Priority: Long Term Conditions and Cancer			
Outcome Objective – Reduced prevalence of the major 'killers' and increased life expectancy			
Outcome measures			
Measure[1][2]	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Rate of deaths of people under 75 from causes considered preventable	105.57	*TBC*	*TBC*
Rate of deaths of people under 75 from cardiovascular diseases (including hearth disease and stroke)	86.58	*TBC*	*TBC*
Rate of deaths of people under 75 from cancer[3]	127.09	124.8	*TBC*
Rate of deaths of people under 75 from respiratory disease	34.8	*TBC*	*TBC*
Percentage of people who have diabetes	5.85	*TBC*	*TBC*
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Develop consistent set of public health messages across the lifecourse for all staff in the Health and Social Care System to "make every contact count". Messages need to be mindful of differences in the community related to prevalence and outcomes. 3 categories of message: 1. Prevention 2. Use of services	Public Health	Draft key messages	March 2014
		Agree key messages amongst all partners	March 2014
		Disseminate key messages	March 2014
		Training programme developed	March 2014
		Training programme rolled out	March 2014

[1] All measures from the NHS Outcomes Framework and refer to under-75 mortality per 100,000 of the population. **Data received from Public Health.**
[2] Where targets have been set they have been set on the basis of having to improve on previous years but there is no Department of Health guidance on what these should be so any target setting would be arbitrary
[3] A trajectory until 2014 was set by the PCT and agreed by NHS London in 2008. It was based on the target of reducing the gap between Tower Hamlets and the national average to no more than 6% and is used in the Tower Hamlets Strategy for Reducing Cancer Mortality 2011-15, approved by the PCT and LA (has been to scrutiny committee

3. Self-care Focus on: • Improving rates for cardiac rehab and reduced emergency admissions • Earlier diagnosis of lung disease and cancer • Increasing uptake of HIV testing (with a focus on gay men (MSM) • Recognising early signs of emotional and mental ill health			
Improve cancer survival through earlier diagnosis of cancer by			March 2014
• increasing the uptake of breast, bowel and cervical screening using targeted outreach (at those who are less likely to present for screening such as Muslim women), primary care endorsement, improved practice systems	National Commissioning Board (NCB) Cancer screening lead	Plan/evaluate interventions with local screening health promotion co-ordinator	March 2014
• raising public awareness of cancer and the need to report symptoms without delay through the small c campaign	Public Health	Commission community engagement for breast, lung and bowel cancer awareness Continue pharmacy campaign Training/support for Network interventions to raise symptom awareness, improve referrals Communications campaign with WELC PH/Barts Health Support Barts Health to	July 2013

		increase reporting of cancer stage at diagnosis	
• reducing delays in referral and investigation in primary and secondary care though safety netting, risk assessment tools, direct access to investigations, audit and significant event analysis, consistent coding	Public Cancer Lead [4]	Plan cycle of cancer audit and SEA of new cancers Review practice systems to improve safety netting, symptom coding Train GPs and use risk assessment tools	March 2014
Reduce the risk of recurrence of cancer by increasing the number of people living with and beyond cancer who participate in programmes to increase their physical activity - Barts Cancer Transitions Programme and Jump Start	Public Health Barts Cancer Services	Review findings of Health Equity Audit to plan interventions which will increase uptake by residents with cancer diagnosis	March 2014
Outcome Objective – More people with long term conditions diagnosed earlier and surviving for longer			
Outcome measures			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Percentage of people who should be screened for breast, cervical or bowel cancer, who received a screening[5]	Breast 65.9% Cervical 72% Bowel 32.5%	Breast 70% Cervical 74% Bowel 39%	*Breast 70%* *Cervical 74%* *Bowel 39%*
Percentage of people who are eligible for the NHS Health Check Programme who undertake one	12%	*12%*	*12%*
Effectiveness of early diagnosis, intervention and	TBC	*TBC*	*TBC*

[4] These are the Public Health actions based on the local and national cancer strategies and discussed/agreed at the HWB workshop on 31 October 2013. Evidence from the cancer NAEDI (National Awareness and Cancer Initiative).**Data received from Public Health.**

[5] The national minimum standard for coverage is 70% for breast screening, 80% for cervical screening and 60% for bowel screening.
The ambitious 2012/13 targets have not been fully achieved

- Target 70% for breast screening (68% at Feb 2013 highest ever recorded)
- Target 74% for cervical screening (71.9% at Feb 2013)
- Target 36.5% for bowel screening (37.2% at Feb 2013)

These local targets were set by the NHS ELC Board for 2011-12 and 2012-13. No targets have been set for 2013-14 and beyond.

reablement: avoiding hospital admissions (placeholder – indicator to be confirmed)			
Percentage of people who survive one- and five-years after being diagnosed with colorectal cancer[6]	1 Year: 66.75% (2007-9) 5 Year: 57.14% (2005-9)	*TBC*	*TBC*
Percentage of people who survive one- and five-years after being diagnosed withbreast cancer	1 Year: 95.34% (2007-9) 5 Year: 75.65% (2005-9)	*TBC*	*TBC*
Percentage of people who survive one- and five-years after being diagnosed withlung cancer[7]	1 Year: 32.88% (2007-9) 5 Year: 10.50% (2005-9)	*TBC*	*TBC*
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Develop single health and social care information resource system for professionals and residents	CEX, LBTH	Agree project scope with the Health and Wellbeing Board	TBC
		Mapping of current information sources complete	TBC
		Identification of information needed complete	TBC
		System options appraisal complete (including agreement of resource for continued updating)	TBC
		Project plan developed for implementation	TBC
Embed equalities monitoring and sharing of information across the system to inform strategic and operational delivery	All organisations through the Health and Wellbeing Board	*TBC*	TBC
Outcome Objective – Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions			
Outcome measures			

[6]National Cancer Intelligence network – PH England

[7] These are NCB (therefore CCG) targets. NEL CSU benchmarking of the national CCG Outcome Indicator Set - awaiting data release April 2013 from National Cancer Intelligence Network (PHE).

Measure	Baseline 2011/12	Target 2013/14	2014/15
Improving the experience of care for people at the end of their lives (Indicator based on percentage of residents diagnosed with dementia with an 'Advanced Care Plan')[8]	TBC	*TBC*	*TBC*
Proportion of people feeling supported to manage their condition[9]	60-90% (Based on diabetes care package care planning metric)	*60-90%*	*60-90%*
Proportion of people who use services and carers who find it easy to find information about services	73	*TBC*	*TBC*
Overall satisfaction of people who use services with their care and support *(national indicator based on sample)*	65.2 (Local Account Jan 2012 page 22 User Experience Survey Feb 2011 was 87.3% satisfaction	70	75
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Lead a cultural change programme for professionals and staff about self-care	Health and Wellbeing Board	To be advised	To be advised
Develop a communications strategy to promote the 'normalisation' of death and promote equity of care during the last years of life	Health and Wellbeing Board	To be advised	To be advised
Develop an integrated community health and social care contact point (Referral hub in health and First Response)	Integrated Care Board	To be advised	To be advised
Improve coordination and consistency between re-ablement and rehabilitation.	Integrated Care Board	To be advised	To be advised

[8] **Awaiting data from CCG for end of life.Other data from LBTH.**

[9] Target based on the care planning metric in the long term conditions specifications which varies between lower threshold of 60/70 – 90% upper threshold and monitored on primary care clinical systems using identifiable read codes. The range allows performance payment to be awarded in increments with bonus awarded on level of achievement. The range has remained static to acknowledge the effort to get patients onto care planning and maintaining levels reached. Being reviewed in 13/14

Review evidence of self-care programmes	Public Health	Complete literature review of evidence of cost effective self care programmes	To be advised
		Make recommendations for the CCG Board to consider?	To be advised
Implement an integrated advanced care plan and record for patients that sit across health and social care	Integrated Care Board	Roll out of ORION pilot	September 2013
		Finalise info sharing agreements	September 2013
		Develop joint care assessment	July 2013
18 month pilot to integrate social workers in the Multi-Disciplinary team meetings for the community virtual ward and co-locate with community matrons	Integrated Care Board	Recruitment and appointment process underway	February 2013
		Co-locate social workers into the locality based clinics	July 2013
Develop and provide robust community-based Geriatric provision focus on admission avoidance, early discharge and effective community-based management of complex and/or vulnerable cases including last years of life.	Integrated Care Board	Recruitment and appointment locum cover	April 2013
		Establish working arrangement to co-locate in the locality based clinics	May 2013
Develop and provide continence service in care homes	Integrated Care Board	Provision of continence equipment	March 2014
Establish jointly chaired forum with health and social care to develop an integrated approach to commissioning the older persons pathway that takes a whole system person centred approach.	Integrated Care Board	Develop workplan for older persons pathway	September 2013
Formalise and make clearer the communication about patient prognosis to patients and between secondary and primary care.	TH CCG	OD with BH	April 2015
		Early Doctor groups	
		Shared language re: prognosis	
Engender a cultural shift that 'normalises' death in the community and supports advanced care planning	Health and Wellbeing Board	Events / road show similar to 'dying matters' (Utilise CCG network structure)	April 2014
		Use engagement to test where advance care planning could	April 2014

		be accessed e.g. when registering with GP / benefit advice etc	
Improve availability and access to information on healthy dying by embedding in single health and social care information resource system for professionals and residents	Health and Wellbeing Board	Collate directory of support available	TBC
Improve support given to those dying and their carers	TH CCG	Create a checklist of things to consider and where to get support for patients / carers.	April 2014
		Checklist triggered when GP issues DS1500 to patients	
Review current programmes that support preferred place of death and produce analysis of what works and what doesn't work	TH CCG	Commission research with public health	April 2014
Outcome Objective – More people with learning disabilities receiving high quality care and support			
Outcome measures [10]			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Overall satisfaction of people with learning disabilities who use services with their care and support *(indicator based on total number of responses and not sample)*[11]	86.3	*TBC*	*TBC*
Proportion of adults with learning disabilities in paid employment	47	50	*50*
Proportion of adults with learning disabilities who live in their own home or with their family[12]	43.0	*TBC*	*TBC*
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**

[10] **Data from LBTH**

[11] There is a national survey that looks at service user and carer satisfaction that goes out every year in January. We also run internal carers sessions where we receive qualitative feedback from carer there would be an aim for continuous improvement.

[12] These targets need to be approved at adults provider meeting and DMT as well as the LD partnership board

Implement the recommendations from the Learning Disability Self Assessment Framework	Learning Disability Partnership Board and the Clinical Commissioning Group	Oversee implementation of the aims of Valuing People Now and other local objectives to improve the lives of people with learning disabilities in Tower Hamlets, namely:	March 2014
Develop and implement plan for autism services and improvement	Autism Strategy Implementation Group	Autism plan developed and agreed	*March 2014*
		Diagnostic and Intervention Team in place	*March 2014*
Improve housing options for people with learning disabilities in Tower Hamlets	Learning Disability Partnership Board	Commissioning plan for accommodation options agreed	June 2013
		Existing learning disabilities accommodation remodelled where appropriate	April 2014
		Delivery of commissioning plan outcomes within identified timescales in the Commissioning Plan, with the exception of those that are reliant on decommissioning or procuring buildings	April 2014
		New services as identified in the plan in place	March 2016
Outcome Objective – More carers having good physical and mental health and feel fully supported			
Outcome measures [13]			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**

[13] **Data from LBTH**

Carer-reported quality of life[14]	33 % (reported feelings of stress,depression and physical strain 2010)	*TBC*	*TBC*
The proportion of carers who report that they have been included or consulted in discussions about the person they care for	25% (Carers Survey 2012	30%	40%
Health-related quality of life for carers	41%(TH Carers Survey 2010 reported their general health to be good)English Av is 49	45%	49%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Deliver the Carers Plan 2012/15through the following workstreams: Pathways to support for Carers; Information Advice and Prevention; Health support and understanding health conditions; Personalising support and personal budgets and Transforming respite Health Checks for Carers	Carers Programme Board (chair: Service Head – Adult Social Care)	Carers awareness training programme for the Out of Hours Service developed	April 2014
		Carers awareness training programme to include: • GPs • Pharmacists	November 2013

[14] Adult Social Care Outcomes Framework