NHS London

2010/11 OPERATING PLAN

PCT: NHS Tower Hamlets

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NHS London

Key contacts at PCT / Sector			
Name	**Title**	**Telephone**	**Email**
Executive Lead:	Andrew Ridley	**020 7092 5838**	Andrew.ridley@thpct.nhs.uk
Finance:	Stuart Saw	020 7092 5845	Stuart.saw@thpct.nhs.uk
Workforce:	Deb Clarke	0207 092 5180	Deb.clarke@thpct.nhs.uk
Performance:	Alan Steward	0207 092 5802	Alan.steward@thpct.nhs.uk
Informatics:	David Butcher	020 8223 8583	David.butcher@thpct.nhs.uk

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

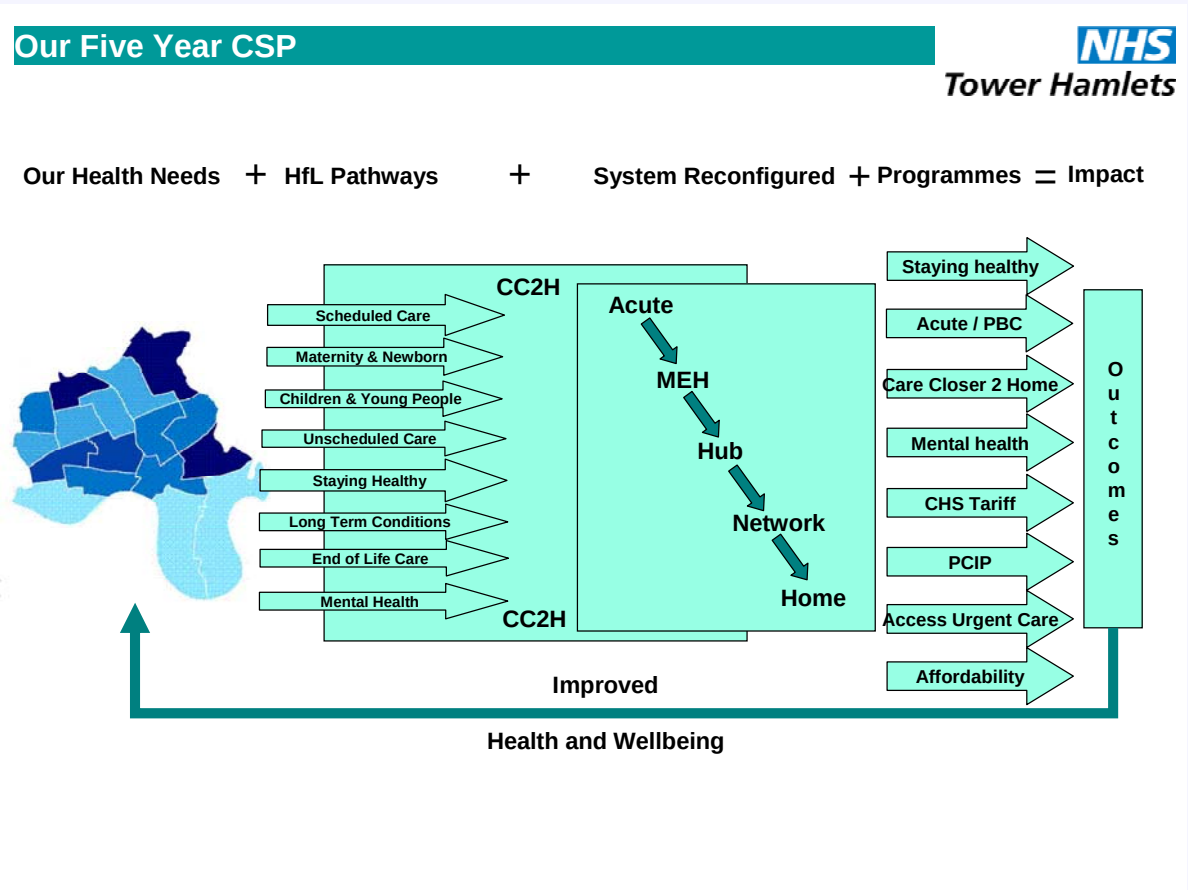
financial scenarios. These include:

- 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. 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. Clinical Engagement: Alongside work using Clinical Trios, there is ongoing dialogue with the PBC Executive, Locality Groups and with CEC. 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. Regular patient engagement about specific hub and spoke plans as they develop with Network groups and patient and public for a Travel: Linking to the Mayors Transport Strategy plan. To review plans for each Locality in terms of travel modelling. Performance Management: Develop clear performance management plans for new polysystem hubs and accountability framework	By April 2010 May 2010 January 2010 – monthly meetings with each Engagement group By April 2010 By April 2010 By July 2010 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):

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: 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.	***Linked WCC outcome(s):*** 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:

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.