given to some of this latter set of issues was disproportionate, given the importance of the deep-seated health issues facing the borough.

49. For example, the view was expressed that an item on the GP 'list cleansing' problem taken at the HSP meeting on 26th January 2010 could have been satisfactorily dealt with off the agenda, between the PCT and the HSP or the PCT and THINk, which first raised the issue. This would have freed up more time for the last item on the night which was the PCT's Commissioning Strategic Plan for 2010/11 to 2014/15. This set out eight programmes for achieving the PCT's ambitious goals while meeting the huge financial challenge of avoiding a potential deficit of £36m by 2014/15, rising to £50m by 2016/17 if nil growth in resources was matched by no action to manage demand and increase productivity to cater for population growth. This was in effect asking the HSP to start taking on a strategic community leadership role around the health programmes that would significantly impact over the next five years on all local residents.

50. On the other hand, for HSP members the time spent on the 'list cleansing' item was a productive exercise in holding the PCT to account for a project management error which impacted on some of their constituents and might impact again when the exercise is conducted on annual basis. As such, HSP members were exercising a community leadership role, in terms of responding to local concerns and employing an immediate problem-solving focus.

51. This example illustrates the problem of demands on the HSP's time and the multiple roles it is asked to play, and therefore in turn how to manage competing views about the content of health scrutiny agendas and how they should be drawn up. We make some recommendations on ways in which this might be done towards the end of this section.

Consistency or flexibility?

52. Secondly, in terms of the HSP's scrutiny reviews, while the panel's Smoking Cessation review was universally welcomed, we found evidence of some disagreement and debate about whether two of the reviews, on End of Life Care and Child Obesity, which were not part of the original programme, should have been conducted.

53. The inclusion of the End of Life Care review was challenged on the grounds of whether it was of a sufficiently high priority. However, it was acknowledged by focusing on the relevant social care services and other related services for which the Council has primary responsibility, the

review dealt with the potential difficulty that the PCT had already adopted the 'Delivering Choice Programme' piloting the Marie Curie toolkit to redesign and improve end of life care services. End of Life Care did not figure as a priority issue in the original HSP work programme. However, by seeking to improve how health and social care services worked together on this issue in order to create a seamless service, it is arguable that this review was anchored to the overall programme theme of 'developing better integration and partnership to improve joint service provision.'

54. The Childhood Obesity review raised a slightly different problem. It is clearly a major issue in Tower Hamlets, with long-term consequences, and has targets in the Local Area Agreement in recognition of the partnership approach that is required to address it. But it had already featured in the health scrutiny programme before 2006 as a case study in examining the delivery of 'Choosing Health'. [9] In addition, the planned review for 2009/10 that it replaced had been on mental health, which had been identified as one of the three specific priority health issues for the borough in discussions between HSP members and health partners.

55. However, although the Childhood Obesity review has not quite yet reported its work, it is evident that it has built on the earlier work and is taking an interesting approach to the issue. One of its aims is to try to add value to existing work on tackling obesity by including consideration of how the council might address directly the twin problems of the proliferation of fast-food outlets, particularly in the vicinity of schools, and the quality of the food that they provide. Although it revisited an issue, what this review illustrates is the HSP's willingness to investigate complex solutions required for cross-cutting issues which impact on health and well-being.

56. For the future, the greatest benefit can be expected from a four year health scrutiny programme that starts with a clear framework, set of priorities and topics for its work but is able to avoid the dangers of rigidity by being willing to judge any new proposals against the programme's priorities and assess their comparative value if undertaken. This will assist deciding in a transparent manner the respective benefits of competing choices.

The choices in scoping and carrying out reviews

57. Thirdly, we found much praise for the HSP's handling of scrutiny reviews but also some constructive criticism. Most respondents thought that the HSP had a thorough and collaborative approach to scoping and carrying

[9] The review attracted funding from the Centre for Public Scrutiny's 'Action Learning in Health Scrutiny' project and featured in its evaluation, "*Learning together: further lessons from health scrutiny in action*" (Centre for Public Scrutiny, June 2007).

out scrutiny reviews: "they're pretty robust…they've got a genuine handle on it." Officers should continue to check what other scrutiny reviews on chosen topics have done [10] and be prepared to try new ways of gathering evidence or drawing occasionally on expert witnesses. This could help to keep the approach to carrying out reviews fresh, innovative and securely evidence-based.

58. But the contrary view about the programme of reviews put to us was that in designing the programme and scoping individual reviews the HSP needed to take more of a cross-sectoral view when examining health issues, for example by looking across the total health pathway. This would involve looking at the whole picture, how different parts of the health system and Council provision interact with each other, and bringing the collective resources of the Council and health partners to bear on issues.

59. As ever, this is easier said than done. Issues of time and resources enter into the equation. The End of Life Care review, for example, consciously excluded end of life care provision for children and young people from its scope on the grounds that it posed different challenges and would benefit from a specialist investigation.

60. But the moves towards a 'Total Place' approach open up possibilities over the next four years to investigate new approaches to efficient use of resources through integration and targeting to produce service improvement in local areas.[11] However, Total Place is by no means an easy option for tackling health inequalities. Inherent in the approach are process issues and tensions over matters such as agreeing joint priorities, targets and performance management and how to use flexibilities such as pooled budgets, joint posts and integrated services. These will need to be addressed in order to reap the health benefits of the Total Place initiative.[12]

61. Nevertheless, there are potential benefits to be gained from examining health issues in the round as much as possible before making any

[10] The Centre for Public Scrutiny has an extensive on-line library of scrutiny reviews carried out by all types of authority across health and social care and other subjects.

[11] One of the 'Total Place' pilots is Worcestershire County Council, which has chosen a range of themes to explore, including tackling obesity and road safety (a leading cause of childhood death and serious injury, disproportionately affecting children from the poorest families), both of which feature on the Tower Hamlets Partnership agenda.

[12] For a discussion of these, see Martin Seymour, "Embedding health in a vision of Total Place" in Fiona Campbell (ed.), *The social determinants of health and the role of local government*, IDeA, March 2010.

recommendations for redesigning or otherwise improving services. We suggest this approach is built into both the overall framing of the new health scrutiny programme for 2010-2014, as well as individual pieces of work, to ensure that all health partners, the Council and the voluntary and community sector in Tower Hamlets are able to play their part in addressing the key health issues that the borough faces.

62. In addition, the practice of doing only one review a year might also be reconsidered. There is a danger with the 'one review for the year' approach that service practice can have overtaken the review's recommendations by the time it reports. Two more focused reviews, completed in a shorter timescale, might be of greater value.

63. Consideration should also be given to making improvements in the sometimes variable quality of the recommendations that the HSP produces in its work, by sharpening up on exactly what is being recommended and by focusing more on what is to be delivered and by whom. This would enable clearer measures of success to be drawn from the recommendations which could then be more effectively monitored and used to hold to account the Cabinet, council officers or health partners, depending on specific responsibility for implementation.

The burden of additional joint scrutiny work

64. Fourthly, the necessity of engaging in two pan-London Joint Health Overview and Scrutiny Committees (JHOSCs) and the Health for North East London JHOSC has had an effect on the HSP's work programme. JHOSCs can involve considerable time and effort on the part of both HSP members and scrutiny officers. This has been clearly the case for the pan-London work, although less so for the sub-regional committee where under the reconfiguration proposals Tower Hamlets' position is essentially non-problematic and has correspondingly received less Member attention.

Delivering a coherent and proportionate programme: managing and balancing the agenda

65. What can be done about the common problem experienced by health overview and scrutiny committees of managing the agenda? Pressure on the HSP's agenda has been acknowledged since 2006.[13] The solution proposed then of considering the issues over a number of years has not lessened the pressures involved. The pace of change in the health service has been relentless, throwing up new issues, not least sub-regional and pan-London reconfigurations of service referred to above.

66. In our interviews there was a detectable willingness among the health partners to have planning conversations at a higher level to try to ensure

[13] *Health Scrutiny Panel Work Programme 2006/07 – 2007/08*, para. 4.9

that agendas can do justice to the 'big issues' in health, while recognising that the final decision on HSP agendas rests with Members. This should be explored.

67. We suggest that the principle 'less is more' is followed. Experience elsewhere shows that fewer but better resourced work items and more manageable agendas are likely to lead to more robust scrutiny, which should have more impact in adding value.

68. Another part of the solution to tackling the problem of overlong agendas that fail to do full justice to the more important items is to try using the most appropriate method for considering different types of items. A suggestion made in 2006 for managing the agenda proposed employing other ways for the HSP to carry out its work, such as councillors working individually or in small groups to undertake specific pieces of work and report to the Panel with their findings. This appears to have been rarely used, although some HSP Chairs have clearly devoted much individual time to their role and there are also a few examples of councillors taking on issues (such as organ donation by the BME community) on an individual basis.

69. We have listed below approaches tried by other health scrutiny committees. Some of these are used already to some extent in Tower Hamlets and some may not be possible because of the limitations on HSP members' time. With 51 councillors (effectively 41 after the Cabinet Members have been deducted), Tower Hamlets has one of the lowest counts of councillors in a London borough to cover all Member responsibilities, particularly given its population size.[14] However, consideration should be given as whether any of the following might be successfully used (or tried again), in order to lessen pressure on the agendas of the five HSP meetings:

- single day panel – where an issue can be resolved by bringing together all key stakeholders for a facilitated workshop day
- member champion – where an issues could be investigated by a single member who would then report back to the panel
- informal briefings – to provide background information particularly on complex issues, thus saving the need for long presentations to the full panel

[14] Only two London Boroughs, Islington and Hammersmith & Fulham, have fewer councillors than Tower Hamlets, but their populations are substantially less – 185,500 and 171,400 respectively, compared to Tower Hamlets' 212,800 (using ONS mid-year population estimates for 2006). Boroughs with more councillors than Tower Hamlets but approximately the same or smaller populations include Kensington & Chelsea (54 councillors, 178,000 population); Hackney (57 councillors, 208,400 population); and Harrow (63 councillors, 214,600 population).

- reports in members' information packs – to provide background information of less complex issues
- portfolio holder briefings – where the portfolio holder is dealing with an issue relevant to the panel's work

Partnership approach

Has the programme:
- been an informed joint enterprise between the Health Scrutiny Panel (supported by the Overview & Scrutiny Committee) and partners in the health economy?
- recognised the range of settings and providers on the 'patient journey', including the contribution of the voluntary and private sectors?
- constructively informed and shaped proposed changes to health service provision which affect residents in Tower Hamlets?

An informed joint enterprise, recognising the range of settings and providers

70. There is strong evidence that the HSP has worked hard to develop a partnership approach and secure partner buy-in to health scrutiny in Tower Hamlets. As a result we found very positive attitudes towards the HSP among its partners – validating one councillor's observation that "a core strength of health scrutiny [in Tower Hamlets] is that it is taken seriously by the partners."

71. The PCT has been a longstanding partner in the health scrutiny process, closely followed by the East London NHS Foundation Trust. The Barts and the Royal London NHS Trust acknowledge that they are perhaps the least engaged of the three Trusts, owing to what it sees as problems on both sides. But the Trust does participate in the induction programme for HSP members, took part in what was the HSP's contribution to the Annual Health Check process and cooperates when requests for information or involvement are made. There is clearly also a willingness in the Trust to be more involved in discussions about the HSP's work programme and an appetite to have more direct communication and information coming back to the Trust about its services.

72. We suggest that this relationship should be nurtured. The Trust will be approaching the HSP again in the near future as it resurrects its bid to become a Foundation Trust. Over the next two years, the huge capital development programme at the London Hospital will change what services the Trust provides for patients very materially, which will have a considerable impact on Tower Hamlets' population. We suggest that these changes should be considered as a potential topic when the next HSP work programme is devised, in order that a scrutiny perspective on behalf

of Tower Hamlets' residents might be brought to bear on these developments.

73. For the future HSP work programme, as well as building on the foundations of a joint enterprise approach already laid down, the induction process for the HSP panel in the new administration after May 2010 will be an important factor. Developing this will need to draw on the experience from the extensive induction programme in 2006 to employ the most effective ways of engaging HSP members, including the panel's co-optees, and health partners.

74. From the point of view of the HSP members, the aim of the induction programme should be to provide them with the information and analysis to acquire a clear picture of the health issues that the borough faces, the strategies that have been devised to tackle the issues, and the key health contacts with whom the HSP needs to develop effective working relationships.

75. What Members told us they appreciated about the previous induction and site visits during the year was the opportunity to see at first-hand what the facilities were for patients, to explore in situ (with patients and staff) what the issues were, and to see what problems HSP recommendations and actions had been addressing. Inevitably, presentations about the issues and the challenges that health trusts face will still need to be part of the new induction programme. But these should be designed with any new councillors in mind – for some, getting to grips with health provision in the borough may be what one councillor described as "an uphill learning curve". [15]

76. The induction process should also include discussions with Tower Hamlets Local Involvement Network (THINk) which has since its inception in 2008 been gathering information about patients' and residents' experiences of health and social care service delivery. Its work targeted at 'hard to reach' groups such as residents from Eastern European and other new communities, young people and women from Bangladeshi and Somali communities could particularly help the HSP to realise the aim of promoting health and well-being in response to local circumstances and the needs of local people. These discussions would be in addition to any contribution that the two THINk co-optees on the HSP might make in HSP formal meetings to the final shape of the new work programme.

[15] All health partners and council directorates that we interviewed expressed a willingness to offer a variety of learning and development opportunities (site visits, briefings, shadowing etc) to HSP members and the health scrutiny officer throughout the year, not just as part of the formal induction process.

77. There is further potential in developing the HSP's working relationship with THINk. As the shape of the local health economy changes over the next few years, particularly with the expected decoupling of the PCT's commissioning and provider functions, the need to recognise the range of settings and providers on the 'patient journey', including the contribution of the voluntary and private sectors, may well increase. Sharing information collected from the performance of THINk's role of "enabling people to monitor and review the commissioning and provision of care services" and particularly the exercise of its 'enter and view' power could also assist the HSP in this regard. One possible way this might be done would be to consider this information at the same time as the HSP reviews the complaints made to the three health trusts.

78. These recommendations, if implemented, could help to strengthen the relationship between health partners and health scrutiny. Also welcome here are the proposals in a report[16] which is being taken to all the Community Plan Delivery Groups to consider the best ways of strengthening the relationship between Overview and Scrutiny and the Tower Hamlets Partnership to help deliver the priorities of the Community Plan. The report notes the work with partners in the current Overview and Scrutiny work programme, including the review of community leadership which will help shape future developments, and asks for suggestions of areas for future reviews and how scrutiny structures and processes could be enhanced to work closely with the CPDGs.

79. In terms of further enhancing structures and processes, in addition to the suggestions that we have already made, four interlinked points were made in the interviews we conducted that need to be followed up. These points all relate to the desirability – recently reinforced by the Marmot review's focus on policies and interventions that address the social determinants of health inequalities – of mainstreaming health scrutiny

80. The first is that health is very much a bipartisan issue, but paradoxically suffers perhaps as a result. The Chair of the Health Scrutiny Panel is from the largest of the minority parties and a non-partisan approach to the health agenda was evident from both our interviews and from the conduct of the HSP meeting that we observed. Given this sort of consensus, health issues in the Cabinet receive less attention, in terms of time and positioning on the agenda, than more contentious issues.

81. While this has some advantages, it can mean that the drive required to ensure the successful pursuit of objectives and commitments can be allocated to other issues – leaving health with a relatively lower profile. One of the common themes emerging from the 'tackling health

[16] *'Strengthening the relationship of Scrutiny between the Partnership to help deliver the Community Plan to 2020'*

inequalities' Beacon authorities was the identification of strong leadership and vision as one of the 'strategic levers' underpinning the success of these authorities in tackling health inequalities. [17]

82. Secondly, the HSP could do more to develop and use its relationship with the Lead Member for Health and Wellbeing. It is significant that the Lead Member has not attended any HSP meetings this year but has recognised that attending some (subject to other commitments) would be helpful in terms of information sharing, debate and discussion and general accountability. This would be in addition to any 'spotlight' or challenge sessions for accountability on specific issues.

83. The third related point is that it would be useful for the Scrutiny Leads on the Overview and Scrutiny Committee to have discussions with their corresponding Executive Leads to ensure that potential or actual health impacts deriving from strategies, policies and services within their particular remit are given full consideration. The Executive Leads in turn need to ensure that this perspective is shared with their Directors and cascaded through directorate structures. This could help ensure that the need for partnership is recognised not just at the strategic and most senior levels but also lower down the officer structure, to help encourage partnership working with NHS colleagues and other working in the health and social care field.

84. The importance of doing this was one of the key conclusions from the 'health inequalities' Beacon authorities. We suggest consideration is given to adapting for Tower Hamlets' use the 'Health: Everyone's Business' course for senior/third tier managers run by Beacon authority Greenwich Council.[18] This aims to provide participants with the knowledge, skills and language to promote health within key council roles and develop a core group of public health champions in decision-making positions across all functions.

85. Fourthly, the Overview and Scrutiny Committee should look at ensuring that a health dimension is included in its considerations of topics for scrutiny reviews and that its Scrutiny Leads are aware of what is available in terms of evidence sources and witnesses, from inside and outside the Council, to make reviews as soundly based as possible in terms of health impacts. To its credit the Scrutiny Team identified in 2006 that Health Impact Assessments (HIAs) are increasingly being used to take into account the health implications of various policies and initiatives, and that

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[17] See '*Reducing health inequalities: Beacon and beyond* ' (IDeA, November 2009), pp 21ff

[18] See '*Reducing health inequalities: Beacon and beyond* ' (IDeA, November 2009), p.12

HIAs should be used as a tool within reviews across all scrutiny themes, to see the potential impacts on health. This objective should still be pursued.

86. The HSP itself needs to ensure that the relevant council directorates are as fully engaged as possible in its work directly. Although a senior officer from the Adults' Health & Wellbeing Directorate has attended the HSP on a regular basis and has contributed to the development of the work programme, the HSP needs to do more to enhance its relationship with the Directorate. Doing so should help ensure that social care services and issues are given their due weight in the HSP's work programme and are not effectively deprioritised. This can be a common problem where an overview and scrutiny committee has a remit combining health and social care but feels the more pressing need is to respond to the issues thrown up by the work of NHS Trusts and the increasing pace of change in the NHS.

87. The same considerations apply to the Children, Schools and Families Directorate and the health of children and young people. This is particularly important in the light of the recent Audit Commission report, *'Giving Children a Healthy Start'*,[19] which found that local authorities and primary care trusts are aware of the key health issues affecting the under-fives in their areas, but this is not always reflected in strategic plans, and is rarely given priority in local area agreements. In Tower Hamlets childhood obesity has been given priority as a target in the LAA and the HSP's scrutiny review in 2009/10 focused on children's obesity. However, interviewees acknowledged that the connections between the Children, Schools and Families Directorate and the HSP could be stronger and identified the 'Be Healthy' sub-group, a theme group for Every Child Matters, as potentially playing more of a role in identifying issues for health scrutiny.

88. This does not mean to say that the result of a closer connection should simply be more 'children and young people' items on the HSP's already crowded agenda. With its structure of an overarching OSC and a Health Scrutiny Panel, the council does not face the common question posed for other councils' overview and scrutiny functions as to which scrutiny committee or panel should be given the children's and young people's health remit. Reviews led by other Scrutiny Leads have therefore touched on children and young people's health issues but from a different perspective. However, closer working relationships may, for example, have contributed a more robust health input into two reviews, one chaired

[19] *Giving children a healthy start: A review of health improvements in children from birth to five years* (Audit Commission, February 2010)

by the Safe and Supportive Scrutiny Lead on young people's alcohol misuse, and the other chaired by the Learning, Achievement and Leisure Scrutiny Lead on young people's participation in sports.

89. The HSP should still hold a responsibility for ensuring that provision for children's and young people's health is adequately covered in its work. From our interview with senior officers in the Directorate, it is clear there is no shortage of ideas for scrutiny reviews or lack of willingness to engage further.

90. For its 2010-2014 programme, the HSP may wish, therefore, after discussions and input from the Children, Schools and Families Directorate and health partners, to include a limited but significant selection of issues relating to children's and young people's health where it calculates that it can add value in some way. The Children, Schools and Families Directorate – or indeed any directorate which may wish to put forward a health issue for inclusion in the HSP's work programme – should be made aware of the criteria which the HSP uses to assess whether topics are sufficiently important to be included in the work programme.

91. The final point to make here is that the key to ensuring that the new 2010-2014 health scrutiny programme is indeed 'an informed joint enterprise' will be to hold extensive open discussions about what the priorities and the content of the programme should be. Councillors and all health partners need to express their preferences and to debate the merits of all the various suggestions before arriving at any decisions on the future programme. Inevitably there will be a clash between 'ideal world' and real world' perspectives because resource limitations will mean that the HSP will not be able to take up all the proposals made. It will be important therefore to use the process to ensure there are realistic – as well as challenging – expectations for the programme. Overall, such a process will help not only to make the programme as relevant as possible to tackling health inequalities in Tower Hamlets but also increase the likelihood of buy-in and co-operation throughout the life of the programme.

Constructively informing and shaping proposed changes to service provision

92. There was general acknowledgement of HSP successes in contributing to the shaping and improvement of service strategies and provision, of which the access to GP and dentistry services and tobacco and smoking cessation reviews were the most often quoted.

93. The HSP regularly takes a number of reports on its agenda on proposed changes to service provision (most recently, for example, on the East London NHS Foundation Trust's proposals to redesign older people's services as part of the Mental Health Care of Older People Strategy) and

questions the officers presenting. However, the lack of time and, possibly, a lack of knowledge about patients' perspectives on proposed changes, appears to restrict the HSP's ability to offer as forthright a 'critical challenge' as it might on service changes without making them the subject of a full-scale exercise, as with the End of Life Care review.

94. There are various ways of addressing this to help build the confidence of HSP members and enable them to be more challenging to the professionals. Some authorities (notably Tameside) hold an all-party pre-meeting before the scrutiny committee sits to develop questioning strategies in advance. We believe a similar arrangement in Tower Hamlets would be beneficial. Where appropriate, these sessions could draw on standard questions drawn up for a range of health and social care topics by the Centre for Public Scrutiny.[20] HSP members might also be briefed in advance about the key issues, drawing on patient experiences relayed by THINk. Extending the number of co-options to the HSP would also help to bring in people with particular experience that might otherwise be lacking on the panel, for example by co-opting a representative from the East London NHS Trust's Council. Finally, all HSP members, including co-optees, might benefit from development support around questioning skills.

95. There are also other ways in which Members may play a part in constructively informing and shaping proposed changes to service provision that play to their strengths as community leaders. We heard one telling example where the East London NHS Foundation Trust had sought to use some empty council premises for the Dual Diagnosis Team, but ran into a public outcry. However, two or three councillors attended the public meetings held on the issue, asked the right questions and were felt by the Trust to be very supportive. This community leadership role could have been performed before the issue blew up, and the Trust acknowledged that a better course of action would have been to engage with the HSP in advance and enlist the help of local councillors to play this role.

96. Equally, though, departmental Council officers could have been more proactive in alerting Members to this potential problem once they knew that this was planned and had been approached by the Trust for co-operation. There therefore needs to be a wider appreciation of how

[20] For example, 'Ten questions to ask if you are scrutinising the transformation of Adult Social Care' (Centre for Public Scrutiny, October 2009), a companion publication to *'Scrutinising the Transformation of Adult Social Care: Practice Guide'* which provides more information about the wider social care agenda and guidance for scrutiny committees undertaking in-depth reviews. Since 2004 CfPS have developed a comprehensive set of guides and briefings about health scrutiny ranging from the fundamentals of accountability in health to practical guides about how to tackle specific issues – see www.cfps.org.uk/what-we-do/publications/cfps-health/ for details.

Members can use their community leadership role and skills as part of the problem-solving process.

97. Overview and Scrutiny has already recognised the need for this wider appreciation by setting up the Scrutiny Review Working Group on Strengthening Local Community Leadership. Its report focuses on a series of recommendations designed to develop a new model of community leadership. If implemented, they should provide Tower Hamlets with what the Group's report sees as "a more sophisticated way of tackling problems" in recognition that "that finding sustainable solutions is often complex." Ensuring that there is a health dimension to this developing work will be particularly important in view of the likely service reductions and changes over the next five years that are forecast under the PCT's new Commissioning Strategic Plan.

98. This also plays into the introduction of the new Councillor Call for Action (CCfA) process by emphasising the need to ensure that ward members can act as champions for an issue raised directly from their ward and engage with Council officers, partners and local residents to work on finding solutions to difficult problems. The link with the LAP Steering Groups and the attendance of the PCT at these meetings is important here because it could potentially create a more direct response to local health needs. The aim should be not to ensure that CCfA does not become a device that is used all the time but only as a last resort if no feasible solution can be found to the health (or any other) issue raised.

99. The final point in this section relates to joint health overview and scrutiny committees (JHOSCs). Participation in all JHOSCs affecting Tower Hamlets is important, even if, as in the case of the Health for North East London sub-regional JHOSC, it is simply to keep a watching brief. For the future HSP work programme, account will need to be taken of the strong possibility of more pan-London and sub-regional health service changes that may require a substantial investment of time and effort by the HSP.

Outcomes

Has the programme:
- resulted in local action and improvements to local service delivery?
- produced outcomes which have helped to improve the health and well-being generally of local people?

100. For some aspects of the HSP's work there are two difficulties involved in assessing whether it has produced outcomes which have helped to improve the health and well-being of local people. Firstly, positive

outcomes for some of the health issues that the HSP has or is attempting to tackle – such as child obesity – may not reliably show for a generation of more. Secondly, it is difficult to define the exact contribution the HSP has made to the initiation and implementation of changes in local service delivery and positive outcomes, such as the substantial improvements made to access in primary care in Tower Hamlets.

101. Nothwithstanding these difficulties, overall the mix of reviews and holding commissioners and providers to account is seen by interviewees as contributing to a greater impetus to the drive to improve services, especially over the last couple of years and particularly in terms of hearing the voices of black and minority ethnic communities. As seen from examples in earlier sections of this report, the HSP is acknowledged to have focused well on poor performance areas where it senses that health partners have not been up to scratch, and accelerated the work of health trusts and the Cabinet. There have been a number of successes in contributing to the shaping and improvement of service strategies and provision, through, for example, the access to GP and dentistry services and tobacco and smoking cessation reviews. Information available to local people regarding health services has also been improved.

102. Health scrutiny in Tower Hamlets is therefore recognised as a lever for change at strategic and local delivery levels, by increasing the visibility of issues and helping to make them a higher priority for health partners or the Council. Elected members are engaging more effectively with service users and NHS trusts across the borough. Health partners have played their role in this, by taking health scrutiny seriously and investing time and effort in working with Health Scrutiny Panel (HSP) members and scrutiny officers.

103. This is a strong platform on which to build, particularly given the enthusiasm and willingness of the Trusts to engage. We have already mentioned some of the ways that the HSP could improve in future on its record of securing improvements in local service delivery and local people's health and well-being, such as a greater emphasis on partnership working and a more robust approach to programme and agenda planning. This could usefully incorporate planning and scoping the HSP's work with a clearer focus on the outcomes that it wants to affect and how, making sure this is aligned with council and area priorities.

104. The desirability of increasing public engagement in health scrutiny was also raised in our interviews. The focus of doing so should not be solely on greater public attendance at HSP meetings - although holding some HSP meetings in more geographically accessible locations than the Town Hall or in a venue that, for example, particular service users would be likely to attend for an agenda item of interest to them might be useful. Efforts to

engage patients and residents in scrutiny reviews should continue, and a number of the measures already proposed, on co-options and more dialogue with THINk, for example, would help to enhance the level of public engagement with health scrutiny.

105. In addition, thought could be given to increasing the amount of publicity given to health scrutiny (and scrutiny in Tower Hamlets in general) through various means: revamping the current website; using 'East End Life' more frequently; and producing a scrutiny newsletter, for notice boards and e-mail distribution, to report back on the outcomes of reviews, give alerts of new ones and provide details of other scrutiny news. [21]

106. More use too could be made by health scrutiny of the eight Local Area Partnerships (LAPs), which play a role in identifying and communicating local priorities and holding health services (amongst other public providers) to account for the quality of services in the area. One way in which the HSP's agenda could be sharpened up and prioritised more would be to develop an understanding with the LAPs about the respective roles in holding health and social care services to account. This could involve the LAPs assuming clear responsibility to do the local holding to account, with the HSP taking the strategic role, for issues that are borough-wide, cross LAP boundaries, cross borough boundaries, or have been escalated up for attention and resolution as a last resort.

107. Similarly, a clearer understanding about areas of responsibility and operation between the HSP and THINk, which in other boroughs has been agreed as part of a protocol between the two bodies, could also help to reap the benefits of effective liaison and joint working by providing greater clarity and co-ordination of effort.

108. Some of the recommendations in the previous sections may have implications for both staff and HSP members. Currently the remit of the scrutiny officer supporting the HSP is servicing its five panel meetings and supporting an HSP scrutiny review and one other scrutiny review. A number of other authorities of comparable size to Tower Hamlets provide a dedicated scrutiny officer for its health scrutiny work. This would enable whoever is in that post to assume a more strategic role around workload planning, prioritisation, analysis of information, commissioning of additional research and providing support for HSP members. This is something that senior management may wish to consider.

109. A new health scrutiny programme will need to be planned and delivered from 2010 to 2014, following the borough elections in May 2010. While some councillors will be re-elected, there will inevitably be new members

[21] See for example Tameside Council's website pages on scrutiny including its scrutiny newsletter at www.tameside.gov.uk/scrutiny

and probably some new faces on the HSP. Health partners told us of the difficulties that the lack of continuity in the Chair's role (three in a four year period) and the wider HSP membership during the current administration posed in terms of building relationships and a shared understanding of health issues and the complexities of the health system.

110. Maintaining the necessary high degree of continuity in the membership of the HSP throughout the life of the new administration will be a key challenge. Dealing with this challenge will be of vital importance in ensuring that the HSP is able to build the effective working relationships with health partners that are so crucial to the success of health scrutiny work. Previous efforts to encourage continuity in the HSP's membership should be redoubled.

111. But a stronger degree of continuity in membership is only half the answer to the challenges of a new four year programme. While the demands on Members' time are fully recognised, giving health a higher profile across the Council and continuing to make inroads on the health inequalities agenda will perhaps require a degree of extra commitment by Members.

112. The last two years of the 2006-10 health scrutiny programme have been perceived as stronger in terms of Member input and engagement, but the burden of health scrutiny has tended to fall on just a few shoulders. If all HSP members contribute regularly from their experience and that of their constituents, then not only would the workload be shared more and patients' and residents experiences across the borough be better represented, but also it is likely that this commitment would be acknowledged and responded to by those working with the HSP.

113. Officers will therefore need to explore how to facilitate HSP members' input and engagement with the HSP's work for maximum effectiveness. Allied with a stronger degree of continuity in membership of the HSP over the lifetime of the forthcoming new administration, this would then provide firm foundations for the next four year programme.

Ideas for the new work programme

114. Encouragingly, there was no shortage of ideas among interviewees when asked what they thought could be usefully included in the HSP's new work programme. While this is positive in terms of giving health a higher profile and involving Adults' Health & Well-being and Children, Schools and Families directorates, it points up the problem of prioritising from a potentially very wide agenda.

115. In an overarching sense, two issues stood out: the need to look at and incorporate the implications of the Marmot report and also ensure that all inequalities strands are included in the new programme; and the need to

deliver services in new ways, driven in part by the challenges posed by the public sector finance settlement. Within those strands, proposals for the programme included:

- significant service variations in older people's services
- dementia care
- safeguarding adults
- alcohol misuse by adults
- maternity services
- health visiting and school nursing services
- approaches to drug misuse and young people
- emotional health and well-being service provision for children and young people
- issues around learning disability service provision
- differential life expectancy across the borough
- the reconfiguration of acute hospital services
- developments around stroke and long-term conditions, including reconfigurations and new service provision
- the development of 'poly-systems'
- service integration between GP services and social care services, possibly involving LAP-based delivery teams
- local input into sector commissioning

Conclusion

116. Much has been done to build the credibility and effectiveness of scrutiny in response to the Audit Commission's earlier criticism of its performance. This improvement was recognised by the Council's Corporate Assessment in 2008 in which inspectors judged that scrutiny locally makes a real and positive difference. Within that judgement, it is evident from the work conducted for this evaluation that the practice of health scrutiny has contributed to overview and scrutiny's current overall standing and achievements. Tower Hamlets has examples of good practice that it is hoped it will be willing to share with, and in turn learn from, other health scrutiny members and officers, through the networks and initiatives such as the Centre for Public Scrutiny's Health Inequality Scrutiny programme.[22] But there are improvements in the way that health scrutiny

[22] The CfPS Health Inequality Scrutiny programme is a 2-year programme funded by the Improvement and Development Agency's Healthy Communities Team to raise the profile of overview and scrutiny as a tool to promote community well-being and help councils and their partners in addressing health inequalities, by:

- extracting examples of good practice from health inequality scrutiny reviews

operates in Tower Hamlets that can still be made. The suggestions in this evaluation of the health scrutiny programme are offered to assist Members and all health partners to make the journey, as one contributor put it, “from good to great.”

--o--

- developing a resource kit designed to provide Councils with help, support and advice to such reviews
- identifying and working with four “Scrutiny Development Areas” who will help make the kit a comprehensive resource by testing existing models of scrutiny and developing new ones
- publishing “How to” guides and the findings from the study about the contribution that health overview and scrutiny committees can make to tackling health inequalities.

Appendix 1

Interviewees

Susan Acland-Hood (Service Head for Strategy, Partnerships & Performance) & Layla Richards (Service Manager, Strategy, Strategy, Partnerships and Performance, Children, Schools and Families Directorate, London Borough of Tower Hamlets)

Cllr Anwara Ali (former Lead Member, Health and Wellbeing, LBTH)

Ashraf Ali (Local Information System Manager, Strategy and Performance, LBTH and former LBTH Scrutiny Policy officer)

Cllr Tim Archer (Chair, Health Service Panel)

Dianne Barham (THINk Director)

Ian Basnett (Joint Director Public Health, NHS Tower Hamlets / LBTH)

Deborah Cohen (Service Head, Commissioning & Strategy, Adults' Health & Wellbeing Directorate, LBTH)

Myra Garrett (THINK representative, Health Scrutiny Panel)

Afazul Hoque (Scrutiny Manager, LBTH)

Cllr Ann Jackson, Vice-Chair, Health Scrutiny Panel

Cllr Emma Jones (former member of Health Scrutiny Panel)

Michael Keating (Head of Scrutiny & Equalities, LBTH)

Shanara Martin (Head of Participation & Engagement, LBTH, and former LBTH Scrutiny Policy officer)

Leeanne McGee (Borough Director, East London NHS Foundation Trust) & Paul James, (incoming Borough Director, East London NHS Foundation Trust)

Andrew Ridley (Deputy Chief Executive, NHS Tower Hamlets)

Graham Simpson (Director of Strategy, Barts and the London NHS Trust)

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**23 March 2010**	**Unrestricted**		**4.2**
Presentation of: **Care Quality Commission** **Presenting Officer:** John Wiltshire, Area Manager Operations Directorate Care Quality Commission		**Title:** 1) Working together: CQC and Overview and Scrutiny Committees. 2) Quick guide to registration **Ward(s) affected:** All		

1. Summary

The Care Quality Commission came into operation in December 2009 as the new regulatory body for both health and social care bodies. It is in the process of introducing a new registration system for all NHS trusts, independent healthcare providers and adult social care providers in England which will come into process at a gradual pace from April 2010.

John Wiltshire, who is the area manager for the London Borough of Tower Hamlets has been invited to the Panel to introduce the CQC to explain who they are and what they do and how this work differs from the previous regulatory bodies.

The presentation also aims to give members an understanding of how the CQC affects the scrutiny process and looks at how both parties can work together.

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the proposals set out in the presentation.

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Working together: CQC and Overview and Scrutiny Committees

Today we will:

- Share our ideas for working together
- Learn about CQC plans for assessing health and social care
- Discuss how you would like to give us your views and experiences of services

The Care Quality Commission

We have been given some new powers

All providers of health and adult social care are required to register with us:

- NHS providers registered from April 2010
- Adult social care and independent healthcare from October 2010
- Primary medical and dental services and others from 2011

We have been given stronger enforcement powers

We will also drive improvements

Periodic reviews assess the performance of organisations that commission and provide care, and making sure they work together better (this includes primary care trusts and councils)

Special reviews of particular services or pathways of care or themes. For example, care for families with disabled children

Comprehensive Area Assessment – we contribute information about care services to overall assessments of the quality of all local public services

Voices into Action

Voices Into Action is our commitment to listening to and working with people.

We will act on behalf of local people

We promise to:

Give more weight to peoples views and experiences of care

Try to make sure people are involved in decisions about their own care

Find new ways of involving people in our work, including governance and inspection

We will involve people….

In all our activities

- In our decision making
- In our assessments of services
- In our reviews and studies

In lots of ways

- Directly as experts by experience and as advisers
- Through surveys and consultations
- Through voluntary bodies, including LINKs and Overview and Scrutiny Committees

Working Together

We both want **better care** for **local people**

Your information has already made a difference:

-97% of you commented in the annual health check 2008-9

-This covered 99% of all NHS trusts

-You gave us the most information of all the groups we invited to comment

-Your information also contained the most useful data

We want to make sure Overview and Scrutiny Committees:

- know who we are and what we do
- help us develop how we regulate health and social care services
- have contact with local Care Quality Commission staff
- be encouraged to provide peoples' views and experiences about services
- know what we have done with any information they give us
- be supported by us as we work together.

Using your knowledge

The information you have about health and social care services is important to us. For example:

- What local people tell you about services and their care
- What you find out from NHS managers or social care services
- The recommendations from your scrutiny reviews and other work
- Whether local services involve you in service reconfigurations and in other local developments

Standards you can tell us about

Essential standards for health and social care providers cover, for example:

- How people are involved in their care and the information they receive
- How people get the individual care and welfare they need, including food and nutrition
- How people are looked after safely (medicines, premises, equipment)
- How people get the right care from the right staff
- Whether services are well managed and work together

Telling us what you know

- **No need to send a commentary about the core standards for the NHS this year**
- We have a new more flexible system. Send information when you want to, in a way that suits you
- We will tell you key dates you can plan ahead for
- Meet with our local area managers to discuss your work over the next few months
- Send information to us through our website. You can fill in a form and attach your reports from December 2009

Key dates

- We will use information you send us throughout the year as part of our monitoring of services

- **We are keen to hear what you know about NHS providers by the end of January 2010, and social care and independent healthcare providers by the end of March 2010.** This will help us decide whether they meet essential standards to register with us

We hope you will raise any urgent concerns with us straight away if local solutions are not being found.

Giving you feedback

- We will give you feedback on how we used your comments in the annual health check 2008-09
- We are planning to give you feedback about what we do with any new information you send us
- We are still working out the best ways to do this – let us know what you think!

Sounding board for representative groups

Overview and Scrutiny Committees can join our informal sounding board for representative groups

You can send in ideas and views about how we should work, our methods and our assessments

We will use phone, emails and occasional meetings in different parts of the country

If you are interested in helping CQC develop, let us know:

Lucy.Hamer@cqc.org.uk Clare.Delap@cqc.org.uk

Involvement managers at CQC

OVER TO YOU!

What else would you like to know?

How do you want to work with the Care Quality Commission?

How would you like to share your information with us?

More information

- Go to our website at www.cqc.org.uk
- Sign up for our newsletter at www.cqc.org.uk/newsandevents
- Talk to your local area managers
- Ring or send enquiries to our National Contact Centre at 03000 616161 or enquiries@cqc.org.uk
- For copies of our reports, you can go to www.cqc.org.uk/publications
- To get involved in our work nationally, contact Lucy.Hamer@cqc.org.uk or Clare.Delap@cqc.org.uk

We hope you find this information helpful.

CareQuality Commission

Your quick guide to **registration**

Your **quick guide** to **registration**

The Care Quality Commission is introducing a new registration system for all NHS trusts, independent healthcare providers and adult social care providers in England. The new system comes in gradually from April 2010.

Registration is a legal licence to operate. We will register services against new essential standards of quality and safety which will apply across the care sector.

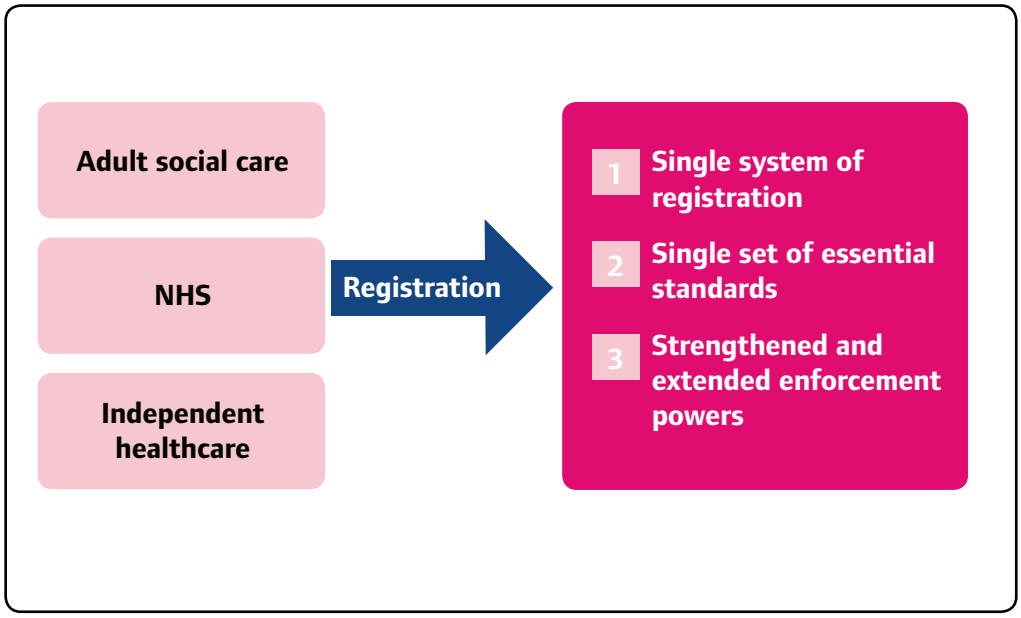
Providers will only need to apply for registration once. After the initial registration application phase, we will continuously monitor whether providers are meeting essential standards as part of a new, more dynamic system of regulation which places the views and experiences of people who use services at its centre.

The new registration system focuses on outcomes – the experiences we expect people to have as a result of the care they receive – rather than primarily on policies and processes. And, we want people to have a bigger say in how we judge whether providers are meeting essential standards.

The aim of registration is that people can expect services to meet essential standards of quality, to protect their safety and to respect their dignity and rights wherever care is provided, wherever they live.

A single system across the care sector

Currently different types of services are regulated under different Acts with different regulations and standards. The Health and Social Care Act 2008 sets out a framework for bringing parity across the sectors. One Act, one set of essential standards, one set of strengthened and extended enforcement powers and one registration system.



Essential standards of quality and safety

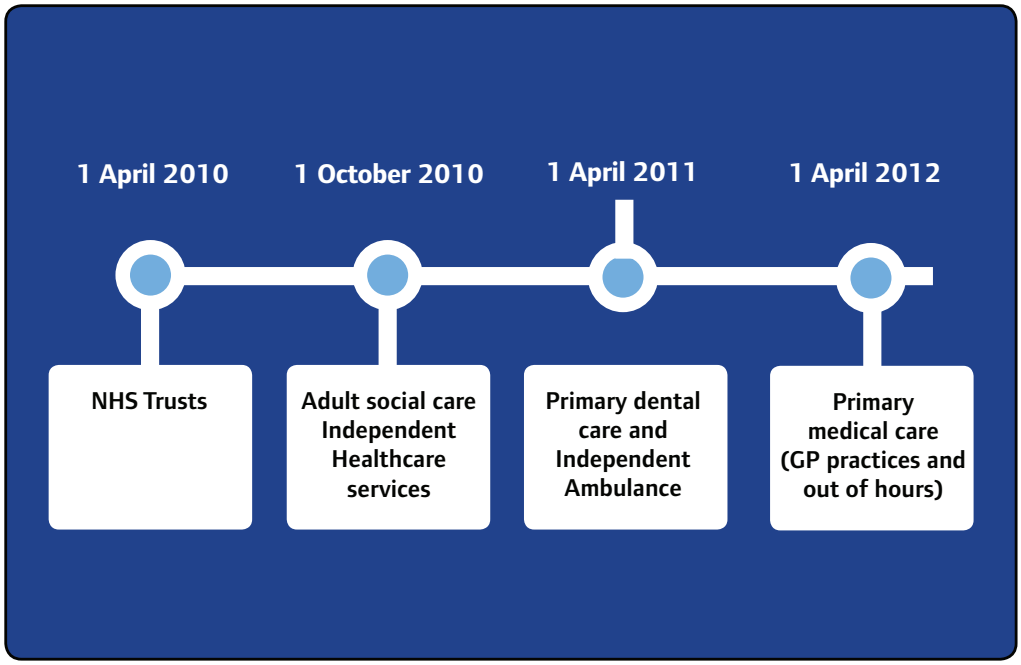
CQC has produced guidance about what providers must do to meet essential standards. The guidance is focussed on outcomes and relates to important aspects of care such as respecting and involving people who use services, care and welfare of people who use services and management of medicines. The outcomes are grouped into six main headings:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

Registration timeline

From April 2010, registration will be introduced gradually across the care sector. These dates are subject to legislation which is currently before Parliament for approval.

NHS Trusts are the first to come into the new system.



How the new system is **different**

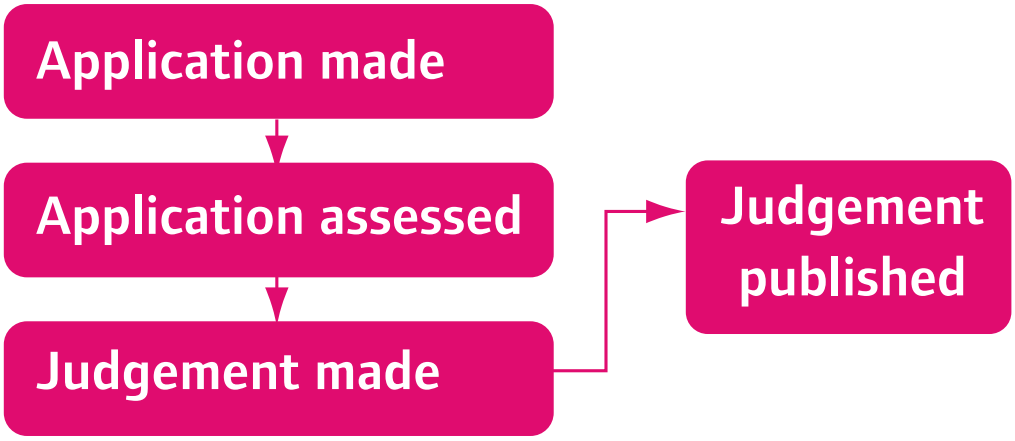
Under the new system there will be ongoing monitoring, near real-time judgements, targeted inspections and a wider range of enforcement powers.

Previous system			After registration
NHS	Adult Social Care	Independent Healthcare	
Rules based	Specific regulations & standards	Specific regulations & standards	Judgement within a framework
Retrospective	Near real time	Near real time	Near real time
Annual cycle	Annual cycle	Annual cycle	Continuous
Trust level only	Location only	Location only	Organisation, location, service levels over time
Non-specific rating	Single quality rating	No rating	Specific conditions (eg. service, regulation)
20% inspections	100% inspections within set frequency	100% inspections within set frequency	All organisations checked at least 2 yearly
Few investigations	Response to concerns	Response to concerns	Multiple specific targeted checks and visits
No enforcement powers	Specific enforcement powers	Specific enforcement powers	Strong enforcement powers
Partners not involved	Limited involvement from partners	Limited involvement from partners	Working closely with partners
People not involved in inspection, limited collection of their view	Some direct involvement in inspections, always asked their view	No involvement	All inspections will involve people. People's views will be given weight in our decisions about services

How **registration** works

NHS trusts applied to register in January 2010. CQC is now considering those applications, cross checking them against a wide range of information we have collected from our inspections, reviews of services, numerical data sets and from other bodies. Where necessary, our local teams are conducting further inspections to check that essential standards of quality and safety are in place.

Registration Application

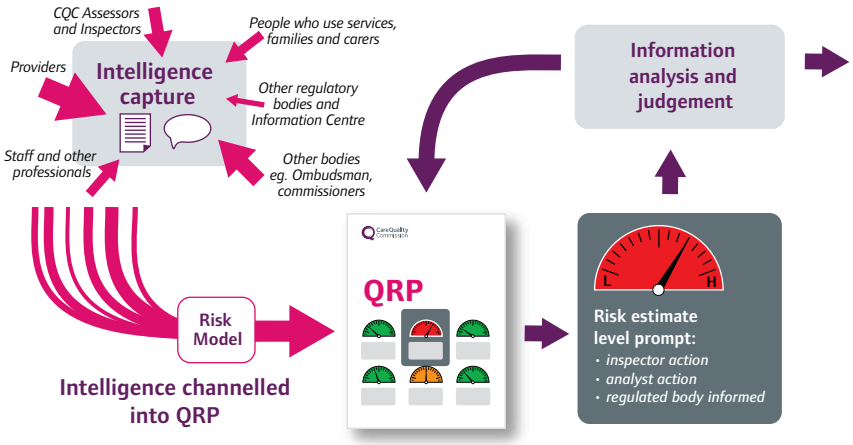


Information about how well trusts are meeting essential standards, whether they are registered with conditions, and the reasons why, will be published on our website following approval of the appropriate legislation in parliament.

Conditions of registration

Where we have evidence that trusts aren't meeting the standards, we may register some providers with conditions. Compliance conditions are a tough test which demand a clear action plan to improve and timescales in place to get it right. These conditions may be removed following improvement, or replaced by further swift, proportionate enforcement action. Other conditions may restrict the services a provider can offer at a particular location, for example that services cannot be offered to children of a certain age.

Continuous monitoring of compliance



Initial registration is the start of a more responsive system which will enable us to continuously check and monitor whether services are meeting essential standards.

We are pioneering a system that brings together a wide range of information from people who use services, our inspections, data sets such as mortality and infection rates, and information from partner bodies. All this will be contained in a quality and risk profile (QRP) for each provider, which will be constantly updated, helping us to assess where risks lie and acting as a prompt for regulatory action such as inspection.

Reviews of compliance

There are two types of compliance review, planned and responsive:

A **responsive review of compliance:**

- is triggered by specific information that raises concern about compliance
- is not a full check of compliance for all 16 outcomes (for the core 16 quality and safety standards)
- is **targeted** to the area(s) of concern

Depending on the concern, may focus on:

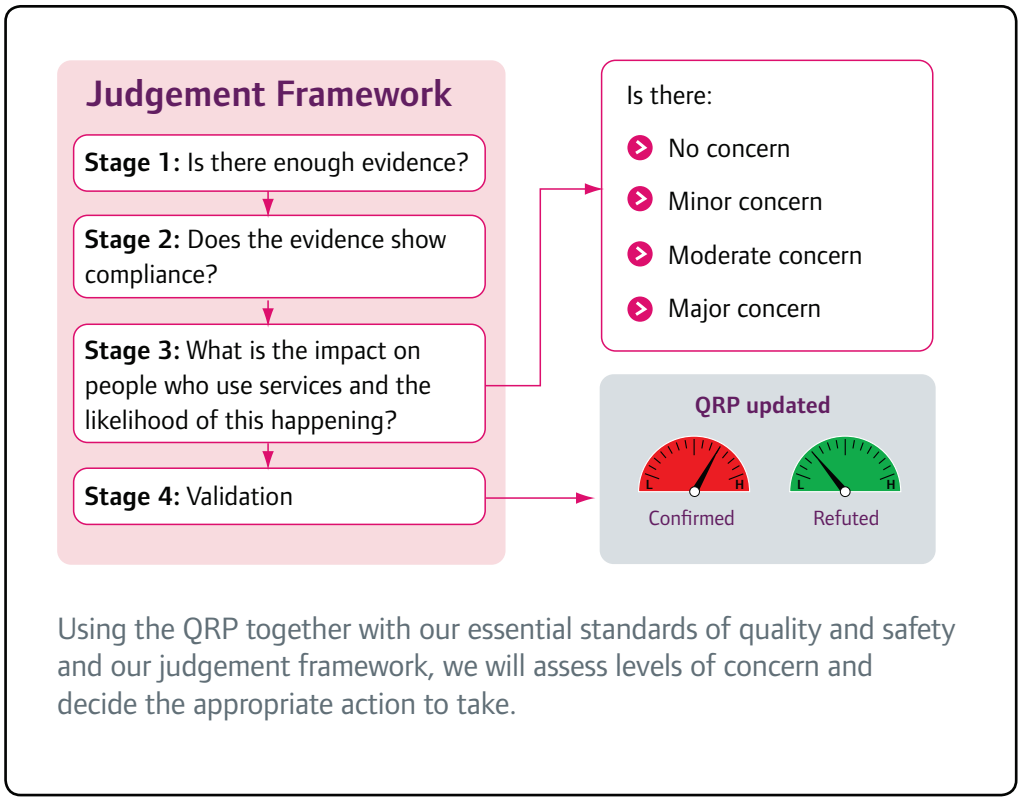
- the whole provider
- one or more locations
- one or more regulated activities
- a particular service
- one or more outcomes

- May include a site visit
- All findings will be published

A **planned review of compliance:**

- Looks across all regulated activities at a location to assess compliance with all 16 outcomes (for the core 16 quality and safety standards)
- Will take place at intervals of 3 months to no less frequent than 2 years
- Will be **proportionate**, with additional activities focused on gaps in information
- May include a site visit
- All findings will be published

Making a judgement

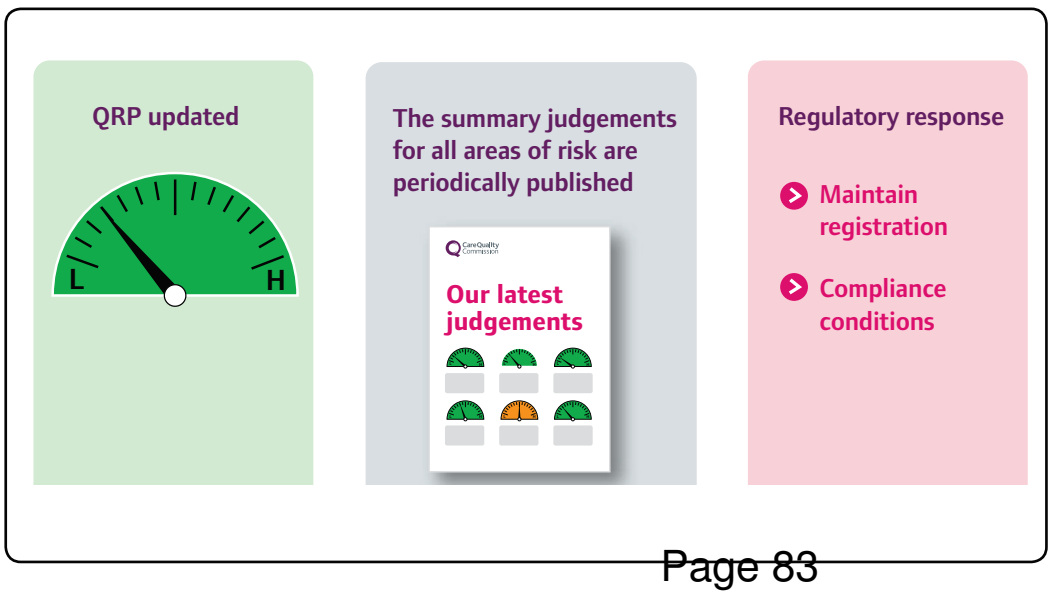


When making our judgements about compliance, we will decide whether no further action is necessary or whether we need to take formal or informal regulatory action.

Informal regulatory action will include suggestions for improvement to the provider. This approach will only be used where issues can be resolved quickly, easily and where there is no immediate risk of serious harm.

Formal regulatory action includes a range of options aimed at achieving improvement without taking enforcement action. We may meet with the provider, send an improvement letter or refer the issue to another agency. We will work with providers, people who use services and other bodies to drive improvements in care. We will check improvements have been made, even where we are not responsible for the improvement actions. If the improvements are not made, we can escalate the concerns.

We may also take enforcement action.



Enforcement powers

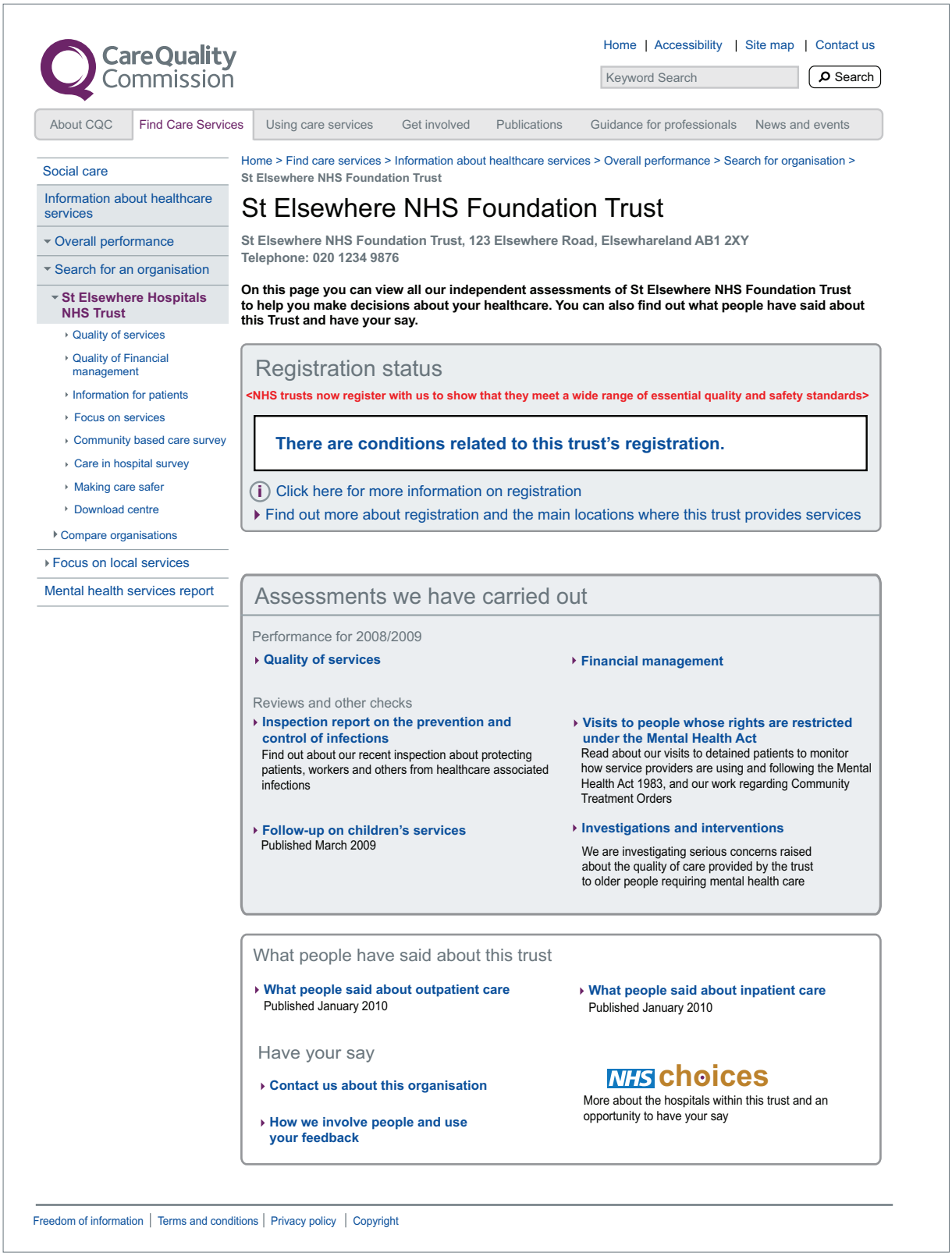
We have a wider range of enforcement powers that allow us to take swift, targeted action where services are failing people. Enforcement action will depend on the level of concern we have about non-compliance with essential standards and our confidence in a provider's capability to take action.

Any enforcement action we take will be proportionate to the risks posed to people who use services and the seriousness of any breach of the law. We will be consistent in the application of these actions and will follow up all enforcement activity through a review of compliance. If the necessary changes and improvements are not made, the concern will be escalated.

- **Warning notice**
- **Imposition or variation of conditions**
- **Suspension of registration to provide certain services**
- **Penalty notices and fines**
- **Prosecution**
- **Cancellation of registration**

Providing **registration information** to the public

When we have completed a review of compliance, we will update our Quality and Risk profile and publish the judgement and regulatory action on our website. We will launch a new way of publishing information on our website later this year. Below is a prototype of how the information might be presented (this format may change).



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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**23 March 2010**	**Unrestricted**		**4.3**
Report of: **The Barts and the London NHS Trust** **Presenter:** Chief Executive, Mr Peter Morris		**Title:** Excellence in Quality: A five-year quality improvement strategy for Barts and the London NHS trust **Ward(s) affected:** All		

1. Summary

The purpose of the Quality Improvement Strategy is to outline the transformational improvement that will be undertaken over the next five years to ensure that all patients experience the standard of care and treatment described above, and continue each year to rate Barts and the London among the best performing healthcare organisations.

The QIS was approved as a high level framework for Quality by the Trust Board in November 2009. The trust is now in the process of developing an annual delivery plan for 2010/11 linked to the annual business planning cycle, details of which will be included in the presentation by the CEO Mr Peter Morris.

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the Excellence in Quality Report provided by The Barts and the London NHS Trust.

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EXCELLENCE IN QUALITY: A FIVE-YEAR QUALITY IMPROVEMENT STRATEGY FOR BARTS AND THE LONDON NHS TRUST

What would it take for all patients to say this about our hospitals and recommend us to their friends and family?

"I have been in four different hospitals over 30 years, and I have got to say that this is top notch. If I had to choose which hospital to go to it would be here" (*Comment from the Inpatient Survey 2008*)

Introduction

The purpose of this Quality Improvement Strategy is to outline the transformational improvement that will be undertaken over the next five years to ensure that all patients experience the standard of care and treatment described above, and continue each year to rate us among the best performing healthcare organisations.

1. Our vision for being world class in health care delivery

1.1 The vision of Barts and The London NHS Trust is to become a world leader in healthcare quality, delivering high quality, patient centred, clinically effective and safe care, and doing so in a way which is measurable and meaningful to all.

1.2 Put simply this means we aspire to ensuring that every patient and visitor contact with us at any site or location and at any time of the day or night is memorable for all the right reasons and not just meets but exceeds that individual's expectations and preferences.

1.3 Whether the contact is by telephone or in person, if someone is simply seeking advice, visiting a loved one, or attending one of our clinics or wards for care and treatment, they will experience the highest quality of care or service from every single member of staff and at every stage of their personal journey or contact.

1.4 The key building blocks to achieve this vision and the improvement goals set out below are for services to strive at all times for:

- Patient centeredness
- Clinical effectiveness
- High levels of patient safety

1.5 Each year, through our Quality Account, we will report our performance and progress in each of these domains and set out the improvement priorities agreed by the Trust Board for the forthcoming year.

2. How will we improve and by how much?

2.1 We predict that through the development and implementation of the Quality Improvement Strategy, and by identifying ambitious annual Quality Development Plans, we will achieve unprecedented levels of clinical quality and patient safety over the next five years. This will include delivering the following high-level improvement and performance goals:

Achieving **patient centeredness**

- Getting it 'right first time' for all our patients
- Patient and staff satisfaction scores in the top 10% of NHS hospitals
- Excellent environment ratings in all hospitals
- 98% of patients recommend our hospitals to family or friends
- 98% of patients rate their care as 'excellent' overall

Being **clinically effective (and efficient)**

- Average length of stay reduced by 20%
- Readmission rates reduced by 30%
- Day case activity increased by 30%
- Six new integrated care pathways implemented each year
- In the top 5 of the Dr Foster 'Best Hospital' league table
- Achieve best outcomes consistently across all services
- Efficiency savings of 3%

Achieving high levels **of patient safety**

- In the top 5 hospitals with the lowest Hospital Standardised Mortality Rate (HSMR)
- Hospital acquired infections reduced by 70%
- 5,000 unintended harmful events avoided
- 95% reliable standardised care in high risk and volume conditions and clinical processes

3. An integrated framework for quality and service transformation

3.1 The Quality Improvement Strategy will engage all services and staff in developing hospital care which is patient centred, safe and effective, while also ensuring that **efficiency, equity and timeliness** are embedded within the service improvement and changes we make. These six interlinking domains or dimensions of quality are depicted in the model below.

Six interlinking dimensions of Quality Improvement

Institute of Medicine 1999

4. Where will we start?

4.1 **Getting it right, first time for our patients** – we will focus on addressing the known issues that are a cause of concern for our patients as part of our requirement to meet our 'licence to operate', i.e.

- Booking
- Way-finding
- Food
- Cleaning
- Cancelled operations
- Patient transport

4.2 **Maintaining and measuring national minimum quality standards –**

While the primary focus of the Strategy is a five-year improvement agenda to identify, develop and deliver best practice and innovation, it is equally important that the Trust achieves and maintains excellent performance against minimum national standards such as Care Quality Commission (CQC) registration criteria, national targets, NHSLA Risk Management Standards and other external inspection or accreditation schemes such as CPA. Delivery of national quality targets and standards (the "must do's") is reflected in the Quality and Safety Indicators Pyramid shown at Appendix 2.

5. Shaping the Future

5.1 Future markers as outlined in Section 1.4 for patient centeredness, clinically effective and efficient care, and patient safety will be further developed with input from the Trust's Clinical Academic Units (CAUs) and Clinical Divisions through the development of an annual Quality Development Plan (QDP), with a focus on areas which improve quality while reducing costs.

5.2 Local markers relating to these three key areas will be developed with each CAU and specialty, in line with business and operating plans to ensure that these are embedded at service line level and are consistent with future financial plans

5.3 Workforce measures will be developed at service line level to incorporate 'team' measures which will address staff-related quality issues, e.g. improved management of poor performance.

5.4 The development of the annual QDP will set out clear objectives and milestones for delivery for each of the quality indicators. The plan will clarify governance arrangements and accountabilities for delivery of the plan.

6. Aligning the vision for quality with the 'Performing for Excellence' Programme

6.1 The Trust's vision and goals for quality and safety improvement are intrinsically linked and integrated with the overall aim and six workstreams of the *Performing for Excellence* Programme. This is to achieve desired productivity, efficiency and financial gains in tandem with increased patient and staff satisfaction and improved clinical quality. It is well researched and documented that poor quality and safety costs highly in human and reputational terms but also wastes valuable and limited healthcare resources.

7. Aligning the vision for Quality with Research and Innovation

7.1 Internationally, the highest quality of care and the best outcomes are found in hospitals that have developed a strong research mission. The evidence shows that this is because patient care is improved by participation in clinical trials and the benefits accrued by the application of clinical innovation and the most advanced surgical and medical techniques.

7.2 Each CAU will develop research plans to drive translational research whose origin lies in the biological sciences units in the School of Medicine and Dentistry. Each research plan will be managed to deliver

scientific partnerships, support for education of students and postgraduate research and appropriate commercial participation. Innovation to develop new care pathways and produce system change will be included in each CAU plan.

8. Identification and planning for Quality Innovation and Improvement through the Commissioning (CQUIN) framework

8.1 The Trust will work with Divisions and Commissioners to identify and align 2010/11 CQUIN improvement schemes with Quality Improvement Strategy goals and ensure that CQUIN schemes are included in the annual QDP.

9. Alignment to Business Plans and Performing for Excellence

9.1 The annual QDP will be developed alongside business plans each year. Discussions have commenced with Divisions and CAUs in line with the development of 2010/11 business plans.

9.2 Alignment and links to the Performing for Excellence programme and CQUIN priorities for 2010/11 will also be made through the business planning process. Where relevant, Lean transformation programmes will also be utilised to support the delivery of the Quality Improvement Strategy.

10. Public and Patient Involvement and Engagement

10.1 The Quality Improvement Strategy makes a commitment and signals even higher levels of engagement and involvement with patients, community partners and stakeholders in supporting the redesign and transformation of services. This will be achieved by integration of quality improvement with ongoing development and implementation of the Trust's Patient and Public Involvement Strategy.

10.2 Quality improvement will also extend where appropriate to preventative and anticipatory care, in support of improving health gain, reducing health inequalities and keeping people out of hospital when it is clinically effective and appropriate to do.

10.3 We will also engage and consult with Commissioners about our improvement plans to ensure that they are consistent and contribute to the vision and quality framework set out in NHS Tower Hamlets Quality Strategy 2010-2012, and we will seek their support in implementation. In particular, we will do this through the Commissioning for Quality and Innovation (CQUIN) payment framework, joint working and the

continuation of collaborative improvement schemes across the sector, e.g. as in the examples of Maternity and Safeguarding.

10.4 Public, patient and staff engagement has already commenced with significant engagement in the development of the strategy thus far. We asked patients and staff what was important to them in ensuring high quality services for all.

10.5 There are many definitions of quality in use. The Quality Improvement Strategy has been shaped with input from staff, users and patients through a series of consultation events and by encouraging dialogue about what quality looks like and how quality of service can be ensured.

10.6 Using this information and existing sources of patient and user feedback, the following themes emerge as to what **Excellence in Quality** and service looks and feels like to patients, carers and staff:

- Caring, **compassionate** and competent staff
- Clear **communication** and **explanation** at all stages of care
- Effective **collaboration** and team work
- **Clean** and **personal care** environments
- **Continuity** of care and service between different stages and organisations
- Clinical **excellence** in care and treatment

10.7 As part of implementing the Quality Improvement Strategy we will investigate these themes further, using Real Time Monitoring and other methods to ask high numbers of patients about their immediate experience of care and services. If patients say they would recommend us to others we will ask why and for those who would not, we will also ask why and use the information to give feedback to staff and target our improvement efforts.

11. The Quality Improvement Strategy Implementation Framework

11.1 The Quality Improvement Strategy framework aims to build on the organisation's strengths and previous successes in improving care and services and to complement the existing clinical governance infrastructure and quality initiatives already in place.

11.2 Quality improvement is a continuous process. Successful quality programmes require vision, creative thinking and ideas but also clear delivery plans with measurable goals and targets to ensure progress and success is tracked and celebrated.

11.3 In implementing the Strategy, the organisation will need to learn and adopt a range of quality improvement techniques and approaches, including measurement and the use of data for quality improvement. Clinicians and managers will need to work together and demonstrate drive and determination to develop the will and infrastructure required locally in each service to deliver and sustain the unprecedented scale of quality improvement we want to achieve.

11.4 The Quality Improvement Strategy quality driver diagram (Appendix 1) identifies four key interlinking and complementary organisational drivers, which when implemented will support achievement of the vision and the improvement goals set out in Section 1.4. These are driving development and implementation of:

- Leadership and culture for quality improvement
- Measurement for quality improvement
- Evidence-based interventions and proven best practice
- Workforce capability and skill for quality improvement

12. Leadership and Culture

12.1 Effective high-performing organisations recognise the significance of quality and continuous quality improvement to achieving their strategic and core business goals and are successful in engaging and communicating this to all staff and to service users.

12.2 The Trust Board will oversee implementation of the Quality Improvement Strategy. It will agree and articulate clear improvement goals, drive an improvement culture throughout the organisation, support effective clinical leadership and ensure and approve an infrastructure for strategy implementation.

13. Measurement

13.1 The challenge set by *High Quality Care for All* was for healthcare organisations to be able to define, deliver and measure quality in the three dimensions of patient experience, safety and effectiveness and in all services and at every service level.

13.2 Implementing the Quality Improvement Strategy across the Trust will require continuing investment in expertise and resources to enhance existing data capture, improve coding and support frontline staff to acquire new skills and expertise in using data to support quality improvement at ward and service level. This will include a revised training and implementation plan for Dr Foster clinical benchmarking and ongoing development and use of visual management and 'Ward to Board' metrics.

13.3 Process and outcome metrics at Board, Divisional, CAU and ward level will continue to be developed to enable progress towards the Strategy's goals and targets to be measured and reported for each implementation year.

14. Evidence-based interventions and implementing best practice and innovation in quality and safety

14.1 The Trust already has experience of implementing proven improvement initiatives such as the Safer Patients Initiative, Lean and Essence of Care. There are also national benchmarks and indicators such as for cardiac, stroke and trauma care which demonstrate that in some clinical services 'Excellence' is already achieved by clinical teams at Barts and The London.

14.2 The Quality Improvement Strategy will require increased use of benchmarking and continued implementation of evidence-based safety interventions and recognised best practice to achieve excellent clinical outcomes.

14.3 All clinical teams and services will identify and define quality and best practice standards and markers for their services, including any nationally-agreed standards, guidelines for clinical effectiveness and quality indicators derived as a result of participation in national audits.

14.4 Non-clinical services and departments will also identify and establish systems to define and monitor the quality of their services, including high quality customer service where appropriate and to demonstrate value for money and service efficiency.

14.5 The Trust Board will encourage and promote innovation in quality and safety improvement at all levels and ensure achievements and successes (big and small) are recognised, rewarded and communicated widely both internally and externally to the community, patients and partners.

15. Workforce capability and skill in quality improvement

15.1 The Quality Improvement Strategy recognises the significant contribution that a well-trained, motivated and supported workforce makes to delivering and achieving high quality care and services. It is well documented that changes and improvements which are owned and driven by an individual service or team are the ones which are most likely to be successful and sustained.

15.2 When asked, patients frequently cite that not only the skills but also the empathy and friendliness demonstrated by the people looking after them are important and are what contribute significantly to their overall experience of care. The Strategy will escalate action to ensure that all staff have and demonstrate highly-developed customer care and communication skills.

15.3 A longer-term strategy aim is to become a learning and quality driven organisation in which every member of staff understands their role in delivering clinical quality and works towards that goal every day. Excellence in clinical leadership and mentorship for safety and quality improvement will be rewarded and effective leaders will be the role models for staff development and career progression.

15.4 The Strategy will align closely with the development of the Trust's new Organisational Development Strategy. Emphasis will be placed on understanding our clinical systems and processes in greater detail, working towards excellence in those systems, engaging all staff in improvement activity, using small tests of change to build momentum, and learning from mistakes and poor quality to do better.

16. The Quality and Safety Indicators Pyramid

16.1 The Quality and Safety Indicator pyramid describes the Performance Dashboard and other indicators collected and reported currently, including the 12 London-wide and local developmental CQUIN projects.

16.2 Meeting national quality standards provides assurance to patients, users and Commissioners that Barts and The London is a safe and high-performing organisation with effective and robust clinical governance, including risk management, processes embedded in every ward, service and CAU.

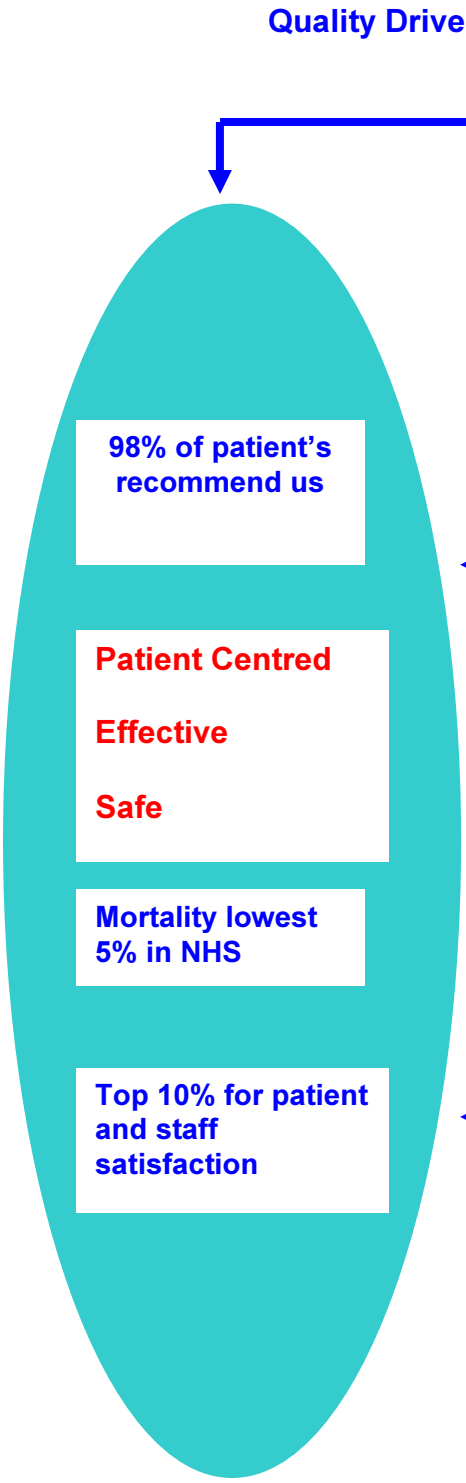
16.3 Where significant gaps or risks to meeting minimum standards, national guidance or accreditation requirements are identified, corrective action will be identified and if appropriate prioritised as part of that year's QDP.

16.4.1 This will ensure an integrated approach to continuous quality improvement, with equal priority given to maintaining minimum quality

and safety standards, as well as working towards Excellence in quality and service delivery, and ensuring year-on-year advances in innovation.

Judith Bottriell
Associate Director Quality Improvement
December 2009

Quality Improvement Framework



Key enablers & deliverables

Leadership & Culture

- Board direction and leadership
- Executive Walkabouts
- Outstanding clinical leaders
- Patient involvement at every level
- Stakeholder involvement at every level
- Evidence based optimal care
- Promote a fair and just culture
- Promote a learning & improvement culture
- Optimize & reward teamwork behaviour
- Continue to build IT infrastructure for electronic record
- Quality & Safety Improvement Board metrics

Measurement

- Mortality (HSMR)
- Adverse events – global trigger tool
- Infection – SSI, UTI, VAP, MRSA, C diff
- Acutely unwell – arrests outside ICU, AE's
- Nurse indicators – Falls, TUs, complaints
- CQUIN outcome measures
- Patient experience and staff satisfaction scores
- PROMS
- Efficiency indicators – LEAN benefits
- Productivity indicators

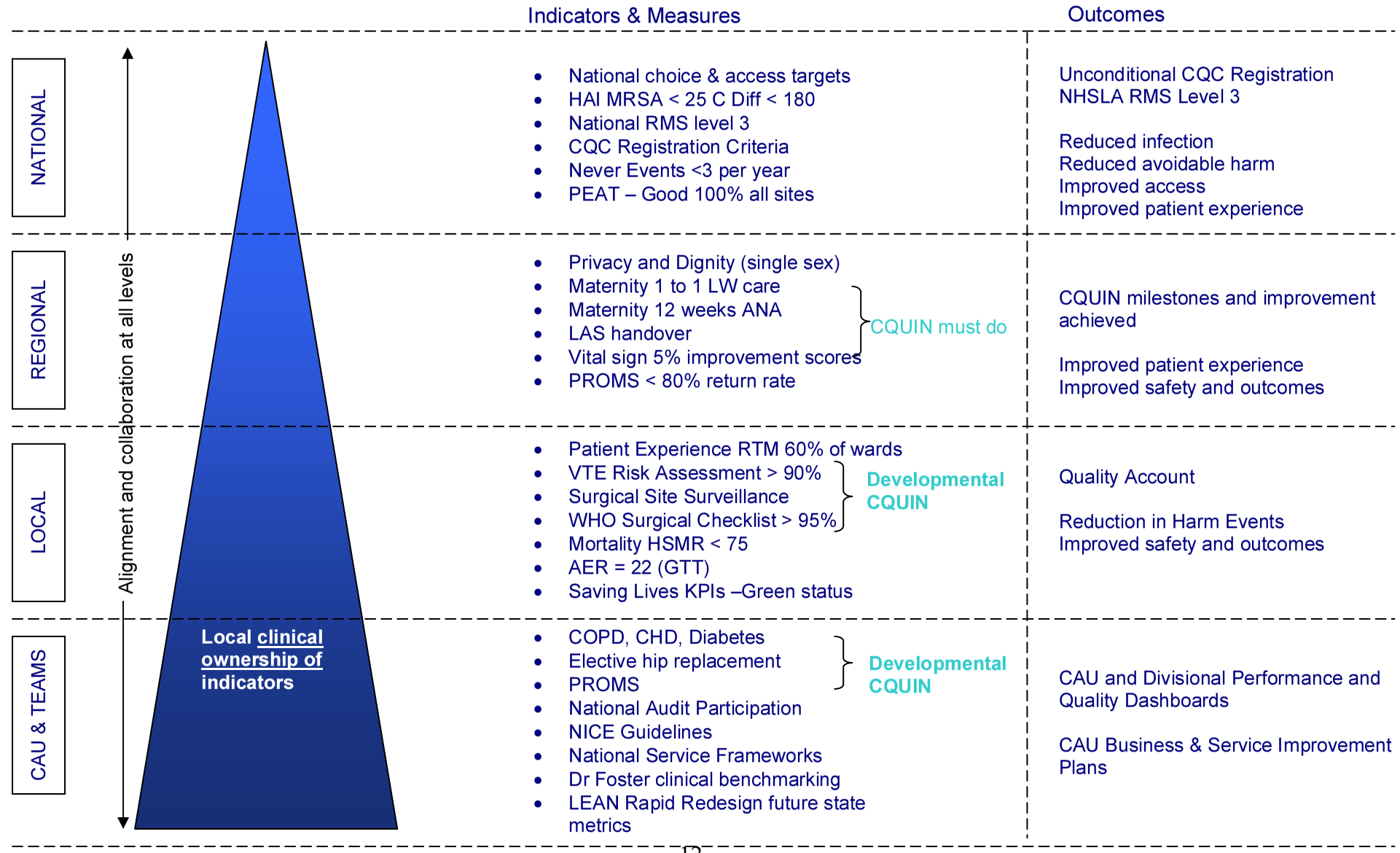
Quality and Safety Interventions & Initiatives

- Rapid Redesign - LEAN
- Productive Ward
- Essence of Care, back to basics
- Patient Experience Improvement Programme (Picker)
- ACE
- Patient Safety First Campaign
- Safer Patients Network participation
- Reliable care for high volume & risk conditions & processes
- Care bundles (Saving Lives, Matching Michigan)
- Improve care of the acutely unwell

Workforce skill & capability

- OD Strategy
- Patients participate in all improvement teams
- Benchmark staff improvement capability
- Build infrastructure and capability for Q improvement in Divisions and CAUs
- Build a culture of continuous quality improvement
- Develop leaders & mentors for QI
- Reward and celebrate successes and spread them quickly
- Recruitment & Retention

Quality and Safety Indicators Framework



Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**23 March 2010**	**Unrestricted**		**4.4**
Report of: **NHS Tower Hamlets** **Author:** Alan Steward, Deputy Director, Corporate Development and Performance		**Title:** **Operating Plan 2010/11** **Ward(s) affected:** All		

1. Summary

The NHS Tower Hamlets Operating Plan 2010/11 reflects the first year of delivery of the Commissioning Strategic Plan.

A draft Operating Plan was submitted to NHS London on 25 January. The feedback was very positive and required only minor amendments. All NHS-London comments have been incorporated into the final version of the Operating Plan that was submitted on 26 February 2010.

The PCT's Operating Plan is aligned fully with the East London and City Alliance (ELCA) Operating Plan.

Key Issues

The 10/11 Operating Plan represents the first year implementation of the PCT's ambitious CSP. Given the potential financial constraints over the next five years, delivery of the initiatives and programmes is essential. To ensure delivery, these will be performance managed through the PCT's Delivery Boards with regular updates to CEC and the Board

2. Recommendations

The Health Scrutiny Panel is asked to note the briefing NHS Tower Hamlets has provided on its Operating Plan 2010/11. This was endorsed by its Board in draft form in January 2010 and in final form in March 2010

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NHS London

2010/11 OPERATING PLAN

PCT: NHS Tower Hamlets

Version: Final

Date: 25 Feb 2010

NHS London

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SECTION 1: STRATEGIC OVERVIEW

1.1 Summary

This is our Operating Plan for 2010/11. It is the first year of our new Commissioning Strategic Plan that sets out to change radically our local health economy by a rapid implementation of Healthcare for London. This will not only deliver significant health gains and service improvements ensure that we can deliver an affordable health economy within five years.

We have made significant progress in transforming many areas of the health economy in Tower Hamlets in line with both HfL and our Improving Health and Wellbeing strategy. Key successes include:

Health inequalities and variation in clinical outcomes

- Improved patient satisfaction with GP access from 69% to 82%
- Increased number of appointments by 25% at no extra cost (with an implicit decrease in unit cost of £5 per patient)
- Performance management of GP practices to reduce variations
- Developed and now piloting IT tools to support 5 core functions of integrated care, including 1) disease registry, 2) multi-disciplinary team, 3) call/recall, 4) performance tracking, 5) patient care planning
- Increase satisfaction with Maternity services
- Met our smoking quitters targets for the last five years
- Increased breast screening by nearly 10% in 2008/09

High cost hospital care

- Only Integrated Care pilot in London
- Focusing on tighter integration across primary care/acute for long term conditions and closer integration of community health services and social services

Productivity

- Defined 12 main care packages using polyclinic economic model, created strategy to increase primary care capacity to deliver best practice care, raising our spend on primary care from 9% to 13% (just above national average)
- Clinical Assessment Service with reduced out patient referrals and improved carpal tunnel management; claims management
- Initiated tariff based costing and performance management system for CHS to provide activity transparency and realise productivity gains of 17%. There is an implicit unit cost reduction of 15%

Improved primary care

- Developed detailed investment plan to roll out best practice care packages across primary care over next 5 years
- Worked in depth with clinicians to agree risk stratification and key interventions for diabetes care package
- Established eight primary care networks through a rigorous developmental and bidding process with a structured organisational development programme for all networks
- Opening of Barkantine centre as a first wave polyclinic and best in class
- Primary care sites have been substantially renovated
- Reduced the number of GP practices from 43 to 34 in five years

Although we have made significant progress in recent years, further transformation is needed to meet the challenges posed by health inequalities and needs and the future

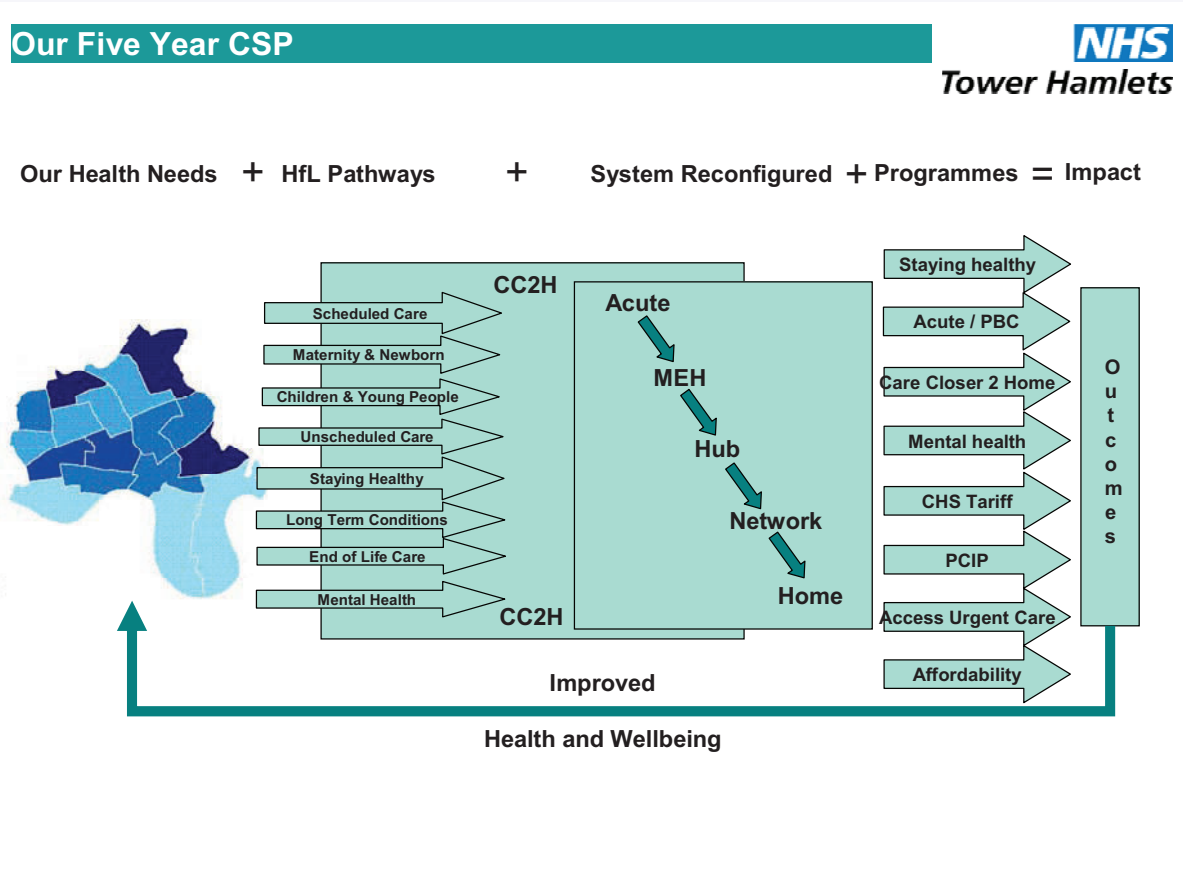
financial scenarios. These include:

- Health needs – Tower Hamlets has intense health needs and inequalities (both with other boroughs and within the borough between LAPs and wards). Key areas include cancer, diabetes and healthy lifestyles.
- Performance – For 2008/09 Tower Hamlets was rated "weak" under its CQC assessment and to meet the health needs of the borough performance we needs to transform performance to deliver improved outcomes.
- Market management – Performance and the likely future financial situation requires work with all providers.
- Financial – The likely future financial situation means that affordability is fundamental to delivering health improvements. The PCT must tackle a potential deficit of £36m by 2014/15. This is given added importance given the financial pressures on other public sector partners, particularly Tower Hamlets Council, over the same period.

Our initiatives – and continuing work – are based on a detailed analysis of each of the Darzi pathways looking at need, good practice, our existing initiatives and the progress we have made and the key gaps we need to tackle so that we close performance and quality gaps. The many continuing programmes including those around staying healthy, end of life, children and young people and maternity are highlighted.

This Operating Plan sets out the performance measures and milestones that we will use to drive the transformation of health in Tower Hamlets in 2010/11. There is considerable emphasis on delivering the polysystem so that we can move care closer to home. We believe that if we are to continue delivering health improvements with less resource then we need to quicken the pace of change that we have already started. This means that in this first year we are giving priority to securing an affordable health economy.

The overall approach for our Commissioning Strategic Plan is set out in the diagram below.



1.2 Care pathway priorities

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

The priority pathways that we will focus on in 10/11 are:

- Long Term Conditions through our Primary Care Investment initiative
- Unscheduled Care through our Unscheduled Care initiative
- Planned Care through our Care Closer to Home initiative
- Mental Health through our Mental Health initiative

There are a number of priority pathways that the East London and City Alliance will lead on. These are:

- Planned Care;
- Acute Care;
- Maternity and Newborn;
- Children and Young People; and
- Staying Healthy (breast screening and evidence initiatives only)

There are also a number of other pathways which will be supported at a sector level to deliver close collaboration across the three PCTs. This includes:

- Mental health.
- Long Term Conditions (sector level programmes of work to support this area are included within the priority care pathways being led at a sector level and not shown separately); and
- Staying Healthy.

The development of polysystems to deliver Healthcare for London is such a key work stream and integral to the delivery of most of the pathways that we are developing a Sector polysystem development strategy.

1.3 Strategic initiatives

Summarise your organisation's strategic initiatives.

Our eight strategic initiatives will deliver health improvements and affordability. They are:

- Staying Healthy – by focusing on the key health challenges facing Tower Hamlets on obesity, tobacco use, screening, and immunisation. This will be delivered systematically through our primary care networks and strengthening further our commissioning through the Tower Hamlets Partnership and Local Area Partnerships.
- Acute Contracting – by focusing on reducing activity of low clinical value, claims management and validation. Acute contracts will be changed to reflect the phased shift of care into polysystem supported by better information and systems to GPs and PBCE to reinforce the shifts of care by reducing referrals
- Care Closer to Home - by continuing and quickening our polysystem development so that we reduce services in acute and shift them into our polysystem,
- Access and Urgent Care – improve access to urgent care while reducing A&E attendances through the polysystem by commissioning an urgent care centre and sustaining and extending access to primary care
- Primary Care Investment Programme – to better manage long term conditions – with improved self care and reduced hospital admissions - through implementing a number of care packages including diabetes, COPD and staying healthy.
- Improving CHS productivity – by introducing a full tariff across CHS to raise productivity and transparency, as well as market testing three CHS services
- Mental Health – by enhancing further our mental health services with a focus on working collaboratively across ELCA and with the ELFT and looking to improve further the efficiency and effectiveness of services
- Affordability / Save to Invest – a number of measures that will deliver early savings to

the PCT to allow investment in longer term improvements.

1.4 Settings of care

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

The table below summarises the shifts in activity and expenditure that we anticipate in 10/11. It shows the proposed changes by each of the affordability levers. It is based on our detailed activity and financial planning model developed by our Sector Health Intelligence Unit for our CSP and ICSP. This shows that financial viability is achieved across all revenue funding assumptions, although the downside has some risks in the medium term because of the extraordinary population growth being experienced in the sector.

Four of the initiatives do not have any activity shifts associated with them.

There is a more detailed version in Section 4.4.

Tower Hamlets CSP Initiatives			**Gross Increased Expenditure**	**Gross Reduced Expenditure**	**Net Change in Expenditure**	**Activity shift**
Initiative	**Description**	**Type of action**			£000s	
2	SACU	Provider productivity	-	4,283	(4,283)	(31,765)
2	SACU Decommissioning	Decommissioning	164	1,672	(1,508)	(15,137)
3	CC2H Polysystems	Polysystem implementation	13,744	2,924	10,820	7,504
3	CC2H Polysystems	Planned Direct CIP	-	27	(27)	(264)
4	PCIP LTC	LTC savings	3,420	2,315	1,105	(248,896)
1	Staying Healthy (Prevention)	Strategic investments	713	965	(252)	(108,199)
5	Community Tariff	Planned Direct CIP	-	1,200	(1,200)	0
8	Management Cost Savings	Planned Direct CIP	-	1,443	(1,443)	0
7	Mental Health	Shifting settings of care / Planned Direct CIP	199	454	(255)	0
6	Urgent Care	Shifting setting of care	897	700	197	(7,504)
8	Procurement & Supply Chain	Enabler		900	(900)	0
Totals			19,137	16,883	2,254	(404,261)

1.5 Implications for provider configuration

Acute
These are set out in the Sector Operating Plan

Mental Health
- No proposed changes to provider configuration in 10/11 but development of mental health currency and review of productivity across Sector may have implications for existing and future providers

Community Services
- Market test four CHS services: advocacy & interpreting, diabetes education, pulmonary rehabilitation and personal dental services. This may have implications for CHS.
- Further implementation of community services tariff – with extension to all CHS services for 11/12 - may have implications for existing and future providers.

Primary Care
- Further implementation of polysystems with procurement strategy that will deliver a mix of new and existing providers. This is being developed through Networks.
- Further development of primary care networks including diagnostic shift and OD activity to support implementation of care packages
- Establish primary care led UCC at Royal London Hospital
- Procuring a revised out of hours dental services (across the Sector), new dental practice in Stepney and existing PCT practice

SECTION 2: WORLD CLASS COMMISSIONING

The priorities for the implementation of our OD Plan are set out below.

Improve the ways in which we make use of data/intelligence and information to ensure delivery and drive better strategic commissioning

1. Optimise potential of the newly established Health Intelligence Unit, as per its business case
2. Engage the commissioning organisation in a process of identifying and improving where data and intelligence sits and how it is used
3. Carry out skills development in data interpretation/analysis

Stimulating the market for services to offer choice to users as well as promoting improvement amongst providers

1. Agree and enable a market management strategy and framework. To include Procurement, Third Sector, and a database of all contracts. Link the commercial strategy to ELCA, identifying a wider footprint for opportunities for market deployment and stimulation
2. Tariff development for CHS and development of a currency for Mental Health
3. Engaging and developing Clinical Commissioning

Strengthen the three PCTs as World Class Commissioners through the further development of the East London and City Alliance

1. Agree and enable a market engagement strategy and framework
2. Tariff development for CHS and Mental Health currency

3. Engage and develop clinical commissioning

Developing WCC competence at an individual, team and organisational level

1. 30% reduction in corporate and commissioning management costs
2. Developing commissioner skills
3. Being a delivery focused organisation with effective infrastructure and programme management
4. Clinical leadership

Delivering exceptional patient and public engagement

1. Embedding a systematic process for involving the public and patients in commissioning decisions
2. Segment the population for effective social marketing in order to drive the 'Staying Healthy' agenda

Value for money and efficiency

1. Identify a process to address total VFM (way we do it and forum where decisions made) and apply it systematically
2. Implement recommendations from the Boorman report to make savings from improving absence management
3. Deliver the OD implications of the top 3 VFM programmes; COOH, Polysystems and long-term conditions

SECTION 3: PERFORMANCE

The detailed actions we will take 2010/11 to implement our CSP, as well as the priorities set out by NHS-London and in the NHS Operating Framework are set out below.

We have attached at Appendix 2 a complete list of our Existing Commitment and Vital Sign targets with trajectories across the year where possible and indicated the main initiatives that will impact on them. The initiatives and associated performance targets will be monitored and managed robustly through our newly established Delivery Boards that are strengthening further our robust programme and performance management to make sure we deliver on our ambitious plans in 2010/11.

The strategic initiatives included within the Operating Plan are the responsibility of the PCT to implement and include associated performance measures, actions, milestones and risks. A number of the initiatives are either linked to Sector initiatives or are being delivered by the Sector delivery vehicles on behalf of the PCT (primarily acute sector). Our Operating Plan includes the financial implications of these initiatives but the Sector Operating Plan contains the details of delivery. These are indicated clearly for easy cross referencing.

Strategic initiative 1: Staying Healthy

Linked Healthcare for London care pathway(s) and/or care setting(s):

Staying Healthy – Immunisation infection against infectious diseases in early childhood and seasonal flu vaccination for adults below 65 years with long-term conditions

Linked pledges and targets:	***Linked WCC outcome(s):***
Contribute to the reaching of the CSP target for MMR2. Using data and information systems to track and manage the immunisation delivery, at a practice, network and borough level 60% uptake of the seasonal flu vaccination for the cohort above 10/11	% of children receiving MMR(I+II) by 5th birthday

Actions:	***When will the action be completed? (month)***
To increase the senior IT analysis in the ICT department to deliver on the IT specification for immunisation.	May 2010
To increase the IT competencies required by Networks and general practice teams to deliver the immunisation programme particularly on the call and recall programme to increase the uptake of the immunisation programme.	May 2010
To develop an Local Enhanced Service for general practice for <65 residents	May 2010
To identify the practices and Networks monthly are not delivering against the Child Imms target and identify any gaps in the IT management system which require improvements. Followup through Network Managers.	April 2010 onwards

To deliver IT training to any new staff in practices and to increase the competencies of appropriate professionals based within Tower Hamlets CHS (eg Child Health teams) to ensure the new immunisation IT management process is not interrupted at a practice or network level or borough level.	May 2010 onwards
To promote <65 LES to all general practice staff and Network Managers	July 2010
Weekly tracking and information sent to practice and network managers on the uptake of <65 vaccination.	October – 31st January '11
Practices meeting the <65 vaccination targets reimbursed	March 31st 2011

Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
MMR 2 reaches 90% uptake by April 2011. Production of monthly or more frequent updates of performance on a practice and network level. Increased competencies of practices and Networks using EMIS web for the immunisation programme. Systematic training programmes have been implemented and participants competencies monitored <65 Flu weekly data from ICT department during the seasonal flu campaign	Current level of activity on CSP immunisation target 81% Current level of activity 50% for under 65yrs	*Q1*	84%
		Q2	86%
		Q3	MMR - 88% <65 - 55%
		Q4	MMR - 90% <65 - 60%

Impact on activity and finance (commissioned / decommissioned):
£100,000 to increase the capacity of ICT to support the delivery of the management system for immunisation at a practice, network and borough level.

£75,000 to fund the LES to commission the GP practices to focus on this vaccination programme for the Under 65 yrs.

Overall the Staying Healthy programme will have the following impact:

Gross Expenditure	Gross Savings	Net Change	Activity Change
£713k	£956k	-£252k	108,199

Impact on workforce:
Create a senior IT analyst post (approx band 7/8a) to deliver on the IT specification and strategic development of the immunisation data/management system.
Increase posts (band 5/6) to support practices and networks to ensure competency in using the immunisation management system

Practices will require to be more systematic in how they deliver service to their under 65 yrs population with long-term conditions

Risks:	High/ Medium/ Low risk	Mitigating actions:
The IT support is not enough to improve all the practices /Networks competencies in the immunisation system.	medium	Ensure the networks and practices with the poorest uptake of the CSP target are focused on initially.
The senior IT analyst work is diverted onto other important data reporting activities.	Low risk	Ensure that the immunisation specification becomes a SLA which can be monitored on a regular basis.
Request for the information from the immunisation management system is not responded to promptly for planning purposes.	Low risk	Use of the SLA and any deadlines missed escalated to Director of PH for action.
Programme is aimed at the whole of this cohort of patients under 65yrs including the exception reported patients	medium	Will require emphasis and clear publicity on the cohort of patients we are expecting practices to reach. Reporting on a regular basis on the uptake of their cohort of patients.

Relevant Sector Initiatives
Sector Strategic Initiative fourteen - work to strengthen the evidence base to inform future investment in high impact staying healthy initiatives (with support from the HIU), ensuring the spread of best practice interventions across ELCA.

Ongoing Initiatives
In addition to the Strategic Initiative described above, NHS Tower Hamlets is continuing its programmes to promote healthy lifestyles. These are described below. Our Emergency Preparedness is also considered under this initiative.

Healthy Weight, Healthy Lives - Healthy Borough Programme

The national Foresight Report 'Tackling Obesity: Future Choices' identified that the reasons for the rising prevalence of obesity in children and adults are complex but are linked to social and environmental circumstances. They highlighted a number of areas that need to be addressed including:

- making cycling and walking easier in the built environment
- limiting exposure to foods that make us obese, e.g. takeaways
- making workplaces healthier

NHS Tower Hamlets successfully led a multi agency bid for funding from the Healthy Community Challenge Fund for Tower Hamlets to become one of 9 'healthy towns' nationally. This means Tower Hamlets is now piloting new ways of tackling the social and environmental causes of obesity to make it easier for children and families to be more physically active and eat more healthily wherever they live, work, travel, play or learn. The funding (Dec 2008 – March 2012) has been used to set up the Healthy Borough Programme (HBP). A delivery team at the heart of the Local Authority is driving forward a range of multi agency interventions to promote healthy eating, active lives and active travel through three overarching themes:

- Healthy Environments
- Healthy Organisations
- Healthy Communities

A multi agency board oversees the programme which is working as a vehicle for strategic and operational change.

Key Actions / Milestones for 10/11		*When will the action be completed? (month)*
Programme Level		
Secure high level engagement in NHS TH and THC to making 'internal' changes (e.g. workplace food) and committing to sustainable changes around tackling obesity in the wider 'external' environment		Board level meetings – quarterly Special events – e.g. evaluation workshop in March 2010
Complete first phase of an external evaluation to evaluate the strategic and cultural impact of the Healthy Borough Programme		July 2010
Equity Impact Assessment of children and families using the HBP		Sept 2010
Healthy Environments		
Build on integration of 'active lives' and 'healthy food' commitments in the Local Development Framework to ensure there are costed plans for developing a green grid and for embedding planning into urban planning		Green grid plans – Sept 2010 Health Guide for Urban Planners – Dec 2010
Promote active lives through promoting physical activity in parks and open spaces, active play and access to swimming for women and girls		March 2011
Promote a range of healthy food outlets, including a pilot food awards scheme for restaurants and cafes and THC agreeing how to embed health into future planning decisions around fast food outlets		March 2011
Healthy Organisations		
Roll out workplace food, physical activity and active travel policies across Tower Hamlets		March 2011
Support development of healthy food and physical activity in early years settings and schools		March 2011
Healthy Communities		
Implement a range of community and estate based programmes to promote cycling and walking		March 2011
Promote a healthy home environment through the integration of healthy eating and physical activity into a range of existing parenting programmes (the Healthy Families project)		March 2011
Support community and voluntary organisation to deliver solutions to environmental barriers to physical active, healthy eating and active travel		March 2011
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***
THC and NHS TH review and share the evaluation programme from the Healthy Borough Programme	Evaluation plans in place but implementation needs support	Build on evaluation strategy and implementation plan to evaluate impact of HBP on: • Reach and access • Processes and Learning • Short term outcomes

		• Longer term outcomes Ensure external evaluations are completed and disseminated including: • Cultural and strategic impact • Reach – diverse communities • Active Travel • Can do community grants • Communications Tracking research
		Q1 support routine monitoring and evaluation across HBP and prepare annual reports for first year
		Q2 High level discussions (locally and nationally) on HBP's progress
		Q3 Bring together information on 'observable differences' made by Healthy Borough Programme and share at a local conference on the HBP
		Q4 Agree continuation strategy for post programme evaluation
THI and NHS TH agree forward plan for HBP	No plan for funding after March 2011 currently	Q1 embed sustainability into evaluation discussions to gauge perspectives and review level of integration into strategic and operational plans
		Q2 Address gaps in strategic and operational planning and scope future funding in context of wider HW, HL strategy
		Q3 Embed HBP into future strategic and operational plans
		Q4 Review progress and report

Healthy Weight Healthy Lives (Obesity) – Children and Families	
Levels of childhood obesity in Tower Hamlets are amongst the highest in the country, most recent NCMP results suggest 13.4% of children in Reception & 25.7% in Year 6 are at risk of being obese (ranking 6th and 2nd highest in England respectively). The Healthy Weight, Healthy Lives in Tower Hamlets Strategy sets out a comprehensive framework for the prevention and management of obesity in Tower Hamlets. 2 multi-agency working groups (early years and CYP) are implementing multiagency action plans to reduce levels of child obesity. There is a separate group taking forward adult weight management and also high level Board responsible for overseeing the implementation of both the Healthy Weight, Healthy Lives strategy and the broader Healthy Borough programme. Levels of childhood obesity at Reception (age 4-5 years) has fallen, but continues to rise at Year 6 (age 10-11 years). NHS TH has drawn up a revised year 6 action plan as a 'call for action' to make childhood obesity a priority challenge within the borough. 'Key Actions' below highlight added value initiatives that will be introduced in 2010-11.	
Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Achieve UNICEF 'breast feeding friendly' award (level 3)	March 2011

Roll out early years healthy accreditation scheme across early years settings		March 2011
Joint launch of adult and childrens' weight management care pathways		October 2010
Develop multi-agency workshops focussing on delivery in primary school and its community to tackle rising rates of Year 6 obesity. Pilot in 1 locality and roll out across other 3.		Pilot by May 2010 Complete by Dec 2010
Provide information and signposting to parents as part of NCMP feedback.		July 2010
Increase pupil participation in Healthy Schools programme through small grants to schools for pupil led projects. Qualitative evaluation by May 2010, full evaluation by December 2010		May 2010 December 2010
Bring together 3 separate children's weight management programmes into one seamless service that meets both specialist (e.g. children with co-morbidities associated with obesity) and community based needs and maximise new funding opportunities.		March 2011
Delivery phase of child obesity social marketing project (Recipe4Fun) targeting 5-11 year olds in schools.		March 2011
Social marketing campaign to promote healthy lifestyles and participation in physical activity in the lead up to the Olympics and Paralympics 2012.		March 2012
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***
VSB09: Obesity among primary school aged children	2008/09 academic year (reported 2009/10) Reception – 13.5% Year 6 - 25.7%	2009/10 academic year (reported 2010/11) Reception – slow down increase in obesity to no more than 14.5% in 2009/10 academic year Year 6 – slow down increase in obesity to no more than 25.5% - CSP (23.7% vital signs) in 2009/10 academic year
Early Years Childcare Settings working towards 'Healthy EY Award' Early Years Childcare Settings achieved 'Healthy EY Award'		Q1: 4 settings working towards 'Healthy EY Award'; 6 settings achieved 'Healthy EY Award'.
		Q2: 4 Settings working towards 'Healthy EY Award'; 6 settings achieved 'Healthy EY Award'.
		Q3: 4 Settings working towards 'Healthy EY Award'; 6 settings achieved 'Healthy EY Award'.
		Q4: 4 Settings working towards 'Healthy EY Award'; 6 settings achieved 'Healthy EY Award'.

Pathway completed and launched (link to adults). Increase number of CYP accessing childrens' weight management service (cwms) from 250 2009-10 to 370 2010-11. Common dataset (in line with SEF) across all child weight management programmes. % change against key performance indicators (inc changes in BMI pre and post etc). Full metrics to be determined.		Q1: 92 participants in CWMS; common dataset established. Q2: 92 participants in CWMS; Q3: 92 participants in CWMS; Pathway complete and launched. Q4: 92 participants in CWMS;

Tobacco Control	
NHS Tower Hamlets has with partners developed a strategy to reduce the prevalence of tobacco use in the borough. The delivery plan is composed of the following workstreams which report to the Tobacco Control Alliance which in turn reports to the CPDG. The workstreams run in line with national strategic aims ; 1. Preventing the uptake of tobacco use 2. Motivating and helping tobacco users to stop 3. Maintaining a smoke free environment and reducing exposure to second hand smoke 4. Communicating and marketing this effectively 5. Developing a research and evidence base The strategy runs to the end of 10/11. This year we seek to build on the existing success of the Alliance and have prioritised the following service developments in order to intensify and improve our efforts: preventing uptake, ensuring our commissioning portfolio addresses inequalities in access and outcomes, using social marketing segmentation to target initiatives with greater precision, further integration smoking cessation into clinical pathways and promotion of smoke free homes. We have commissioned an external evaluation of the strategy which will inform a refresh of the Alliance strategy.	
Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Commission peer education, social marketing and enforcement services (underage sales, counterfeit tobacco) to prevent uptake of tobacco	June 2010
Commission a portfolio of services in primary care, community pharmacy, voluntary sector organisations, workplace, mental health and hospital setttings in order to increase access to stop tobacco services. This commissioning is based on local need (from JNSA and Healthy Lifestyle Survey) Performance manage these services on a quarterly basis	April 2010- March 2013 quarterly
Market these services to the public and front line staff	June 2010
Embed referral into clinical pathways and care packages	October 2010
Commission a portfolio of services to protect people from the effects of second hand smoke	June 2010

Commission an evaluation of the tobacco control strategy		April 2010	
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
4 week smoking quitters	Expecting at least 1800 quits in 2009/10	Q1	300 4 week quits
		Q2	400 4 week quits
		Q3	600 4 week quits
		Q4	600 4 week quits

Adult Obesity Care Pathway			
Obesity (Adults) is a significant problem in Tower Hamlets and is a major risk factor for premature mortality. . The Healthy Weight, Healthy Lives in Tower Hamlets Strategy sets out a comprehensive framework for the prevention and management of obesity in Tower Hamlets. This addresses the need to address the causes of obesity both within the wider environment and people's lifestyles. This section describes specifically the adult obesity care pathway element of the strategy focussing on those who are already overweight and obese and would benefit from individual or group support. . Our priorities this year are to further embed the adult obesity care pathway guidelines that we have developed. This describes a set of tiered interventions depending on the level of obesity and associated risk factors ranging from health trainer interventions, weight management programmes, exercise on referral (recently recommissioned) and specialist obesity services.			
Key Actions / Milestones for 10/11		***When will the action be completed? (month)***	
Promote and provide training for the adult obesity care pathway to frontline providers		October 2010	
Joint formal launch of adult and child obesity pathways		October 2010	
Tier 1 – Health Trainers Programmes Recommissioned		April 2010	
Tier 2 – Weight management programmes recommissioned		June 2010	
Tier 3 – Specialist services recommissioning		June 2010	
On going quarterly performance management of above services		April 2010 – March 2011	
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Tier 1 obesity services –		Q1	125 people attending lifestyle sessions and 100% of clients having 1-1 interventions and identifying weight loss as primary goal to have reduced their body weight
		Q2	125 people attending lifestyle sessions and 100% of clients having 1-1 identifying weight loss as primary goal to have reduced their body weight
		Q3	125 people attending

			lifestyle sessions and 100% of clients having 1-1 identifying weight loss as primary goal to have reduced their body weight
		Q4	125 people attending lifestyle sessions and 100% of clients having 1-1 identifying weight loss as primary goal to have reduced their body weight
Tier 2 obesity services – Number and completion rates of weight management programmes	Data currently being collated for this year. Expecting 400 completers	Q1	
		Q2	125 completers (at least 50% of those starting)
		Q3	125 completers (at least 50% of those starting)
		Q4	125 completers (at least 50% of those starting)
Tier 3 obesity service – Exercise on Referral – Number and completion rates of exercise on exercise on referral programme	Previous service (now decommissioned) had 150 completers	Q1	98 completers (66% of those starting)
		Q2	98 completers (66% of those starting)
		Q3	98 completers (66% of those starting)
		Q4	98 completers (66% of those starting)
Tier 3 obesity service – community based specialist service – metrics to be determined			
Staff training on adult obesity care pathway		Q1	
		Q2	
		Q3	100 staff trained
		Q4	200 staff trained

Physical Activity Pathway (Adults)	
Physical inactivity is a major cause of preventable ill health and disability. 83% of adults in Tower Hamlets do not meet the minimum standards for physical activity. 'Lets Get Moving' is a national programme that provides guidance on systematically promoting physical activity with the NHS. Our priority this year is to use this as a basis for developing a local physical activity pathway within primary care. This entails identification of low physical activity through use of the GPPAQ screening tool, delivering brief interventions, signposting to local services and following up patients.	
Key Actions / Milestones for 10/11	***When will the action be completed? (month)***

Establish a physical activity pathway for adults following stakeholder involvement using guidance from 'Let's Get Moving').		June 2010	
Develop an implementation plan encompassing a) Integration of GPPAQ into GP systems b) Training of Primary Care c) Development of a local directory to healthcare professionals and the public link to local services		September 2010 December 2010 June 2010	
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Number of practices with GPPAQ on template Percentage of people undergoing vascular checks whose GPPAQ score is known (metric performance to be determined)	Not known currently	Q1	
		Q2	
		Q3	GPPAQ metric to be agreed
		Q4	All practices have GPPAQ on template
Tier 3 obesity service – Exercise on Referral – Number and completion rates of exercise on exercise on referral programme	Previous service (now decommissioned) had 150 completers	Q1	98 completers (66% of those starting)
		Q2	98 completers (66% of those starting)
		Q3	98 completers (66% of those starting)
		Q4	98 completers (66% of those starting)

Assaults			
Violence and abuse are pervasive in our society. Because much of violence and abuse are invisible they act as a hidden and unrecognised determinant underlying many social problems. Given the scale of deprivation endemic in the borough; a key indicator for a high prevalence of interpersonal violence; Tower Hamlets Partnership has adopted a public health approach to early prevention. In essence this primarily aims to stop violence and abuse from occurring and secondly, targets high risk groups to reduce the occurrence of further harm.			
Key Actions / Milestones for 10/11		***When will the action be completed? (month)***	
Sharing of intelligence between acute hospital Trust and CDRP regarding victims of assault and specifically by sharp object (ICD10-X99) for local tasking by police and trend analysis		March 2011	
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Audit of all assaults seen in acute Trust; analyses of nature/type of assaults	Not captured currently	Q1	25%
		Q2	50%
		Q3	65%

		Q4	75%
72 hours post assault with a knife, information to have been shared with the local CDRP (this will include non TH assaults for the CDRP to then forward to relevant authority)	Via 'Millennium' data system there were 404 assaults in the last 10 months, 3 of which were stabbings. Via TARN (the Trauma calls) in 1999 there were 274 stabbings and 131 blunt assaults; 39 GSW = 444 in a year (out of 1,621 trauma calls).	Q1	15%
		Q2	35%
		Q3	50%
		Q4	75%

NHS as Healthy Employer and Healthy Organisation	
The NHS as a Healthy Employer recognises the link between employee wellbeing and productivity. NHS employees are on average absent through sickness for 10.7 days a year compared to 6.4 days in the private sector. There is evidence that as staff health and wellbeing improve so do indicators such as patient satisfaction, mortality and MRSA rates. NHS Organisations should act as an exemplar in protecting, promoting, maintaining and improving the physical and mental wellbeing of NHS staff, and through them, service users, partner agencies and the wider community. Existing initiatives: • Adopted a Health and Wellbeing at Work Policy, strategy and action plan February 2009 • Appointed a joint Healthy Workplace Manager and joint Active Travel Promotion officer with Tower Hamlets Council. • Commissioned the Centre for Workplace Health and East London Business Alliance to provide support and resources for businesses and organisations in Tower Hamlets to become accredited Healthy Workplaces by 2011. • Working with BLT to become a Health Promoting Hospital • Commissioned a Mental Health Model Employer project to improve the mental health of staff; signed up to Mindful Employer Status July 2009. • Participated in phase 1 of the DH Healthier Food Mark Scheme in October 2009	
Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Review strategy and action plan to take account of recommendations of the NHS Health and Wellbeing Review (Nov 2009) and NICE guidance on Increasing Physical Activity in the Workplace and Improving Mental Health in the Workplace	June 2010
Improve management of sickness absence including better sickness reporting	March 2011
Promote healthy lifestyles further by signing up to the government sponsored "Cycle to Work" scheme	March 2011
Provide support and resources for businesses in Tower Hamlets to become accredited Healthy Workplaces	March 2011
Participate in the Phase 2 of the DH Healthier Food Mark Scheme	May 2010
Commission, promote and evaluate an early intervention service for staff with musculoskeletal problems	January 2011
Extend Health and Wellbeing policy across all employers including Tower Hamlets Council, through including THC in	March 2011

the Healthy Workplace Accreditation Scheme			
Provide MIND training and guidance for managers in mental health issues		April 2010	
Work with commissioners to embed measures to promote healthy employees in specifications with providers and include these within performance monitoring		March 2011	
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Support and resources for Tower Hamlets businesses to become accredited healthy employers	14 organisations enrolled in the accreditation scheme March 2010	Q1	20 organisations receiving support
		Q2	28 organisations receiving support 5 large organisations agreed to mentor 5 small/medium enterprises
		Q3	35 organisations receiving support
		Q4	35 organisations receiving support of which at least 5 organisations fully accredited

Emergency Preparedness	
The Major incident and business continuity plan was revised following the split between NHS Tower Hamlets and the Community Health Service (provider arm) in April 2009. The plan was updated in October 2009 following the first wave of the pandemic flu and severe weather incidents. Each Directorate has a business continuity plan. All directorates' plans were audited and updated. Similarly the pandemic flu plans have been updated to reflect the operational arrangements and procedures put in place by the Swine flu incident management team.	
Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
• BSI NHS Business Continuity Self-assessment • Increase emergency planning capacity and recruit emergency planning officer	By End o f April 2010 Action plan agreed by May 2010 May 2010
• Review and update the PCTs major incident and business continuity plan in line with national and regional guidance. This will be supported by updated directorates' business continuity plans. NHS Tower Hamlets will work with local partners to ensure that major incident & business continuity planning complement each other. • Update the current heatwave plan in line with national guidance.	Complete and update MI & BC plan by October 2010 July 2010
• Build on the lessons drawn from the Swine flu pandemic and update the Pandemic flu plan which will include escalation triggers and processes. • Work closely with local partners: acute trust, Tower Hamlets	Completed by August 2010

Council (THC) to update the multi-agency pandemic flu plans drawing on the debriefing session and lessons learnt from local response to pandemic flu	
• Building on the lessons from PCT's major incident and Business continuity exercise in March 2010, conduct table top exercise to test command and control arrangements and communication systems	Exercise report by November 2010.
• Develop business continuity and associated workforce protection strategies and strengthen the workforce plan including staff vaccination programme	Complete by Dec 2010
• Develop a range of vaccination deliveries strategies relevant to pandemic flu including school-based campaigns, vaccination via primary care	Complete by Dec 2010

Strategic initiative 2: Acute Contracting

Our Acute Contracting initiative is being led – on behalf of all three INEL PCTs – by the SACU. The details are set out in the Sector Operating Plan under the following initiatives:

Initiative 2: Shift setting of care for outpatient activity (excluding maternity and newborn) and development of new pathways
Initiative 3: Decommission procedures of low clinical value and agree means of addressing referrals if made
Initiative 4: Shift of 40% of A&E activity to UCCs (adults)
Initiative 5: Drive productivity of acute providers to upper quartile targets
Initiative 6: Redesign care pathway to increase productivity by reducing N12s/NZ
Initiative 9: Shift children's A&E activity into UCCs

The overall financial and activity benefits are included within our Operating Plan Section 4. Initiatives are split into productivity and decommissioning workstreams: productivity delivers savings of £4.2m, with decommissioning (outpatient, elective and non-elective) saving £1.5m.

Strategic initiative 3: Care Closer to Home

Linked Healthcare for London care pathway(s) and/or care setting(s):
Planned care

Linked pledges and targets:	***Linked WCC outcome(s):***
Vital signs: Access to GUM clinics Patient experience of access to primary care Self reported experience of patients and users Maternity early access Targets are linked to the Access pledge, re access to services, transparency of decisions and smooth transition between services.	*Primary care access*

We have developed our Care Closer to Home programme by:

- developing an activity and capacity model to support our understanding not only the volume of activity to shift, but the implications that this will have on our workforce and on

	our polysystems. The model covered all activities and projects and looked at the skill mix. settings and cost required to deliver the care shifts. This included looking at the current activity and budget, likely growth, the impact of our Primary Care Investment Programme and services that required decommissioning. This was used to project the staffing mix, estate and space requirements and cost needed by 2019. • engaging clinicians from primary and acute sectors through "clinical trios" to validate the shift to community settings. They considered not only the potential volume of shift but also the key requirements and potential barriers to the shift including clinical space and staff and skill mixes. Our trios discussed in detail 5 selected specialities: A&E, Diabetes, Paediatric Surgery, Anti-Coagulation and Maternity. • developed detailed locality health needs assessment to ensure services are co-located based on need. • holding a borough-wide conference with over 200 representatives from acute and all Networks to outline our future vision for care closer to home in Tower Hamlets. This discussed the proposed shift of activity and the configuration of our polysystems. This was a resounding success with overwhelming support for the Vision.

Actions:		***When will the action be completed? (month)***
1.	Establish revised Programme management office and review governance and meeting structures to progress polysystem development as a key part of the integrated care programme	Jan 2010
2.	Review Health Needs and progress detailed activity, commissioning and financial modelling for each polysystem Using Local Model plus Healthcare for London model and links to INEL demand and capacity model- Ongoing	outline to be completed by April 2010
3.	20 specialities have been identified that will be moved from primary care to secondary care. Of those 20, 9 specialities will commence phased movement in 2010/11 and the remaining 11 in 2011/12. For each of the specialties to be moved in 2010/11, service specifications, or revisions to existing SLAs are being written detailing the activity, estate requirements, clinical protocols etc. for delivery in a community-based setting. Development of operational delivery plan for polysystems building on existing network structure and capacity. Identify building and equipment requirements and factor in administration, waiting room etc. requirements. To assess the future locations for diagnostics and to review activity predictions across the Borough and the % shift of diagnostic activity Review reconfiguration of estates hub and spoke development strategy based on detailed activity capacity modelling and costs (See more detail in Estates Template in terms of phasing and costs) Development of new Hub and spoke Business cases (See Estates Template for more detail re phasing and costs)	Completed By April 2010 By June/July 2010
4.	Workforce- further develop the strategy for recruitment and retention of key staff groups and for new ways of working and skill mix e.g. Open Doors, Salaried GP Scheme, Healthcare assistant roles, development of specialist roles ICT- progress IT development plan for polysystems building on the work to date with Networks	April 2010

5.	Contracting- To develop the procurement strategy for key services to be provided in polysystems. Development of a procurement strategy that takes into account the local provider landscape. The procurement strategy will include a mix of existing and new contracts. Any new contracts will be drawn up taking advantage of the various contractual vehicles which could be used, and taking legal advice where necessary.	By April 2010
	Management: To develop new contractual and governance arrangements that will enable the extension of the role of Networks to employ staff and deliver key services across a network or polysystem. To further develop Centre Manager roles.	May 2010
	Clinical Engagement: Alongside work using Clinical Trios, there is ongoing dialogue with the PBC Executive, Locality Groups and with CEC.	January 2010 – monthly meetings with each Engagement group
	Community Engagement and Public consultation: Outline proposals for polysystems as part of H4 NEL public consultation. Detailed public consultation plans to be drawn up for each locality polysystem with key stakeholders.	By April 2010
	Regular patient engagement about specific hub and spoke plans as they develop with Network groups and patient and public for a	By April 2010
	Travel: Linking to the Mayors Transport Strategy plan. To review plans for each Locality in terms of travel modelling.	By July 2010
	Performance Management: Develop clear performance management plans for new polysystem hubs and accountability framework	By July 2010

Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Quantity of additional outpatient activity delivered in a community-based setting.	Gastroenterology (G) 70 Trauma & Ortho (T&O) 2830 Community Surgery (CS) 0		*Non-Cumulative Activity Additional to the Baseline*
			G T&O CS
		Q1	200 200 0
		Q2	225 270 100
		Q3	250 300 300
		Q4	325 400 600

Impact on activity and finance (commissioned / decommissioned):

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Specialty - Acute OP	Activity (contacts) shifted in 2010/11	Start date for shift	Link to polysystems development
Haematology	6,991	May	Anticoagulation - activity to be delivered in spokes with critical mass per provider to be agreed to ensure quality, safety and economies of scale
Trauma and orthopaedics	2,606	May	T&O, Gastroenterology, Dermatology and Urology are currently provided as part of the Clinical Assessment Service. Service models and currently provision is being reviewed to secure apporpriate capacity and accomodation will be provided as part of the hubs
Gastroenterology	1,681	Apr	
Dermatology	812	June	
Urology	628	Apr	
Community surgery	611	Aug	Minor Surgery - Day case activity across a number of HRGs (Carpal Tunnel and Trigger finger surgery, Circumcisions, Vasectomies, Injection/banding haemorrhoids, Hernias, Varicose veins, Minor eyelid procedures (tbc), Tooth extractions (tbc), Minor skin surgery). Service currently being procured and will ultimately be provided in hubs
GUM	2,338	April	Service provided in hubs - First hub opens in Jan 2010, second in Q4 10/11
Diabetes	425	July	Hub service linked to Diabetes care package delivery to support network delivery based in spokes.
Paediatric medicine	65	September	Remodelled service to be provided in 1 of 3 hubs or super spoke at Newby Pl. Service model based on Health for NEL paediatric clinical refernce group work on paediatric general medicine.
A and E	18,938	Ongoing	Already provided in A&E at Royal London Hospital and will be part of the reprovision of Urgent care services both in the Urgent Care Centre planned for Whitechapel (opening Dec 2011) and polysytem hubs in remaining 3 localities
Low clinical priority procedures	266	June	Stopping entirely; not reprovided: Activity for elective and day case activity across a number of HRGs will be reduced by 80%(Tonsillectomies, Grommets, Varicose veins, Minor skin procedures, Rhinoplasties)

Gross Expenditure	Gross Savings	Net Change	Activity Change
£13,744k	£2951k	£10793k	7,240

Impact on workforce:

Reconfiguration of estates – Polysystems development strategy

Workforce – adapting skill mix of specialist and generalist staff to deliver more services in community settings, examining new ways of working

Modelling predicted increase in workforce required to delivery integrated care based on population growth and care package development

Reconfiguration of IT so that all providers have access to data

Risks:	High/ Medium/ Low risk	Mitigating actions:
Financial envelope to develop polysystems	High	Agree CSP funding for 10/11
Clinical engagement PBC Locality groups engagement with wider Locality commissioning plans and links to Network structures	Low	Network Structure in place Clinical engagement structure in place and well established PBC Executive and Locality Groups and Leads
Estate Business cases- timescale for completion and approval	Medium	Format and Structure agreed for each Business case.
Procurement Strategy timescale for agreement and implementation	Medium	In development

Data analysis - capacity to populate the Healthcare for London model for each polysystem hubs and spokes	High	Commissioners will work with the Health Intelligence Unit and Public Health and finance to populate detailed service line activity modelling for each Locality and Hub building on the care package work already completed for key long term conditions

Relevant Sector Initiatives

- Strategic initiative two – shift setting of care for outpatient activity (excluding maternity and newborn) and development of new pathways
- Strategic initiative three - decommission procedures of low clinical value and agree means of addressing referrals if made
- Strategic initiative ten – breast screening improvement programme
- Strategic initiative eleven – create a mental health commissioning unit to drive productivity
- Strategic initiative twelve – support borough redesign of dementia pathway
- Strategic initiative thirteen – implement the sector End of Life CCI
- Strategic initiative fourteen - strengthen the evidence base to inform future investment in high impact staying healthy initiatives (with support from the HIU), ensuring the spread of best practice interventions across ELCA.
- Strategic initiative fifteen - delivering a sector-wide strategy for polysystem development

Strategic initiative 4: Primary Care Investment – Long Term Conditions

Linked Healthcare for London care pathway(s) and/or care setting(s):
Long Term Conditions, unscheduled care, staying healthy and end of life care

Linked pledges and targets:	***Linked WCC outcome(s):***
Access Public Health Quality Communication To offer our patients easily accessible, reliable and relevant information to enable them to participate fully in their own healthcare decisions and to support them in making choices and make transition of care between services as smooth as possible. Committing to working in partnership with our patients families and representatives. Ensuring all services is provided in a clean and safe environment that is fit for purpose.	Health inequalities Life expectancy Mortality rate CVD mortality COPD prevalence Diabetes controlled blood pressure

Actions:	***When will the action be completed? (month)***
1. All networks delivering diabetes care package	April 2010
2. Diabetes: 30 – 50% of patients controlled	March 2011 (as per payment metric)
3. All networks delivering CVD care package	December 2011

4.	Confirmation of legal status of networks	April 2010
5.	New contractual vehicle written	March 2010
6.	Development of respiratory care package	April 2010
7.	All networks delivering respiratory care package	April 2011

Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
% Diabetes patients controlled	22.4% (wave 1 Sept average)	Q1	25% 3.5% 24%
% of eligible population having NHS Health Check	2.7% (Dec 09 LDP data)	Q2	27% 6.5% 26%
		Q3	29% 9.5% 28%
% patients with CHD controlled	24% (CHD stratification data)	Q4	31% 11% 30%

Impact on activity and finance (commissioned / decommissioned):

Gross Expenditure	Gross Savings	Net Change	Activity Change
£3420k	£2315k	£1105k	248,896

The implementation of the LTC care packages will reduce secondary care activity through:

- Reduction in emergency attendances and admissions due to more systematic and consistent quality of care delivered across the borough
- Less outpatient activity through the use of secondary care clinical expertise in community settings and support for primary and community care clinicians

There are close dependencies between this work and the care closer to home programme. It is anticipated that by March 2011 we will have moved 850 diabetes outpatient appointments into a community setting.

Impact on workforce:

In order to support the development of Networks, Network Manager and Network co-ordinators have been recruited to all 8 networks.

All staff in GP practice have been involved in the transformational change required to deliver within the new structure

GP's nurses and admin staff have been involved in Organisational Development support from the PCT including workshops, training and coaching.

The Care Package is specific as to what level of competency and skill is required to delivery the standard of care required.

Networks have completed a skills audit of their staff to determine what if there is a gap in existing staff and have individual plans on how to skill up appropriately.

This has resulted in each practice having at least one clinician with the Warwick Diabetes Course and all staff connected to the Diabetes Care Package having Year of Care- Care Planning training sessions.

In 3 Networks, so far, extra clinical staff have been recruited to fill the skills gap and create extra capacity to deliver the care package.

The admin staff in all Networks have also received training on new IT systems to support the imputing of date and operating Call and Recall systems.

Multi Disciplinary teams have been developed in each Network to support Diabetes care these are led by a secondary care Consultant.

Risks:	**High/ Medium/ Low risk**	**Mitigating actions:**
Financial situation prevents full investment in care packages	Medium	Review of services currently commissioned to ensure investment is aligned with need, redistribution where necessary

Lack of available workforce	Low	There is currently a workforce workstream looking at gap analysis between what is required and what is available. Steps will then be initiated to develop the workforce through existing routes such as open doors and the overseas doctors programmes
Lack of agreement on contractual vehicle	Low	There is a contracting workstream and evolving discussions with local clinicians and network leads to establish what the best way forward is for both networks and the PCT

Strategic initiative 5: Develop tariff for community services	
Linked Healthcare for London care pathway(s) and/or care setting(s): Long term conditions End of Life Unplanned care Community health settings Polysystem setting	
Linked pledges and targets: THPCT: Up to 20% productivity over 5 years To inform the public about healthcare services available both locally and nationally and to provide easily accessible, reliable and relevant information to aid full participation in healthcare decisions and choice. To be provided with information to be able to influence and scrutinise the planning and deliver of NHS services. That the PCT make decisions in a clear and transparent way, so that the public can understand how services are planned and delivered	***Linked WCC outcome(s):*** *None*

Actions:	***When will the action be completed? (month)***
1. Stock take of existing currencies, activity in priority areas and agreement of priority services for shadow tariff year 1. Define the data collection (categories and systems). Define the rules of engagement with commissioning for shadow tariff (activity and finance reporting, financial management of over and underperformance). CHS providers implement internal performance management in shadow tariff services.	Apr – July 2010
2. Validation phase of data, costs (lead by commissioning) and testing of “rules of engagement”.	Aug - Oct 2010
3 THPCT finalise plan for tariff implementation following	Mar 2011

shadow year and renegotiated financial plan for 2011/12			
Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Number of activities per day per staff adjusted for complexity (productivity)	To be determined by first data collection	*Q1*	To be determined by first data collection
		Q2	To be determined by first data collection
		Q3	To be determined by first data collection
		Q4	To be determined by first data collection

Impact on activity and finance (commissioned / decommissioned):

Gross Expenditure	Gross Savings	Net Change	Activity Change
£0k	£1200k	-£1200k	0

Impact on workforce:
Significant issues around productivity and work on CHS tariff development is already well underway in Tower Hamlets.
Tariff roll out will require structural and cultural changes in service providers
IT reconfiguration and roll out of CHS software essential to underpin delivery
May require review and reprocurement if necessary of poorly performing services

Risks:	**High/ Medium/ Low risk**	**Mitigating actions:**
End State plans for each PCT for the CHS may mean tariff priorities differ across INEL	Medium	Priorities for INEL will be agreed between Commissioner and Providers
Planned roll out is delayed for other reasons	High	Single INEL tariff board set up to oversee planning and provide support

Relevant Sector Initiatives
- Strategic initiative one – develop sector-wide tariff for community services

Strategic initiative 6: Unscheduled Care

Linked Healthcare for London care pathway(s) and/or care setting(s):
Unscheduled Care

Linked pledges and targets:	***Linked WCC outcome(s):***
Targets 48hr GP Access Target, 4hr A&E waiting time standard Both targets are linked to the Access pledge, re access to services, transparency of	48hr GP Access Target

decisions and smooth transition between services.	

Actions:	***When will the action be completed? (month)***
Establish Clinical Reference Group and UC Executive Programme Board	March 2010
Sign off specification and performance management framework for interim urgent care service Implementation of interim urgent care service	September 2010
Agree costings for final urgent care centre, community based spokes and single telephone access number Sign off business case with NHSTH Executive, Clinical Executive Committee and Board Agree procurement strategy for final urgent care service	September 2010
Identify site for UC spokes and single telephone access number Agree footprint at Royal London Hospital for final urgent care centre	September 2010
Agree workforce planning required for final service Agree IT architecture required for integrated data sharing and reporting	September 2010
Review clinical case mix and demand management for short stay wards Redesign and negotiate change from several short stay wards into single acute assessment unit (AAU)	September 2010
Implement weekend unscheduled GP appointment services from 8am to 8pm on Saturdays and Sundays on a network and locality basis	September 2010
Implement new Access LES which rewards GP practices for the provision of high quality access on a network basis	September 2010
Provide all residents with quarterly newsletters, delivered to their home, from their GP practice	April 2010
Patient advisors to be employed in 13 practices to advise patients on a variety of "get the right treatment" issues	1st April 2010

Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
4 hour waiting time standard at A&E (acute only)	2008/09 (96%)	*Q1*	98%
		Q2	98%
		Q3	98%
		Q4	98%
Access to a GP appointment within 48 hours (measured by the GP Patient Survey)	2008/09 (82%) NB We are installing survey touch screens in all GPs over Q1. These will provide real time feedback on all aspects of access. Trajectories will be set	*Q1*	0%
		Q2	0%
		Q3	0%
		Q4	85%

	based on this data during Q2.		

Impact on activity and finance (commissioned / decommissioned):

Gross Expenditure	Gross Savings	Net Change	Activity Change
£897k	£700k	£197k	7,504

Impact on workforce:
Requires reconfigured provider capacity to implement integrated system between primary and secondary unscheduled care for UUC
Reconfiguration will ensure that primary care is initial point of contact for adult, ambulatory patients during operational hours.
More efficient use of skill mix - essential for networks to deliver
Reconfiguration of IT to ensure all providers have access to shared data
Improved pathways across urgent & emergency care will facilitate 1) timely, high quality care provision for patients 2) more efficient use of resources.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Project over-run	Low	Working groups, Project plans, Programme Board with executive membership to oversee implementation of urgent care strategy, all agreed and in place.
GP Patient Survey Results do not reflect service improvement	Medium	Comms campaign to increase survey completion from 23%

Relevant Sector Initiatives

- Strategic initiative four – shift 40% of A&E activity to UCCs
- Strategic initiative nine – shift children's A&E activity into UCCs

Strategic initiative 7: Mental Health

Linked Healthcare for London care pathway(s) and/or care setting(s):
Mental Health

Linked pledges and targets:	***Linked WCC outcome(s):*** Physical health care of people with severe mental illness (mental health outcome)

Actions:	***When will the action be completed? (month)***
Local Enhanced Service around physical health reviews of patients on SMI register, with incentive payments for smoking quitters	April 2010
Establish a Dementia Liaison Service	July 2010
Develop joint local authority/NHS business case and project plan for increase in capacity of mental health supported housing facilities, with corresponding decrease use of residential care	June 2010

Performance measure(s):	*Baseline level of performance:*	*Target level of performance each quarter:*	
% of people on SMI register offered an annual review Number of patients referred to dementia liaison service Number of acute bed days saved through appropriate transfer of care to dementia services Number of mental health users placed in residential care	93% (march 2009) N/A (new service to be developed) 4598 acute bed days with secondary coding of in 08/09 (though this is under-estimate due to poor coding) 137 (at December 31st 2009)	*Q1*	
		Q2	
		Q3	
		Q4	93.5% SMI patients offered annual review Other performance metrics tbd

Impact on activity and finance (commissioned / decommissioned):

The implementation of the mental health projects will have impact on the following activity:

- Number of acute bed days occupied by patients with a secondary diagnosis of dementia (accurate baseline of activity to be established in year one following 'case finding approach')
- Reduction by half of the number of service users in residential care over a five year period (starting from baseline of 137.)

Gross Expenditure	Gross Savings	Net Change	Activity Change
£199k	£454k	-£255k	0

Impact on workforce:

- Dementia liaison service will have implications for staff training and skills in acute hospitals, in order to ensure possible cases are identified and referred on.
- The locally enhanced service will incentivise further development of skills around the care of patient with severe mental illnesses amongst primary care practitioners.

Risks:	**High/ Medium/ Low risk**	**Mitigating actions:**
Poor interface between acute and mental health clinicians reduces impact of dementia liaison service	Medium	Protocols to be developed as part of service specification.
Registered social landlords are unable to develop sufficient capacity of supported housing to reduce use of residential care	Medium	Business case being developed between local authority and NHS with high priority given to this area in consultations with RSLs.

Relevant Sector Initiatives

- Strategic initiative eleven – create a mental health commissioning unit to drive productivity
- Strategic initiative twelve – support borough redesign of dementia pathway

Strategic initiative 8: Affordability			
Linked Healthcare for London care pathway(s) and/or care setting(s): None			
Linked pledges and targets: 30% reduction in Management Costs		***Linked WCC outcome(s):*** n/a	
Actions:		***When will the action be completed? (month)***	
• Set up cost improvement programme team and revalidate management cost quantum. The team will: a) Review all discretionary budgets. b) Identify and agree savings targets with Directors and ADs c) Hold budget holders to account for savings achievement d) Work with staff side organisations to identify cost improvement measures to reduce waste. e) Administering 'invest to save' projects. f) Provide regular reports to the Executive Team. g) Identify and take remedial action as required to ensure that targets are delivered.		Apr 2010	
• Set up Management Costs programme team (by 31 Mar 2010)		April 2010	
• Issue sector tender documents for re-commissioning/procurement of legal services		May 2010	
• Integrated sector legal contracts put in place.		Nov 2010	
• Review relevant continuing care expenditure against the LPP framework agreement to ensure that overall value is being maximised. Areas to be covered will include organic mental health, frail elders and learning disability placements. The new resettlement team will be in post, and will provide support to panels. This team is working to introduce the care cost calculator, a nationally validated tool to help determine a fair price for accommodation based care, alongside the London LPP framework.		To be confirmed – work will start Apr 2010	
• Review the take-up of other LPP framework agreements – including agency staff, Telco, IT and professional services		To be confirmed	
• Savings plan for the delivery of £1.4m worth of management cost implemented		Apr 2010	
Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
To be determined before	08/09 Management Costs	*Q1*	£300k

Final Plan submitted		*Q2*	£500k
		Q3	£400k
		Q4	£200k

Impact on activity and finance (commissioned / decommissioned):

Gross Expenditure	Gross Savings	Net Change	Activity Change
£0k	£2343k	-£2343k	0

Impact on workforce:
Management costs team will work with Staff side to identify staff implications of proposed measures

Risks:	High/ Medium/ Low risk	Mitigating actions:
Savings programme does not deliver savings to schedule	Medium	Monthly report to Executive Team on progress with Delivery Board with executive membership to oversee implementation.

As indicated in 1.2, our strategic initiatives address both our priority pathways, as well as the need to secure an affordable future for the local health economy. AS set out in our CSP however, there are a number of other initiatives that we will continue to deliver that fall within three pathways that are being lead by ELCA. These are Maternity, Children and Young People (including safeguarding) and End of Life Care. Our action in 2010/11 for each of these pathways is described below.

Maternity

Although there have been significant improvements in the Maternity Service as set out below, there is a need to ensure that future developments to improve local services are in line with Health4NEL and can deliver the Care Closer to Home priorities.

Priorities for action 2010/11

- To agree a Maternity Strategy and implementation plan that can continue to deliver improvements to the service and implement the Health4NEL and Care Closer to Home priorities through the Maternity Strategic Board and the Maternity Services Liaison Committee.

  The Maternity Improvement Project Plan was agreed following the 2006/7 Tower Hamlets Review to implement the recommendations for that Review. Most of theses recommendations have been completed or are near completion but require more work to embed the changes and evaluate their impact. The Maternity Strategic Board decided in December 2009 to develop and agree a Maternity Strategy that sets out the commissioning and implementation plans to deliver improvements to the service and implement the local priorities for Health4NEL and Care Closer to Home.

  The Maternity Improvement Project Strategic Board has reviewed its terms of reference and the new Maternity Strategic Board will take a stronger role in terms of commissioning, performance review, and quality and monitoring the delivery of the Maternity Strategy's implementation plan.

- Implement direct access to midwifery services including central booking

The direct access pathway that has been developed and plans are in place for direct booking for midwifery care and by phone and on line. Further work during the early part of 2010/11 will focus on embedding changes to referral behaviour through the Care Closer to Home agenda and pathway design, social marketing to change behaviour and to link with GPs. The effectiveness and uptake of the new arrangements will be monitored and reviewed.

- Increase antenatal and postnatal care in community by establishing more post natal clinics

  Antenatal Parent Education classes are delivered by various members of the multi-disciplinary teams, including breast feeding specialists, children's centre staff, health visitors and midwives. The classes are in easily accessible places across the borough, in different languages as required (predominantly English and Bengali) and take place during the day and evenings.

  Although antenatal care is delivered through a number of community settings including Children's Centres offering local women choice there is not the same level of choice for women about where to access postnatal care. Women are usually seen at home for the initial postnatal visits although there are now a number of community based postnatal clinics across the borough. These need to increase to meet the needs and expectations of local women.

- Developing and implementing low risk maternity pathway to ensure care is delivered in community settings

  The Maternity improvement Project's Care Pathways Group, that includes clinicians form both the Maternity Service at BLT and Primary Care has been developing a low risk care pathway. Once again further work is required this year to implement the pathway to embed the changes working closely with GPs and service users. The implementation of the pathway will be monitored and reviewed.

Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Draft Maternity Strategy and implementation plan for consultation	April
Maternity Strategic Board to agree Strategy and implementation plan	May
Working groups identified and workplans agreed	June
Performance monitoring reports to Maternity Strategic Board	Sept, December, March
Arrangements for direct central telephone booking for midwifery in place	April
On line booking	May
Agree monitoring process and commence monitoring current usage and knowledge of the service, analyse data and determine next steps to increase knowledge.	July
Plan in place to improve knowledge of the service	July
Changes implemented	September
Develop and agree a postnatal model of care based on national standards.	June
Identify location of services and suitable premises and staffing resources.	September
Agree a plan for setting up new postnatal clinics	December

New postnatal clinics provided		March	
Develop agree and the low risk care pathway and service model for midwife led care pathway in line with NICE guidelines linking with GP networks		July	
Develop and agree guidelines for midwifery led care in the community working		August	
Determine the number of clinics and capacity to meet any increase in numbers of women seen outside the Maternity Unit.		September	
Implement low risk care pathway		September	
Increase in clinics and /or capacity for care in community settings		March	
Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***	
Having an agreed and clear Maternity commissioning and implementation plan that can support the delivery of all local priorities. Meeting 90% of key milestones and deliverables in the implementation plan for 2010/11.	Strategy and action plan in place by June 2010	75% of all actions met by December 2010 90% of all actions met by March 2011	
The direct access arrangements are to meet the Maternity Matters choice agenda and women's access to this new direct booking service will be measured. Increase in the number of women responding positively to questions about access to maternity services and to test knowledge about direct booking arrangements. .	New service to be in place by May 2010 Target will be the 90 % of women answering positively in a continuous survey. Baseline to be determined in Q2	*Q1* *Q2* *Q3* *Q4*	Direct booking service to be in place Design question for survey and determine base line 50% 90%
Increase in the number of postnatal clinics to meet need in each locality.	Currently there is one clinic in each locality. The target for additional clinics and their location will be determined by the work to develop the model of postnatal care during QI	Q1 Q4	Model agreed for postnatal care including numbers locations of clinics required to deliver the model 50% of new clinics will be in place
Reduction in the numbers of women assessed as 'low risk' and on midwife pathway seen at RLH.	Audit of notes to be carried out in August 2010 to determine baseline	Q1 Q2 Q4	Initial work to develop and agree pathway Draft pathway and audit for baseline started. Repeat baseline audit

Maternity Health Improvement	
Following a formal review of maternity services in 2007 the Maternity Improvement project was set up. This was led by a multi-agency Maternity Improvement Board with 4 working groups (Care Pathways, Workforce, Communications and Public Engagement and Health Improvement). Most of the original actions have now been achieved and we are now building on this to take forward further improvements. This section focuses on Health Improvement (the other areas are described in other sections of the CSP). There is a Health Improvement Strategy for Maternity Services in place that was developed as part of the original improvement project that provides the overarching framework for this work. Detailed action plans have been agreed for each area (this strategy also links to the Teenage Pregnancy strategy and action plan and Family Nurse Partnership pilot, not covered below)	
Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Infant Mortality: Identify gaps and update Health Improvement Strategy for Maternity Services following Infant Mortality National Support Team visit (23-26 February 2010)	Action plan agreed by June 2010
Nutrition and Healthy Weight Action Plan: Raise awareness about adequate pre-conceptual intake of folic acid, promote access to Healthy Start vitamins and awareness of healthy diet and appropriate exercise during pregnancy. Refer pregnant women who are found to be obese at booking to early intervention service to support healthy weight gain during pregnancy and prevent obesity in their children and families.	Implement distribution system for Healthy Start vitamins by September 2010 Review of early intervention service (as part of wider child weight management pathway) by October 2010
Breastfeeding Action Plan: Promote exclusive breastfeeding until 6 months and alongside solids during weaning	Achieve 90% coverage of breastfeeding data at initiation and 6-8 weeks by April 2010 Achieve stage 3 Baby Friendly Initiative accreditation by March 2011
Smoking in Pregnancy Action Plan: Reduce the prevalence of smoking in women of child bearing age, during and post pregnancy. Reduce passive smoking in the home	Achieve 90% coverage of smoking data at booking and delivery by October 2010
Safeguarding Children and Domestic Violence Action Plan: Ensure routine questions are asked by health professionals about domestic abuse to women during pregnancy with appropriate referral to confidential advice and support	80% of all frontline child health professionals to be up to date with safeguarding training by April 2010
Parenting Action Plan: Referral of all primigravida women to antenatal parenting classes with choice of suitable time and location. Language and other special needs to be accommodated wherever possible. Multigravida women to have access to antenatal parenting classes according to need and preference	Finalise improvement plan (following recent evaluation of new antenatal parenting programme) by June 2010

Mental Health Action Plan: Promote positive mental health and self esteem. Identify past or present severe mental illness and family history of perinatal mental illness. Routine use of screening questions to detect possible depression with further assessment and referral to preventive or specialist services.		Ongoing training for frontline staff on perinatal mental health assessment and screening (September 2010 and March 2011)	
Control of Existing and Pregnancy Associated Clinical Conditions Action Plan: Ensure awareness and implementation of BLT clinical guidelines by relevant health professionals to ensure that appropriate care is provided for pregnant women with existing and pregnancy related conditions, e.g. diabetes and high blood pressure		Review current provision for pregnant women with pre-existing and gestational diabetes by October 2010	
Antenatal and Newborn Screening Action Plan: Ensure women that pregnant women in early pregnancy are fully informed of the purpose of all antenatal and newborn screening tests, to enable informed choice. Ensure that screening providers meet all quality standards.		95% coverage of data on gestational age at booking by June 2010 Increase uptake of antenatal HIV screening to 90% by March 2011	
Key Performance measure(s):	Baseline level of performance:	Target level of performance:	
1. Early access to maternity services (% of women recorded as having completed full health and social care assessment by 12 weeks 6 days gestation)	81% (Q3 2009/10)	March 2011	90%
2. Smoking status at booking, delivery and 6-8 weeks	Booking – 5.5% Delivery – data not currently available 6-8 weeks – data not currently available	March 2011	Booking – 4.5% Delivery – re-establish baseline 6-8 weeks – establish baseline
3. Breastfeeding prevalence at initiation and at 6-8 weeks	Initiation – 82% 6-8 weeks – 66% (provisional Q3 2009/10 – to be updated on verification of data from HV database)	March 2011	Initiation – 84% 6-8 weeks – 73%

Relevant Sector Initiatives

- Strategic initiative six - capture savings in acute trusts by reducing N12s/NZ
- Strategic initiative seven – shift maternity and newborn care into non-acute settings

Children & Young People

We have made very good progress with implementing the healthy child programme including:

- Prevention: Initiatives in smoking, obesity, breast feeding support, immunisations and vaccinations commissioned and in place
- Community Initiatives to expand the hours of the community children's service commissioned with a planned start of April 2010
- Health care is commissioned from the local authority and being delivered in children

- centres
- Family Nurse Partnership programme an intensive home visiting programme for at risk parents has commissioned jointly with Tower Hamlets Council and is being piloted

Our activity and action for childhood obesity and immunisation programmes are set out within the Staying Healthy strategic initiative. Our action around safeguarding is also described below.

Relevant Sector Initiatives

- Strategic initiative eight – commission paediatric assessment and treatment services on all sites
- Strategic initiative nine – shift children's A&E activity into UCCs

Safeguarding

In the year 2009/10 we have undertaken an external review of safeguarding arrangements in Tower Hamlets and worked on the following priorities within our safeguarding project plan.

We have completed: a safeguarding training needs analysis; resolved the issue of how to collect accurate training data for both mandatory and optional safeguarding training; rolled-out EMIS web to all frontline teams working with children; developed guidance on a safeguarding template for vulnerable children on EMIS web; reviewed GPs' safeguarding arrangements, based on CQC criteria; agreed safeguarding training expectations for GPs, dentists, pharmacists and optometrists and monitor compliance through commissioning arrangements; a review of procedures to notify NHS trusts of looked after children placed out of area, in line with new national guidance.

We have confirmed compliance with all of the minimum standards set out in David Nicholson's letter in June 2009 with the Board, confirmed our position with an external review and achieved the minimum standards for training at level 3 ahead of time and achieved 76% (target 80% for level 2).

We have revised our safeguarding policies to take account of the latest guidance and are putting in place a process to launch those and ensure all staff are aware of them and using them.

We are shortly to complete: an agreed trust wide supervision policy; a review of our current safeguarding policy to make sure it takes full account of the needs of children with disabilities; a review of the transfer of care processes in community nursing when the use of EMIS web has been embedded; clarification within agency contracts process for ensuring that eligible agency staff have received the appropriate level of safeguarding training; the development of a safer recruitment module within mandatory recruitment training for managers; the development of appropriate fields within the EMIS Web template for recording the status of the father / other adults with the child and ensure the guidance sets out how to use this; agreeing quarterly monitoring expectations with THCHS, RLH and ELFT; a review of current service specifications to ensure that safeguarding requirements are clear and fit for purpose.

Our remaining priorities form our key actions and milestones for 2010/11

Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Implement findings of the LSCB section 11 audit and improve the data within the health sector on referrals to children's social care.	July 2010
Develop a competency framework tool to enable HOS,	June 2010

managers and supervisors to evidence training has impacted on practice and that staff have achieved expected competencies.	
Write up a clear summary on an annual basis of lessons learned from audit. This is to be shared with the board and with frontline practitioners.	April 2010
Establish a secure and easy to access electronic system for sharing the up to date list of children for whom there are child protection concerns with A&E and frontline community health services.	July 2010
Establish quarterly reporting using the safeguarding template from BLT and East London Foundation Trust	Ongoing, but first report in April 2010
Complete our review of arrangements in independent practitioners	Completed for all GPs by end April 2010 Completed for all other independent contractors by end September 2010
Develop a safeguarding training package for GPs and other independent contractors which can be delivered flexibly, on a modular basis, to achieve maximum take-up	June 2010
Establish a programme to support and performance manage the development of robust arrangements in independent contractors, eg CRB checks, policies and child protection training	Programme established by March 2010 and work ongoing – milestones to be developed
Audit implementation of clear guidance for independent contractors on information sharing to include 3rd party communications, recording the presence / identity of a carer, identifying child protection concerns at registration, and transferring records.	September 2010
Audit implementation of clear guidance for GPs safeguarding arrangements, based on CQC criteria.	September 2010
Establish a system in EMIS flagging children at risk which is accessible by all community health service providers and provide support via training programme Establish an alert from EMIS for all clinicians including GPs in EMIS when they open the record of a child who has been assessed as at risk	Access available for all staff April 2010 followed by training July 2010
Review issues and themes which appear repeatedly in SCR, SUIs and safeguarding audits and ensure that these are built into ongoing service planning	December 2010
Ensure strong ongoing management of coordination and planning for the child death overview panel to maintain timelines and rigor of core processes	December 2010
Respond to the recommendations from the service improvement team visit in March 2010	TBC, dependent on the recommendations

End of Life
09/10 Actions so far - The delivering choice programme as completed phase 1 (July 2009) and

commenced phase 2 (September 2009) with some solutions ready to implement
- the out of hours service at BLT and St Josephs are now operational (St Josephs since April 09 and BLT since December 09)
- Increasing non cancer work at St Josephs – care pathway for heart failure designed and implemented, joint clinics set up with acute sector, staff training on non cancer care continued, non invasive ventilation therapy commenced at St Josephs instead of at hospital
- Bereavement service – tendered and commissioned. Service started September 2009

Actions for 10/11
- Complete phase 2 of delivering choice programme
- Commence phase 3 of delivering choice programmes (service redesign)
- Appointment of end of life are facilitators for Care homes and community
- Monitor commissioned services
- Review services with users
- Develop working strategies to link services and coordinate care
- Redesign existing services to provide best care
- Education of staff across sectors
- Develop and implement End of life care pathway and map of medicine
- Implement quality markers in service provision and monitoring

Key Actions / Milestones for 10/11	***When will the action be completed? (month)***
Delivering Choice Programme phase 2 – completion of all work streams	Completion by July 2010
Delivering Choice Phase 3 - Development and implementation of a coordination centre and development of a working process for rapid response service for End of Life Care	Start-up – March 09-July 10 Operational coordination centre – August 2010-02 Operational process for rapid response – November 2010
Delivering Choice programme phase 3 - End of life care facilitators (care homes and community)	Staff recruitment commence – March 2010 Staff in post – August 2010
Delivering Choice programme phase 3 - outcomes of hospital work stream considered and implemented	August 2010
End of life care pathway designed and rolled out	May 2010
Map of medicine localisation complete	July 2010
Improve data collection around end of life care	March 2011
Publish TH End of Life Care Strategy"	June 2010

Key Performance measure(s):	***Baseline level of performance:***	***Target level of performance each quarter:***
Increase in numbers of patients dying at home	**19% (2007)**	*Increase of min 1% per quarter*
Reducing in number of patients dying in hospital	**64% (2007)**	*1% reduction per quarter*

Increasing use of LCP in hospital and community setting	Anticipate data collection starting in ACNS from April 2010 and from acute setting from September 2010. Acute baseline is 17% and community baseline is unknown	*By end March 2011, we aim to have 30% of expected death on the Liverpool care pathway*

Relevant Sector Initiatives

- Strategic initiative thirteen – implement the sector End of Life CCI

SECTION 4: FINANCIAL PLANNING (PCTs only)

Please complete the financial planning spreadsheets attached as Annex A.

4.1 Productivity

List the productivity improvements expected in 2010/11 and 2011/12.

- ***Where relevant identify any impact on the workforce, including the impact on workforce utilisation***
- ***Where relevant identify the impact on asset utilisation***

Acute

All acute contracts will be expected to deliver 3.5% CIP's in 2010-11. This rises to 4% in 2011/12. In addition there will be approximately £4 million worth of productivity and decommissioning savings in work being led by the new Strategic Acute Commissioning Unit – SACU in 2010/1 rising to £6.8 million in 2011/12.

Primary Care

Primary Care contracts will be uplifted by a net maximum of 1.5% in both years equivalent to a CIP of 2% in each year. In addition the Polysystem initiative will price packages of care at a rate which is cheaper than the existing benchmark for a GP attendance.

Community Care

The PCT has implemented a tariff based system in CHS - community health services. CHS will be treated in the same way as acute service contracts and nil net uplift will be applied to baseline values in 2010-11. In addition, further productivity savings worth 2% of the baseline SLA value will be applied. This is worth an additional 1.2 million on top of the tariff impact and forms part of a three-year plan to deliver 10% productivity savings from CHS. Financial years 2011-12 and 2012-13 will see the application of a further 4% productivity saving in each of those years.

Mental health

Mental Health SLAs will be uplifted in the same way as acute contracts and will therefore be expected to deliver a CIP of 3.5% in 2010/11 and 4% thereafter.

4.2 Expenditure

Please explain the significant changes in expenditure (including tariff changes, MFF and new investments / divestment of services).

Applications of New Funds 2010/11

The table below summarises the applications of funds as a first call on total resources.

There is a significant list of commitments on the total sources of funding, which must be funded before expenditure on new services is committed. These are listed below in the applications table and consist of:

1. Commitments on prior year investment are assumed to be nil and all full year effects are assumed to have taken place in the current year.
2. The costs in-year of developing the Polysystem hub and spoke model will be £1634k recurrently and £1673 non-recurrently. These costs are for the infrastructure costs of new developments and do not reflect planned service costs. These are dealt with at the end of this section.
3. The full year effect of bringing such schemes onto the PCT balance sheet will be £800k.
4. £500k cost pressure on stroke and trauma services. This figure is based on the NHSL plan for rolling out the new tariffs.
5. £1 million cost pressure on high cost acute drugs excluded from tariff.
6. The impact of 2010/11 population growth on the costs of acute services and primary care is assumed to £2.4 million and £701k respectively based on locally validated population growth assumptions reconciled back to the revised GLA low model. Additionally non-population derived growth of £1.685 million has been applied to the acute baseline cost. Population growth has not been applied to CHS services as these are subject to a new tariff mechanism and will have a further productivity target of 2% CIP in addition to net tariff uplift of zero. Acute Mental Health services are also assumed not to have population and non-population growth effects in 2010-11 as a direct result of the large investments into community based and non-acute mental health services in 2008-09 and 2009-10. The effect of these will be to shift a significant caseload from acute to other settings of care. The creation of new services has absorbed new demand and population growth, as patients' care has been transferred from existing community mental health teams to, for example, early intervention, assertive outreach services and IAPT services.
7. Growth on the cost of services within 'Specialist Commissioning' is assumed to be in the order of £1.5 million – on the basis of a LSCG draft Operating Plan submitted to London Commissioners.
8. Continuing Care packages are assumed to be subject to a £1million cost pressure based on over-performance for the last two years and the evidence of a rising cost trend.
9. A further cost pressure of £690k has been inserted here in relation to the additional costs of moving to a full tariff basis for End of Life Care – EOLC – third sector providers as outlined in the EOLC CCI and the relevant business case.
10. Around £8.4 million net will be required for inflation – net tariff uplift being set at zero which is also the likely marker for non-tariff activity. An assumption of 1.5% for CQUIN on all NHS acute and community baseline contracts is included under the general inflation figure. GMS/PMS inflation is assumed at 1.5% but is dependent on the ongoing negotiations between the DH and the GMS/PMS representative groups. It may well be in excess of this figure and the PCT's investment plan will need to take account of this risk. For Primary Care Prescribing inflation has been set at 8% based on historical outturn over the past five years less the price reductions for Category M generic drug costs. This also includes an assumption for the cost impact of new NICE drugs in 2010/11 prescribed in Primary Care – which explains why no non-demographic cost pressures have been applied to Primary Care drugs. Further work is on-going to finalise the detailed prescribing budgets. Inflation for Community services is as per tariff with an additional 2% CIP based on adoption of new tariffs for Community Services. Inflation for non-NHS agreements are prudently assumed at 5%. Efficiencies of 3.5% are assumed for all Commissioned activity excluding non-NHS contracts.
11. The PCT has allocated uncommitted contingencies in the 2010/11 Operating Plan of £3 million or 0.6% of its planned resource limit.
12. The PCT has assumed that it will be required to fund the second year of the levy for London risk pool funding at a rate of 0.79% of resources. This is non-recurrent and is £3.48million.
13. Planned surplus in 2010/11is £2 million which is essentially the residual element of the PCT's £21.6 million return of lodged funds.

In summary, the PCT has net £10.4 million to 'contingency' in 2010/11. This equates to around 2%

of resources and will be used to transition the PCT to a new Polysystem-based commissioning model. The next stage of the financial section will therefore go on to describe what plans NHS Tower Hamlets has developed to meet this challenge.

Acute

The only significant cost pressure on acute spend will be population growth and non-population growth factors. NHS Tower Hamlets has one of the largest population growth projections of any London PCT and typically this will add around £2.5 million to acute spend. The PCT will be decommissioning around £4m worth of acute services in 2010/11. In addition there have been significant investments in the following areas;

- Clinical assessment service (CAS) for musculo-skeletal specialty. The CAS model is essentially a 'referral management' type service which treats patients in a primary/community care setting rather than an acute one. The musculo-skeletal CAS was set up in 2006-07 and is now delivering a significant level of savings. Phase 2 will look at using Extended Scope Practitioners to list for surgery and see some follow up patients who would normally have attended a BLT clinic. Investment into such services needs to be mindful of the fact that recurrent savings are not likely to be delivered from day one and that it may take some time to develop both the service capacity and the pathway before 'break-even'. THPCT has taken this approach with all of its new demand management investments - seeking medium term sustained savings within well-developed service models.
- CAS model for Chronic Pain services
- CAS model for Dermatology services
- Community Urology and Gastroenterology Services
- Consultant to consultant referrals protocol
- Clinical exclusions policy
- Triage and streaming of A&E attendees to the PCT Walk-in centre next door
- Long-term conditions –LTC – investments into case managers, Community matrons and community elderly care services for example to reduce repeat non-elective admission and out-patient attendances.

The key financial assumption for investment in service redesign is that activity is deflected away from a (mainly) acute in-patient of outpatient setting at a cost cheaper than the relevant tariff.

Primary

Population and non-population growth factors add £701k to overall costs whilst inflation adds a further £800k.

Community

Community services are mainly commissioned from the PCT's own service which is now externalised as an APO. Inflation assumptions for CHS are the same as for acute contracts as is the attribution of 3.5% CIP's. Net inflation uplift is thus zero. In addition a further CIP of 2% is being applied in 2010/11. This is worth an additional £1.2 million as a CIP to commissioners.

Mental Health

The PCT intends to use some of the existing mental health spend to invest in implementing the national dementia strategy. Existing investments have been decommissioned and prioritised in the following areas:

- Development of a memory clinic/service with strong links to primary care
- Establishment of 'dementia advisor' posts, probably in the third sector

Polysystems

The Polysystem infrastructure development costs are outlines in the applications section above.

4.3 Revenue

Please explain the significant changes in revenue.

The summary analysis of the PCT's total funding sources is outlined in the table below. This shows all of the new recurrent and non-recurrent funds which the PCT can expect to receive next year. It assumes that the PCT meets its control total requirement of £10.2 million surplus and that the NHS growth assumption within the last year of the current CSR is not amended downward. There is a risk that this might happen depending on the strength of the UK economy and the PSBR.

Summary analysis of the PCT's total funding sources – 2010/11

Source of Funds 2010-11	Recurrent £'000	Non Recurrent £'000	Total £'000	Comment
1. Growth allocation 10/11	23,014	0	23,014	5.1% on initial resource baseline.
2. Headroom from previous year investment programme	5,905	0	5,905	Recurrent elements of prior year non-recurrent investment programme
3. Impact of surplus/deficit	2,791	7,409	10,200	PCT Revenue Surplus/(Deficit) position
4. MFF Gain	1,800	0	1,800	Assumed 2% cap annually
Sub total	**33,510**	**7,409**	**40,919**	**Real increase in resources - mix of growth and technical adjustments**

Recurrent Assumptions

Please refer to the numbered items on the table above.

1. £23 million growth funding equivalent to 5.1% on baseline.
2. Recurrent headroom from the prior year non-recurrent investment programme.
4. £1.8 million gain under the agreed transition for the recalibration of MFF.

Non-Recurrent Assumptions

3. Non-recurrent funds of £10.2 million current year surplus to control total.

Total sources of new funds available for investment for 2010/11 are therefore £37.5 million

4.4 Commentary on overall position

Please provide an explanation of your overall financial position including sections on:

209/10 Financial position

- The January 2010 Board report shows that the PCT is online to achieve a surplus of £10.2 million for the current financial year. This is in line with the control total agreed with NHS London.
- The year to date position or 'run-rate' is on plan at £8.5 million surplus as at the end of January.
- The PCT has split out its Provider (APO) and Corporate/Commissioning functions and has created a separate financial ledger for reporting. The forecast year-end outturn for the APO is a small surplus which is reflected in the overall PCT position.
- At the end of December a total of £4.6 million has been lodged in committed reserves for 2009/10 Commissioning Intentions from an initial total reserve of £34.5 million. The remaining reserve will be issued during the course of the year.

- The PCT is meeting all of its statutory financial duties in the current financial year. There are no issues to raise on the cash limit or cash drawdown.

- The balance sheet is satisfactory and no significant risks are raised.

- The capital programme has been reviewed to reflect the allocation received of £8.2 million and capital to revenue transfers anticipate of £0.5 million leaving a capital programme of £7.6 million. Progress on delivery is satisfactory and no significant risks are noted.

2010/11 Financial position

The 2010/11 financial position shows that the PCT has a net fund available of just over £10 million after funding all commitments and cost pressures. This is outlined clearly in the Sources and Applications analysis above. This is a favourable position but needs to be set against the risks inherent in the PCT's medium term financial strategy – MTFS – outlined below.

Medium Term Financial Strategy (MTFS)

The CSP submission and Operating Plan shows that NHS Tower Hamlets is in financial balance in 2010/11 and throughout the CSP period. The MTFS essentially rests on delivery of a small number of affordability levers which underpin the development of Polysystems and Care Closer to Home. In addition there are a number of initiatives to decommission acute healthcare services and to improve productivity.

NHS Tower Hamlets has an integrated set of affordability levers to narrow the projected gap between resources and expenditure in the cycle to 2013/14 as well as to release further resource headroom in 2010/11 for investment into Polysystems. This approach has been developed across the whole of the ELCA or INEL sector through the sector Health Intelligence Unit – HIU. A sophisticated activity and planning tool has been developed by the HIU and all three INEL PCTs are following a similar approach. The downside funding assumption has been used to populate the model so that a worst-case set of planning assumptions is produced.

The following table summarises the costs, savings and the transition for each commissioning lever and the gross costs, savings and net overall impact of all levers in each financial year. The £10 million of funding available in 10/11 will be used to fund the transition costs of the Polysystems and act as a risk reserve.

Tower Hamlets CSP Initiatives Working Paper					Gross Increased Expenditure		Gross Reduced Expenditure		Net Change in Expenditure		Activity shift	
Initiative	Description	Sub-Initiative on CSP template	Type of action	Description					£000s			
A	SACU Acute Commisioning	1	Planned Direct CIP	New to follow up			1,392		(1,392)		(14,393)	
A	SACU Acute Commisioning	2	Planned Direct CIP	Demand Management			2,545		(2,545)		(17,372)	
A	SACU Acute Commisioning	3	Planned Direct CIP	Excess Bed Days			49		(49)		-	
A	SACU Acute Commisioning	4	Planned Direct CIP	Excess Bed Days		-	297	4,283	(297)	(4,283)	-	(31,765)
B	SACU Decommissioning	1	Cessation of service	Decommissioning	9		94		(85)		(37)	
B	SACU Decommissioning	2	Cessation of service	Decommissioning	138		1,401		(1,263)		(9,996)	
B	SACU Decommissioning	3	Cessation of service	Decommissioning	5		54		(49)		(64)	
B	SACU Decommissioning	4	Cessation of service	Decommissioning	12	164	123	1,672	(111)	(1,508)	(5,040)	(15,137)
C	CC2H Polysystems	1	Shifting setting of care	Polysystem implementation	255		199		56		(78)	
C	CC2H Polysystems	2	Shifting setting of care	Polysystem implementation	210		165		45		(79)	
C	CC2H Polysystems	3	Shifting setting of care	Polysystem implementation	2,768		2,161		607		(14,449)	
C	CC2H Polysystems	4	Shifting setting of care	Polysystem implementation	149		116		33		(136)	
C	CC2H Polysystems	5	Shifting setting of care	Polysystem implementation	362		283		79		(28,912)	
C	CC2H Polysystems	6	Strategic investments	Polysystem implementation	10,000	13,744		2,924	10,000	10,820	51,158	7,504
D	CC2H Polysystems	1	Planned Direct CIP	Polysystem first to follow up		-	27	27	(27)	(27)	-264	(264)
E	PCIP LTC	1	Strategic investments	Roll out of NHS health checks care package and long term condition management	12		8		4		(2)	
E	PCIP LTC	2	Strategic investments	Roll out of NHS health checks care package and long term condition management	2,923		1,978		945		(924)	
E	PCIP LTC	3	Strategic investments	Roll out of NHS health checks care package and long term condition management	5		3		2		(2)	
E	PCIP LTC	4	Strategic investments	Roll out of NHS health checks care package and long term condition management	480	3,420	326	2,315	154	1,105	(247,968)	(248,896)
F	Staying Healthy (Prevention)	1	Strategic investments	Adults with long-term conditions vacc programme	609		824		(215)		(388)	
F	Staying Healthy (Prevention)	2	Strategic investments	Adults with long-term conditions vacc programme	104	713	141	965	(37)	(252)	(107,811)	(108,199)
G	Community Tariff	1	Planned Direct CIP	Tariff Efficiency Saving	-	-	1,200	1,200	(1,200)	(1,200)	0	-
H	Management Cost Savings	1	Planned Direct CIP	management cost savings	-	-	1,443	1,443	(1,443)	(1,443)	0	0
I	Mental Health	1	Planned Direct CIP	Dementia care review	178		422		(244)		0	
I	Mental Health	2	Planned Direct CIP	alternative to residential care	-		-		-	-	0	-
I	Mental Health	3	Planned Direct CIP	staying healthy	21	199	32	454	(11)	(255)	0	-
J	Urgent Care	1	Shifting setting of care	Polysystem implementation	897	897	700	700	197	197	(7,504)	(7,504)
K	Procurement & Supply	1	Enabler	Enabler			900	900	(900)	(900)		
Totals					19,137	19,137	16,883	16,883	2,254	2,254	(404,261)	(404,261)

The affordability lever summary shows that a net cost of £2.2 million is planned across all affordability levers for 2010/11. It is a net cost because it reflects the transition and set-up costs for Polysystems. The risks around 2010/11 assumptions are deemed to be very high and therefore the retention of the £10 million outlined in sources and application above is considered to be sensible. The CC2H (Care closer to home) Polysystem lever shows the recurrent cost of setting up the Polysystems in year one and it is shown as a cost to distinguish it from the savings which accrue functionally through the LTC, prevention, new/FU and GP referral saving levers. The first year of the long-term conditions lever is a net cost as savings are not assumed to accrue immediately and will take time to develop.

The levers are described in more detail below;

1. Polysystems

As outlined above the Polysystem lever is a net cost lever. It reflects the costs of putting into place the new services that will deliver Care Closer to Home- the main polyclinic programme. The following table shows the percentage of baseline activity moved to a Polysystem for each category by PoD. Note that in some cases the percentages may be less than expected, i.e. the input value. This is due to activity already being removed through other initiatives (particularly reduction in OP follow ups and reduction in non-GP referrals).

Specialty	% Shift
A&E	40.00%
OP	14.82%
Non-Elective Medicine Complex	10.00%
Elective Medicine Complex	20.00%
Non-Elective Medicine Non-Complex	10.00%
Elective Medicine Non-Complex	20.00%
Non-Elective Medicine LTC	10.00%
Elective Medicine LTC	20.00%

Non-Elective Medicine Under 17s	10.00%
Elective Medicine Under 17s	20.00%

The planning assumption is that the 'Polysystem' initiative will determine the Activity shifts are phased linearly over 5 years.

2. **LTC and Case Management**

LTCs are shown as a net cost in the planning model in 2010/11 because it is considered unrealistic that savings will follow immediately. A 'time-lag' is therefore built into the LTC delivery assumption and full ramp-up of savings is not assumed until 2012/13 with some savings coming through in 2011/12. The planning model assumes 'aggressive' HfL shift percentages but assumes a proportion cost of 75% - i.e. that the substitution effect of treating LTCs in Polysystems effectively saves 25% of the relevant acute tariff cost. The specific shifts of activity are detailed below;

20% of elective LTC
10% of non-elective complex medicine
30% of non-elective non-complex medicine
40% of non-elective LTC

All of the above are phased linearly over the first 5 years

3. Prevention

The planning model uses the HfL shift percentages, and assumes a 'substitution' saving of 25% of the relevant acute cost - equivalent to a proportion cost of 75%. The core assumption here is that the PCT will shift 10% of non-elective medicine, phased linearly over the first 5 years.

4. Decommissioning

The PCT assumption is less aggressive than the HfL model – as outlined below;

3% of all elective procedures
20% of outpatients
0% of A&E

Again, this is phased linearly over 5 years and this is a SACU lever initiative.

5. Reduction in OP Follow Up Appointments

The PCT planning assumption is to move to a first OP to follow up ratio (FU to FA) of 3:1. The assumption is that this will be phased equally over two years. This is a SACU lever initiative.

6. Reduction in Non-GP Referrals

The planning assumption is that 75% of all referrals will be by GP for both Polysystem and acute activity. The phasing of this lever is 40% next year and movement to 100% in 2011/12.

7. Reduction in Excess Bed Day Cost

The planning assumption is that we will save 15% of the XBD cost. Based on the input specialties where XBD costs are incurred (as determined from SUS 08/09 data), the planning model has identified specialties where XBD savings can be made and which will be targeted by the SACU from April 2010. The phasing of this is linearly over two years.

8. Tariff Efficiency

The planning model has only applied this productivity/tariff decrease to Community Care which is currently provided by the PCT. For Community Care the following productivity assumptions have been assumed over the CSP planning period. These are in addition to efficiency/productivity

savings which result from the application of the tariff deflation and net uplift assumptions for acute Provider being applied to Community Providers as well.

11/12 -2%, 12/13 -4%, 13/14 -4%.

Position after Application of Affordability Levers

The table below shows the impact year on year of the affordability levers being applied to the 'do nothing' downside scenario. The revenue funding assumptions show the revenue resource limit allocation plus additional funds received on the allocation working paper such as Dental funding and the central bundle. As can be seen, the 'do nothing' cost scenario leads to a £24 million cumulative deficit by 2013/14. This is mitigated by the application of the affordability levers which yield £29.2 million of savings by the end of the period. The impacts of the savings realised through lever application on the deficits within year are also shown. Across the period and broadly, financial balance is achieved across the CSP period although the levels of projected surplus are not huge. This is further justification for holding the £10m balance of sources and applications as a risk contingency in 2010-11.

Descriptions - Downside	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's	2013/14 £000's
Revenue Funding Assumption - Core	474,524	501,564	494,390	487,438	486,951
Do nothing cost	464,274	488,910	497,942	509,476	516,893
Surplus/Deficit	10,251	12,654	-3,552	-22,038	-29,942
Cost with affordability levers applied	464,274	491,164	490,942	484,476	481,893
Value of affordability levers	0	-2254	4462	15198	7536
Surplus/(deficit)	10,251	10,400	3,448	2,962	5,058

Historic debt

The PCT is not carrying any historic debt and has consistently delivered financial surplus since its inception.

Assumed Sector support

The PCT does not require any sector financial support.

Contingency

The PCT is holding £3 million in uncommitted contingencies. This equates to just over 0.6% of total resources. In addition the PCT has just over £10 million to invest in new services next year - mainly Polysystem development.

Cash

The PCT has no specific cash issue and has always remained within its cash limit.

The possible impact of IFRS

The principal impact of IFRS on the PCT is the requirement to account for IFRIC 12 Service Concessions as owned assets from 2009-10. As a result, two existing LIFT funded schemes have been brought onto the restated balance sheet. These are the Barkantine polyclinic hub in the Isle of Dogs and the Specialist Addictions Unit situated at Mile End. 2010-11 will see a further scheme brought onto the balance sheet later in the year. Other schemes that might be approved in the future would also be treated as owned assets. The financial impact of the two schemes totals £1.2 million of which £500k is assumed as the full year effect in 2010-11.

Depreciation: £662k
Cost of capital: £533k

The part-year impact of the third scheme will be approximately £300k next year.

Material changes from your draft WCC submission in December

No material changes.

4.5 Key assumptions included within your financial plan

Among your key assumptions, you must include a section on inflation, funding growth, acute activity growth and inflation on prescribing, GMS/PMS. Please ensure you also include any other material assumptions.

Assumptions

1. The latest detailed planning guidance issued by NHS London in January – version 6 – applies. This is consistent with the table above.
2. Resource growth for next year is as per the exposition booklet - 5.14% for THPCT.
3. All NHS Providers except GMS/PMS/APMS and GDS receive the same net inflation uplift as is applied to acute tariff activity costs – 0%. Cost efficiencies are therefore assumed at the same rate as the acute sector – 3.5% next year and netted against inflation - 3.5% (2.5% normal inflation + 1.0% incremental cost inflation)
4. CQUIN costs are assumed at 1.5% of baseline SLA costs for acute, mental health and CHS contracts.
5. The net inflation uplift for Primary Care providers is assumed at a flat 1.5% net although this would need to be tested against central contract uplifts. This is purely a net inflation uplift. Primary care costs in general are uplifted by demographic growth factors also – see point 5 below.
6. Productivity savings which are significantly in excess of price 'deflation' will need to be found from all functional spend areas to bridge the affordability gap.
7. Compound annual growth rates – CAGR – are applied to current year activity cost baselines using local analysis and reconciled back to GLA low and HfL assumptions. These have both demographic and non-demographic components.
8. The demographic growth element in the CAGR rates is derived from testing the GLA population growth scenario for Tower Hamlets against the localised planning model developed in partnership with the Borough of Tower Hamlets. It has been applied to all contracts with the exception of acute mental health and PCT Provider services which are treated as block contracts in line with historic treatments. There has been substantial investment into mental Health services in the past 5 years with the creation of new community based services which have absorbed new demand and population growth. Patients' care has been transferred from existing community mental health teams to, for example, early intervention or assertive outreach services. It is assumed that the impact of population growth on mental health services will be resourced by productivity improvements in new services. The same argument applies to Community Health services where significant productivity improvements will be leveraged using activity based tariffs.
9. Productivity assumptions in excess of the inflation deflator take account of population

growth in both groupings.

10. Non-demographic growth assumptions are applied to current year baselines using local analysis and reconciled back to HfL assumptions.

11. Prescribing costs include demographic and non-demographic factors as well as inflation and are assumed to increase between 7% and 8% per annum based on historic trends. It may be that these assumptions will be lowered pending the agreement of a strategic pharma management plan to support the CSP submission.

12. A contingency equivalent to 0.5% of total resources is built into each year of the scenario planning.

13. A surplus assumption of £2 million has been assumed in the outlook for 2010/11.

4.6 Key risks included within your financial plan

Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
The cost of creating polysystems is higher than planned.	H	£10 m uncommitted funds identified in the Sources and Applications to be held as a risk reserve
Savings do not accrue from polysystem development on a timely basis. The entire programme is very complex and control will be difficult.	M	As above and also no savings have been assumed in 2010/11 which are significant to the Operating Plan. The PCT is setting up detailed Programme management functions for each component element of Care Closer to Home and Polysystem development.
Acute Activity is not decommissioned as per plan	M	SACU now very much established and in post
Acute Over-performance exceeds available funding	M	£10 million uncommitted funds held as general contingency plus £3 million identified contingencies and a £2 million planning surplus. Both the SACU and he HIU are now functional and the quality of MIS is increasing impressively.
Population Growth Impact - North-East London has one of the largest projected increases of population in the country over the next ten to fifteen years. There is a significant variation in how the ONS model (used for allocations) counts population and how the GLA planning model projects population growth over the next 15 years. The PCT's 10-year strategic plan for service development assumes that population growth funding will be available to secure investment into new infrastructure and services. However, the existing allocation methodology has large variances to the population and service planning model. This is a problem over the medium/long term and has been flagged for further discussion with NHSL. Over the period of the CSP the population effects within the	H	Flagged with NHSL - a case for additional resources is being worked up and will support the PCT final Operating Plan submission

CAGRs are typically between 2% and 3% per annum. These are being afforded within the projected resources because of the relatively high levels of growth over the cycle and the prudent approach taken to investing in new services. However, beyond that there are obviously significant risks that allocations will not offer a fair capitation basis for projected populations.		

4.7 CQUIN

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

In 2010/11 the only uplift within acute, mental health and community service contracts will be for the CQUIN element, which this year increases to 1.5%. This will be split between mandatory national, regional and local elements. The precise proportion of these splits and the detail of the London-wide elements will be agreed by early February. The CQUIN values will be on top of and in addition to baseline contract income for all Providers.

At a London-level, CQUINs will be aligned to the delivery of Healthcare for London and the ISP/the affordability challenge. The measures will reflect the three dimensions of quality: patient experience, safety and effectiveness; and will incentivise the transformation of services, rather than just the shift of existing provision to alternative care settings. The London-wide CQUINs will focus on long term conditions management; emergency admissions and readmissions; and effective discharge.

We have developed a local framework for our decision-making in Inner North East London, to complement the London-wide guidance. CQUIN funding – amounting to almost £9 million across INEL for 2010/11 – will be used locally to incentivise changes in services which complement the strategic shifts set out in the CSP, and will reflect priorities from the CPG, PBC and secondary care clinicians. Contracts with acute providers will not be signed without the CQUIN measures being agreed.

As the SACU becomes fully established, the focus on quality will be an increasingly core aspect of the way that the SACU works with the Trusts and with individual PCTs. Clinical engagement in the development of CQUIN and other quality measures is fundamental.

4.8 Cost Improvement Programmes (expenditure savings only)

Pay CIPs

All post regradings and restructuring will be delivered with no new resources. This includes contributions to the new sector commissioning functions including the SACU (strategic acute commissioning unit), and the HIU (health intelligence unit).

Non Pay CIPs

The PCT has set up a management cost group whose role is to agree the realisation of 30% savings on the PCT's management cost baseline.

A best value initiative is being put into place to make procurement and best value initiative savings on:

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Legal service costs
Continuing Care costs
Take up and compliance with London Purchasing Programme - LPP – and other framework agreements.

Other cost CIPs

A 2% productivity CIP has been applied to Community Health Services (CHS) in addition to net zero baseline SLA uplift next year. The PCT has externalised its CHS which is currently defined as an APO – Autonomous Provider Unit. The value of the additional CIP next year is £1.2 million.

Unidentified CIPs

There are no unidentified CIP's in the PCT Operating Plan for 2010-11.

How will the achievement of these savings be managed in year and what are the risks to achievement?

The PCT has set up a management cost group. The management cost savings target will be its key area of focus and progress will be reported via the PCT Executive team and Board.

The best value initiative progress will be reported and monitored by the PCT executive team.

4.9 Demand management schemes

NHS Tower Hamlets has 11 specific initiatives schemes outlined in its CSP submission and the Operating Plan is essentially year 1 of these. The 11 schemes could all be described as 'demand management schemes but the majority are the 'shifting of care' initiatives which are outlined in section 1.4. They are included here for completeness.

1. **Acute Sector Management - SACU led schemes to manage acute activity more productively mainly by moving to upper quartile productivity.**

   - **Amount notified to providers**
     £4.2 million has been notified to acute Providers - mainly Barts & the London NHS Trust - for 2010-11. This consists of 3 separate workstreams which are
     - Acute Productivity improvement leading to deduction in Outpatient new to follow-up ratio - £1.4m
     - PBC led- specific schemes to reduce the number of first and follow OP attendances by applying locality and network benchmarks and reducing GP referral variability.
     - Reduction in Excess beddays - £356k.

   - **What will the impact be on activity?**
     A reduction of around 31,000 OP attendances will be sought in 2010-11. This is split between:
     - Reduction in new to follow-up ratios – 14,400
     - GP referral reduction in OPs – 17,372

   This is being led by the SACU as an INEL sector initiative and is being enacted through the 2010-11 contract setting process.

   - **Have providers been included within your plans?**
     Yes – Barts & the London has been included in all discussions and the impact included in the Commissioner/Provider SLA discussions for 2010.

Risks:	High/ Medium/ Low risk	Mitigating actions:
Unanticipated consequences of pathway changes in setting up polysystems and care closer to home change the case mix within the acute trusts and make it difficult to achieve the scale of productivity savings anticipated	*Low*	*Due to the phasing of the start of polyclinic models in year one this will be less of an issue that in subsequent years and the benchmarking demonstrates that there are high levels of unproductive practice that can be driven out of the system.*
Differences between the baseline years used to calculate savings in the model and current trust performance	*Low*	*Current benchmarking data demonstrates that there are still considerable savings that can be driven from the system.*
Insufficient clinical engagement in taking forward the consultant-to-consultant protocol and changing clinician behaviour	*Low*	*Building on Health4NEL clinical engagement. Embedding phase one of this will be a key component of the contract negotiations in 2010/11. There will then be a full year to engage acute clinicians in the work up of criteria for phase two of implementation.*
PBC gate keeping of referral needed, as Trusts will regard referral as authority to treat	*Medium*	*SACU working with CPG and PBC to maximise primary care ownership; acute contracts to specify expectations of Trusts in managing referrals*

2. Acute Sector Management - Decommissioning

Decommission procedures of low clinical value and agree means of addressing referrals if made

- **Amount notified to providers**
  £1.6 million has been notified to acute Providers - mainly Barts & the London NHS Trust - for 2010-11.

- **What will the impact be on activity?**
  There are 4 sub-initiatives within this overall CSP Initiative. These are:
  - NHS and Foundation Acute Trusts - Elective spell reduction of 37
  - NHS and Foundation Acute Trusts - Outpatients attendances reduction of 9996 appointments.
  - NHS and Foundation Acute Trusts - Planned same-day procedures reduction of 64 procedures.
  - NHS and Foundation Acute Trusts - Other.

  This is being led by the SACU as an INEL sector initiative and is being enacted through the 2010-11 contract setting process.

- **Have providers been included within your plans?**
  Yes – Barts & the London has been included in all discussions and the impact included in the Commissioner/Provider SLA discussions for 2010.

- **What are the risks to delivery?**

Risks:	High/ Medium/ Low risk	Mitigating actions:
PBC gate keeping of referral needed, as Trusts will regard referral as authority to treat	*Medium*	*SACU working with CPG and PBC to maximise primary care ownership; acute contracts to specify expectations of Trusts in managing referrals*
Insufficient clinical engagement from acute trusts and so difficulty in embedding changes in thresholds and criteria	*Medium*	*Building on Health4NEL clinical engagement. Embedding phase one of this will be a key component of the contract negotiations in 2010/11. There will then be a full year to engage acute clinicians in the work up of criteria for phase two of implementation.*
Insufficient planning by PCTs of alternative care pathways for activity coming out of acute trusts and so activity stays within the provider or becomes a pressure on community services	*Low*	*These are not high volume specialties and so referral numbers are not high. The SACU will need to work with primary care teams and PBC clusters to ensure that any residual activity is able to be managed appropriately.*

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3. Care Closer to Home (Planned Care) - Polysystems

This is the main Polysystem activity shift lever in the CSP and it has a net cost as it is contains the costs of setting up the whole polysystems mechanisms in year 1. There are 6 specific sub-initiatives which are:

- NHS and Foundation Acute Trusts - Elective spells shift into polysystems in year 1 of 78 spells.
- NHS and Foundation Acute Trusts - Non-elective spells shift into polysystems in year 1 of 79 spells
- NHS and Foundation Acute Trusts - Outpatients attendances shift into polysystems in year 1 of 14,449 appointments.
- NHS and Foundation Acute Trusts - Planned same-day procedures – shift into polysystems in year 1 of 136 procedures.
- NHS and Foundation Acute Trusts – Shift of 'other' (mainly nPbR diagnostic and path tests) of 28,912 in year 1 of polysystems.
- Polyclinics – Attendances increase in year 1 as a counterpart to the shifts out of acutes. There will be increased attendances in year 1 of polysystems of just over 51,000.
- There is a net cost in year 1 of this total initiative of £10.8 million. This reflects the cost of setting polysystems up, transition costs and the subsidy to other CSP initiatives. It is this initiative that contains most of the polysystem costs.

- **Amount notified to providers**
  £2.9 million NHS Tower Hamlets total has been notified to Acute Providers mainly applicable to Barts & the London NHS Trust.

- **What will the impact be on activity?**
  As above.

- **Have providers been included within your plans?**
  Discussions have been taken place with key Providers across North-East London as part of the H4NEL pre-consultation business case for the reconfiguration of acute healthcare services across the inner and outer North-East London sectors – ONEL and INEL. A series

of discussions have been taking place during the latter half of 2009 at a strategic level. The detailed operational planning of this was picked up by the INEL Strategic Acute Commissioning Unit – SACU – on behalf of all three PCT in INEL

- **What are the risks to delivery?**
  This scheme is integrated on an INEL sector basis and enacted through the SACU. The risk matrix for the sector is shown below

Risks:	High/ Medium/ Low risk	Mitigating actions:
Investment in infrastructure costs of new community provision, however GP referral patterns do not change sufficiently – resulting in double running costs	*Medium*	*PCTs have undertaken work with GPs via PBC groups to work through implications of new pathways and the changes which will need to happen in referral patterns to support new pathways.* *Impact of new pathways on acute activity levels will be reviewed monthly, with joint action plans between the SACU and PCTs to mitigate any the impact of any under-utilisation of community capacity.*
Insufficient alignment across common sector pathways, result in lack of engagement from the acute sector and failure to support shifts of care	*Medium*	*Work has already been undertaken through Health4NEL to work with clinical leads from primary and secondary care and to develop best-practice pathways. This will be built upon to look at other pathways of care where the majority of patients will be treated in a community setting.*
PCT timescales for implementation of polysystems too ambitious and as a consequence savings are not achieved to the timescales anticipated	*Medium*	*There has been a very thorough process of modelling the shifts from secondary care to a community setting. The shifts in year-one of the model allow for phasing around set-up as a consequence are more modest than in subsequent years of the model.*
Insufficient clinical engagement within the acute trusts and lack of engagement in pathway redesign results in difficulties embedding new pathways of care	*Low*	*Through Health4NEL there has been a very comprehensive process of involving acute clinicians in reviewing and contributing to the discussion around pathways of care. This has been replicated at PCT level with acute sector clinical representation at the groups looking at the design of care closer to home services.*

4. Care Closer to Home (Planned Care) – Health Inequalities/GP Access.

This is a relatively small part of the overall demand management programme and refers to the quantum of 'shifted' OP activity that would diminish as a part year effect of providing care in a different way to patients.

- **Amount notified to providers**

£27k NHS Tower Hamlets total has been notified to Acute Providers mainly applicable to Barts & the London NHS Trust.

- **What will the impact be on activity?**
  264 OP first and follow-up attendances will be shifted to an Out of Hospital setting in 2010 – NHS Tower Hamlets total.

- **Have providers been included within your plans?**
  Yes – Barts & the London has been included in all discussions and the impact included in the Commissioner/Provider SLA discussions for 2010

- **What are the risks to delivery?**
  This scheme is integrated on an INEL sector basis and enacted through the SACU.

- **What is the timescale for implementation?**
  From 1st April 2010 and to reflected in 2010-11 contract values

5. Primary Care Investment Programme (PCIP) (Long Term Conditions)

This is the main LTC programme for NHS Tower Hamlets and as one would expect there is a relatively slow 'ramp up' of savings with significant upfront investment being required next year. This area is another net cost item therefore in year 1 but pays back over the course of the CSP.

- **Amount notified to providers**
  £2.3 million 2010-11 notified to acute Providers mainly Barts & the London NHS Trust..

- **What will the impact be on activity?**
  - NHS and Foundation Acute Trusts - Elective spells decline by 0 in 2010-11.
  - NHS and Foundation Acute Trusts - Non-elective spells decline in 2010-11 by 924
  - NHS and Foundation Acute Trusts - Outpatients attendances decline by 0.
  - NHS and Foundation Acute Trusts - Planned same-day procedures – shift into polysystems in year 1 of 136 procedures.
  - NHS and Foundation Acute Trusts – Decline of 'other' (mainly nPbR diagnostic and path tests) of 248,896 in year 1 of polysystems.
  - There is a significant gross cost item which is the key dependency for LTC benefit realisation – in 2010-11 the roll out of 'packages of healthcare' and LTC year of care approaches will cost almost £3million.
  - There are no net savings in year 1 – there is a net cost of almost £1m.

- **Have providers been included within your plans?**
  Yes – Acute Providers have been included in all discussions and the impact included in the Commissioner SLA 'offer' for 2010.

- **What are the risks to delivery?**
  The LTC model of benefits and ROI will be monitored through a program board to ensure that investments into LTCs are paying off in reducing activity at the back end of the LTC pathway.

- **What is the timescale for implementation?**
  From 1st April 2010. The diabetes care pathway and 'Year of Care' have already been substantially rolled out to the networks and localities.

6. Staying Healthy (Prevention)

This is essentially a screening, Immunisations and Vaccinations programme which will avoid non-elective admissions for a particular cohort of vulnerable patients. The costs in year one broadly equate to the savings although there may be a bigger ROI payback

downstream in future years.

- **Amount notified to providers**
  £965k 2010-11 notified to acute Providers mainly Barts & the London NHS Trust..

- **What will the impact be on activity?**
  - NHS and Foundation Acute Trusts - Non-elective spells decline in 2010-11 by 388
  - NHS and Foundation Acute Trusts – Decline of 'other' (mainly nPbR diagnostic and path tests) of 107,811 in year 1.

- **Have providers been included within your plans?**
  Yes – Acute Providers have been included in all discussions and the impact included in the Commissioner SLA 'offer' for 2010.

- **What are the risks to delivery?**
  The main risk to delivery is that screening, immunisation and vaccination programmes do not result in fewer non-elective acute admissions. The risk will be reviewed and monitored through Programme Board and Management mechanisms - the same as for LTCs.

- **What is the timescale for implementation?**
  The second quarter of 2010-11 and into quarter 3.

7. Community Tariff Efficiency

- **Amount notified to providers**
  2% of the recurrent SLA value for 2010-11. This is worth £1.2 million in 2010.

- **What will the impact be on activity?**
  No impact on activity

- **Have providers been included within your plans?**
  Yes – NHS Tower Hamlets DPO has been included in all discussions and the impact included in the Commissioner SLA 'offer' for 2010.

- **What are the risks to delivery?**
  None from a Commissioner perspective. There are risks from a Provider perspective which are addressed in its Operating Plan submission.

- **What is the timescale for implementation?**
  From 1st April 2010

8. Management Cost Savings

The PCT has an Operating Plan target to save £1.4 million Management costs in 2010-11. This is roughly 30% of the 2008-09 audited accounts total for Management Costs. NHS Tower Hamlets has established a 'Best Value' Board led by Directors and there is a program in place. However, it is considered that the debate around Management Costs is more of a strategic one which will be resolved at a sector level and more guidance is awaited.

9. Mental Health

- **Amount notified to providers**
  2% of the recurrent SLA value for 2010-11. This is worth £1.2 million in 2010.

- **What will the impact be on activity?**
  No impact on activity

- **Have providers been included within your plans?**
  Yes – NHS Tower Hamlets DPO has been included in all discussions and the impact

included in the Commissioner SLA 'offer' for 2010.

- **What are the risks to delivery?**
  None from a Commissioner perspective. There are risks from a Provider perspective which are addressed in its Operating Plan submission.

- **What is the timescale for implementation?**
  From 1st April 2010

10. Care Closer to Home (Urgent Care)

- **Amount notified to providers**
  £700k notified to Providers for 2010-11. This is linked very much to the development of Polysystems and the recommissioning of Urgent Care

- **What will the impact be on activity?**
  Net decline of 7504 A&E attendances in year 1. This is being led by the SACU as an INEL sector initiative and is being enacted through the 2010-11 contract setting process

- **Have providers been included within your plans?**
  Yes – Acute Providers have been included in all discussions and the impact included in the Commissioner SLA 'offer' for 2010.

- **What are the risks to delivery?**

Risks:	High/ Medium/ Low risk	Mitigating actions:
Complex negotiations with acute trusts around removing residual payment arrangements supporting UCCs	*High*	*This is one of the key outcomes needed in the SACU negotiation strategy and contracts will not be signed without these elements being resolved.*
Risk averse clinical protocols means more referrals from UCCs to A&E than anticipated in modelling	*Low*	*There are established UCCs up-and-running at all three sector A&Es, underpinned by clinical protocols.*
Supporting elements of polysystem model for unscheduled care in the community are not well utilised (either because of issues with the model or through lack of patient education) and therefore demand within the UCCs exceeds capacity to deliver	*Low*	*There is already a history in the sector of running successful out-of-hospital unscheduled facilities in a number of walk-in-centres. The unscheduled elements of the polysystem model are being phased to mitigate the risks of under-utilisation.*

- **What is the timescale for implementation?**
  From 1st April 2010

11. Procurement and Supply Chain Initiative – enabler

- **Amount notified to providers**
  Internal Supply chain and Procurement initiative

- **What will the impact be on activity?**
  No impact on activity

- **Have providers been included within your plans?**
  No Providers

- **What are the risks to delivery?**
  The targeted savings are relatively modest and relate to the sector retendering of legal

services, movement to use of LPP contracts for Purchased Healthcare, use of best value Procurement Contracts throughout the sector and a sector based review of NHS Professionals and use of bank/agency. This initiative is considered to be low risk..

- **What is the timescale for implementation?**
  From 1st April 2010

4.10 Capital investment and disposal (including sources of funding)

The Table below is the outline 2010-11Capital Plan submitted to NHSL for CRL funding next year. There is additionally a revenue funded capital section below that. Brief details are given for each scheme. No capital disposals are planned for 2010-11.

Project Name	Brief Project Description	Pre-existing Commitment	Contractually Committed?	Total spend pre 2010/11	Total CRL Required in 2010/11
				£000	£000
ICT	Development of ICT capability across the Trust in line with local and national strategies	*No*	*No*	800	1,000
Therapy Unit Refurbishment	Penultimate phase of the therapy department at Mile End Hospital which is a refurbishment to facilitate the provision of new and improved services including a sports therapy centre and hydrotherapy unit.	*Yes*	*No*	1,800	4,100
Bancroft Unit Refurbishment	Refurbishment of the Mile End Hospital Bancroft unit to support the delivery of wider range of services in support of the PCT Polysystem and Improving Health and Wellbeing Strategy	*No*	*No*	30	750
Gill Street Refurbishment	Major refurbishment of Gill Street Primary Care Health Centre to provide spoke services in support of the PCT Polysystem and Improving Health and Wellbeing plans	*No*	*No*	35	2,000
Works Programme	A programme of works to upgrade and install fixtures and fittings to ensure that the Trust achieves fire, health & safety schemes and DDA compliance	*No*	*No*	789	1,000
Diabetes centre refurbishment	Refurbishment work to improve the functional use of the diabetes centre at Mile End Hospital, to accommodate an increased provision of services and comply with infection control and health & safety standards	*No*	*No*	-	750
Alderney Building	Major refurbishment of Grade 2 listed building at Mile End Hospital to facilitate moving office activities out of clinical areas and to ensure the building complies with health and safety and DDA guidelines	*Yes*	*No*	1,125	1,800
Carbon Reduction	Programme of works to support the Trust wide Sustainable Development and Energy Management Strategy - reducing waste, efficient use of resources and a reduction in carbon footprint. This includes a major boiler refurbishment programme.	*No*	*No*	-	1,000
Other Projects not captured above				250	1,100
			Total	**4,829**	**13,500**

The value of the CRL funded schemes for 2010-11 is £13.5 million. This may be subject to further modification as the final CRL funded plans are agreed with NHSL. The table above shows that most of the schemes are already phased and have already had capital investment. Most of the schemes relate to the ongoing modernisation of Mile End Hospital or the refurbishment of existing Primary care estate to deliver new Polysystem 'spoke-based services. The table also outlines where there are pre-existing commitments and contractual commitments.

NHS Tower Hamlets has also committed a significant amount of revenue funded capital development -

notably on the costs in-year of developing the Polysystem hub and spoke model. The value of this in the 2010-11 Operating Plan will be £1634k recurrently and £1673k non-recurrently. These costs are for the infrastructure costs of new developments which are either LIFT or other third party long term lease agreements which fall under IFRS balance sheet rules. These schemes are

Newby Place – a Polysystem spoke with the Barkantine as the hub
Harford Street – Polysystem spoke
Dunbridge Street – Polysystem spoke
St. Andrews – Polysystem hub

Funds have also been committed in the current year to all four and the 2010/11 costs are additional. All four will open at some point next year.

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

None

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

Managing Finances

The PCT achieved a score of 3 in the UOR exercise for 2008-09. A detailed action plan – with nominated Director leads - has been agreed via the PCT audit committee to further strengthen the financial reporting KLOE specifically around production of annual accounts working papers and the overall production of the Annual Report.

Governing the Business

The PCT achieved a score of 2 in the UOR exercise for 2008-09. A detailed action plan – with nominated Director leads - has been agreed via the PCT audit committee to improve the overall score in this area to a 3 for 2009-10. The specific areas are outlined below.

KLOE 2.2 (data quality and use of information) score - 2
No specific issues of weakness were noted. The PCT action for this KLOE focuses on the competencies required to score a mark of 3.

KLOE 2.4 (risk management and internal control) score - 2
No specific issues of weakness were noted. The PCT action for this KLOE focuses on the competencies required to score a mark of 3.

Managing the Resources

The PCT achieved a score of 3 in the UOR exercise for 2008-09. A detailed action plan – with nominated Director leads - has been agreed via the PCT audit committee to improve the overall score in this area to a 4 for 2009-10. Areas of notable practice have been developed during the year – particularly around carbon footprint and use of natural resources, as well as a number of contractual areas. The latter includes the development of a meaningful tariff for Community Health Services, a detailed Polysystem activity and economic model, and a remodelling of the Primary Care contract to support that.

SECTION 5: WORKFORCE (PCTs and sectors)

5.1 Workforce impact of strategic goals

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

Our eight strategic initiatives will deliver both health improvements and affordability.

Strategic initiative	Workforce implications
Staying Healthy – by focusing on the key health challenges facing Tower Hamlets on obesity, tobacco use, screening, and immunisation. This will be delivered systematically through our primary care networks and strengthening further our commissioning through the Tower Hamlets Partnership and Local Area Partnerships.	Widening the scope of clinical/medical roles to include health promotion. Skills and knowledge development. Skills and knowledge transfer into primary care. Managerial and leadership skills in polysystems. Need for polysystems/primary care to have talent management strategies. Moving physical locations and possibly contractual (including employment) arrangements. Hospital specialists may become even more specialist. Need for HR functions to work together across the system to deliver this. More skills development in primary and community care, commissioners involved in commissioning education and training in modular forms for primary care to increase capability and confidence. This to include a focus on nurses, HCAS in new technical roles and administration, including data management and analysis. For CHS, managerial accountability will need to increase so an emphasis on management development, IT skills will be a really big issue and there is a likelihood of workforce reductions or at
Acute Contracting – by focusing on reducing activity of low clinical value, claims management and validation. Acute contracts will be changed to reflect the phased shift of care into polysystems supported by better information and systems to GPs and PBCE to reinforce the shifts of care by reducing referrals	
Care Closer to Home - by continuing and quickening our polysystem development so that we reduce services in acute and shift them into our polysystem,	
Access and Urgent Care – improve access to urgent care while reducing A&E attendances through the polysystem by commissioning an urgent care centre and sustaining and extending access to primary care	
Primary Care Investment Programme – to better manage long term conditions – with improved self care and reduced hospital admissions - through implementing a number of care packages including diabetes, COPD and staying healthy.	
Improving CHS productivity – by introducing a full tariff across CHS to raise productivity and transparency, as well as market testing three CHS services	
Mental Health – by enhancing further our mental health services with a focus on working collaboratively across ELCA and with the ELFT and looking to improve further the efficiency	

and effectiveness of services	
Affordability / Save to Invest – a number of measures that will deliver early savings to the PCT to allow investment in longer term improvements.	

We will use six levers to deliver affordability:

- **shifting settings of care** – moving services out of acute hospitals and reproviding them in our polysystem
- **demand management and decommissioning** – stopping activity that is of low clinical value and better managing referrals
- **LTC management** – so that more peoples' conditions are controlled avoiding clinical (and particularly acute) intervention
- **Ill Health prevention** – targeted programmes that focus on the major killers and avoidable health conditions such as immunisation, tobacco use and obesity
- primary care productivity – driving up activity with less than proportionate funding growth by improving estates, IT, performance management
- **CHS productivity** – through tariff and a greater transparency on costs and the integration of CHS services within the polysystems.

As can be seen from the above, CSP and Organisational Development Plan recognises that we have to deliver a shift in activity from acute provision to community, through the development of polysystems. We have mature plans and arrangements in place for excellent engagement with clinicians, contractors and providers in achieving this change.

The activity shift will create significant size, scope, skill, structural and cultural changes in our service providers' workforces, and we are working to engage with them at all levels to anticipate and plan the changes that are necessary.

For example the move to care closer to home links both a reduction in acute provision and workforce with an in train Primary Care Investment Programme. We are already working with Primary Care Networks (who have identified the recruitment and retention of talent as a key issue) on developing a compelling employer brand and developing pipelines of talent (as much local as possible) into both administrative and clinical roles. We are modelling a competency framework for primary care staff in tandem with revised care pathways.

5.2 Effective communication with providers	
(PCTs) Does your organisation have a process in place by which it can assure the workforce strategies of its provider organisations are fully integrated with service and financial plans, and aligned with the PCT's vision as highlighted in its commissioning intentions communicated to its providers?	***Y***

Commissioners have a range of levers to assure the workforce strategies of provider organisations through commissioning, contracting and performance management processes. Our primary imperative over the next twelve months is to embed and systematise our approach to this, recognising the different requirements of providers which range from major acute providers to our own Community Health Service and to both private sector and very small third sector providers. One size will not fit all in assuring their workforce strategies across the health economy.

For the major providers (acute, mental health and community services, they are required by commissioners to provide Operating Plans which include details on workforce numbers and skills and the changes required to workforce to deliver the commissioning intentions that we have worked with them on as part of the process of developing our CSP.

We have a detailed contracting process which requires workforce information and assurance of compliance with key standards on workforce from private sector contractors.

We are developing key metrics in relation to workforce productivity, particularly around sickness, but also on the cost of individual items within case pathways, these metrics enable robust discussions on practice productivity.

5.3 Quality of Service / Education considerations

(PCTs) Has the PCT made clear to their provider organisations that their education and training funding should be used to transform their workforce to support the delivery of the PCT's service vision, and does the PCT have mechanisms in place to assess whether provider organisations have appropriate plans to support this objective?	***Y***

As stated previously, commissioners work closely with providers on all workforce implications of commissioning intentions and strategy; this includes Education and Training.

Of course, the approach to this will vary across the provider landscape, varying from large hospitals with well resourced arrangements and plans for education and training, to small third sector organisations with relatively little resource and/or a volunteer workforce.

As well as the detailed work undertaken by lead commissioners on specific commissioning workstreams, we also scrutinise workforce and education plans through the quality review arrangements with each provider, including CHS. This will also include organisation wide reviews of workforce metrics (including outcomes from staff surveys).

NHS Tower Hamlets Education (commissioning) lead is working with Tower Hamlets CHS education lead to strengthen processes and systems to ensure services effectively allocate their education funding to support the delivery of their provider operating plan which is designed in respond to the CSP.

The NHS Tower Hamlets Education (commissioning) lead is also supporting joint working between CHS and BLT to maximise opportunities for the development of staff e.g. development of bands 1 - 4. NHS Tower Hamlets Education Commissioning Lead is taking a systems leadership role in bringing the leads together to facilitate this type of joint working. It is planned that this will be expanded during 2010/11 and to encompass the range of providers in Tower Hamlets.

NHS Tower Hamlets has recently opened a state of the art Education Centre at Mile End Hospital which has greatly increased local capacity for education and development to support the developments of the CSP.

NHS Tower Hamlets has been a proactive partner in the successful Health Innovation & Education Cluster (HIEC) plan for North East London. We will work closely with Alliance colleagues to ensure that the opportunities offered by the HIEC are maximised in helping us to translate H4NEL strategy into reality. We will be working closely with the Sector Workforce Transformation Director to redesign education commissioning arrangements locally to maximise impact and influence.

(PCTs) Does the PCT have processes in place to ensure that provider organisations carry out appropriate workforce risk assessments and address capability or capacity issues ahead of the changes that the PCT's local service vision will require?	***Y***

As stated previously, commissioners work closely with providers on all workforce implications of commissioning intentions and strategy; this includes workforce risk assessments. These risks are monitored through a number of routes: the quality review arrangements to get assurance of how they are being managed at a corporate/strategic level within the provider organisation and the specific commissioning programmes led by commissioners. System wide risks will be aggregated so that a strategic response can be coordinated.

5.4 Statutory Workforce Obligations	
(PCTs) Does the organisation have a process in place by which it can assure statutory workforce obligations (e.g. EWTD, mandatory training, % appraisal rates, quality of appraisals, medical revalidation) are delivered within its provider organisations?	***Y***

Statutory workforce obligations form part of all standard contract documentation and cover as follows:

- EWTD
- CRB checks / safeguarding
- Compliance with equality and diversity legislation on Race, Gender/Marital Status, Sexuality, Disability, Age and Religion
- Health and Safety at Work Act, including risk assessments
- Control of infections
- Medical revalidation and CPD

Statutory workforce obligations are monitored as part of contract monitoring processes. For example in Primary Care there is a well established Balanced Scorecard which is reviewed quarterly and includes statutory workforce obligations for example on safeguarding (CRB checks, training etc). Any failures to comply are identified and a written action plan agreed. In Community Health Services, monthly contract monitoring meetings are held at which evidence is scrutinised on all contract conditions and targets, including workforce. These meetings are minuted and are supplemented by quarterly contract review sessions again including statutory workforce indicators.

We are continuing to improve and develop a standard set of commissioning and contracting documentation to ensure this focus on legal workforce obligations is embedded in all contracts. We also periodically scrutinise these contract requirements through the quality review arrangements with each provider.

We monitor safeguarding level 1 training which although not statutory is a high priority and commissioners have made this a Key Performance Indicator for our Community Health Services.

5.5 Productivity & Efficiency	
(PCTs) What percentage increase in workforce productivity is the PCT expecting from its providers, and does the PCT have mechanisms to monitor the clinical productivity of provider organisations?	***Y***

There are a range of annual workforce productivity expectations, as follows:

Acute	=	3.5%
CHS	=	5.5%
ELMHT	=	3.5%
Other provider	=	3.5% (average)

These expectations are clearly set out in commissioning intentions and have been discussed at length with providers.

Mechanisms to monitor productivity are well established and regular (on different timescales depending on provider) contract monitoring meetings review providers against productivity targets amongst other indicators.

For example the principles of productive increases in CHS have been discussed as a cash releasing saving and plans are in hand to achieve it through a reduction in agency staff and by managing productivity via tariff.

5.6 Leadership	
(PCTs) Does the PCT have a strategy on developing talent and leadership in line with service delivery and financial management?	***Y***

NHS Tower Hamlets has a well developed approach to developing talent and leadership, and is recognised as a successful, ambitious and well led organisation as a result of this approach. We are recognised as having secured high levels of talent in commissioning and corporate functions and believe our relative successes rest on our ability to attract and retain talent. We also have a well developed approach to succession planning and are embedding an approach to securing pipelines of talent into the organisation through, for example, our scheme for local graduate trainees in commissioning. We believe that much of our future talent must be secured locally in order to deliver culturally sensitive and responsive services and are working towards being 'the employer of choice'. We have well developed programmes for leadership development in the organisation, including a bi-monthly leadership forum where external speakers deliver cutting-edge inputs. Our programme for our BAME staff is now in its second year and has delivered measurable outcomes.
Our mentorship programme is currently aligning itself to the NHS London programme to maximise opportunities for us to develop potential leaders and talented staff.

The organisation has a Leadership Alumni to support the development of future leaders and we arrange regular opportunities to encourage participation for multi professionalism.

SECTION 6: INFORMATICS (PCTs only)

Please complete the informatics template at Annex B.

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Appendix 2: Vital Signs 2010/11

Group	Vital Signs Reference No.	Indicator Name	2008/09 Perform	2009/10 Performance	2010 /11 Trajectory														
					April	May	Q1	July	August	Q2	October	November	Q3	January	February	Q4	Annual Target	Initiative / Pathway
Existing Commitments	No Reference number	Access to Gum Clinics	99.82%	99.99%													98%	Staying Healthy
	No Reference number	London Ambulance Services -Cat A 8 mins,	75.55%	74.50%													75%	SACU
	No Reference number	London Ambulance Services-Cat A 19 mins	98.56%	98.62%													95%	SACU
	No Reference number	London Ambulance Services-Cat B 19 mins	84.50%	86.27%													95%	SACU
	No Reference number	Commissioning of crisis resolution-Home treatment services	775	629													689	Mental health
	No Reference number	Early Intervention Psychosis services	78	69													52	Mental health
	No Reference number	Data quality on ethnic group - HES and MHMDS	92.271%, 95.661%														90%	OD
	No Reference number	Delayed transfers of care		9.68													15	SACU
	No Reference number	Diabetic Retinopathy	107.70%	106.70%													95%	PCIP
	No Reference number	Inpatients 26 weeks	0.37%	0.13%													0.03%	SACU
	No Reference number	Outpatients 13 weeks	2.20%	0.26%													0.03%	SACU
	No Reference number	Revascularisation waits(13 weeks)	0	0													0	SACU
	No Reference number	Total time in A&E	96.57%	98.50%													98%	Access
	VSA 01	MRSA Commissioner	38	22	1	1	1	1	1	0	1	1	1	1	1	0	10	SACU
	VSA 03	Incidence of Clostridium difficile-commissioner trajectory	188	71	14	14	13	13	14	12	13	14	14	13	13	14	161	SACU
	VSA 04	NHS-reported waits for elective care	Data Incomplete	82.8%, 95.3%													90% admitted, 95% non-admitted, 95% audiology	SACU
	VSA05	**18 weeks and Supporting Acute Activity lines(includes audiology / diagnostics/ other acute activity)**																SACU
	VSA05_01	Number of written referrals from GPs for a first outpatient appointment in general & acute specialties			2720	2363	2897	3179	2479	2409	2616	2725	2371	2764	2573	2852		
	VSA05_02	Number of other referrals for a first outpatient appointment in general & acute specialties			1941	1806	1912	1761	1806	1725	1870	1698	1677	1955	1821	2019		
	VSA05_03	Number of first outpatient attendances (consultant led) following GP referral in general & acute specialties			2359	2282	2659	2852	2090	2482	2347	2543	2047	2387	2221	2463		
	VSA05_04	Number of all first outpatient attendances (consultant led) in general and acute specialties			4210	4100	4709	5164	3930	4143	4326	4383	4021	4677	4349	4773		
	VSA05_05	Total elective G&A day case FFCEs			1101	1118	1232	1459	1129	1085	1153	1262	1062	1238	1224	1262		
	VSA05_06	Planned elective G&A day case FFCEs			127	84	127	176	142	198	259	254	301	350	346	356		
	VSA05_07	Total elective G&A ordinary admission FFCEs			360	414	442	461	403	373	400	477	402	409	402	395		
	VSA05_08	Planned elective G&A ordinary admission FFCEs			30	45	50	56	47	76	83	78	43	43	43	42		
	VSA05_09	Non-elective G&A FFCEs, excluding well babies			1769	1780	1712	1806	1863	1792	1904	1797	2249	2299	2043	2343		
	VSA05_10	Activity for 15 key diagnostics tests			4374	4374	4374	4374	4374	4374	4374	4374	4374	4374	4374	4374		
	VSA06	Patient experience of access to primary care																Access
	VSA07	Extended opening hours for GP practices (% target)	97.20%		97.22%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	Access
	VSA08	Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	Not applicable															Staying Healthy / SACU
	VSA09	Proportion of women aged 47-49 and 71-73 offered screening for breast cancer (cumulative figures)	Not applicable				0%			0%			0%			8%		Staying Healthy / SACU
	VSA10	Proportion of men and women aged 70-75 taking part in bowel screening programme (cumulative figures)	Not applicable				0%			0%			10%			30%		Staying Healthy / SACU
	VSA11	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)	Not applicable															Staying Healthy / SACU
	VSA12	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	Not applicable		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%(2 patients per month)	Staying Healthy / SACU
	VSA13	Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less than 62 days from referral to treatment																Staying Healthy / SACU
	VSA14	**Stroke Care**																SACU
	VSA14_09	Proportion of people who spend at least 90% of their time on a stroke unit	80%	89.66			81%			81%			81%			81%	81%	
	VSA14_12	Proportion of people who have a TIA who are scanned and treated within 24 hours	75.93%	100			66.70%			66.70%			66.70%			66.70%	66.70%	
	VSA15	Proportion of women receiving cervical cancer screening test results within two weeks			99%	99%	99%	99%	99%	99%	99%	99%	100%	100%	100%	100%	100%	Staying Healthy / SACU

						2010 /11 Trajectory											
Group	Vital Signs Reference No.	Indicator Name	2008/09 Perform	2009/10 Performance	April	May	Q1	July	August	Q2	October	November	Q3	January	February	Q4	Annual Target	Initiative / Pathway
National Priorities	VSB01	All-age all cause mortality rate per 100,000 population																Staying Healthy
	VSB01_03	Mortality rate per 100,000 (directly age standardised) population, males, from all causes at all ages in Spearhead Group PCT, based on Local Authority data[1]. (Population as in line 4)	856	Not available													787(Calender year 2010)	
	VSB01_07	Mortality rate per 100,000 (directly age standardised) population, females, from all causes at all ages in Spearhead Group PCT, based on Local Authority data[1].	570	Not available													547(Calender year 2010)	
	VSB02	Under 75 Cardiovascular mortality rate	120.6	Not available													108(Calender year 2010)	Long Term Conditions
	VSB03	Under 75 Cancer mortality rate	144.7	Not available													127(Calender year 2010)	Staying Healthy
	VSB04	Suicide & Injury of Undetermined Intent Mortality Rate															monitored at SHA level	Mental Health
	VSB05	Smoking prevalence among people aged 16 or over and, aged 16 or over in routine and manual groups (quit rates locally 2008)	2333	1164			300			400			600			600	1900	Staying Healthy
	VSB06	Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy.	63%	81.33%			87%			88%			89%			90%	88.50%	Maternity
	VSB08	Under 18 conception rate per 1,000 females aged 15-17	45.8	Not available													26.06(Calender year 2010)	Children and Young People
		no. of conceptions(under 18)															83 conceptions	Children and Young People
	VSB09	**Obesity among primary school age children**																Staying Healthy
	VSB09_05	Percentage of children in Reception with height and weight recorded who are obese.	13.70%	13.51%													15%	
	VSB09_07	Percentage of children in Reception with height and weight recorded.	85.85%	88.30%													85%	
	VSB09_12	Percentage of children in Year 6 with height and weight recorded who are obese.	24.45%	25.69%													25%	
	VSB09_14	Percentage of children in Year 6 with height and weight recorded.	86.70%	92.17%													89%	
	VSB10	**Proportion of children who complete immunisation by recommended ages**																Staying Healthy
	VSB10_03	Immunisation rate for children aged 1 who have completed immunisation for diphtheria, tetanus, polio, pertussis, Haemophilus influenzae type b (Hib) - (i.e. all 3 doses of DTaP/IPV/Hib) - calculated	88.94%	90.81													90.0%	
	VSB10_08	Immunisation rate for children aged 2 who have completed immunisation for pneumococcal infection (i.e. received Pneumococcal booster) (PCV) - calculated	86.75%	93.04													90.01%	
	VSB10_09	Immunisation rate for children aged 2 who have completed immunisation for Haemophilus influenzae type b (Hib), meningitis C (MenC) - (ie received Hib/MenC booster) - calculated	94.20%	92.17													87.0%	
	VSB10_10	Immunisation rate for children aged 2 who have completed immunisation for measles, mumps and rubella (MMR) - (i.e. 2 doses of MMR) - calculated	81.74%	81.14													87.0%	
	VSB10_14	Immunisation rate for children aged 5 who have completed immunisation for diphtheria, tetanus, polio, pertussis (DTaP/IPV) (i.e. all 4 doses) - calculated	67%	79.25													85.0%	
	VSB10_15	Immunisation rate for children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e. 2 doses) - calculated	78.93%	83.02													90.0%	
	VSB10_18	Immunisation rate for girls aged around 12-13 years who have completed immunisation for human papillomavirus vaccine (HPV) (i.e. all 3 doses) - calculated		98.64													89.9%	
	VSB10_21	Immunisation rate for children aged 13 to 18 who have been immunised with a booster dose of tetanus, diphtheria and polio (Td/IPV) – calculated	65.24%	Not available													66.0%	
	VSB11	Percentage of infants breastfed at 6-8 weeks																Maternity
	VSB11_05	Prevalence during quarter	58.60%	64.13%			71.30%			71.60%			72.30%			73%	72.10%	
	VSB11_06	Coverage during quarter	87%	90.50%			91%			92%			93%			95%	92.80%	
	VSB12	Effectiveness of Children and Adolescent Mental Health Service (CAMHS) (percentage of PCTs and Local Authorities who are providing a comprehensive CAMHS)	4	4			level 4			level 4			level 4			level 4		Mental Health
	VSB13	Percentage of 15-24 tested / screened for Chlamydia	21.28%	10.13%			9%			9%			9%			9%	35%	Staying Healthy
	VSB14	Number of drug users recorded as being in effective treatment	1434	1434													9% (1476 in treatment)	
	VSB15	**Self reported experience of patients & users**																Access
	VSB15_01	Adult inpatient patient experience score **(Acute Trust)**															70	
	VSB15_02	Adult outpatient patient experience score **(Acute Trust)**															70	
	VSB15_03	A&E patient experience score **(Acute Trust)**															70	
	VSB15_04	Patient experience score **(Community mental health trust)**															100	
	VSB15_05	Patient experience score **(PCT survey of primary care services)**															74.0	
	VSB16	**Public confidence in local NHS**																OD
	VSB16_01	Focus on the person score															66.3	
	VSB16_02	Focus on dignity and respect score															83.5	
	VSB16_03	Focus on improving as an organisation score															31.4	
	VSB16_04	Overall score															60.4	
	VSB17	NHS staff survey scores based measures of job satisfaction	3.546	Not available													3.65	OD
	VSB18	Primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the numbers of patients accessing NHS dental services	107563	108497														Access

				2010 /11 Trajectory														
Group	Vital Signs Reference No.	Indicator Name	2008/09 Perform	2009/10 Performance	April	May	Q1	July	August	Q2	October	November	Q3	January	February	Q4	Annual Target	Initiative / Pathway
Local Priorities	VSC03	Number of adults (18+) supported directly through social care community care assessment, to live at independently at home *plus* those supported through organisations that receive social services grant funded services.															Change in definition TBC	Care Closer to Home
	VSC08	Proportion of adults in contact with mental health services in employment(18-69 age group)	10.48%														11.20%	Mental Health
	VSC11	People with long term conditions feeling in control of their condition - Number of emergency bed days	92924														118,619	PCIP
	VSC15	Proportion of all deaths that occur at home	19.49														20.00%	End of Life
	VSC20	Emergency bed days	92924														118,619	SACU
	VSC21	Rate of Hospital admissions for ambulatory care-sensitive conditions per 100,000 population	912														1200	SACU
	VSC26	Rate of Hospital admissions for alcohol-related harm per 100,000 population															1750	Staying Healthy
	VSC27	Patients with diabetes hba1c measured with in previous 15 months and is less than 7.5	58.54%														58.60%	PCIP
	VSC29	**Hospital admissions caused by unintentional and deliberate injuries to children**																Children & Young People
	VSC29_04	Proportion of Resident population aged under 19 admitted with an external cause of morbidity or mortality in ICD range V01-Y98 excluding X32-X39 and X52 (all admissions)	0.23														0.30%	
	VSC29_05	Proportion of Resident population aged under 19 admitted with an external cause of morbidity or mortality in ICD range V01-Y98 excluding X32-X39 and X53 (emergency admissions)	0.21														0.30%	
London Priorities	No Reference number	Percentage of newly-diagnosed HIV-infected patient with <200 cells per mm3	20%														15%	Staying Healthy
	No Reference number	Percentage of TB cases whose treatment was completed		83.80%													85%	Staying Healthy

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**23 March 2010**	**Unrestricted**		**4.5**
Presentation of: NHS Tower Hamlets **Author and Presenter:** John Wardell, Programme Director of Integrated Care,		**Title:** Overview of Integrated Care **Ward(s) affected:** All		

1. Summary

This presentation gives an overview of the plans for integrated care concentrating on the local needs and priorities for the borough.

It looks at the following issues:

- Polyclinic/polysystem plans
- Enabling changes in acute care
- Admission prevention
- Discharge support
- Children's services and
- Local engagement

NHS Tower Hamlets supports a large integrated care agenda including the integration of adult social care provision and commissioning with the local authority and CHS to improve the health and wellbeing of all our residents.

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the proposals set out in the presentation.

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Overview of Integrated Care Agenda Tower Hamlets

John Wardell
Programme Director of Integrated Care

Overview and Scrutiny Committee

March 2010

NHS
Tower Hamlets

Overview

- Local needs and priorities for borough
- Polyclinic/polysystem plans
- Enabling changes in acute care
  - Admission prevention
  - Discharge support
  - Children's services
- Local engagement

Local Needs

By demographics …

- 4th most deprived borough in England (IMD)
- Diversity: 50% BME of which 33% is Bangladeshi
- A young borough with 35% under 25 years-old, 70% from BME communities
- Population growth +13% to 2013
- 18% of families living on less than £15,000
- High unemployment of 11%
- Highest rate of housing overcrowding in London – 14%
- Population will grown by 11% over next 6 years

And on health our JSNA tells us …

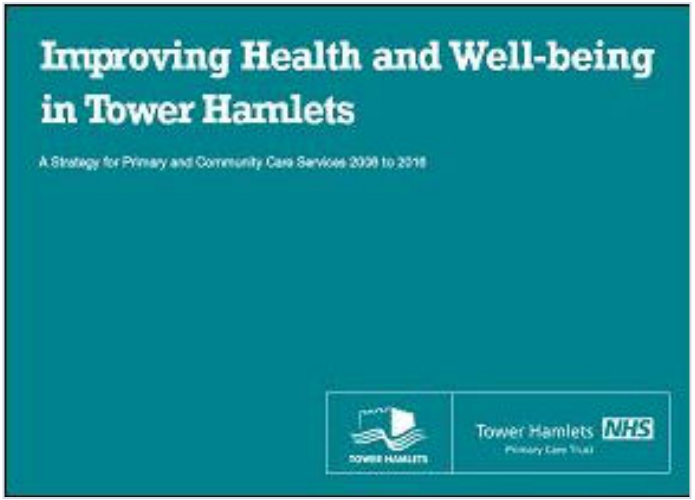
- Low life expectancy and the health inequalities gap; male life expectancy is 2.1 years lower than national average
- High mortality rates– cancer, cardiovascular disease, chronic resp disease,
- High burden of disease – diabetes, mental health, diabetes, obesity, HIV
- Significant health inequalities within the borough – 8 year male life expectancy gap
- 2nd highest standardised emergency admission rates in London in 08/09
- Mean length of stay is the 4th highest in London (07/08)

Our Vision

"is to improve the quality of life for everyone who lives and works in the borough by building One Tower Hamlets."

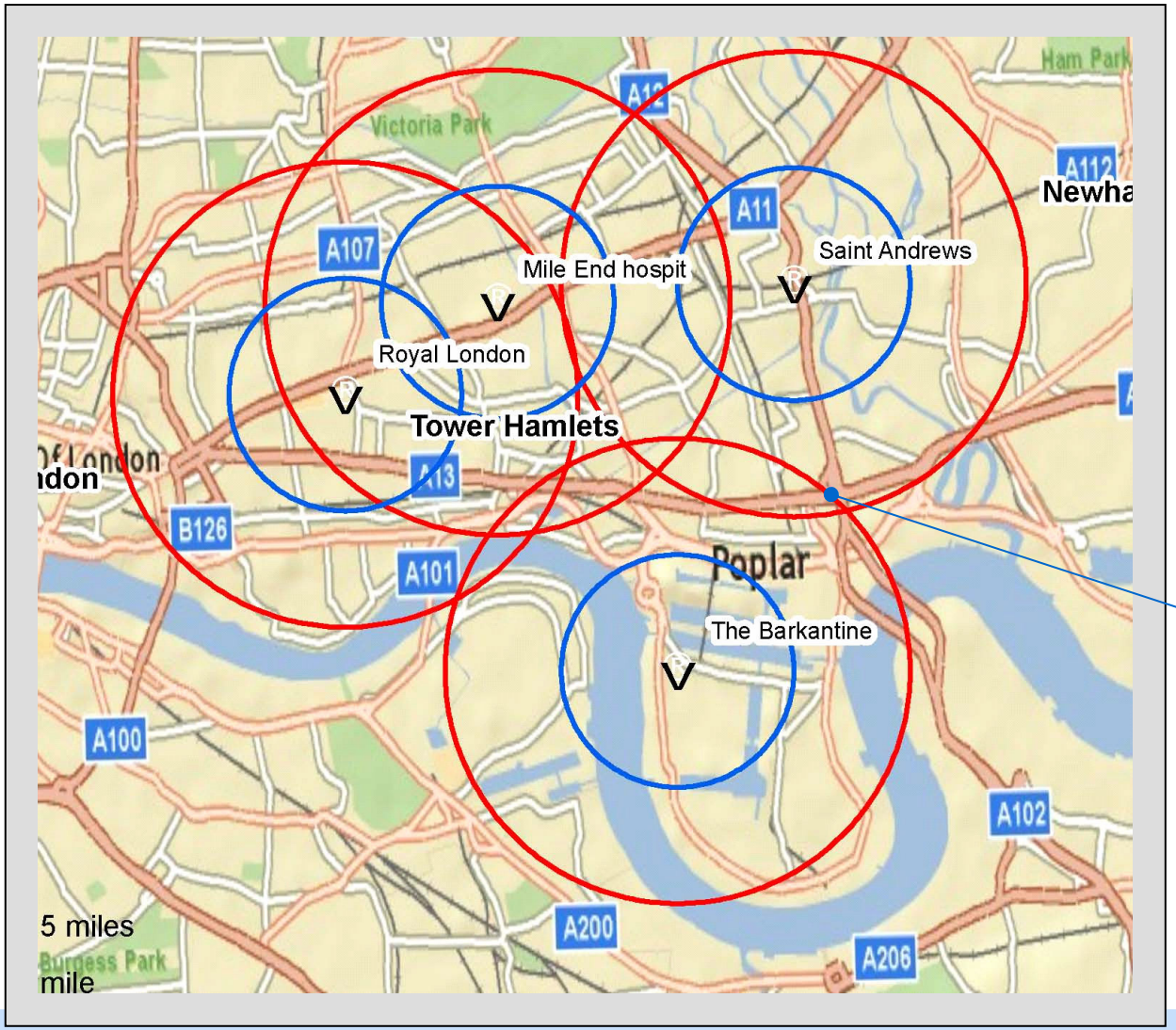
Our Strategic Aims

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



Health4NEL and our Care Closer to Home strategy are critical to delivering these aims

4 Proposed Polysystems – geographical, aligned with LAPs and networks



NHS Tower Hamlets

Our proposed Polysystem model

Polysystems will consist of *hubs* and *spokes*

- Each polysystem will consist of a ***hub*** (e.g Barkentine)
- We plan for 4, aligned with the 4 geographic localities
- Each locality is co-terminous to PBC and is composed of 2 paired network areas and 2 LAPs
- Each of the 8 networks consists of a number of GP and health centre practices, pharmacies, childrens centre etc (***spokes***)
- Will be open 8am – 8pm, 7days a week and cover a population of 60-75,000 people

  - Mile End in the NW
  - St Andrews in the NE – planned 2011
  - Royal London Hospital in the SW
  - Barkantine* in the SE - currently offers primary care and extended hours, community mental health, birth centre, dental services, diagnostics, children's centre activities, community health services, therapies, community gynaecology, voluntary sector activities, pharmacy and a cafe

- Hubs will offer a variety of services across planned care, unplanned care (urgent care centres), maternity and children and Long Term Conditions

- Networks of practices and community services have been established to drive our integrated care and long term condition strategy – bringing together health and social care services to deliver care for that population. It is also aligned to the delivery of evidence based care packages, which put the patient at the centre of their care.

Role of Polyclinic Hubs

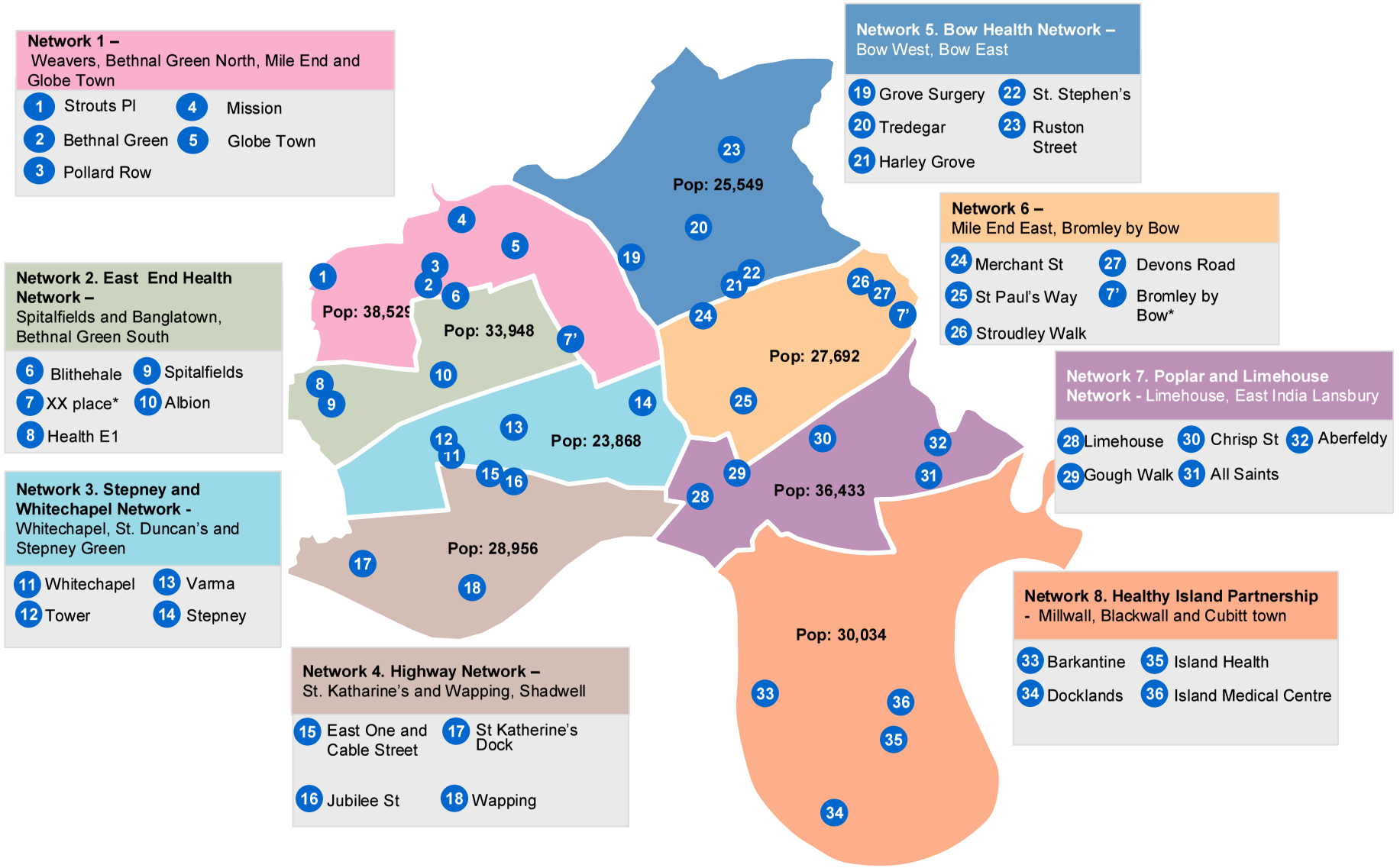
What a hub will do

- Provide an integrated non-acute setting for care delivered by specialists, GPs, and AHPs
- Serve as a base for consultants when they work in the community, and for mobile AHP/CHS providers
- Host regular contact among consultants, MDTs, CHS and GPs
- Allow local access to advanced diagnostic equipment
- Provide specialist care in a selection of clinical areas

What a hub will not do

- Function only as an outpatient specialist centre
- Displace GP practices, or 'spokes' (although some may co-locate)
- Operate in isolation from spokes
- Duplicate what is already provided in other settings (e.g. transitional community beds in Mile End)
- Provide care in all clinical areas
- Be identical to other hubs

In 2009 we established 8 networks across the borough (2 per locality)



SOURCE: Tower Hamlets PCT

NHS Tower Hamlets

Care packages, being delivered through networks of practices, have already started to reduce variability, improve and provide care in community settings

Why Care Packages?

- Access to **acute consultants through multi-disciplinary team** (MDT) meeting approach
- **Reduce variability** through the use of evidence based protocols
- Ensure the **right people to do the right tasks**
- Ensure **transparency of data** to individual patient, clinician, practice, and network level
- Ensure an **integrated** and **coherent** approach to care that harnesses the disparate work underway

Why Networks?

- Focus on **population health** across a geography
- Ensure **sufficient scale and cost efficiencies** to
  - Access rare skills and resources (e.g., equipment)
  - Ensure access
  - Allow specialisation of staff
- Build collaborative relationships with **wide range of partners** (e.g., Borough, schools, charities)
- Integrate with **estates plan**
- Serve as basis to **coordinate with NHS**
  - Acute sector (e.g., for consultants to work in community)
  - CHS services (e.g., for coordination of field deployed staff)

Details of our Polysystem plans

Care Closer to Home modelling work completed:

- Aim to shift 125,000 appointments across several specialties from acute setting by 2019
- Local clinical focus groups reviewed shifts and determined requirements for community delivery
- Re-provision costs, workforce implications and estates requirements in 2019

Currently developing plans for optimal configuration in each locality:

- Locality health needs assessments
- Detailed modelling of activity, estates and inter-dependencies
- Analysis of travel accessibility, including transport links, and cross-border flows for each locality
- Review of existing estate and finalise business plans for proposed developments
- Ongoing engagement with GP practices (completed and planned) and CHS
- Extended clinical groups for all specialties with proposed shifts

Workforce being considered to ensure appropriate development and recruitment:

- primary care in 2019*
- Skill mix required to deliver care in the community assessed at service line level**

Working closely with Local Authority and CHS on integrated care plans:

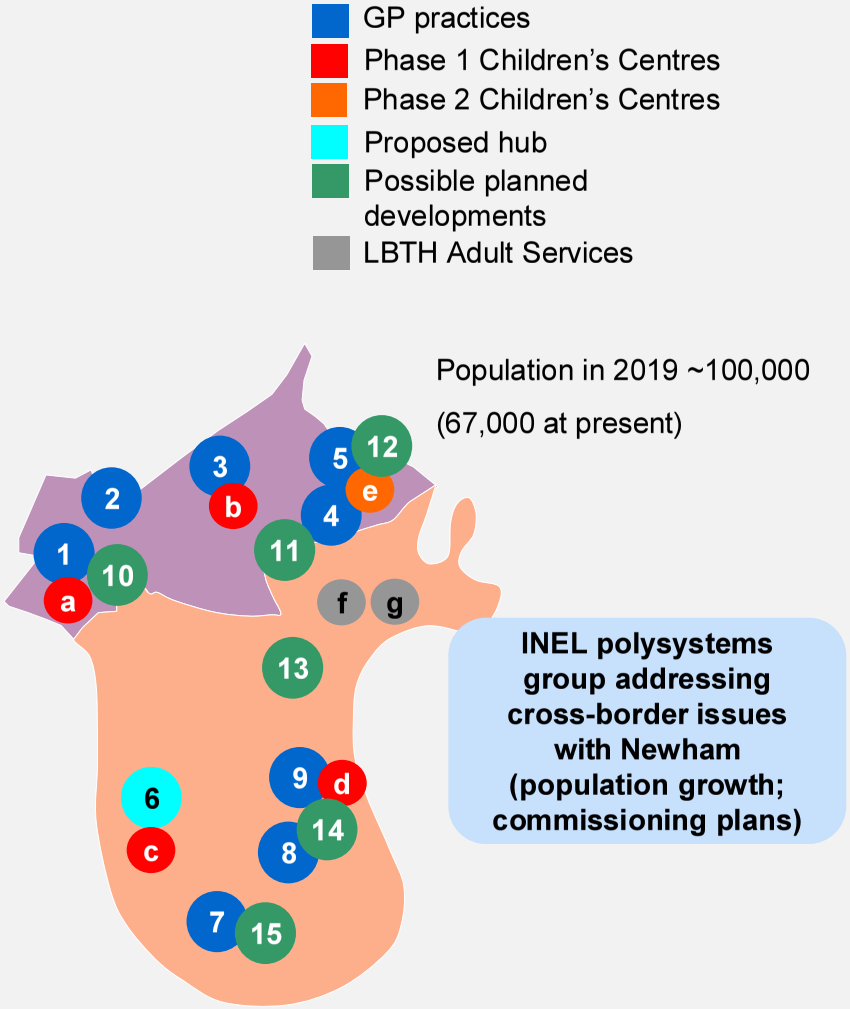
- Includes co-location of social and health teams, in hubs within each polysystem
- Analysis of available estate (all organisations) and opportunities to use this most effectively

* including CHS staff and additional staff required due to PCIP best care growth and activity shifted from acute

** Based on Health4NEL assumptions ('core' HfL assumptions)

Polysystem plans using South East locality (locality 7&8) as an example: Possible developments and planned polysystems

Geography



1 Includes clinical and non-clinical area
2 Assumes 45% clinical space
3 Data includes new space being developed

Relevant data

	Practice	Total[1] m²	Clinical[2] space m²
1	Limehouse	1,040	468
10	Gill St / Farrance St[3]	…	…
2	Selvan	150	68
3	Chrisp Street	624	281
4	All Saints	271	122
5	Aberfeldy	370	167
6	Barkantine (GP)	…	…
6	Barkantine (hub)	3,749	1,687
7	Docklands	537	242
15	Docklands Medical[3]	…	…
8	Island Health	1,465	659
9	Island Med centre	347	156
11	Newby Place	1,887	…
12	Aberfeldy	+630	…
13	Wood Wharf	+650	…
14	Asda / Island Health	+1,000	…

Children's Centres

- a Around Poplar and East India Children's Centre
- b Chrisp Street Children's Centre
- c Millwall Children's Centre
- d Blackwall Children's Centre
- e Aberfeldy Children's Centre

LBTH Adult Services

- f Mulberry Place
- g Anchorage House

SOURCE: http://www.towerhamlets.gov.uk/data/in-your-ward; Allocation practice to LAP as per Team Analysis (Aug 2008); PCT demographic data CSP; 2009 PCT self-reported estates survey; CC2H model; H4NEL

NHS Tower Hamlets

Enabling changes in acute care (1/2)

Admission prevention

- Plans to reduce admissions include:
  - Demand management schemes to reduce GP elective referrals through PBC
  - Decommissioning of low or no value acute services
  - Acute assessment unit to 'diagnose to admit' rather than 'admit to diagnose'
  - Community consultant access from care packages/MDTs and shifting acute appointments
  - Care packages focus on self-care, management and prevention as per local health need
  - Integrated care to focus on crisis prevention, early intervention and condition management

Supporting discharge

- Plans to reduce hospital length of stay include:
  - Best care packages for management of long term conditions
  - Tighter integration across primary care/acute for long term conditions and closer integration of community health services and social services
  - Targeting excess bed day numbers and reducing lengths of stay
  - Reducing the ratio of first to follow-up outpatient procedures

Enabling changes in acute care (2/2)

Children's Services

Child health services hub incorporating an ambulatory care service, urgent care services and a paediatric assessment unit

- Facilities for primary care and the care of children with complex needs/long term conditions in a community-based hub
- Multi-disciplinary teams of health professionals (including community teams) working across traditional care settings and boundaries

Urgent Care Centre

- Current initiatives include:
  - Urgent Care streaming at RLH A&E (patients streamed to community option or self-care if appropriate; service currently streams 13% of total attendances away)
  - 3 walk in centres (7 day) across Tower Hamlets (which will be decommissioned in order to fund Urgent Care Centre and Acute Assessment Unit on the BLT site)
  - GP extended hours (35 of 36 practices provided services) accounts for 50,000 appointments as an acute alternative
  - Urgent care strategy refresh with planned provision within each locality

Local engagement

Improving Health and Wellbeing

- IHWB strategy refresh
- Community Plan development and delivery

Integrated Care programme

- Large integrated care agenda including adult social care integration of provision and commissioning with the Local Authority and CHS
- Clinical leads for each network
- Primary care development programme – large stakeholder engagement
- Locality workshops for practices and service providers
- Year of Care pilot – patient engagement
- Joint Integrated Care launch event in Nov '09 was run by PCT with Local Authority representation for all internal staff and primary care networks
- Care Closer to Home programme started in 2009:
- Clinical Focus Groups (trios) across acute and community care
- Borough-wide workshop and the four locality workshops

ELCA

- Aligned work programme in polysystem development